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The Imperatives of Health and Weight in Primary Care Clinics: Current and Envisioned Practices

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The Imperatives of Health and Weight in Primary Care Clinics: Current and Envisioned Practices

by

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A THESIS

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Abstract

Biopower imperatives about body weight, eating, and exercise are embedded in primary care practice. The dominant discourses about body weight frame the body as notably malleable, a direct reflection of eating and exercise behaviours, to the exclusion of other influences. In this dissertation, I aim to open dialogue on the question of how to care well for patients in a time when talking about weight, eating, and exercise is both expected and potentially stigmatizing and/or contributing to health disparities. I observed primary care appointments in three Alberta clinics, and a Canadian Obesity Network *5As of Obesity Management*[™] continuing professional development workshop. I interviewed the observed primary care clinicians, and key informants in the Canadian Obesity Network. Using analytic insights from discourse analysis, actor-network theory, and visual studies, I analysed both clinical practice and the workshop through the theoretical lenses of governmentality and Mol's logics of choice and care. In the clinic, weight-related talk elicited face-saving and confessional talk from most patients (that is, across body sizes), an indication of the strength of dominant discourses that assume malleability of bodies and behaviours, interpret fatness as failure, and reinforce individual responsibility for health. Clinicians' responses to patients' face-saving talk, and the ways in which clinicians used epidemiological knowledge to guide action varied. In the continuing professional development workshop, the Network's vision moved obesity management closer to the logic of care, in part translating some obesities into a chronic disease frame through the folding in of a physiological theory to re-interpret epidemiological studies and clinical trials. This dissertation adds to conversations about anti-fat stigma and discrimination in health care, making visible some modes by which patients, clinicians, and knowledge brokers use and/or attempt to disrupt

individualistic, blame-oriented discourses about fatness. The dissertation foregrounds a range of potential mediators that may influence translation of less-stigmatizing clinical practices into primary care clinics.

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I dedicate this text to my mother, Réjane.

Her life was a testament to how attentive care changes lives.

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Chapter 1: Introduction

1.1 Fat: A series of problematisations

Fat is a problem. We hear that message through multiple channels every day. The ubiquitous rhetorical trope of the “obesity epidemic” links bodily fatness to urgency, crisis, and threat (Rich, Monaghan, & Aphramour, 2011; Saguy, 2013). The rise of corpulence is visible on individual bodies and made visible in a population via measurement and statistical manipulation. Fatness is worked up as a risk factor for chronic diseases via epidemiological studies of associations. We hear government agencies, associations, and academics declare that this rise in the mass of the masses is more than just a health problem; it is an economic threat as well, responsible for rising health care costs and losses in productivity (see for example, the Canadian Institute for Health Information & Public Health Agency of Canada, 2011 report on obesity in Canada).

Obesity – fatness shifted into a medical frame - is typically defined as a bodily characteristic that is the result of a chronic imbalance of energy. What comes into the body in the form of calories is not fully expended, and stored in the body as fat. This energy imbalance is commonly understood as a problem of eating too many calories, and not burning enough via physical activity; the storage of fat is linked in the dominant discourse to particular human behaviours (Lupton, 2013; Saguy, 2013). The need to reverse this energy imbalance has become a biopower imperative (Harwood, 2009; LeBesco, 2011), in service of reducing risk factor and chronic disease prevalence, as well as improving people’s own quality of life and health.

Many look to health care institutions as central to this work. Proponents for action argue health care in general – and primary care¹ specifically - is an important site for intervention on the risk factor/disease of obesity, and the problems of eating and activity (see, for example, two Canadian bodies: Brauer et al., 2015, on behalf of the Canadian Task Force on Preventative Health Care; Canadian Institute for Health Information & Public Health Agency of Canada, 2011). Clinicians are charged with the responsibility of working with patients to motivate them to change their behaviours, assuming that reduced weight and improved health will follow. This sets up a proposed chain of action for addressing rising bodily mass in the population after the fact: changing one individual at a time, via interaction with a clinician or team of clinicians.

1.2 The present project

Primary care is, then, a site where imperatives to contain fatness in the population are brought into contact with lives. How this is done, and the effects it generates form my core interest. With this dissertation, I aim to open dialogue on the question of how to care well for patients in a time when talking about weight, eating, and exercise is both expected and potentially stigmatising and/or contributing to health disparities.

At the same time that some argue clinicians need to talk more about weight, eating, and exercise, others name health care as a site of stigmatization of people based on their weight, which can produce less than optimal health and life outcomes for those affected (Malterud & Ulriksen, 2011; Puhl & Heuer, 2009). While obesity causation models would suggest a complex

¹ I use the term primary care rather than primary health care purposefully. Though these terms are often used interchangeably, primary health care involves consideration of what are now called determinants of health, if one follows the World Health Organization's (1978) *International Conference on Primary Health Care* declaration. Primary care is the health care specific element of primary health care, in this conception.

range of factors to tinker with to reverse the 'epidemic' (see the obesity causation models in Canadian Institute for Health Information & Public Health Agency of Canada, 2011 and Public Health England, 2015), the argument that people simply need to choose to eat less and move more is a common and dominant mantra, especially when speaking about treatment of those deemed already excessively fat (Lupton, 2013; Saguy, 2013). The ease of this connection of fatness with an individualistic blame/responsibility frame reflects the strength of the discourses of choice, self-reliance, and individual responsibility in advanced liberal democratic societies (Austin, 1999; Lupton, 1994, 1995, 2013; Saguy, 2013). Bias, stigma, and discrimination studies highlight that the 'eat less/exercise more' mantra that pervades clinical conversations about weight is not just ineffective; it has negative, unintended consequences for the individual (Puhl & Heuer, 2009).

My interest was in keeping this topic as open as possible, to find a way to explore current clinical care specific to weight, eating, and activity. I decided to start this ethnographic project in primary care practices, exploring influences on how weight, eating, and activity are approached in the clinic, and the effects of such practices. Observing talk about eating, exercise, and weight in three primary care clinics provided an opportunity to see which problematisations and solutions rub up against each other, in relation to what else is present in the room. At this point, any number of technologies and techniques are aimed at changing primary care in service of improved population health, including: performance measurement; guidelines; health care teams; pay-for-performance bonuses; quality improvement initiatives; continuing medical education courses; and more. All of this is happening concurrently, and intertwined with other shifts in medicine (such as the rise of care oriented to producing

personal optimization of health – Clarke, Shim, Mamo, Fosket, & Fishman, 2010). Clinicians are working with different and not-always-harmonious imperatives, with different visions of what ‘good care’ means.

While I was in clinics observing the care provided and mapping out influences on care, I found myself particularly interested in the work of knowledge brokers trying to change practices in primary care clinics. Knowledge brokers (Meyer, 2010) are those who de- and re-assemble knowledge for transport into new sites. Callon (1986) highlighted how trying to insert an actor in a new locale displaces some actors and attempts to re-assemble relations among others already on the scene to produce alignment and fit for that which is new. The work of knowledge brokers can be understood, then, as an attempt to introduce a new order in primary care practice.

Studying clinical care and those trying to change it specific to the topics of eating, exercise, and weight provides insight into the immediate questions of interest, but also much bigger ones facing medicine. Clinical care happens at the nexus of various change-oriented policies and techniques with the flux of other discourses, texts, material objects, and bodies in the room. It is not up to me to order or tame the mess of agencies in the consultation room; it is more valuable to consider how those in these sites do so.

1.3 Dissertation outline

In Chapter 2, the **literature review**, I outline three major fields of scholarship that influence how I approached the current project. Critical weight scholars argue that current ways weight is known and classified create a range of problems. Foucauldian scholars offer an understanding of the rationalities guiding current weight-related discourse, knowledge, and

practices in health care. Academics focused on bias, stigma, and discrimination offer a more interactional approach to the study of clinical care, and focus our attention on the effects such interactions have on lives. Each group of scholars highlights issues specific to clinical care provision, and suggest fruitful ways to focus on what happens in the clinic.

In Chapter 3, the **theoretical frame** chapter, I describe and justify the two lenses through which I explored my data. I orient to both governmentality, and Mol's (2008) logics of choice and care. Both recognise the contingency of the present, and study everyday mundane practices that reflect dominant rationalities. Recent governmentality theorists and Mol take up insights from actor-network theory, attending to a wide range of actors that compose the present. Governmentality focuses attention on the work done, the assemblages made to act on the actions of others – on clinicians, or on patients. Mol's logics frame helps explore difference in practices, and make visible different 'bads' and goods created in practice. Together, these two lenses open up complementary ways to examine the work of knowledge brokers and interactions in clinical care.

In Chapter 4, **methodology and methods**, I describe how I stepped into the messiness of clinical practice and attended to a wide range of influences on care. Studying action is the critical hinge: what 'is' only is because it is produced, crafted, enacted (Latour, 2005; Law, 2004; Mol, 2002). To study action is, then, to study many entangled agencies that make a difference to the state of affairs in a particular time and place, and create occasions for other actors to act (Latour, 2005). Studying action allows exploration of the question of what is acting when "we" act? (Latour, 2005). The goal is to learn from the actors themselves the methods they use to make things fit. To do this, I combine broadly ethnomethodological ways to approach talk

between people with an actor-network theory orientation to the material world. I then describe the specific activities I undertook in three Alberta clinics, and with knowledge brokers, in my work to explore primary care practice on the topics of weight, eating, and exercise.

The first two analytic chapters attend to existing practices observed in the clinics. In Chapter 5, I focus attention on patient action - specifically, **patient fluencies with weight-as-choice** discourse. In the dominant discursive frame, our weight reflects our values, our investment in healthy living practices, and the extent to which we are individuals who 'take responsibility' for our health. The acts of weighing and talking about weight with the physician are moments when these discourses are made salient in the clinic in notably patterned ways. I apply discourse and conversation analytic insights to argue that patients proactively work against the negative identity threat such discourses create, through confessional practices that display that they know and care about ideal norms of weight, eating, and exercise, and recognise the possibility of judgement. They work against negative judgements being made against them specifically, while leaving the norms themselves unchallenged.

In Chapter 6, **Mol's logics in the clinic**, I switch the focus of attention to clinicians' actions. I trace out differences in how clinicians fold in patient concerns, epidemiological and other scientific knowledge, measurements and classifications, and more into care. Working through four different examples, I demonstrate how technologies and epidemiological knowledge do not determine care or effects. Instead, care practices incorporating the same elements can produce different effects. I highlight how these effects can preserve the assumption that weight reflects personal choices (and thus, choices are all that can be acted

on), or how the focus can shift from weight to supporting the patient in living a better, healthier life.

In the final of my analysis chapters, Chapter 7, I describe the work of the **Canadian Obesity Network**, a knowledge broker offering workshops on an assemblage called the *5As of Obesity Management*[™]. I explore the order they try to develop for obesity management in primary care, and the techniques and paraphernalia used to reach into new sites. I explore what the Network has assembled: their understanding of the problems and solutions, and their methods to act on clinicians. I argue that the *5As of obesity management*[™] attempts to shift weight management much closer to the logic of care than what I observed in primary care practices, in part through active disruption of the ‘eat less/exercise more’ discourse that dominates at present.

In Chapter 8, I review and make connections among these three separate analyses. Building on the clinic data and the work of other scholars, I offer an informed imagining of points of friction or resistance that may affect translations that occur as the *5As of obesity management*[™] travels into clinics. I also highlight the synergies and tensions that emerge from applying governmentality and Mol’s logics in this dissertation.

1.4 What I offer

For those concerned about clinical discussions about eating, exercise, and weight, my work offers proximity to the action. Following Mol’s (2006) argument, health care practices are material, bodily, and social. We can begin to explore ‘good care’ only if we consider daily practice in its complex cluster of actors, foregrounding practices and the tensions that exist among the resulting enactments. When we have proximity, we can scrutinise the circuits by

which things are held together, enabling identification of possibilities for future interventions (Latour, 2005). By foregrounding the means by which ties are held together, we can better understand the production of what is – including the production of asymmetries (Latour, 2005).

My work helps make visible the contradictions, challenges, and proliferation of potential mediators swarming into the clinic, a flux through which clinicians must figure out how to practice. At root, the clinician has to figure out what to do, how to intervene (Mol, 2002). Uncertainty is a constant in medicine, but action is required (Bosk, 2003). I offer a close description of primary care through a particular lens, one that is open enough to offer a glimpse into the local standards and what counts as real in a particular site (Mol 2002). While medicine is not a monolith, and clinics can vary a lot, vivid description of practice offers a feel for the flow. Clinicians can explore their own practice by reflecting on such descriptions: do they fit? What feels awkward? Those trying to change care may (re)appreciate the complexity of that in which they try to intervene, and (re)evaluate their expectations for change. For those concerned about weight bias and discrimination, my tracing of these particular actor-networks may offer real-life examples of how things can be done differently, better than they are known to be done elsewhere.

I believe this study has several resonances beyond the immediate interest. At present, medicine best knows itself through statistics, specifically epidemiological ones (Mol & Law, 2004). Many quantitative studies isolate variables from each other, and as a result, cannot articulate links or tensions among the variables. The models are neat, arguments succinct, and recommendations build smooth narratives that offer coherence but may miss the point. Assumptions are often left unchallenged. The local contingencies of practice are glossed over,

and effectiveness in achieving a particular aim is emphasised over effects, considered broadly (Mol & Law, 2004). This way of knowing the profession, of knowing medical interventions, tends to focus on the effect on bodies, not on lives (Mol & Law, 2004). My work helps bring lives back into focus, seemingly paradoxically by keeping in view a range of agencies beyond human ones. My work is, then, one contribution to knowing medicine differently than how the world of statistics and epidemiology would structure it for us.

Studying family medicine practice through the lens of when, how, and why eating and physical activity come up as topics for conversation, and what happens when they are on the metaphorical table, is an entry point to some long-standing debates about medicine. How can a physician provide good care to the individual person sitting in front of them? In an era of increasing scrutiny on population statistics – those which are easy to measure – and new strategies to change the work of clinicians to better align with population imperatives, my work helps foreground some of the possibilities as well as potential harms in the work of knowledge brokers and performance accountability mechanisms. While these do not determine care outright, they can reinforce care practices that shift health care to caring well for populations while potentially reducing quality of care for individual patients.

1.5 A note on language choices

To write about body weight and composition is to write on tricky discursive terrain. The terms *fat* and *fatness* have come to have a derogatory quality. *Overweight* and *obese* are common terms, but have normative and pathologising connotations, both of which I seek to unsettle. I follow the lead of other sociologists, such as Lupton (2013) and Saguy (2013), and fat studies scholars in general who use the terms *fat*, *fatness*, *large*, *heavy*, and *corpulent* as neutral

descriptors of bigger bodies. I use the term *adiposity* as well. When I use the words *overweight* and *obese* in the text, I use them purposefully as a reflection of their use in the existing literature, and in the clinics and course I studied.

Chapter 2: Literature Review

This study is situated in a time and place characterised by a “collective negative knowingness about fatness” (Murray, 2005, p. 154). In this chapter, I dive into different sociological understandings of the existence and ramifications of this ubiquitous system of judgement that marks fat bodies as a problem. This is a notably productive field; I focus attention on approaches that address health care provision specifically or offer important background to highlight absences in health care discourse and practice. I trace three traditions:

- 1) Critical weight studies approaches to the topics of weight and lifestyle
- 2) Weight, eating, and exercise as moral imperatives, within a Foucauldian frame
- 3) Fatness interpreted through bias, stigma, and discrimination theories

While distinctly different, each tradition resonates with the other bodies of work. Each tradition helps inform this dissertation.

2.1. Critical weight studies approaches to the topic of weight and lifestyle

2.1.1 Critical realist appraisals of the biomedical science

One focus of critical scholarship mobilises scientific knowledge to challenge the dominant narrative about weight. These authors tend to uphold the notion that if science is done properly, without bias, we will be better able to trust the results (Campos, 2011; Gard, 2009; Lupton, 2013). They highlight problematic assumptions in research and policy, measurement difficulties, scientific errors, and/or limited applications of the foundational knowledge of ‘obesity’. They argue that the assertion that fatness is always unhealthy is a misrepresentation of the best available evidence.

Epidemiology is a scientific discipline that dominates how we think about weight and health. Most epidemiological knowledge about weight builds upon the notion that there is a 'normal' weight in relation to height that is universally healthy (Campos, 2004). One particular calculation that links weight to height – the body mass index (BMI) – has become the central way through which obesity is known. Much has been written of the limitations of the BMI as a measure. The BMI measures mass, not adiposity, eating behaviours, or physical activity levels, though some epidemiological studies imply or directly assert the latter (Campos, 2004).

How BMI has been interpreted raises additional problems. The BMI is a continuous measure, but is applied through a classification model of 'underweight', 'normal', 'overweight', and 'obese'. From a purely statistical perspective, this exaggerates differences across categories and minimises variation within a category (Nicholls, 2013). Furthermore, the appropriateness of the cut-off points for each category has been questioned for decades (Campos, 2011; Lupton, 2013) due to what critical weight scholars deem to be inaccurate interpretations of epidemiological results. For example, the influential, large-scale, longitudinal epidemiological Nurses Health Study divided the population into non-equivalent 'exposure categories' and used linear tests for what look like non-linear data (Austin, 1999). Austin flags this as introducing distortion. Of note, in the Nurses Health Study results, statistically significant risk for cardiovascular disease and cancer first appears in the group weighing 120-129% of 'ideal', yet the authors argue there is a "direct association between BMI and mortality", implying that the lower our weight, the better (Austin, 1999). The better survival rates of those who are heavier in general or those who gain weight as they age but are not at the extreme of weight has been called the "obesity paradox" (Myers et al., 2011). The word paradox marks the survival of

people deemed overweight as counter-intuitive, when decades of epidemiological studies have found the same (Campos, 2004). This parallels numerous epidemiological studies and World Health Organization reports flagging that what is designated as ‘normal’² weight was not the range with the lowest mortality (Austin, 1999; Campos, 2011; Myers et al., 2011). The lowest mortality rates are in those designated overweight, and relationships between weight and risk are weak except at the extreme ends (Campos, 2011, reviewing multiple epidemiological analyses). Attempts to redefine what is designated as ‘normal’ – that is, healthy - have been marginalised (Campos, 2004) and met with entrenchment (Austin, 1999). For this reason, some argue the existing classification methods for BMI and interpretation of epidemiological studies are influenced by anti-fat weight bias³ (e.g. Austin, 1999; Campos, 2004).

Others focus on the lack of scientific evidence for current interventions that promote weight loss. Campos (2011) flags the studies that show the detrimental effects of weight cycling (i.e. cycles of weight loss and gain) compared to weight stability. Weight cycling can be exacerbated by both community-based and medical weight loss programs. Aphramour and Gingras (2011) argue that dieticians who promote weight loss violate multiple ethical principles, including nonmaleficence (in that promoting weight loss that results in weight cycling does harm to a person’s body) and lack of veracity in the failure to inform patients of the risks of weight loss attempts and the existence or benefits of other treatment options. Buetow and Docherty (2005) flag that many generic anti-obesity health promotion interventions are of unknown effectiveness - that is, are not evidence-based. The possibility exists, they note, for

² Here used in the ideal sense of the word (see Canguilhem, 1989).

³ Which links to the work I review in the third section of this chapter.

health promotion experiments to produce small negative effects on the health of the population as a whole as a result of “unsafe health promotion” (p. 400). They add that any implementation is then experimental, in need of ethical scrutiny and evaluation. Germov and Williams (1996) go further, arguing that negative effects of anti-obesity health promotion exist but are unrecognised, a function of the co-existing pro-thinness aesthetic that dominates wealthy, Western countries. On this basis, Germov and Williams (1996) call for a moratorium on health promotion specific to weight until the effects are better understood. The absence of evidence, or evidence of harms from current practices, is the core issue here.

Clinical interventions based on the BMI and population studies have also been flagged as problematic. The BMI lacks sensitivity and specificity when applied to individuals (Nicholls, 2013). Both false positives and false negatives are possible in the application of probabilistic based knowledge (Rose, 2001). Specific to weight, this manifests in healthy, heavy people being labeled overweight or obese based purely on BMI, and subjected to behavioural interventions to promote weight loss even if they are metabolically healthy⁴ (see Jutel, 2005, 2009 for more on this phenomenon).

Even if this categorization blind spot could be overcome, there is a core tension in application of epidemiological knowledge to the care of individuals. An action may confer large benefits to a population, but give little benefit to or even harm specific individuals (Buetow & Docherty, 2005; Nicholls, 2013). Complex personal needs of the patient and their family may

⁴ Of note, the recently released Canadian guidelines continue this trend. Canadian primary care practitioners are to calculate BMI routinely, and follow clinical pathways based on the result (most recently reinforced in the Canadian Task Force on Preventative Health Care “Obesity in Adults” guideline (Brauer et al., 2015)).

not align well with interventions most oriented to changing population health (Buetow & Docherty, 2005). Allowing population health informed imperatives to determine care may reduce access to the care that is most helpful to a specific individual, including for those who are thin (Aphramour & Gingras, 2011).

Critical realist critiques are based in statistical theory and standards of scientific objectivity. They highlight potential negative effects on lives lived, and utilise common discourses such as 'evidence-based medicine' to bolster their argument. Yet the BMI remains the dominant standardised measure in use in population studies and health care, a function of its easy application (Nicholls, 2013; Saguy, 2013). This ease of use has led to its embedding in knowledge infrastructure for clinical care – guidelines, systematic reviews, intervention studies, and risk profile calculations, for example. A looping effect results: it is hard to get rid of the BMI despite known limitations because it is the measure used in the scientific literature that forms the core of scientific evidence (a limitation recognised explicitly in the current Canadian guideline, written by the Brauer et al. [2015]).

2.1.2 Invisibilities made in epidemiological models

The critical realists help us understand some of the problems with common ways of objectifying body weight, problems that have direct consequences for clinical care. Selection of variables and assumptions of theoretical models create visibilities and invisibilities that are consequential. Other scholars critique our current models of weight and health on different grounds: the erasure of relational influences on health in epidemiological models; closure in how we think of influences on weight; and/or mobilising notions of racial or class-based

superiority. Here, critical weight scholars flag that the consequences of the limited ways epidemiology knows and interprets weight may be contributing to health disparities.

Most epidemiological studies produce accounts of the statistical relationship between a particular bodily characteristic or health condition and multiple variables (Mol & Law, 2004; Rich et al., 2011). Variables include biomedical measures and demographic factors such as sex/gender, race/ethnicity, geographic region, and socioeconomic markers. These variables are conceptualised as attributes of a person or a group, rather than relational or influences on routines that develop within a geographic and social field (Aphramour & Gingras, 2011; Broom, 2008; Larsen, 2011; Mol & Law, 2004; Shim, 2010). Rendering relations invisible via epidemiological models allows lifestyle to come to be interpreted as ‘individual risk factors’ which are treated as readily modifiable (Rich et al., 2011), as are the bodies marked as problematic. When determinants of weight or health are identified beyond the individual – such as income, education, or the food environment – the typical response is to label those as unmodifiable (Broom, 2008; Shim, 2010). Shim (2010) argues that while epidemiology may include racial and socioeconomic differences, the models often exclude consideration of structural forces that produce that difference. Epidemiological ways of knowing skew our understanding of the relationships between social factors, personal behaviours, and outcomes (Rich et al., 2011).

The insistence on focusing on individuals is consequential: it does nothing to alleviate differential risk (e.g. from living in under-resourced communities), and may entrench existing stratifications and popular logics about disease causes and solutions that have racialised or class-based undercurrents (Broom, 2008; Shim, 2010). This can be observed in frames that label

certain groups as cultural problems that are in need of amelioration (Shim, 2010). Broom (2008), Larsen (2011), and Saguy (2013) all take note of the intersection of class ideologies with how lifestyle and fatness are portrayed. Saguy (2013) offers an evocative example: poor food choices are described as fast food rather than high calorie premium ice cream or brie. Racial superiority ideologies are embedded in obesity causation talk that marks minority group practices and values as pathological, such as labeling preferences for bigger bodied women in certain racialised groups as a problem (Saguy, 2013). Similar undercurrents can also be found in homogenization of racialised groups of people, who are then portrayed en masse as less physically active, for example (Lupton, 2013). While theories are emerging that begin to shift attention away from individuals, the most well-known theory does not ameliorate these types of problems.

An alternative model to obesity causation locates the problem in the 'obesogenic environment', which is considered modifiable. Obesogenic environment theories, with roots in geography, emphasise environmental features that influence eating or physical activity (Guthman, 2011). Such a problematisation invites solutions that involve a spatial dimension, demarcating spaces as obesogenic or leptogenic⁵ (Guthman, 2011). Guthman (2011; 2012) agrees that some good comes out of this emphasis. Food industries and regional planning are flagged as influences on body weight, which diminishes the over-emphasis on personal responsibility. However, the obesogenic environment model continues to rely on a linear and simplistic calories in/calories out 'energy balance' model for obesity and perpetuates the notion

⁵ The opposite of obesogenic; a physical environment associated with or productive of thin bodies.

of bodily malleability (Guthman, 2011). Reinforcing the energy balance model of obesity causation black-boxes⁶ the body, making it more difficult to recognise emerging physiological theories of weight and metabolism, such as those that consider the effects of high cortisol (a stress hormone) or exposure to endocrine-disrupting chemicals on weight (Guthman, 2011; 2012). Furthermore, the obesogenic environment model neglects or downplays the salience of race and class in explaining spatial patterning of obesity (Guthman, 2011). Is it clearly the physical environment, or race/class clustering effects that better explain the spatial patterning? Guthman (2011) notes it is possible that replicating leptogenic environments for all could make all thinner, but that outcome is not a given. The association of weight with particular types of environments does not mean that the environments alone determine weight; neighborhoods altered to make them more leptogenic tend to gentrify, and clustering may continue (Guthman, 2011).

Guthman (2011), Lupton (2013), and Rich and colleagues (2011) draw attention to neoliberal economic policy and capitalism as part of the environment in which all this concern about obesity arises. Lupton (2013) flags the co-existence of and tension between the imperatives of disciplining consumption to ensure a healthy body, and constant incitement to consume. Disciplining bodies and consumption are both growth industries, echoes Guthman (2011): “In the interest of economic growth, contemporary U.S. capitalism has helped create obesity as a material phenomenon and then made it a moral problem that must be resolved in a

⁶ A term with roots in technical fields, referring to devices or systems where the inputs and outputs are visible, but the inner workings are unknown, unscrutinised, naturalized, and/or invisible to most. Latour and Woolgar’s (1986) study of scientific laboratory work highlighted the work involved in stabilizing an object to the point at which it is black-boxed. Once a device has been black-boxed, its representations are no longer considered contestable. In the present case, the BMI calculation and its interpretation have been black-boxed.

way that is equally kind to capitalism” (p. 163). She traces how numerous policies have contributed to the rise of obesity, from the loss of the social safety net and reductions of wages that have made cheap food a necessity, to policies that allow exposure to chemicals and processed foodstuffs that affect metabolism through physiological pathways (such as endocrine disruption, and more recently talked about, the microbiome). These practices and policies promoting consumption and overlooking toxic exposures are ones that care little about worsening health inequalities, Guthman (2011) argues.

The arguments reviewed above do not speak directly to clinical care. However, these arguments provide a helpful backdrop when considering clinical practices rooted in epidemiological knowledge. As background, these critiques help us understand what ideas have not yet traveled into attempts to address patients’ body weight and behaviours, and part of why that might be the case.

2.2 Weight, eating, and exercise within a Foucauldian frame

A second genre of sociological scholarship applies Foucault’s insights to explore the ‘obesity epidemic’, and the associated public health and medical attempts to address it. These scholars build on Foucault’s concepts of biopower, governmentality, and advanced liberalism - rationalities that dominate in wealthy democratic countries at present. They explore the rise of techniques and technologies meant to act on populations and individuals: their bodies, behaviours, and subjectivities. I first introduce key concepts from Foucault, before reviewing several applications of Foucault’s ideas to weight and lifestyle behaviours in health care and policy.

2.2.1 Biopower

By the late 1970s and early 1980s, Foucault argued that we are living in an era where the dominant rationality understands life as a political object in the form of the aggregate 'population' (Foucault, 2004/2007b). Population, a novel idea in the mid-18th century, assumes that humans form a collectivity that has its own characteristics, characteristics which are not the same as but influenced by the wills of individuals (Rose, O'Malley & Valverde, 2006). Phenomena of life, such as mortality, morbidity and fertility, became constituted as objects, which were known through statistical techniques and believed to be modifiable and optimizable via political strategies (Foucault, 1976/1990). This way of structuring a problem and its solution fits squarely within a rationality Foucault (1976/1990) called 'biopower'.

Expressions of biopower operate based on new, historically contingent modes of knowledge production that make problems and differences observable. The rise of statistics, and the notion of 'norm' are especially critical to biopower (Foucault, 1976/1990; Nealon, 2008). The norm is in part a statistical concept used to analyse the status of the population. However, the resulting distribution is insufficient to mark or decide what is desirable (Canguilhem, 1989). What is average in a statistical distribution may or may not be desired. A constant state of good physical health, for example, is abnormal but valued. Canguilhem argues that normativity intervenes; that is, a norm comes to have an effect when established as preferable.⁷ Foucault builds upon Canguilhem to argue that the biopower impetus for

⁷ Porter (1995) argues that quantification is a technology of distance, one that erases concerns about judgement and the struggle against subjectivity – an impersonality that has long been taken as a hallmark of science. Quantification allows for standardisation of methods of measurement and statistical analyses, which in turn create a common language to exist across boundaries (Porter, 1995). While Porter does not orient to Foucault, his work offers a helpful complement on the effects of quantification for the current discussion.

optimisation operates as a norm; what is deemed normal is not necessarily average, but a prescriptive, desired result (Foucault, 2004/2007a).

Problems defined can then be acted upon by a range of techniques of power (Foucault, 1976/1990). Objects marked as abnormal become targets of action, of intervention, in service of providing security to said population. Biopower *includes* the abnormal (Foucault, 1999/2004). The basic process: assess against recognised risk factors, then act to bring the unfavorable in line with the favorable (Foucault, 2004/2007a).

Biopower is a bipolar assemblage, comprised of the disciplinary and the regulatory/biopolitical (Foucault, 1997/2003; Rabinow & Rose, 2006).⁸ Disciplinary technologies, sometimes referred to as anatomo-politics of the body, involve breaking down individuals, time, actions, movements, etc. into components that can be seen, measured, and evaluated. Once the minutiae are understood, they can be transformed to align with the desired objectives (Foucault, 2004/2007a). Disciplinary technologies mobilise focused, individualised surveillance and training of the body (Foucault, 1976/1990). In contrast, regulatory technologies (also known as biopolitics) focus on man-as-species, orienting to knowing and optimising characteristics of an aggregate population (Foucault, 1976/1990, 1997/2003). Examples of regulatory technologies include statistical assessments, predictions and forecasts, and interventions aimed at the whole or a delineated part of the social body (Foucault, 1976/1990). Within a regime of biopower, the disciplinary and the regulatory coexist and articulate with

⁸ Larsen (2011) notes the inconsistency in the usage of biopower and biopolitics. Like Larsen, my project is not to answer this debate. For clarity, I choose to use biopower as the inclusive term for the bipolar assemblage described in Foucault (1997/2003) and as argued for by Rabinow and Rose (2006). I reserve the term 'biopolitics' for the population-focused technologies that come to articulate with individual people's lives through an intermediary cluster of relational techniques, technologies and strategies (Foucault, 1976/1990).

each other in the pursuit of the same outcome, attending to different objects (Foucault, 1997/2003). Both individuals and their material worlds are acted upon in the name of establishing security. Disciplinary and regulatory knowledges and techniques arise from *and* generate new experts.

The two poles of biopower are enacted in medicine, among other institutions.

“Medicine is a power-knowledge that can be applied to both the body and the population, both the organism and biological processes, and it will therefore have both disciplinary effects and regulatory effects” (Foucault, 1997/2003, p. 252). Epidemiological studies are the statistical form used to define population norms and threats, and identify opportunities for intervention. Epidemiological studies describe existing disease or ‘risk factor’ distributions, which are conceptualised as current or potential future threats to the population, and help define the norm sought. Variables included in epidemiological studies range from bodily measures (such as body mass index or blood sugar levels) to income levels, gender, age, and environmental conditions. A variety of public health and health promotion strategies follow, aiming to act on populations (LeBesco, 2011; Lupton, 2013).

A new method to test medical interventions has come to the fore in the last half of a century: randomised controlled trials. Randomised controlled trials are the ‘gold standard’ method through which to evaluate intervention effects on pre-selected outcomes (Timmermans & Berg, 2003). These experiments involve two or more matched study groups exposed to one different condition; the effects of that exposure are evaluated using statistical methods to detect differences in outcomes between the two groups. Randomised controlled trials may include ‘structural variables’ such as income or education, which are relegated to the

background as control variables (Shim, 2010) by which the two groups are matched. Of note, this method for testing intervention effects can only be used for certain types of interventions. For example, it is not possible to randomise participants into an intervention of university education; it is unethical to prevent those in the control group from securing a degree. In this sense, the 'gold standard' for intervention research aligns well with health care practice where specific, singular changes are possible, such as a prescription or a referral.

Foucault considers sexuality as a privileged intersection for the expression of biopower. Procreation affects individuals and populations, and thus benefits from being both disciplined and regularised. However, sexuality is only one of many intersections of individuals and populations. Lifestyle behaviours (Larsen, 2011), chronic diseases (Galvin, 2002), food consumption practices (Finn, 2009), and obesity (Harwood, 2009) have all been situated in biopower frames. Assumptions of malleability underpin the attempts to act on body adiposity.

Population studies of health and weight – using the BMI - are central to the problematisation of obesity. As highlighted in the former section of this chapter, the measurement and classification norms in use are contested but remain entrenched. Those people labeled excessively fat are not quarantined or otherwise excluded from the populace, but acted upon to bring their body weight down to the ideal. Attempts to reduce weight include both individualised assessment and intervention, and population-oriented approaches such as health promotion campaigns and changes to physical environments to promote healthier forms of food consumption and increase physical activity.

2.2.2 Governmentality and Advanced Liberalism

The political dream of optimising characteristics in the population may not be realised, but remains consequential in that knowledge, techniques, experts, and technologies develop to attain it (Foucault, 1999/2004; Rose, 1999b). Over his career, Foucault traced several assemblages that formed to act upon the action of individuals labeled deviant or abnormal. Foucault named the study of such a project 'governmentality', and opened up a line of study into the small, mundane techniques described in minor texts which when taken together, reflect identifiable rationalities (Foucault, 1994a, 2004/2007a). Governmentality focuses our attention on the means thought best for governing subjects at particular times and places (Larsen, 2011).

Much work of Foucault's later period and the work of subsequent scholars explores governmental rationality as it developed within liberal and advanced liberal democracies. Liberalism starts from a concern that the state governs too much, a skepticism that is applied in particular to state governance of the economy and individuals (Cruikshank, 1999; Foucault, 2004/2007b). Liberal forms of governmentality require freedom, which Foucault (1994b) defines as "a field of possibilities in which several kinds of conduct, several ways of reacting and modes of behaviour are available" (p. 342). Freedom is understood as delicate. Governing individuals too much will suppress freedom and instead generate passivity and dependency (Cruikshank, 1999; Foucault, 2004/2007b). Dominating is clearly governing too much in a liberal society, in that dominating crushes freedom. Liberal forms of governmentality, which have been developing and evolving for over a century, seek to align the capacities and activities of 'free' individuals with broader political goals (Dean, 2010). Cruikshank (1999) succinctly describes the liberal orientation to governmentality as "...forms of action and relations of power that aim to

guide and shape (rather than force, control or dominate) the actions of others” (p. 4). Relations of governmentality in liberal societies recognise capacity for action, and seek to act upon it (Rose, 1999b).

Subjectivity is a central concept for those engaging in governmentality studies. Starting from the assumption that individuals may think or act otherwise (Dean, 2010), liberal enactments of governmentality rely on securing *voluntary participation* in techniques that produce results hoped for at the level of the population (Cruikshank, 1999; Foucault, 2004/2007a; Rose, 1993). Rose (1999a) argues that combinations of historical events, cognitive shifts, and technical innovations make up our current ways of understanding and relating to ourselves as human beings with a certain subjectivity. “Our repertoires of subjectivity – feelings, intentions, motivations and the like” (Rose, 1999a, p. xviii) appear natural within our community, but are historically contingent and intelligible only within the particular field.

Advanced liberal forms of subjectivity fabricate new subjects capable of bearing the burdens of liberty (Rose, 1999a). Being active, rather than docile, is the preferred subjectivity. Governmental tactics promote active subjects; subjectivity is both the object and outcome of governmental tactics (Cruikshank, 1999). This active subjectivity cannot be forced because the results would only last as long as force continued to be applied (Cruikshank, 1999). Central to advanced liberal forms of subjectivity is that individuals understand everyday behaviours as rendering lives meaningful (Rabinow and Rose, 2006; Rose, 1999a). Each individual can be hampered by learned behaviours; to express our full potential, we benefit from constant self-inspection and scrutiny, calculated acts, and targeted investments in our capabilities (Rose, 1999b). Behavioural techniques such as tracking behaviours lose association with repression;

instead, they become emancipatory methods through which to (re-)establish self-control (Rose, 1999b). Within advanced liberal forms of governmentality, what begins as a norm (whether average or ideal) is to end as personal desire (Rose, 1999b). Freedom is conceptualized as being the result of slow, painstaking and detailed work on ourselves with the support of experts, that results in certain choices being made more frequently (Rose, 1993, 1999a). The knowledge, authorities, and technologies that have developed to achieve this political vision link freedom with changing ourselves and our actions (Rose, 1999b). Enticements to change are made, in part, through aligning hoped for changes for the population with this active, entrepreneurial subjectivity.

Appeals made that orient to the currently idealised subjectivity form part of how it is we become caught up in changing our lives to align with goals delineated by biopower. Such appeals rely on our recognition and desire to be a certain type of person, in part through normative judgement of who we are in relation to who we could become. We are enticed to pursue paths that bring us closer to the norm; the norm makes intelligible who we are and could become (Dean, 2010). In advanced liberal societies, choice comes to mark our identities, to define our subjectivity. We cannot opt to not choose; we are obliged to express our freedom if we are to retain the identity of 'full citizen' (Rose, 1999a).

Larsen's (2011) exploration of health policy conceptualizations of 'lifestyle' offers an instructive example and starting point. Applying Foucault's arguments about biopolitics and governmentality, Larsen studied shifts in how the idea of 'lifestyle' was conceptualised across three phases of health policy-making in the USA and Denmark, from the 1970s to the near present. Lifestyle was initially a sociological concept, one understood as developing in relation

to the collectives in our respective lives. As lifestyle became an object of health policy, it was translated into a more individualistic notion of 'choices'. Choices came to be interpreted through an epidemiological lens as 'individual risk factors', such as smoking, alcohol intake, eating, and physical activity. A sense of modifiability came to be attached to the concept of lifestyle in this translation, and with it, a characterization of irresponsible for those people who fail to make 'good choices' in the name of health. Over the decades of policy documents Larsen studied, what started out as simple rules for living developed into a more involved subjectivity. The policy documents called for people to reflect more on their daily practices, and retain sovereignty over the self no matter their surroundings.

Larsen's work exemplifies how governing does not involve acting on a pre-existing world with natural divisions. Governing involves structuring a possible field of action of others, deciding what is to be governed and acting upon it (Foucault, 1994b; Rose, 1999b). In Larsen's example, the sociological concept of lifestyle becomes known as 'risk factors', which are to be acted upon for the sake of the nation state. Such a governmental rationality prioritises acting on individuals and their choices more than interventions that act on the social and physical environments in which we live, though there are some signs of change in that regard.⁹

Through such a governmental rationality, health has become a matter of ongoing moral work (Clarke, Shim, Mamo, Fosket, & Fishman, 2003). We are to act in the present to influence our future (Rose, 2007 in Clarke et al., 2010). Good health at present is not enough; we are to pursue activities that reduce our susceptibilities to future illness (Rose, 2007 in Clarke et al.,

⁹ In the most recent Danish health policy documents Larsen (2011) examined, there were beginnings of a new object of governmental action: settings, which involves changing the physical environment to 'make the healthy choice the easier one'.

2010). Underpinning this is a shift toward valuing enhancement and optimization (Clarke et al., 2010).

For the autonomous individual to strive for self-realization, the knowledge of how to do so must travel. Capillary networks develop to reach and act upon individuals (Foucault, 1999/2004; Nealon, 2008; Rose, 1999b). Experts are critical to this process. Experts define and spread knowledge of risks, and direct individuals to what are considered productive paths. The ‘psy’ experts – psychiatry, psychology – have had special prominence in recent decades (Rose, 1999a; Cruikshank, 1999). Psy-based concepts have informed work done in multiple sectors, including health care, prisons, workplaces, and families, some of which Rose (1999a) traces.

2.2.3 Weight, eating, and exercise through a Foucauldian lens

When biopower is the dominant rationality, as Foucault and successors (e.g. Cruikshank, 1999; Rabinow & Rose, 2006) argue is presently the case, both its poles orient to the goal of eliminating threats to a population (Foucault, 1997/2003). We now live in a time where the intensity of focus on weight in the public health and medical fields has led to an abundance of initiatives to change people’s bodies and behaviours, some oriented to preventing weight gain, and others at producing weight reductions. Here, I review some of those authors who situate corpulent bodies and lifestyle behaviours into Foucauldian frames.

It is not inevitable that any particular bodily characteristic or behaviour will come to be seen as abnormal and in need of remediation. Such an attribution happens over time, through social processes. The norm – the ideal – of thin bodies has a historical trajectory that paved the way for the medical frame of obesity. A moral, religious privileging of thinness preceded and informed the current medical frame of obesity (Boero, 2010; Jutel, 2005; Jutel, 2009). The

notion that fatness reflects an inability to tame one's appetites has roots in religious beliefs (Lupton, 2013). Finn (2009) notes a proliferation of discourses in the 18th and 19th centuries specific to eating practices tied together medicine, psychiatry, and social reform: "The growing associations between moderation in the use of food and drink, social reform, religious salvation, and self-betterment" (p. 357) were part of both fringe and mainstream health crusades. Epidemiological constructions of risk factors have cast these concerns about fatness, appetite, and bodily movement into a scientific discourse.

The rise of 'evidence-based medicine' further privileged and entrenched quantitative measurement and probability-based knowledge in clinical decision-making (Jutel, 2009; Timmermans & Almeling, 2009; Timmermans & Berg, 2003). Evidence-based medicine requires variability to be defined, populations discerned, results compared and similarities to the patient to be established. Probabilistic studies of risk now organise how the normal and pathological are delineated (Rose, 2001), and how treatment is organised – at least on paper.

How to bring people in line with the norm? Non-individualised actions taken include:

- health promotion message campaigns to improve eating and exercise habits (Germov & Williams, 1996; Austin, 1999)
- mass surveillance or educational programs (e.g. in schools, see Coveney, 2008; Evans & Coll, 2009; LeBesco, 2011)
- urban planning design attentive to food and activity infrastructure (Guthman, 2011)
- reality TV shows including *The Biggest Loser* (Finn, 2009) and celebrity chef Jamie Oliver's *The Ministry of Food* (Warin, 2011)
- commercial weight loss programs such as Weight Watchers (Heyes, 2006).

Each attempts to fold disciplinary practices into lives in ways that produce new skills and capacities, including new forms of attentiveness to the self. The regulatory and disciplinary touches our lives in a myriad of ways.

Most, though not all, of the population-oriented initiatives locate the problem of obesity in individuals. This is embedded in both intervention design, and statistical evaluation methods. First, most health promotion and public health practices tend to orient toward practices of the self, encouraging self-surveillance and policing (Austin, 1999; Lupton, 1995). That is, they orient to the liberal form of subjectivity, trying to incite desire to change our bodies and our behaviours. They rely on notions of malleability of body, and are often linked to notions of individual responsibility (Lupton, 2013; Puhl, Peterson, & Luedicke, 2013; Saguy, 2013). Second, when prevention and health promotion initiatives are evaluated, measures used focus on individuals (Austin, 2000). In spite of recognition that environmental and social contexts influence behaviours, prevention research tends to evaluate the responses of individuals to stressful environments rather than attempting to alter the environments (Austin, 2000).¹⁰ There are more tools available to measure (in positivistic terms) individual change than that of settings (Austin, 2000) or relations (Epstein, 2009; Mol & Law, 2004; Shim, 2010). As long as the individual remains the unit of analysis, ecological or relational influences on outcomes will likely remain unevaluated and un- or underappreciated (Catalano & Dooley, 1980, cited in Austin, 2000; Epstein, 2009; Mol & Law, 2004; Shim, 2010). For these reason, most non-individualised

¹⁰ Of note, there are signs that settings are becoming an object to be governed to improve lifestyles (Larsen, 2011) and prevent/address obesity (Guthman, 2011; Lupton, 2013).

public health and health promotion practices can be interpreted as contributing to the moralistic understanding of fat and health (Austin, 1999; LeBesco, 2011; Lupton, 1995).

The working up of fatness as a public health threat justifies application of disciplinary actions to attempt to contain and correct it (Austin, 1999). The human sciences – including medical care – are prime sites of disciplinary actions (Foucault, 1976/1990, 1999/2004). The combination of examination and confession together brings norms and normalising judgements into the lives of individuals, and facilitates individuals pronouncing a truth of their own transgressions. The examination is a ritualised process through which persons are made into objects that can be described, analysed, differentiated, and judged (Foucault, 1975/1995). Confession involves avowals and pronouncements of our own truths, a process of individualization through which we are ‘free’, according to Foucault (Foucault, 1976/1990, 2014). In institutions, confessions occur within a relationship with an authority. The authority figure has the capacity to use the speech to judge, console, and reconcile (Foucault, 1976/1990). He argues that the ritual expression of confession changes the person who articulates it – in addition to any other external consequences. Confession is a ritual of exoneration, redemption, and liberation (Foucault, 1976/1990).

Few have directly applied Foucault’s insights to empirical studies of clinical care. Instead, those working with Foucault’s ideas tend to focus on generalities. Jutel (2005; 2009) makes visible the history that makes weight-as-norm possible in the clinic, including the development of ideal height/weight charts, and the introduction of scales into clinics. Halse (2009) argues that the discourses about weight are virtue discourses, defined as: “sets of values, beliefs, practices and behaviours that establish regimes of truth and shape subjects and subjectivities

by articulating and constructing particular behaviours and qualities as worthy, desirable and necessary virtues” (p. 47). Virtue discourses strive for excellence, which can only be achieved by constant activity (Halse, 2009). Murray (2009) comes closer to interactions with patients, mobilising Foucault and Grosz to talk about confessional practices in clinical care. Living in a fat body is to be marked as a problem. The fat body is always seen, and thus confesses a pathology. This pathology is not just of the body; one’s subjectivity is caught up, interpreted as reflecting an unwillingness to recognise one’s own disease, a lack of moral investment in one’s own health and normality. This reasoning relies on an assumption of malleability of bodies (Murray, 2009).

The confession of flawed subjectivity sought is not a revelation for the one who hears it; the fat body is interpreted as already confessing. Rather, the verbal confession is structured as a moment of confirmation of what is already known. Committing one’s self to this confession means measuring one’s self against a norm:

The equalising function of a number, or a ‘virtuous mean’ as Burry (1999) describes it, to which we should all subscribe, is a powerful means of control that taps into a fundamental desire to achieve normative status, and to understand oneself as occupying the privileged position of ‘health’ in the health/pathology binary equation (Murray, 2009, p. 82).

The confession is a moment that involves owning our bodily transgressions. Citing Diprose, Murray (2009) notes this confession remakes the confessor as a subject of the pathology, taking on the cultural meaning of this pathology in a vulnerable, clinical space.

Murray imagines clinical practices in a theoretically informed way, but with minimal empirical support for her arguments. Much of the empirical research on anti-obesity bias, stigma, and discrimination in health care – detailed next - aligns well with Murray’s clinically-based arguments.

2.3 Fatness interpreted through bias, stigma, and discrimination theories

Studies tracing the legacy of socioeconomic inequalities, psychosocial stress, and discrimination help us comprehend that physical bodies are also social bodies, accumulating advantages and disadvantages over a lifetime (Monaghan, 2005). Those who study bias, stigma, and discrimination help quantify and otherwise make observable the dominance, varying enactments, and impacts of anti-obesity discourse and practices. Key to this field: negative biases against fat are so normalised as to discredit those living in fat bodies. This discrediting involves a certain moral heft because fatness is perceived as self-inflicted (Warin & Gunson, 2013). Being stigmatised, and experiencing discrimination, has impacts on people's lives and health (Earnshaw & Quinn, 2012; Malterud & Ulriksen, 2011; Puhl & Heuer, 2009).

Goffman (1963) is a central figure in understanding stigma through a sociological lens. Stigma is a relational concept; in interaction, one person is reduced from the status of an unstigmatised person to a discredited one on the basis of possessing a certain attribute or history. Attributes are not discreditable in and of themselves; it is only through contact among persons that stigma can be enacted. It is through language, interactions, cautionary tales, and the like that people come to associate an attribute with a negative judgement. We each learn who we are via how we are treated. Those discredited, or discreditable (with attributes that are not immediately observable), tend to believe themselves as deserving a fair chance but perceive the lack of acceptance of others and become versed in the standards against which they are judged. These standards extend beyond the specific attribute; we tend to ascribe a wide range of imperfections based on the original one. There is no opting out. Goffman describes patterned

ways in which these relations play out, and methods that discredited and discreditable persons take up to manage the way they are received.

The psychological literature about bias helps demonstrate the strength and breadth of negative assumptions made about people living in corpulent bodies. Bias research orients to cognition, and explicit or implicit beliefs in stereotypes. Anti-obesity bias, also referred to as fat phobia or weight bias, has been quantified and found to be high in the general public as well as health care professionals – regardless of their own personal weight (Puhl & Heuer, 2009; Puhl, Gold, Luedicke, & DePierre, 2013). Clinicians from various professions and countries perpetuate negative stereotypes about overweight and obese people, asserting or assuming they are lazy, unmotivated, lacking in self-discipline, less competent, non-compliant, and sloppy (Ferrante, Piasecki, Ohman-Strickland & Crabtree, 2009; Puhl & Heuer, 2009). This is not a new trend: Austin (1999) describes DeJong & Kleck's (1986) review of studies that found signs of anti-fat bias among physicians and other health care professionals.

The psychological conception and cognitive focus of bias research has been received as helpful for sociological studies of stigma. Link and Phelan (2001), in their attempt to 're-sociologise' the concept of stigma, note that social psychological studies matter because they help us understand mechanisms that lead to stigmatising relations and discrimination. In contrast to psychological studies about bias, sociological studies of stigma and discrimination focus attention on relations among people. Stigmatising and discriminatory relations have been documented in health care, education, employment, and interpersonal relationships (see Puhl & Heuer, 2009 for a comprehensive review).

Lewis and colleagues (2011) explore various actions that indicate fat people are discredited. Without any direct solicitation on this topic, they found weight-based stigma to be a consistent experience in the lives of 142 adults with obesity they interviewed. Their participants spoke of people making judgemental comments around, but not to them; offering unsolicited diet and weight loss tips; telling them that their weight compromised their job performance (including in sedentary jobs); staring at them when they ate; and examining the contents of their grocery carts. They heard friends mock other fat people. They noted the media lacked positive images of fat persons, and was often dismissive or negative. The material environment – sizes of seats, clothing, exercise equipment – could exclude them. On the whole, these individuals thought anti-fat rhetoric was everywhere and unavoidable.

These experiences had a wide variety of (mainly negative) impacts on their lives (Lewis et al., 2011). They were fearful of being laughed at when at gyms or pools, and often felt shame that was difficult to shake off. This constancy of being on display and judged strained their emotional health and sense of well-being, especially sense of self-worth. They had internalised the negative messages, and believed themselves deserving of the criticism. These emotive experiences are what Scrambler (2009) calls 'felt stigma', and what Earnshaw and Quinn (2012) call 'internalised stigma'. The participants in Lewis and colleagues' study (2011) felt socially disconnected and excluded. They described negative impacts on their sense of identity, because others so often ascribed negative qualities to them. Stigma shaped how they lived and experienced their lives.

Other studies confirm and extend Lewis and colleagues' (2011) findings. Seacat and colleagues' (2014) study involved fifty overweight and obese women tracking stigmatising

events on a daily basis using a standardised checklist. Of the 298 useable days of data, the participants reported over 1000 weight-stigmatising events. The most common were physical barriers (84%) and receiving nasty comments from others (74%). Sixteen per cent experienced judgemental comments from doctors, a finding of note for the present dissertation given that participants would not have seen a physician on each day of tracking. BMI was the strongest predictor of stigmatising experiences, which echoes Jackson, Beeken, & Wardle's (2014) recall-based study.

Earnshaw and Quinn's (2012) statistical modelling found that both enacted stigma and the internalised effects have health impacts. One pathway is prospective: both enacted and internalised stigma lead people to anticipate stigma, which impacts their quality of life and makes them less likely to seek out care (Earnshaw & Quinn, 2012). A second pathway is specific to stigma enacted in care by clinicians. Malterud and Ulriksen's (2011) meta-ethnography found the following examples of stigmatising actions in clinical care, with references indicating others with the same finding:

- providing overly simplistic, unhelpful advice before checking with patients to find out what they have tried, and why those strategies did not work (Thille, 2005);
- equating lack of goal achievement with lack of motivation or knowledge; relatedly, underestimating history of past efforts of patients;
- attributing obesity to a lack of sense of responsibility or investment in change, when there is an extensive body of research demonstrating that patients feel a keen sense of responsibility, agree with the attribution that weight is their own fault (see Kirk et al.,

2014), and over half have tried to reduce their weight in the previous twelve months (Kirk, Tytus, Tsuyuki & Sharma, 2012);

- pointing out weight is a problem without offering practical advice and support (see Scott et al., 2004 for an example of an article that promotes this);
- over-attributing signs or symptoms to fatness without assessment (see Thompson & Thomas, 2000 in Puhl & Hueur, 2009);
- perceiving clinicians were negative, disdainful, or uncomfortable when talking about managing obesity.

Absent from Malterud and Ulriksen (2011) was the experience of having the BMI usurp the patient's report or understanding of their problem - that is, the BMI as being received as telling a truth against which patients must account (Thille, 2005; Throsby, 2007). Large people avoid care for several reasons, including avoidance of stigmatization.

Kirk and colleagues' (2014) Canadian study makes articulations among the perspectives of three groups interviewed: twenty-four persons living with obesity, sixteen clinicians, and four health policy makers. Individuals with obesity blamed themselves for their weight, and had tried multiple methods to lose weight in the past, with limited or no success. They knew what to do, but had not succeeded in making the dramatic changes in a sustained way for a range of reasons. They felt they needed support, but met a health care system unprepared to support them. Clinicians named environmental and social factors that influence body weight, but emphasised, in frustration, what they viewed the primary problem: unwillingness of individuals to commit to lifestyle changes. For example:

People...want the quick fix. They want the Atkins, they want the Weight Loss, they want the South Beach Diet, whatever they want. They don't want to come and hear it's all

about them, it's all their fault. They want someone to fix it. Well, nobody can fix it but you (p. 794).

This strong personal responsibility/blame frame has been found in numerous other studies of clinicians, including those reviewed by Malterud and Ulriksen (2011). Being fat often means being read by clinicians as lacking willpower or commitment to one's health.

That fatness is a spoiled identity is further demonstrated in Boero's (2010) and Throsby's (2012) studies of care in bariatric surgery clinics. Boero (2010) explores the articulation of biomedical failures and moral discourses of health and illness, using failed weight loss surgery as her ethnographic case. Surgeons and pro-surgery advocates cite discrimination as a compelling reason to have surgery, and use promotional materials that note post-surgical patients no longer face the stigma associated with obesity. They emphasise that people are not fat because they are lazy, undisciplined, or eat too much. They highlight that traditional diets do not work, and mobilise genetics language to talk about causation. Patients receive health professionals' acknowledgement of blaming, stigma, and discrimination in a particularly potent way; such a frame stands in stark contrast to previous negative interactions with other health care professionals. This pre-surgical support takes the form of challenging dominant discourses about weight, marking the problem as outside of individual control.

The anti-blame frame offered by surgeons in Boero's (2010) study is contingent on post-surgical weight loss. Surgical success or failure is a bit grey; while the surgery is often rationalised as necessary to prevent or alleviate other medical conditions, both patients and surgeons fixate on weight loss itself as the outcome that matters. In the absence of clear surgical failure, Boero found that surgeons explain less-than-hoped-for weight loss results as a function of patient non-compliance. Of note, patients must follow rules of eating post-

operatively that are restrictive, including a) no more than one bite of food every ten minutes and b) no liquids immediately before, during, or after a meal. Those patients who say they are following these rules but whose weight is not decreasing are described by surgeons as being less than honest with themselves or their clinicians. Post-operatively, the numbers tell the truth, not the patient.

Throsby's (2012) and Webb's (2009) studies of bariatric surgery clinics further highlight how people with obesity are worked up as failures in clinical interaction. In both studies, patients' responses varied to open-ended questions that start consultations in post-operative follow-up appointments, with the amount of weight loss affecting the responses. Both Throsby and Webb found that people who had continued to lose weight answered confidently and affirmatively, while those who had regained or plateaued in their weight loss confessed to some sort of transgression, demonstrated awareness of the post-surgery rules, and displayed a commitment to improving.

Throsby (2012) describes responses to 'failure' as highlighting the moral associations with body size management that become part of all weight management appointments. Surgery itself comes to bear moral weight, in that fat people are consuming public resources. In this sense, surgery can intensify rather than reduce patients' senses of moral responsibility and failure (Throsby, 2012). And for those with loose, excess skin after weight loss, the skin could be experienced as more problematic than the original fatness. Excess skin was treated as a cosmetic issue by clinicians: "fat can kill you; no-one dies from loose skin" said a surgeon (p. 11). But loose skin is experienced as marking former fatness, continuing to link a body to excess

weight and the negative moral associations usually implied. In this sense, even medical ‘success’ could still expose people to negative assumptions about their investment in being healthy.

Narrative studies also help explicate the impact of living in a discredited fat body, and when set against clinician biases, can help us understand why people who are deemed excessively fat run into interactional difficulties in clinical care. As Goffman (1963) highlighted, the expectation of biographical coherence and singularity presents unique challenges to the stigmatised. People with fat bodies have to find a way to address biased and stigmatising discourses that dominate current interpretations of adiposity when crafting a coherent biography.

Throsby (2007) explores the narrative resources used by fat people to make sense of their weight and weight loss attempts. She interviewed 35 weight loss surgery patients (pre or post-surgery), mostly women. Participants sought to tell a coherent story, and worked against being discredited because they live in fat bodies. Many evoked a sense that their weight was ‘not me’, distancing themselves from the negative stereotypes associated with fat bodies. In addition, they tended to use any or all of following three narrative themes to work against being blamed:

- 1) Having a fat prone body, whether due to genetics or metabolism. With this, they translated the general notion that fat people overeat to one where they overeat ‘for my body’. They pathologised the fat body, and displayed the sense that they are determined to do something; the failure to not ‘do something’ becomes the focus of moral disapproval.

- 2) Speaking about childhood, and the nature of eating in their home (e.g. being rewarded with food; being coerced into eating more as a sign of love). This narrative thread draws on circulating convictions that overweight children are destined to become overweight adults, a repertoire that justifies a great deal of obesity prevention public policy on childhood at present, but which also blames parents – mothers, in particular - for obesity.
- 3) Life gets in the way: Injuries, disruptions, work demands, emotional eating (women), or ‘boys will be boys’ indulgences (men) all impede the demanding, preoccupying, and often “soul-destroying” activities of weight management.

Throsby (2007) argues it is important not to frame such narratives as excuses, something she points out that others with similar findings have done – and which I would mark as a sign of weight bias in research. Throsby implores readers to consider the lack of culturally intelligible and socially available narrative resources available to people who are trying to make sense of their weight histories.

Sarlio-Lähteenkorva’s (1998; 2000; 2001) interviews with ‘once-obese’¹¹ and ‘relapsed-obese’ persons make vivid the narrative and identity challenges involved in weight loss activities and maintenance. Both groups noted that while in the process of changing their behaviours or losing weight, they found themselves in situations where they had to account for the changes occurring. Positive reactions about behaviour changes or weight loss during initial changes generated a sense that the prior self was not fully accepted (Sarlio-Lähteenkorva, 2001). These changes in how they lived could stress interpersonal relationships (Sarlio-Lähteenkorva, 2001),

¹¹ who had sustained weight loss of 10 kgs or more over 7+ years.

and the sustainability of these dramatic behaviour changes could be undermined by other events in one's life (Sarlio-Lähteenkorva, 1998; 2001). Those who sustained the changes found they were unable to identify with the 'never-obese', or with those currently-obese who seemed content (Sarlio-Lähteenkorva, 2000). Those who maintained weight loss found it was difficult to build a coherent narrative that could embrace both past and present without marking the past self as a failure.

As noted earlier, narratives that locate weight causation outside of willpower and behaviours are often met with disbelief and rejected by clinicians. This is the case despite systematic reviews of quantitative studies evaluating weight loss interventions showing minimal short-term weight loss that attenuates over time (Wadden, Butryn, Hong & Tsai, 2014), clinicians' own sense of futility (Kirk et al., 2014), and qualitative studies of the rare people who sustain weight reductions that make visible how substantial the changes are that need to be sustained (Sarlio-Lähteenkorva, 2000; 2001). These latter studies help us understand that current expectations about weight reduction are unrealistic.

Anti-obesity biases influence care practices in ways that influence outcomes. Quantitative studies have found physicians made fewer emotional rapport remarks to persons classified as obese - that is, fewer empathetic, legitimising, reassuring statements (Gudzune, Beach, Roter, & Cooper, 2013). Bertakis and Azari (2005) analysed videorecordings of more than 500 first-visit appointments with primary care resident physicians. After controlling for patient health status and sociodemographic variables, they found that care delivered varied by BMI. Resident physicians spent less time educating patients about health as their weight increased, and more time on technical tasks. Hebl and Xu (2001) compared physicians' evaluations of a

hypothetical medical chart of a patient attending for a migraine (which varied by gender, and weight categorization). They found that physicians estimated they would spend less time overall with the larger patient, and spend more time doing weight-related tests. This means that heavier patients with the same presenting condition – migraine – would have less time spent on their presenting concern than a ‘normal’ weight person who is otherwise matched. Patients come to regard health care as unhelpful on the topic of weight (Kirk et al., 2014). Trust in clinicians is damaged, and they delay or avoid care (Malterud & Ulriksen, 2011; Earnshaw & Quinn, 2012). This contributes to health inequities due to delayed diagnosis of serious disease. While some of these studies are dated, there may be pockets of different styles of practice, and changes may have occurred, the work done in this field points to people living in more corpulent bodies receiving care of lower quality. Or said more directly, that people deemed excessively fat may be neglected in current care.

2.3.1 The impetus to address anti-obesity stigma

An underlying theme of most (but not all) of the critical weight studies and bias/stigma/discrimination studies described above is a hope to change the status quo. The argument may be made in variety of rhetorical registers: biomedical language such as that employed by the critical realists; ethical terms; and/or through appeals to goals of improving health of the population. My work reflects my understanding that the effects of current practices are troublesome, that they produce health disparities, and that there is much to gain from undermining the stereotypes and practices that mark people as failures for living in fat bodies.

Goffman (1963) argued that the perceived undesirability of any particular attribute has a history, and can be changed with purposeful action. Cook and colleagues (2014), Earnshaw and Quinn (2012), Heijnders and van der Meij (2006), Kirk et al. (2014), Link and Phelan (2001), Puhl & Heuer (2009), and Throsby (2007) are but some of the scholars who argue that reducing stigma requires multi-faceted and multi-level approaches. Much of the work in bias and stigma intervention research focuses on changing beliefs and behaviours of the lay public, those living in fat bodies, or clinicians. Rebecca Puhl's work is exemplary, as one of the leaders working to disrupt anti-obesity bias and stigma in health care and health policy. She and her collaborators have demonstrated that anti-fat bias is malleable via educational intervention that exposes pre-licensure health professions students to obesity causation models that emphasised genetic and socio-environmental determinants of weight (O'Brien, Puhl, Latner, Mir, & Hunter, 2010). How long this effect held, and how it impacted clinical practice, are relevant questions. In another study, Puhl, Peterson, and Luedicke (2013) explore the impact on self-reported compliance of health promotion campaign messages that implied personal blame for excess weight or appealed to personal responsibility language. People ranked messages that implied blame as the ones they would be least likely to be follow. I suggest that while such work is useful, it is limited by its foregrounding of human belief and intention.

2.3.2 My project

Foucauldian, critical weight scholars, and bias/stigma/discrimination studies of weight resonate with one another, while bringing our attention to different objects and phenomena. My own work builds on insights from each. Each approach gives a sense of what to examine,

what actions to look for, and what to consider in terms of influences on and effects of talking about eating, exercise, and weight in primary care clinics.

Critical scholars flag problems with the visibilities and invisibilities made via epidemiology and the use of the BMI categorization. The Foucaudian scholarship highlights the clinical tasks of making the body into an object, and describes the rationalities influencing the rise of measurement and categorization that the critical realists judge. Foucault's work highlights the historically contingent knowledge and material tools involved in the work of medical institutions, and invites us to explore how those deemed in need of remediation are enrolled into change. A more Foucaudian perspective helps us consider how the biopower-inspired dream of optimization specific to weight has been folded into health care - and lives. An entire sector/industry has come into existence to promote the uptake of evidence-based medicine into clinical care (Meyer, 2010), and a vast, complex knowledge and technological infrastructure is in play. Clinician and patient 'decision aids' (including guidelines, systematic reviews based on available scientific literature), BMI classification tables and risk profile calculations, clinical communication models, continuing education courses, training in quality improvement, and performance incentives are but some of the ways anti-obesity bias may be translated and made relevant for the primary care clinic. Foucaudian work brings our attention to the range of influences on care. Extending this insight, those advocates aiming to change the fat-stigmatising status quo could consider far more than each individual's beliefs and communicative behaviours, an insight that becomes relevant when looking at the work of the Canadian Obesity Network later in this text. The bias and stigma work draws my attention to

specific actions both clinicians and patients may take in care, and offers a sense of the function and effects of such actions.

The extent to which any of the insights from different fields of scholarship hold in practice is an empirical question. In the theory chapter that follows, I link insights from these bodies of work to my particular interest and the framework through which I approach this research.

Chapter 3: Theoretical Frame

The biopower objects of weight, eating, and exercise are marked as in need of improvement. In the clinic, much of the work focuses on changing people's bodies and behaviours. In parallel is a proliferation of knowledge brokers (Meyer, 2010) who aim to improve health outcomes by changing how clinicians practice. The project I will present in the chapters to follow explores current primary care in three clinics, as well as the vision and work of a knowledge brokerage that seeks to change how clinicians practice specific to weight, exercise, and diet.

With this dissertation, I aim to open dialogue on the question of how to care well for patients in a time when talking about weight, eating, and exercise is expected, is potentially stigmatising and/or is contributing to health disparities. The publications I reviewed in the previous chapter help situate the work done in clinics - current measurement and classification practices; biopower and governmental rationalities shaping care; the prevalence and impact of anti-fat bias and stigmatization, including the possibility for clinical neglect. In the current chapter, I describe the theoretical frame for my own work.

I found two theoretical lenses to be especially productive to explore the work done to push and pull lives, to change patients and clinicians: 1) governmentality, as developed by Foucault and subsequent scholars, described in the previous chapter, and 2) Mol's (2008) logics of choice and care, which I supplement with Timmermans and colleagues discussions of standards and objectification (Timmermans and Berg, 2003; Timmermans & Almeling, 2009; Timmermans & Epstein, 2010). Both lenses share a concern with rationalities and how they inform practices. Medical practice, in all its variability, involves the fleshy bodies of patients and

clinicians, measurement and treatment devices, procedures, computers, calculations, conversations, classification schemas, and more. Both have capacity to include the mishmash integral to producing the medical (and in this case, sociological) topic of interest. They also share a common vocabulary, with contemporary governmentality scholars (e.g. Rose, Dean) mobilising insights from actor-network theory, a theory-methodology in which Mol's work is influential.

A governmentality lens helps locate the practices I study within the current, dominant rationality that shapes what are considered acceptable and effective ways to govern others. The logics of choice and care, and Timmermans and colleagues' discussions of standards and objectification, help explore the ends to which all this change orients, and ask questions about what goods and 'bads' result. They create different, and complementary, visibilities through which to explore weight, eating, and exercise in primary care. I apply both to clinical practices and attempts to change clinicians' work practices. In this chapter, I outline Mol's ontological politics and health care logics she has attempted to make more visible. I develop a theoretical frame for my study of knowledge brokers. I then describe articulations with governmentality, and application of these ideas to my project.

3.1 Ontological politics

The concept of 'ontological politics' is one that infuses Annemarie Mol's work. Her composite term brings together that which belongs to the real – ontology – with politics, where reality is an outcome of practices (Mol, 1999). Ontological politics draws attention to the active process of shaping reality. Mol (2002) suggests that the key contribution of her book *The Body Multiple* is theorising medicine's ontological politics: "a politics that has to do with the way in

which problems are framed, bodies are shaped, and lives are pushed and pulled into one shape or another” (p. viii).

Part of how Mol has sought to make ontological politics observable is by attending to different realities enacted by different sets of practices. Attending to practice is key; when we stay close to practice, we no longer have grounds to treat medicine as a monolithic whole or a totalising force (Mol & Berg 1998; Mol 2002). There is, then, no reason to criticise or defend it as a whole – a common tendency of many scholars exploring the management of weight, eating, and exercise in health care. Mol (2002; 2008) uses ethnographic work to highlight patterns of practice, opening up dialogue about whether these are ‘good’ enactments. She notes that ‘good’ is a concept to be developed in situ through consideration of effects, rather than assumed a priori.

The concept of **multiplicity** is one of Mol’s lasting contributions made through her exploration of practices in health care. “Attending to enactment rather than knowledge has an important effect: what we think of as a single object may appear to be more than one” (Mol, 2002, p. vii). A multiplicity is that which is more than one, but not two - different, and yet coordinated in a way that these differences hang together under one name (Mol, 2002). Her book *The body multiple* (2002) illuminates this phenomenon. Mol uses the example of atherosclerosis, demonstrating that what atherosclerosis is varies depending on where one is in the hospital. Two of her examples: atherosclerosis is pain with walking and diminished pulses when in the examining room, and a thickening of an arterial intima in the pathology lab. These different atheroscleroses co-exist, and often without friction. Throsby (2012) has used the concept of multiplicity to make visible different obesities enacted in bariatric surgery clinics,

highlighting which obesities are prioritised by clinicians and patients. Multiplicity opens up not different perspectives on the same realities, but different realities. Conceptually, multiplicity allows for exploration of how these different realities relate to one another and consideration of how choices are made among the different realities in the particular locales (Law, 2004).

In the example of different atheroscleroses, Mol makes visible different processes of objectification. Timmermans and Almeling's (2009) arguments about how to approach objectification theoretically offer a useful supplement to Mol. Objectification processes involve purposeful and consequential abstractions. Objectification of human bodies and lives is core to health care examinations. Critical scholars (including many taking up Foucault) write of the dehumanization involved in these processes, and argue alienation results. Timmermans and Almeling (2009) counter the critical scholars, arguing that the effects of any process of objectification are not known in advance. Using examples from health care, they highlight how patients actively participate in their own objectification to achieve goals, and that their evaluations of the experience of such objectification shifts (e.g. based on outcomes; see Cussins, 1998 for an oft-used example). Objectifying the self and the body may be part of the process that restores health and/or improves a person's life in any number of ways.

Timmermans and Almeling argue we must look at what objectification does, in particular.

Attending to practice closely creates an intellectual opportunity for something previously unimagined to emerge (Mol, 2002, 2008; Walkerdine, 2009). By describing the practices used to enact particular realities, we can wonder when and where we might do better. We can make it easier to see that things might be done differently here, because they are already are in other places (Mol 2002). In a world where nothing is fixed but instead a

movement in need of continuation, foregrounding the practicalities and materialities involved in the crafting of action can help open up a dialogue about which realities might be best to bring forth (Law, 2004; Mol, 2002). The concept of ontological politics helps us ask ‘what effects do we seek’ and ‘in what reality should we live?’ (Mol, 2002). As we answer those questions, we can develop and mobilise information, material tools, research methodologies, and more to help us achieve the desired goods or ends (Mol, 1999). Ontological politics makes space to consider reasons to prefer to enact particular realities (Law, 2004). Approaching research this way is not consistent with critical approaches, but it is not neutral (Mol, 2002).

3.2 The logics of choice and care

In *The logic of care*, Mol (2008) uses ‘logics’ as way of making sense of practices: practices that have affinities, commonalities, and coherence within specific cultural and historical settings. Logics are patterns that may or may not hold across locales. She chose the term logics over discourses or modes of ordering to focus attention on the rationality of the patterns. She aims to show how logics envision “a specific mode of organising action and interaction; of understanding bodies, people and daily lives; of dealing with knowledge and technologies; of distinguishing between good and bad; and so on” (Mol, 2008, p. 7). Studying patterns increases our awareness and our capacity to ask questions about current practices.

It is the logics of ‘the West’ that Mol aims to unpack. Choice is a celebrated ideal, a cliché of the West, a logic that embraces post-Enlightenment fantasies of individualism and autonomy. This imagined autonomy is consequential, but not the only ideal in circulation. Care, solidarity, justice and others co-exist in the West. Care, she notes, lacks language in part because it has not needed to be defended until recently, now that other logics have made their

way into health care services (Mol, 2008; Mol, Moser, & Pols, 2010b). Choice-logic is a prominent example of a logic that started outside of health care and has been shepherded in during recent years.

Mol (2008) develops both choice-logic and care-logic, before offering a comparison in health care. Choice, if compared to force, is usually considered a good. Choice acts as a contrast to paternalism: will you deny this person their choice? Choice, as a logic, prizes autonomy above all else, and positions patient decision-making as the key outcome of care. In this sense, choice logic resonates with the advanced liberal governmental rationality. In contrast, care is neither choice nor force. Care prioritises 'doing good', by which she means doing that which leads to a better life in the face of an ongoing and unpredictable disease course. In care-logic, the work done in the clinic is tinkering – doctoring – on an ongoing basis with all that may affect a life.

Like governmentality scholars, Mol (2008) highlights the small, everyday technologies that together produce recognizable logics. She contrasts how disease constructions, scientific knowledge, material technologies, clinician and patient roles, categorizations/inscription devices, goals of care, and verbal/non-verbal communication are folded into choice or care practices. She uses diabetes care as her example to develop her argument, in part because we understand that diabetes treatment does not cure people; what then does diabetes treatment do? Mol aims to contribute to theoretical registers that include the body, in all its fragility, rather than marginalising it. She contrasts choice-logic with care-logic, highlighting how both inform contemporary medical practices, but produce different effects – that is, different 'goods' and 'bads'.

Mol (2008) argues that choice-logic will not produce the desired ends for those living with chronic diseases. When enacted, choice-logic alters daily practices in ways that do not fit well with living with lifelong disease. Mol argues that care-logic practices align better. In the next two sections, I summarise her arguments about choice-logic and care-logic, and offer my interpretation of each logic with a weight-specific example.

3.2.1 The logic of choice

Choice is a logic that developed outside health care and came to be translated for uptake in health care practices. Mol (2008) traces two different models of choice relations that inform choice-logic in the clinic. The market version of choice-logic works via desire to sell products to consumers. Market versions of choice depict life as being without suffering or fragility; instead, we can purchase the good life. The market frame evokes supply, demand, and exchange of goods for money. The second model of choice-logic is one of citizenship, where choice is about a relation with the state, about governing ourselves collectively and somewhat independently. Autonomy is celebrated, and transcendence of the rational mind over the body lauded. Citizenship is a frame of contracts, rights, and duties. Both rely on the notion of individuals being in charge of their path. Both embed negative evaluations of a life with suffering due to disease; the person has not chosen well and needs to make new choices, as per the market logic, or has failed to exercise appropriate control over their body and is now reliant on the state, not meeting the expectations of good citizens.

Mol explains that choice-logic translated for the clinic creates moments where patients get to make decisions. Clinicians are to present scientific facts about their current health and possible outcomes, then recommend technologies to patients that may act on the pre-

determined, desired outcomes. Clinicians inform patients of the potential risks and benefits of different choices. Patients then make a calculated choice. That choice marks the culmination of the interaction; the patient's autonomy has been respected, and a course of action determined.

Much has been decided for the patient before they arrive on the scene:

What information might be worth gathering, or which technologies worth building is not a matter of choice for individual patients in the consulting room. This has been decided earlier and somewhere else. Which methods have been used to create knowledge? Which research questions have been addressed? Which technologies have been made? And why these and not others? None of this is relevant. (Mol, 2008, p. 55).

Choice-based clinical services orient, perhaps non-intuitively, to pre-determined outcomes. That is, the outcomes that matter are pre-defined in epidemiological studies. Patient choice is, then, limited to a menu of pre-determined options rather than selection of outcomes that matter to patients personally. Technologies and facts are assumed to be neutral means that serve an end. If a patient 'chooses' not to comply with recommendations based on epidemiological knowledge, they are to be respected as expressing their individual autonomy and values.

People make choices, and bodily outcomes follow. Patients are to make choices freely, not be coerced into particular actions. If something goes wrong, the patient's choices are the problem. In this frame, poor choices lead to diseased bodies – a frame that aligns strongly with how obesity causation is most commonly understood. "It's your choice" is then, a double-edged concept, respecting autonomy while implying blame.¹²

Mol's description of choice-logic resonates with how current Canadian guidelines (Brauer et al., 2015) order obesity management with adults for primary care providers. This recently published guideline privileges the measurement of body mass index as the guide to

¹² Mol does not use the terms compliance or adherence, or the debates about them, in her argument.

clinical action. If an individual's BMI measurement is classified as a problem, the individual is then to be enrolled into behaviour change. The measure drives care, and the possibilities of what is to be done determined by the results of intervention trials. That is, the guideline marks people's prior choices as the root of the problem and recommends clinicians inform patients of their options, which are essentially about accessing resources so that patients change their behaviours. The choices offered in the text are based on the results of systematic reviews and individual studies of effectiveness of interventions in producing weight loss. Weight loss is the pre-determined outcome that matters, and very small, unsustained short-term reductions in weight are deemed worthwhile to pursue (which is all these interventions have been found to produce – see Wadden et al., 2014). The guideline sets up a linear progression, one justified by appealing to scientific knowledge of risk and risk reduction measured in very specific ways.

A recent Canadian qualitative study with patients, health care providers, and health policy makers about weight management exemplifies Mol's description of choice-logic. In their interview-based study in Nova Scotia, Kirk and colleagues (2014) found that clinicians may note determinants of weight beyond personal choice, but demarcate their expert role to assessing and informing the patient with obesity about options.¹³ In the clinicians' description, the patient is to figure out how to make these changes fit in their lives. Their failure to do so is interpreted by clinicians as a lack of commitment. Clinicians emphasise the core issue is that patients know what to do to produce weight loss, but do not do it. The patients in the study spoke of multiple methods and attempts to manage their weight that were unsuccessful, and wanted support from health professionals. Clinicians ranked themselves as less important in the ongoing work of

¹³ Which I read as options defined by the evidence – to eat fewer calories, and exercise more.

weight loss than patients did. The effects of the changes involved in weight loss on the life of the patient were outside of clinical concern for the clinicians in Kirk and colleagues' (2014) study. Instead, a version of risk reduction that assumes significant bodily malleability guides what clinicians think is to be done.

Mol (2008) argues that the assumptions and orientations to clinical services such as those described in the above example do not map well onto the realities of living with a chronic disease. Not all knowledge or technologies serve the same ends, and thus do not have equal worth to all people living with the same condition. Statistical knowledge based on probabilities does not produce predictable outcomes when folded into an individual life. That is, statistical associations never guarantee a particular treatment will produce the outcome for an individual. Technologies are not always obedient, and can interfere with more than they were meant to. Technologies generate multiple effects beyond those intended, effects that may be pleasures or pains. Living a life without disease may be desired, but is often not possible. What is good, what the better life looks like when having a chronic disease is not pre-given, but something understood iteratively as practices continue, and bodies and lives change.

Mol's depiction of choice-logic also maps well onto studies of weight loss attempts covered in the literature review. Attempts to lose and maintain reduced weight generated pleasures and pains. Weight loss itself, and the behaviours involved, interfere in lives in ways that were unanticipated, including having to strategise how to manage situations that were likely to interfere (Sarlio-Lähteenkorva, 2000), dealing with people commenting on bodily and behaviour changes (Sarlio-Lähteenkorva, 2001), and straining close personal relationships (Sarlio-Lähteenkorva, 2001). The hoped-for weight reduction results of the intense effort are

not achieved by all, and when not experienced, could undermine a person's willingness to maintain the behaviour changes that reduce quality of life (Sarljo-Lähteenkorva, 1998), leading to clinicians labeling them non-compliant (Kirk et al., 2014; Throsby, 2012). People living with obesity stressed the need for support, which was not forthcoming from clinicians (Kirk et al., 2014; Sarljo-Lähteenkorva, 1998, 2000, 2001). It is worth noting that calling fatness a chronic disease is deeply contested, with dominant discourse about weight resting on the idea of malleability, all excess weight as risky, and promoting the possibility of complete reversal of high weight in spite of contrary evidence (Campos, 2011; Wadden et al., 2014).

Together, these studies create a picture of ineffective health care practices, ill-suited to those living with obesity and the hard work involved in sustaining a lower body weight. Neither the Canadian guidelines (Brauer et al., 2015) nor the talk of clinicians in Kirk and colleagues (2014) note these empirically-found effects of weight loss on lives. Both these examples, and many others already outlined in the literature review, assume that weight loss is possible and worth the effort.

3.2.2 The logic of care

Care-logic practices start from recognition that chronic diseases make life harder, and that clinicians are to attend to that difficulty and support the divergent needs of different people. Disease is not just a property of a body, but of a life with all its attachments, including those to the various collectives of which we are a part. Capacities to deal with whatever arises in a life are crucial. The concern is less with independence; dependencies may be good in that they can extend capacities. Care-logic involves attending to the balance inside the body, and flows between the body and its particular surroundings. The aim is for balance, in the way a

high wire artist may achieve it: through striving to attune all that might be making a difference in the current situation. Who is in charge matters less than how well-tuned the influences on the current situation are.

In care practices, the end sought is not defined by epidemiological knowledge. The 'good' target value is the one that is achievable in practice: a value that is technologically possible, can be integrated into a person's life without too much disruption, and makes life better. Choosing what parameter to measure is part of what is figured out in care processes. A categorization or technology is useful only if it helps take good care of patients. Scientific knowledge and technologies are mobilised to help figure out what might be done.

There is always uncertainty, and a recognition of lack of control over how a disease progresses. In care-logic, clinicians and patients mobilise that which is helpful, and adjust as needed. Tinker in service of improvement, and let go of the sense of complete control over outcomes – a sensibility both clinicians and patients hold. What is sensible and possible guides health care practices:

Care is attentive to suffering and pain, but it does not dream up a world without lack. Not that it calls for cynicism either: care seeks to lighten what is heavy, and even if it fails it keeps on trying. Such, then, is what failure calls for in an ethics, or should we say an ethos, of care: try again, try something a bit different, be attentive (Mol et al., 2010b, p. 14).

Thus, care is an ongoing process, while choice has a clear end point. Care-logic recognises that new problems emerge, and failed attempts are not conclusions. All the skills, habits, technologies involved may be adjusted. In care-logic, clinicians and patients accept that nothing is fixed or guaranteed. All can be changed, and clinicians have an imperative to change whatever it takes, including themselves. Failure is not an invitation to blame; within a logic of care, blame and moralising are recognised as leading to self-castigation and guilt. Mol argues that care-logic

practices aim to foster tenacity, adaptability, and perseverance in the face of unpredictable diseases.

Care-logic practices about weight, eating, and exercise would need to disrupt biases and stigmatising health care practices described in the literature review chapter, where eating less and exercising more are thought to have predictable effects on weight (Lupton, 2013; Puhl & Heuer, 2009), blame and moralising about fatness are prevalent (Malterud & Ulriksen, 2011; Murray, 2009; Throsby, 2007), tenacity and adaptability are something patients are to develop on their own (Kirk et al., 2014), and clinicians show little awareness of how their practices can have a negative impact (Kirk et al., 2014). Care-logic oriented clinical practice for those deemed to have weight problems would not ask patients to choose to adhere prescribed actions to achieve pre-determined outcomes. Instead, such clinical practices would recognise the unpredictability of interventions on outcomes, and prioritise improving a patient's health, broadly understood rather than framed primarily as a reduction of risk. Such care would focus less on producing disciplined selves than on good lives. These clinical practices would focus on improving capacities rather than assigning responsibility. Such care practices would value pleasure in life (Berlant, 2010; Mol, 2008; Klein, 2010), and understand that both pleasure and health are undermined by the insistence we behave in ways that meet economic and biopolitically-defined imperatives regardless of the impact on our mental or emotional health (Berlant, 2010).

An approach called Health-At-Every-Size aims to disrupt weight-biased and stigmatising care in several ways that echo care-logic. Proponents de-centre weight as the object of concern, working with patients to help them find healthful and pleasurable eating patterns, enjoyable

physical activities, and psychological resilience to weather stigmatising experiences (Aphramour & Gingras, 2011; Lupton, 2013). The BMI is rejected by Health-At-Every-Size practitioners because of its implied assumption that the ideal weight is the same for everyone of a particular height (Lupton, 2013).¹⁴ Instead, they argue that each body has a healthy weight range to which they are physiologically predisposed, and that trying to work against this healthy weight range is deleterious to health (Lupton, 2013). Health care services are to orient to and track a range of biomedical and other outcome measures relevant to the individual person, such as blood pressure, quality of life scores, scales that measure eating disordered attitudes and behaviours, and coping scores (Aphramour & Gingras, 2011). There is relatively little empirical research on the effects of Health-At-Every-Size aligned health care, and it remains a marginal approach at present (Aphramour & Gingras, 2011).

3.2.3 Care and choice

These two logics orient to different ways to organise health care services. Choice-logic treats epidemiological knowledge, intervention research trials, and classification systems as facts that precede choice. Patient choice is circumscribed to a very particular moment in the clinical interaction. In contrast, care-logic offers many more moments where patients can influence the direction. In care, the work is ongoing, dealing with problems as they arise, tinkering with whatever works to produce good effects. Mol (2008) argues care-logic is better suited to the intricacies of living life in a body with a chronic disease, and to the messy reality of clinical practices.

¹⁴ Fat acceptance activists make similar assertions. Fat acceptance activists reject the individual responsibility discourse about weight, and instead portray fatness as a natural phenomenon that exists within the spectrum of body weight (Lupton, 2013). Thus, fatness should not be judged negatively.

Chronic diseases have unpredictable courses, and attempts to ameliorate the effects of disease produce disparate results. Choice-logic fails to recognise this, and instead assumes people have chosen their paths. For this reason, choice-logic enables neglect by making neglect by professionals incomprehensible; as long as clinicians have informed patients of their choices, they have met their duty of care. This is ill-matched with values in the health care field, where care is bad if people are being neglected (Mol, 2008).

Mol (2008) notes that while health care professionals will usually agree to the linear way choice-logic organises practice at an abstract, theoretical level, they often tell stories that do not fit. These stories hinge on unexpected twists and turns, on times when values influence facts, and of technologies that do not live up to their promise. Daily practice, in all its messiness, fails to mirror the theoretical ideal. She asks us to consider that the linear format and ideals of choice-logic are what fail, not daily practice.

Mol's book, and my interpretative summary of it presented above, can make the two logics look stark. Mol acknowledges that in real life, care and choice are mixed together, and interferences may make for better living than 'pure' forms. Only empirical studies in differing sites and situations can give insights into the various interferences. She invites others to pick up these ideas, apply them to other situated examples. My research takes up this invitation. Mol (2008) offers a frame that opens up care practices, and attending to enactment allows for exploration of difference.

3.3 Governmentality and Mol's Logics: Studying care practices, and knowledge brokerage

Governmentality and Mol's (2008) logics approach have several commonalities. Both theory frameworks recognise the contingency and impermanence of the present. They share a

common focus on practice, in all its complexity. Mol and many governmentality scholars integrate insights from actor-network theory (described in the methodology chapter to come) to help direct an analyst's attention. Both help to open up questions such as: what comes to be a problem? How is the truth of the problem established? What follows problem formulation? What actions, roles, or subjectivities are envisioned, authorised, produced in such an assemblage? What is the envisioned end? These commonalities make it easier to apply both, separately, within my ethnographic work.

I apply a governmentality frame to my exploration of primary care practices specific to eating, exercise, and weight-management. Governmentality studies involve considering the small, mundane techniques through which attempts are made to conduct the conduct of individuals, to align what is designated as non-normative with norms. A study of the work done to change people's bodies by changing their behaviours fits easily within an advanced liberal governmentality frame, as others have done before me (reviewed in the previous chapter). My contribution to this literature, in Chapter 5 on the patient fluencies with weight-as-choice, is in my focus on how patients appeal to socially-valued, liberal forms of subjectivity to position themselves as good subjects in spite of bodies that may be interpreted otherwise. Governmentality is better built to develop this analysis of subjectivity and subjectification in the clinic than Mol's logics.

I also apply governmentality insights to my study of knowledge brokers' work to change clinicians' behaviours. I highlight governmental strategies used by the knowledge brokers involved with the Canadian Obesity Network's *5As of obesity management*[™] course to enrol clinicians into changing their clinical activities. This is one of the unique contributions of my

dissertation: highlighting governmental practices in the work done to change the actions of clinicians. Physicians, in particular, fought for and have maintained a degree of autonomy from the governments in Canada (Tuohy, 1999). As health care practices are increasingly marked as problematic via biopolitical means, a governmentality lens helps me explore some of the methods by which change is initiated – whether successful or not. An understanding of governmental rationalities helps make sense of why particular methods are in use to change behaviours, out of all the range of possibilities. Governmentality highlights the question of who we are to be, if we are to claim a positive identity for ourselves – including if the ‘we’ in question are health care providers. And yet, relying on governmentality exclusively is too limiting for this topic and my specific aim, to open dialogue about caring well for patients in a time when talking about weight, eating and exercise is both expected and potentially stigmatising or otherwise harmful.

In Chapter 2, I outlined how weight, eating, and exercise have been worked up as problems via biopolitical methods – developing norms, statistical forecasts of risk, new forms of expertise, and the like. The epidemiological framing of the problem has spurred a range of governmental actions, many of which reinforce an advanced liberal governmental frame of responsibility and blame. The bias, stigma, and discrimination literature reviewed earlier argues that many current governmental activities to lower the population’s body weight jeopardise the wellbeing of people living in bodies deemed excessively fat. My study of clinical practices takes this concern seriously. I aim to open how to think about caring well for patients in a time when talking about weight, eating and exercise is both expected and potentially stigmatising or otherwise harmful.

Governmentality is not the theoretical lens that allows me to do that in a robust way. Governmentality studies help us understand the present, but do not focus analytic attention to variation or effects. That is not what governmentality scholars seek to do. I need a theoretical frame that can consider effects of specific practices, and tune into different practices and effects. Highlighting variation in practice allows us to better consider the different realities possible, a central interest of Mol (1998; 2002; 2008). It is Mol's ontological politics that is better designed to explore reasons to prefer particular enactments of realities (Law, 2004), something I value in a time and place where dominant discourses about fat bodies are producing harms and potential health disparities.

Approaching research through ontological politics is not consistent with critical approaches, but it is not neutral (Mol, 2002). Mol's (2008) logics model offers a way to explore whether the actions taken help craft a better existence for those living with disease – or, in the case developed here, for people living with a bodily characteristic that some think of as disease. For this reason, I think my study of the work directed at changing patient behaviours is enriched by bringing the care-logic aligned practices into view. Choice-logic echoes/parallels advanced liberal forms of governmental rationality, while care-logic helps show health care situations where choice-logic does not apply or fosters neglect. Not all health care practices necessarily orient to choice or desire, something Mol and others help foreground (see Mol, Moser, & Pols' [2010a] anthology). The 'goods' and 'bads' produced by processes of standardization or objectification are not known in advance (Cussins, 1998; Timmermans & Almeling, 2009). Applying Mol's (2008) insights, as well as those of Timmermans (and colleagues of both),

demands I highlight and closely consider variations in how clinicians tinker in patients' lives, and the outcomes that follow.

3.4 The work to change clinicians

My research started in clinics, but moved to other sites, specifically to sites where there is work done on clinicians to change their practices. That is, part of my work involves the study of what Meyer (2010) calls knowledge brokers. Knowledge brokers are people – individuals and collectives – who work to move knowledge to new sites, to connect researchers with audiences (Meyer, 2010). Pharmaceutical companies offer multiple examples of knowledge brokering work, such as the outreach activities of their sales representatives, advertisements designed for medical journals, and direct-to-consumer advertising in countries that allow it. Knowledge brokering has expanded significantly in recent years in the health care field (Meyer, 2010).

Knowledge brokers translate existing information into assemblages that can move into new locations with more ease. That is, they create new knowledge: brokered knowledge. Meyer (2010) encourages researchers to pay attention to the work of knowledge brokering, and the variety of tools brokers use. She describes the work of brokering knowledge using Callon's (1986) notion of translation: where connections, displacements, and movements are made, retaining some, but not all, of the original. Knowledge brokers, and brokered knowledge, exist at the intersection of sets of practices (Meyer, 2010).

I follow Mykhalovskiy (2003) in thinking that Foucault and successors who take up Foucault's ideas are useful to study the work of a knowledge broker. There is value in considering knowledge brokering through biopower and governmentality. Knowledge brokers are developing new forms of knowledge, expertise, and practices in service of goals consistent

with biopower. New, historically contingent modes of knowledge production make problems perceivable, observable. In the case of knowledge brokers who work with clinicians and others employed in health care, their work focuses on addressing ‘implementation gaps’ (Meyer, 2010) - that is, the lack of uptake of procedural standards recommended.¹⁵ Such gaps are identified by audits of current practice against set standards or desired outcomes.¹⁶ A field of research has emerged that studies the effectiveness of methods to change clinical practice,¹⁷ which knowledge brokers both pull on and contribute to via their work.

The work of knowledge brokers is political, aiming to push and pull patients’ lives in particular directions. Their work is governmental: aiming to act on the action of others. The tools and standards they promote further help us understand the political nature of their work. Procedural standards embed particular ways of organising care. The new obesity guideline mentioned earlier, released by the Canadian Task Force on Preventative Health Care (Brauer et al., 2015), is one example of a procedural standard promoted by a knowledge broker that aims to act on clinician action specific to point-of-care activities with patients.

There is no natural, unifying way to order the world (Bowker & Star, 1999). Standards are political because they order; they create particular visibilities and invisibilities, change positions of actors, transform practices, alter relations (Bowker & Star, 1999; Timmermans & Berg, 2003;

¹⁵ There have been waves of standardisation in health care. The focus of standardisation emerging in the late 1980s and persisting to this day is clinical processes – that is, standardising activities done at the point of care, activities once protected from standardisation in the name of professional autonomy (Timmermans & Berg, 2003). This movement, now called evidence-based medicine, involves extensive institutional investments (Timmermans & Almeling, 2009).

¹⁶ My dissertation work does not focus on this work in particular. For more, see Bowker & Star (1999) and Timmermans & Epstein (2003).

¹⁷ For an example, see the Cochrane Collaboration’s “Effective Practice and Organization of Care” group at <http://epoc.cochrane.org/>

Timmermans, Bowker, & Star, 1998; Timmermans & Epstein, 2010). Every standard implies an evaluation of what matters at the expense of other evaluations, but this is often obfuscated (Timmermans & Epstein, 2010). Standards can reflect base agreements among actors, the power of a particular party involved in development, a negotiated order, or a confirmation of how things are already done by most (Timmermans & Epstein, 2010).

Standards are justified as serving the common good, but the goods they produce differ by position and the particular situation (Timmermans & Berg, 2003). Different standards, if taken up at all, result in different benefits and harms (Timmermans & Berg, 2003). One example Timmermans and Berg (2003) develop is of the unanticipated effects of exposing residents to clinical practice guidelines. Guidelines can make salient the uncertainties, unknowns, and lack of conclusive answers about which treatment is best, demonstrating to residents that there is no pure version of 'informal experience' or 'formal evidence'. Standards may change more than was intended in their design.

Timmermans and Almeling (2009) bring our attention to the ad hoc reasons people ignore, partially follow, or completely follow a rule. Implementation of any standard involves managing local contingencies (Timmermans & Almeling, 2009) and a range of co-existing infrastructure including other standards already in place (Timmermans & Epstein, 2010). For all these reasons, Timmermans & Almeling (2009) stress that the effects standards produce – the goods and the 'bads' that result in people's lives from the use of any such standard - requires empirical study.

The standards promoted by evidence-based medicine texts and knowledge brokers attempt to fold population-based knowledge into the clinic. This work is rationalised as

contributing to progress and optimisation of the health of the population. The strategies knowledge brokers use to enrol clinicians into changing their practices are governmental. Meyer (2010) notes that the work of knowledge brokers, and the effects that follow, are understudied.

Chapter 4: Methodology and Methods

My goal for this ethnographic study of primary care is to provide rich description of a range of practices and actors involved in dialogues about eating, exercise, and weight, practices that aim to change patients' bodies and behaviours. In the previous theory chapter, I described how this dissertation orients to two different theoretical lenses: governmentality and Mol's logics of care and choice. These share a common concern with practice, and draw attention to how problems and solutions come into existence in the here-and-now. What is evaluated as important or relevant? How do clinicians and knowledge brokers attempt to reach the intended audience? In this chapter, I describe the methodologies and methods I used to attend to practices in the clinic and in continuing education courses for clinicians. These methodologies and methods produce the data I analysed using the theoretical lenses developed in the previous chapter.

4.1 Methodology

I take seriously Law's (2004) argument that research methods not only describe but help produce the reality they understand. I build on actor-network theory (ANT) and discourse analytic approaches that orient to ethnomethodological principles. Both of these traditions focus an analyst's attention on action underway. I apply these methodologies together to examine an education course for clinicians as well as primary care appointments where weight, eating, or exercise are discussed. Together, these two methodological approaches allow me to analyse the different types of data available (interactional; textual; material) through the bifocal lenses of governmentality and the logics of care and choice.

Actor-network theory was influenced by, and shares an ontological foundation with ethnomethodology. The core premise of actor-network theory is that we need look no further

than the everyday mundane practices to understand social order; there is no need for sociologists to add hidden, unexplained forces such as intention or motivation to explain practice. This order is perpetually re-assembled often in relatively stabilised ways, but change is always possible. This order is not a function of completely 'free' or 'determined' actors, but of an assemblage¹⁸ with many dynamic parts bringing about the whole, in a particular moment and place. My goal is to study practice with an openness to what makes a difference to how action unfolds, how and what actions are accomplished, and to what end.

I have built this study bridging methodological insights from both ethnomethodology and actor-network theory because the visibilities each creates are insufficient for what I aim to accomplish. Neither offers a wholly satisfying foundation for this study of clinical and educational practices, which involve fleshy bodies, measurement and treatment devices, procedures, computers, calculations, conversations, classification schemas, and more. Ethnomethodological approaches focus attention on human action and interaction, relegating the rest to context read by the actors. I need a way to attend to human action, especially talk, yet I opt to not relegate non-human influences to 'context'. ANT ethnographies often emphasise objects, calculations, categorizations, and inscriptions more than language and speech, despite some acknowledgement that patterns of language may mediate in actor-network assemblages (see Law, 1994 cited in Mol, 2002). Given that much of clinical practice involves speech and non-verbal communication between two or more actors, I included ethnomethodological methods

¹⁸ A term from Deleuze and Guattari used frequently in actor-network theory. Grosz (1994) defines an assemblage as "provisional linkages of elements, fragments, flows, of disparate status and substance: ideas, things – human, animate, and inanimate – all have the same ontological status." Assemblages are produced by modes of organizing of heterogeneous elements, provisional and temporary in status. (Grosz, 1994).

to attend to communication. Using the two in concert, I am better able to explore clinical practices and continuing education assemblages specific to eating, exercise, and weight.

In this chapter, I explain foundational concepts of actor-network theory and ethnomethodology. I highlight ontological consistencies between the two methodologies. I then describe the methods I used to generate and interpret the data for this dissertation.

4.1.1 Ethnomethodology: Seeing action as actors do

Starting in the 1960s, Garfinkel sought to study empirically how it is that, in interaction with others, we come to know in common what we are doing and the circumstances in which we do it (Heritage, 1984). He sought to see action from the position of actors in a given situation, learning to reason as they do – that is, to learn their ethnomethods. He used both experiments and observation of everyday activities to explicate the mutual competences, methods, and background expectancies we take for granted in our everyday interactions (Garfinkel, 1967).

Garfinkel explored how, in practice, we are actively involved in producing social order without much conscious effort or many problems of understanding between us. Actors' primary motivation is the production of a recognizable order – the ability to understand each other - though secondary motivations may be at work as well (Garfinkel, 1967; Rawls, 2006). Enacting a recognizable identity that is relevant to the situation is part of how social order is produced and maintained (Garfinkel, 2006).

Actors become aware of norms that are typically brought to bear in particular types of situations through intersubjective experiences. Norms are not transcendent, but situated.

Actors learn to act in ways that align their motivation to produce a recognizable order with their other motivations in the given situation (Garfinkel, 2006).

We assume others are aware of norms and are capable of anticipating the consequences of breaches. That is, our actions are treated as a product of accountable moral choice (Heritage, 1984). These assumptions allow participants to hold each other accountable for 'chosen' departures. If there is failure of shared meaning, we interpret deviations not as senseless, but motivated deviations (Garfinkel, 1967; Heritage, 1984). Deviations from the norm elicit justifications, repair work, and/or sanctioning (Garfinkel, 1967; Scott & Lyman, 1968). For example, if a person greets another but there is no reply, the person who offered the greeting may account for the non-responsiveness by assuming the other person did not hear the greeting.

We cannot remove ourselves from normative accountability for our actions. Others will impose accountability upon us (Heritage, 1984). Regardless of what is taken for granted or considered 'natural' in a given setting, the norm has a dual nature. It provides for the intelligibility of the scene, and generates visibility of departures (Garfinkel, 1967).

Thus, actors neither choose 'freely' among possible responses, nor are they following pre-determined rules. They act in recognizable ways to bring about social order appropriate to a specific situation, but at times actors attempt to reconfigure the situation by mobilising other resources. This may require that they accept the interactional costs of breaching expectations (Garfinkel, 1967). Actors are actively engaged with others, using situationally available resources, ad hoc processes, and reflexive adjustments to co-produce a recognizable order.

Garfinkel and subsequent ethnomethodological scholars rely upon observation of naturally occurring social processes as the central research method. Ethnomethodologists move research away from theoretical abstractions such as the 'sick role' or 'attitudes', and instead look at the processes used by actors in a given situation. They displace concerns with the whole person, their consciousness, and their motivations, and instead consider situational identities and personal characteristics made relevant and having an impact on interaction (Rawls, 2006). Garfinkel and the actor-network theorists who follow his lead keep us close to action, examining what makes a difference to action underway, while remaining aware of any interaction happening located in a time and space.

4.1.1.1 Conversation Analysis

Conversation analysts continue the ethnomethodological project, focusing more explicitly on how certain communicative actions are accomplished via talk between human beings. Building on the insights of Goffman and Garfinkel specific to maintenance of social order, Harvey Sacks, Emanuel Schegloff, and Gail Jefferson developed a style of inquiry that explores the resources speakers use and rely upon to speak with others that makes speech economical and easier to understand by the speakers involved. Resources in conversation analysis are thought of as auditory features of speech (such as pauses, speed of talk, overtalk and interruptions, rising or falling pitch, and more), and structures that competent communicators orient to when in dialogue (including adjacency pairs/turn taking, preference organization, membership categorization devices, repair initiations). Focusing the attention this way has helped illuminate how we open and close conversations, pass the floor to other speakers, prepare the other for possible disagreement, or repair disruptions to typical speech

norms – and how we hold one another morally accountable for this co-production of social order.

The resources described by conversation analysts influence the trajectory of interactions. Over many decades, empirical conversation analytic studies of clinical communication have traced the influence resources have, from Byrne and Long's (1976) describe how doctors shape therapeutic possibilities through their talk to more recent collections, such as one studying primary care explicitly (Heritage & Maynard, 2006). The conversation analysis tradition deepens the argument that speakers are influenced by normative frameworks made salient and reinforced in each interaction by the actors involved. Speakers do not respond mechanically, and can blur or avoid a proposed direction of talk. Each person exerts agentic controls over the direction of talk, but outcomes are co-constructed, not within the control of any given speaker (Heritage, 1984).

Conversation analysis and ethnomethodology offer useful tools to tune into human communication, but do not offer a complete enough foundation for my dissertation topic. Conversation analysts have tended to rely heavily on audiorecordings of naturally occurring speech, and pay little attention to body language or material objects (for limited exceptions, see Heath, 2006; Rhodes, Langdon, Rowley, Wright, & Small, 2006). In contrast, ethnomethodologists made room for, and sometimes explicitly studied, communication resources other than speech (e.g. bodily movement as per Ryave & Schenkein, 1974) that highlight the morally accountable nature of social interaction. The tendency of both ethnomethodology and conversation analysis is to relegate anything material to 'context', the background that is interpreted by actors to help them read what norms are appropriate in a

given situation. While this minimal recognition reflects a certain sense of influence of the material, my research interest requires a more robust approach.

The exclusive conversation analysis aim (circa Heritage, 1984) was to explicate members' methods of producing social order. A long-standing loss produced by the conversation analytic framework, which Heritage (2009) acknowledges in a limited way, is any sense of *the content* of actions that are preferred and the norms that are made salient in interactions. This is starting to shift, with hybrid methodologies incorporating conversation analysis insights, such as Kitzinger's study of crisis line calls¹⁹ (described in Silverman, 2007). It is this applied orientation to conversation analytic methods that I find most useful in the present study.

4.1.1.2 Thinking about content: Interpretative repertoires, narratives, and subject positions

The strengths of ethnomethodology and conversation analysis lie in demonstrating how it is that speakers hold each other accountable for maintaining a social order. But what order is maintained, and what consequences follow? And what about textual forms of communication, now ubiquitous? How do changes in how we act in the world come to be? Other methods to analyse communication orient more explicitly to the content of what is communicated, and have room for textually mediated forms of communication. "Individuals, when they speak, do not create their own language, but they use terms which are culturally, historically and ideologically available" (Billig, 2001, p. 217). The intersubjective resources we use when expressing ourselves include narratives, interpretative repertoires, and (related) subject positions, all of which circulate within groups.

¹⁹ Kitzinger analysed recorded crisis line calls deemed exemplary by the members of the crisis line organization, and both the resulting analysis as well as audio-recordings were used for initial training and ongoing feedback purposes.

Frank (2010) describes one intersubjective resource that guides perception and action: **narratives**. Narratives create the sense that one thing happens in consequence to another. Narratives help make life livable, ordering the blooming, buzzing confusion of life into foregrounds and backgrounds of both attention and value. We are each born into particular histories and cultures that rely on particular narrative resources – templates, tropes, plotlines, and the like – to order the world and explain our experiences in it. Stories can be considered a form of narration that have the capacity to attract and hold listeners in a particular moment and place (Frank, 2010). Stories precede other selection and evaluation guidance systems. While other guidance systems, such as logic, can override stories, and some selection among those stories circulating is possible, stories continue to function when those later guidance systems fail. Stories help us to interpret the world, guide us to attend to certain things and ignore others, create boundaries and groups, and affect what we see as possible or worth doing. Communicating our experience is enabled via stories; they shape how we know our experiences. We get caught up in situations that fit a familiar narrative plot, a plot that can then lead us onward. Yet, not every story calls to every person. Analytically, we can learn from the stories overlooked as well as those that people become caught up in.

Not all forms of narrating life, not all selection and evaluation guidance systems are recognizable as stories (Frank, 2010). Another resource that circulates within a group is **‘interpretative repertoires’**: relatively bounded, consistent units of language available to a range of communicators within a shared culture (Wetherell & Potter, 1988). Interpretative repertoires work as a lens, focusing attention on some details to the exclusion of others, and privileging certain versions as ‘real’ that result in behavioural and material consequences (Gee,

2005; Gill, 1995; Taylor, 2001). An example of an interpretative repertoire relevant to my topic is the ubiquity of the notion that people need to 'take responsibility for their health'. Taking responsibility identifies who is to take action, and implies that that person is in control of outcomes (and thus to blame for poor outcomes). This interpretative repertoire obscures the impact of other influences that could be acted upon to produce the desired result.

Interpretative repertoires also guide how to perceive and evaluate any given situation.

Narratives and interpretative repertoires can make salient particular **subject positions** for the persons involved (Davies & Harré, 1990). Subject positions are culturally-available, recognizable character types through which to interpret the actions of those involved in the given situation (Davies & Harré, 2001). To continue the 'take responsibility' thread from before, those who 'take responsibility' successfully (an evaluative judgement) in a health care context may be said to be 'activated patients', a subject position developed in widely circulated and cited chronic disease management articles (Wagner et al., 2001). In the same vein, stories call on characters to be certain sorts of selves, and invite listeners to recognise themselves in these characters (Frank, 2010).

In a given situation, communicators – in face-to-face as well as textually-mediated interactions - use these inter-related resources to promote one version of the world while disqualifying others. Communicators introduce intersubjective resources selectively to a given situation; that is, they propose and apply an interpretive lens, to which others are invited/expected to orient. Said another way, speakers propose a way to understand a situation (orienting to that which is already sensed to be present), and depend on others to recognise and take up what is proposed (Wetherell, 2001). Stories, interpretative repertoires, and subject

positions can be mobilised in flexible ways to achieve particular effects (Wood & Kroger, 2000). However, there is no guarantee that the hearers or readers will recognise or take up the proposed interpretive lens.

Promoting one version of the world and disqualifying others are neither a necessarily conscious choice nor an automatic reflex. Like the ethnomethods described earlier, stories, repertoires, and subject positions can become tacit, embodied knowledge. Both Edley (2001) and Frank (2010) argue a degree of patterning is reasonable to expect to be articulated by an individual in a consistent type of situation. However, novel assemblies and inconsistency are possible, in part because competing ideas are readily available (Billig, 2001; Gee, 2005).

Bodies and behaviours become known and made into objects or problems in a highly verbal and textual field, one that includes medical charts, policy reports, media stories, or published scientific articles. Attending to narratives, interpretative repertoires, and positioning aligns well with my research for three reasons. First, discursive methods that focus on these types of intersubjective resources apply to both textual and verbal exchanges. I sought a theoretical and methodological foundation that has room for both talk and texts (without assuming that these are the only actors that make a difference in actor-networks). Second, some forms of discourse analysis make explicit this situated nature of communication, and examine the consequences and transformations that follow. Staying close to action and describing what is observable in a specific time and place are consistent with an actor-network theory insistence on tracing connections and associations made or unmade. Finally, analysts can map how the discursive and material world are enmeshed. The discursive is made material, and the material world shapes the discursive. Foucault (1975/1995), for example, traces how

Bentham's theory of the panopticon is made material in penal institutions. Rose (1999a) describes the material and practical conditions under which psychological explanations come to be formed and accepted, and then examines the consequences of these new truths. Mykhalovskiy (2008) describes how biomedical discourse operates as an active constituent of extended relations, embedded in technologies and bodily inscription devices, including those designed to support the needs of patients. Frank (2010) makes note of examples of stories performing themselves into the material world – into bodies, yes, but also architecture and machines. Many ANT ethnographies foreground the material world more than talk, but I argue there are ways to include talk and discourse in an ontologically consistent manner, when talk is part of the action.

4.1.2 Actor-Network Theory: What is acting when 'we' act? Making space for the material

Central to the multiplicity that is actor-network theory (Gad & Bruun Jensen, 2010) is the study of associations and connections made between things, however temporary or stable, that bring into existence a particular local reality. Actor-network theory (ANT) ethnographies follow connections made between actors, describe how action is distributed among actors within a network, and explore whether that which is transported from one place to another is transformed in the process. Ethnographic ANT research helps explicate the perpetual (re)assemblages that form the present. ANT offers an approach that does not over-assume which actors are important or the shape of a given network; these are matters of empirical study. A particular strength of ANT is its opening up of the possibility that things may be done otherwise, in part because they already are in other places (Mol, 2002). The present is not a monolith.

By the term 'actor', ANT does not mean only humans. An **actor** is that which makes a difference to the state of affairs (Latour, 2005). Making a difference implies that an actor in a given assemblage influences the course of another actor's actions, whether in predictable or unpredictable ways. Actors cannot be presupposed, but must be observed in action with a concomitant recognition that such network assemblages are always changing. An actor is situated in a time and place, a point on a metaphorical map, with temporary associations made with other actors. Actors are granted a complex present, where their identities are fragile and may differ between sites (Mol, 2002).

The hyphen in actor-network is purposeful; no 'actor' ever acts alone (Latour, 2005). Latour (2005) argues that notions of human agency are enacted by social science researchers who do not attend to the other actors on the scene. Mol (2002) notes that like other actors, humans are enmeshed in networks that frame (but do not determine) action. Notions of interiority such as 'intention' and 'motivation', central to psychological or phenomenological theories, are not a prerequisite of an actor in the ANT world. An actor is that which is made to act by many others, which in turn makes a difference in the course of another actor's activities.

Any particular actor exists only in relation to other actors in the network, a network that can be mapped in a given moment in time. For example, in a clinical setting, where the software program for the electronic medical record may flash a reminder on the screen based on results, the clinician is made to do something – if only to close the reminder. The EMR software algorithm acts based on data inputted; the clinician acts as a result of the software. Another example: architectural details like walls and acoustics influence who is seen and heard, whether in jails, lecture halls, or medical offices (Latour, 2005). No human and non-human actor

determines the action outright, but are folded together in ways that produce it. I believe that ANT complemented with forms of attending to talk that are ontologically consistent offers a powerful way to make visible the assemblage that forms in clinical appointments.

4.1.2.1 Texts and visibility: The value of visual research methods

Texts and other objects are part of actor-networks if folded in, activated, or made to act in the specific moment. When studying a chain of action in institutions, texts often serve as materially replicable forms that can connect persons across time and space (Smith, 2001). Writing devices allow actors to be set into a narrative, which formats reality (Callon, 2002).

The actors (in the ANT sense) embedded in texts include and go beyond embedded interpretative repertoires, stories, and subject positions. Inscription devices have a particular salience in the science and technology studies field. Inscription devices are apparatuses, calculations, and the like that objectify, mark, and transform material substances into figures, diagrams, or numbers (Latour & Woolgar, 1986; Rose, 1999b). “Unlike their subjects, which are characteristically of three dimensions, and whose image is subject to variations of perspective, inscriptions are ideally of two dimensions and amenable to combination in a single visual field without variation or distortion by point of view.” (Rose, 1999a p. 137). Inscriptions transform the ephemeral into stable forms that can be repeatedly examined and accumulate over time (Rose, 1999a). Inscriptions make things stable, mobile, durable, comparable. Inscriptions and their related devices are central to knowledge of bodies and populations. The health care field is saturated with inscriptions and inscription devices that shape what is marked as healthy or not, and who or what is marked as an object of intervention.

Thus, textual content matters. But the message of a text is shaped by more than the semantic quality of words (Chaplin, 1994). Fyfe and Law (1988) argue that we should not act as if the visual is absent or simply peripheral to texts. Instead, sociologists should take the visual features of texts seriously, even in subjects that are not typically thought of as explicitly visual. Images, formatting, and written word together shape meaning and effect of a text (Chaplin, 1994).

Part of how meaning and effect of a text are achieved is by visual conformity within a recognizable genre. The visuality of a text can strengthen or stabilise an argument, create equivalences, invoke emotional responses, and/or mark content as contentious (Chaplin, 1994); that is, visuality makes a difference to how a text is interpreted and the action that follows. Images and depictions can orient to and assume a shared set of visual competencies, even in fields not commonly understood as explicitly visual (Fyfe & Law, 1988). Similar to how Frank (2010) talks about narratives, visual conventions reflect cultural orders that operate on a pre-reflective level (Spencer, 2011). In this sense, typography, layout, images and other feature of texts can also be actors in an actor-network. The use of conventional visual presentation - typography, layout, images, captions, and organization of ideas – promotes certain readings while signaling ‘ignore us’ (Chaplin, 1994).

By understanding texts as constructions, we can examine how specific institutions order the world and authorise specific perceptual flows (Rose, 2012). Texts that create coherences and singularities present us both with the sense of ‘this is the way the world is and has to be’ and ‘this is the way I have to be’ (Corrigan, 1988). We can interrogate what they standardise,

systematise, and normalise, as well as which subjectivities are invited, encouraged, or discredited (Fyfe & Law, 1988; Rose, 2012).

However, the effects of a text are never assured or uncontested. Interpretation varies by many factors – including accumulated cultural knowledge, context of viewing, intended audience, and the position of the viewer/reader (Spencer, 2011). Activating a text presupposes the existence of other knowledge (Spencer, 2011). Thus, texts should be studied in the circumstances in which they are used (Fyfe & Law, 1988; Smith, 2001). Representations and texts must be brought into the present, where there are always unanticipated contingencies (Chaplin, 1994; Smith, 2005). Those activating a text bring their own subjectivities and visibility to the text (Fyfe & Law, 1988). Loftus (1988) argues, “an image is not static, but is further developed each time it is used or re-produced...In the course of these processes it both acquires additional layers of meaning and has a real impact on social, political, economic and religious developments” (p. 129-130). I would argue this is not just a function of an image, but of any material object. An image-text derives meaning from and contributes meaning to the overall visual language of its producers and users (Loftus, 1988). Reception, or ‘activation’, of the texts is not necessarily always as intended. We are well served, then, by studying texts in situated practices.

Texts are types of objects, or embedded in objects (e.g. computers). Yet some material actors - some objects - differ from texts in some key ways. The walls of a room, the ways chairs are assembled in a waiting room, or a video-camera built into a surveillance system, act differently than texts which travel easily from one site to another. Actor-network theorists

create a space to hold these different types of material actors together, by considering that which makes a difference to action as it unfolds in a given time and place.

4.2 Methods: Data collection

I sought to develop a project that could hold together, attend to, make visible these various actors that together produce effects. My project starts in clinics, shifting to other locations that connect to observed practices in clinics. I present the data collection section to come following a roughly chronological path.

4.2.1 Recruitment of physicians

I studied the practices of three physicians, each located in a different clinic. Physicians who were approached were chosen for variation specific to their clinic, along two axes: the socio-economic status of the population served by the clinic, and whether the practice was considered (from a policy perspective) to be a 'multi- or interdisciplinary team', which is delineated by having allied health professionals such as pharmacists or diabetes educators on site. Dr. Maeve O'Beirne, Associate Professor at the University of Calgary's Department of Family Medicine, identified and approached physicians on my behalf. Four agreed to speak with me about the study. Of these, three agreed to participate in the project.²⁰ The final one declined, but reached out to colleagues on my behalf, without success. Participation involved two interviews and multiple observation sessions with each physician.

²⁰ More detail about the three physicians who participated and the clinics in which they work is outlined in Chapter 5.

4.2.2 Data assembled in clinics: Interviews, observation, conversations, and documents

Patient case interview: In each clinic, I began data collection by conducting an interview with the participating physician based on a patient case (in Appendix 1). The case developed for this study was a comprehensive medical exam²¹ for a relatively new patient. I hired a patient actor²² to enact the case with the physician. My primary goal was a case that led to discussion about weight, eating, and/or exercise with the patient actor – my topics of interest – rather than medications.

I worked first with a physician I knew²³ to develop the initial draft of the case. I then met with the patient actor²⁴ and Dr. Maeve O’Beirne to pilot, refine the content, and discuss variations on how the patient should appear and respond (a series of if/then statements). We opted to make the case patient be a 40-something woman and mother classified as mildly obese by BMI standards, with some cardiovascular or metabolic measures – blood pressure, cholesterol - on the verge of what is deemed abnormal. Measures to include, and values for those measures, were recommended by each of the physicians as the core laboratory tests that would be ordered by most if not all family physicians.

The standardised patient case helped introduce me to the clinic and the physician’s routines, prompted dialogue about how a physician thinks about what to do, made my research interest clearer to the physician, and served as an orientation point for future discussion, when

²¹ Also known as periodic health exams, or annual physical exams. The title and content of these visits has changed over time and across physicians, but in general, these are longer appointments where non-urgent issues are addressed.

²² Commonly referred to as a ‘standardised patient’; used in contemporary medical education for both learning and evaluation purposes. The University of Calgary’s Medical Skills Centre helped me find an appropriate actor for the case.

²³ Dr. Martina Kelly, who volunteered out of interest.

²⁴ A woman who has been involved in medical education for over 7 years as a standardised patient.

contrasts appeared with new observations. Each physician typically schedules 30 minutes for this type of appointment; we scheduled an hour for the physician to work through the case with the actor and to complete the subsequent interview. I attended the simulated medical exam with the patient actor and also video- and audio-recorded the physician and patient actor as they played out the case, occasionally interjecting to ask a question. The physician and I then spoke at some length about what the physician had done, what had prompted them to follow that path, their interpretation of the case, and what information they would typically have already gathered about the patient that was missing from the simulated case. Dr 3 actively bridged the standardised patient into that conversation, soliciting her perspective/feedback. On the whole, the patient case as elicitation tool was helpful on many levels, especially in establishing familiarity between the physician and me.

Observations: I observed care using two different processes.

The first process involved observing – shadowing - each physician for two half days. I observed and wrote field notes about appointments with patients, activities outside of patient care (such as physicians talking with nurses at the start of the day), and the physical environment (e.g. size of chairs; location of equipment; clinic and room layout; visuals and texts in waiting areas and appointment rooms).

In each clinic, the nurse or medical office assistant²⁵ who first met with a patient gained consent on my behalf. Because these are each teaching clinics, patients are accustomed to students being around, though it was explained I was a different type of student. Each clinic had

²⁵ All of whom consented in writing to participate in the research. In total, seven nurses and medical office assistants were observed.

its own system to communicate patient consent or lack thereof. Most patients consented, but a few did not in each clinic. I only observed appointments with children during these half-day shadowing observation sessions, and only if their parent was there to consent. My focus in these appointments was to better understand the physician's routines, and the variety of ways in which eating, exercise, and weight may come up as topics for conversation. I jotted brief notes while in the clinic, and composed field notes within a day of each of these observation periods.

In the second process, I observed and audio-recorded visits with patients attending for either the 'annual medical'²⁶ or a chronic disease care planning visit.²⁷ Appropriate adult patients²⁸ to approach were identified in advance by the physician, and an administrative staff member in the clinic called the patient in advance to ask if they would be willing to allow a researcher to talk with them about participating in a project. Most agreed. I called those who consented to talk with me in advance of the actual appointment, unless they told the administrative staff member that a call was not necessary. Those who agreed were asked to come a few minutes earlier than their appointment. When they arrived at the clinic, I met with them and talked about the project, about my interest in better understanding how and why patients and primary care clinicians talk about eating, exercise, and weight. Most, but not all consented. I observed and recorded all communication between the patient and clinicians - the

²⁶ These exams are usually when the most time is devoted to prevention and health promotion activities (or so I am told by practicing primary care practitioners), the topics related to weight are raised most often (Scott et al, 2004), and are pre-booked so were easier to identify and arrange consent.

²⁷ Referred to as a 'J-code' by Dr. Maeve O'Beirne; observed only with Dr 3, in the clinic serving older adults exclusively.

²⁸ Clinicians ruled out an occasional patient, based on judgment of their mental competency or where introducing me into the appointment might heighten paranoia.

medical office assistant or nurse who saw them first, and the physician who followed. I observed and audiorecorded ten visits with each of the three physicians, and simply observed one²⁹. My brief notes made during the appointments focused on posture, eye contact, body movements,³⁰ and computer use. Later, I wrote complete field notes - usually the same night as the observed appointment, though my ability to do so was dependent on how many appointments I viewed in one day.

Following the actor-network theory insights into how to attend to practice, the bodily, textual, material, and digital were integrated into the field notes. I aimed to describe more than summarise, asking myself 'how do I know what I know' to keep myself grounded in description. I wrote analytic asides to flag my interpretations, embodied reactions to the action, or questions within the field note documents, but marked these asides as separate from description.

Conversations: Informal conversations with clinicians were par for the course when I was in the clinic. Physicians occasionally provided information about the patient, unsolicited, before the visit. After the appointment, they occasionally asked me if I had any questions, or offered information that they thought I would benefit from. I would sometimes request a quick explanation. In addition, other people in the clinic occasionally asked me about my research, or spoke about their experiences specific to my topic. I captured what I could of these conversations in field notes.

²⁹ The exception was due to problem with my audiorecorder.

³⁰ Communication is more than verbal speech. Posture or eye contact, for example, both can influence how action unfolds (Potter & Wetherell, 2001). Body movements, like other aspects of communication, are learned patterns that demonstrate competence in given situations (Latour, 2005). Our body movements are often habitual, and can change the interpretations – intended or received - of words. For a primary care specific example, see Heath (2006).

Final Interviews: The final task in each clinic was an interview with the clinicians I had observed.

I conducted brief interviews with the six of the seven³¹ nurses and medical office assistants I had observed who were responsible for weighing patients. I asked them questions about the weighing practices that I had observed. These were short interviews, 12 minutes maximum.

The final interview with the physician involved audio-elicitation. I selected bits of audio from the recorded appointments to review and discuss. I selected these clips for variation, considering the patient's weight status, their current pattern (loss, gain, or stability), and deviations from physician routines (such as asking one patient far more questions about their diet than usual). With each case, I asked the physician a common set of questions after they listened to each audio-clip:

- a. Immediate impressions?
- b. What do you think is going on with (patient first name)?
- c. What's the highest impact thing that would improve (patient first name)'s health?
 - i. What's the chance that this outcome will be realised?
 - ii. What might limit the achievement of that outcome?
- d. How concerned are you about his/her weight, if at all? How concerned do you think (patient first name) is?

I then asked questions that were specific to the more unique qualities of each purposefully selected case, before exploring the physicians' more general ideas on the topics of weight management and behaviour change. I pursued topics that emerged from answers as seemed appropriate. These interviews lasted 60-90 minutes.

³¹ This was a function of how much time we had to talk, and if they were available on my last day in the clinic.

My approach to interviews with clinicians was guided by DeVault and McCoy's (2006) description of interviewing in institutional ethnography. Similar to ANT informed researchers, institutional ethnographers do not make people the objects of research; instead, IE aims to gain insight into the institutional relations that 'hook into' or shape people's everyday activities (DeVault & McCoy, 2006). Institutional ethnographers consider participants as informants who are knowledgeable and can describe the everyday work they do in reliable ways. Institutional ethnography-informed interviews involve prompting for detailed descriptions of mundane work activities, bringing into focus partial views of the institutions that shape situated work activities (Smith, 1998; Smith, 2005). In my case, the auditory elicitation device provided a reminder of an experienced situation to talk about their work and enabled probing questions about less overt actors involved in care.

Documents: I requested copies of documents that were observed in use and relevant to my research interest; e.g. dietary information sheets, or information about programs. I did not collect any documents that identified patients, nor did I view patient charts.

Analytic notes: Throughout, I wrote analytic notes to capture emerging questions or ideas, 'a-ha!' moments. These notes informed data collection that followed (observation or elicitation interviews), in line with Becker's (1993) argument that these emerging insights often deserve follow-up if they are to be useful.

Honoraria: Honoraria were given to any clinic member whose participation involved time outside of their usual work hours. Physicians were paid an honorarium of \$100/hour³² for

³² The rate the Faculty of Medicine paid physicians to sit on committees at the time I submitted my application to the research ethics board.

the time we spent in interviews. In the third clinic, I paid an administrator a \$50 honorarium for making the first patient contact calls on her own time.³³

4.2.3 Traces taking me out of the clinic

Part of what ANT ethnographies involve is following connections made between actors. I used these observations and interviews to help identify non-human actors in the room as clinicians and patients talked about eating, exercise, and weight – from inscription devices, to communication frameworks, risk classification schemas, and quality improvement initiatives. Primary care was the point of entry to a densely connected terrain.

The actors I followed out of the clinic most closely, and present in this dissertation, were those that were not fully established. Of all the possible paths I could have focused on, I opted to attend to knowledge brokers doing work to change clinical care specific to eating, exercise, and weight management. Knowledge brokers seek to change care. Embedded in their brokered knowledge assemblages are problematisations of current practices, and assertions that their tools offer solutions. The change initiatives I studied were justified as being in service of important population goals, such as reducing chronic disease prevalence and ‘burden’. They are assemblages designed to create smooth passage of solutions into practice, to coordinate the actions of others (to use Smith’s [2001] language), to address what have been flagged as deficiencies in clinical care. Leaders of each knowledge brokering organization I approached consented to participate in my study.

³³ A task she did on her own time. It was not clinic routine to call patients to remind them of upcoming appointments.

To learn more about these actor-networks, I first read the websites of the home organizations of the relevant change initiatives. I attended two continuing education courses as a participant observer. And I interviewed key informants about each of the change initiatives.

4.2.3.1 Toward Optimized Practice

Two initiatives to change clinical care had presences in two of the clinics I observed: *Access*Improvement*Measurement* (AIM) and *Adult Screening and Prevention* (ASaP). Both were hosted by an organization called Toward Optimized Practice (TOP), which is an offshoot of the Alberta Medical Association. “Working with Alberta physicians, TOP helps implement clinical practice improvements using evidence-based best practices and quality initiatives, improving both patient care and clinical management within the Alberta Health Care system.” (Toward Optimized Practice, 2012). AIM focuses on reducing wait times and improving patient access to health care. ASaP aims to improve delivery of adult screening and prevention manoeuvres in primary care, specific to those patients who do not present routinely for such care. ASaP, in particular, was flagged by a participating physician as folded into and influencing the course of appointments I observed.

There was no opportunity to observe TOP’s work with clinicians within my time or ethics-board approved frame. My limited description of this work (included in the “logics in the clinic” chapter) is based on observations of and interviews with clinicians, the TOP website, and a key informant interview with Mark Watt, Program Delivery Lead. I do not analyse TOP’s ASaP program through the governmentality and logics lenses directly, but make note of how ASaP was folded into care in a way that makes a difference.

4.2.3.1 Continuing education courses

My decision to be a participant observer in two continuing education courses for clinicians came out of my emerging interest in the work being done to change the way care is delivered in Alberta via a swarm of knowledge brokers/actor-networks trying to establish themselves in clinical care. Both courses came to my attention during data collection in clinics, yet neither had a direct presence in the appointments I studied. I include only one in this dissertation, but describe the data collection for both given it was part of my work completed.

Studying the particular continuing education courses involved taking a leap from the practices and clinicians I observed, something Latour (2005) would say is inconsistent with ANT. I opted to do so anyway. Had I observed in a different Calgary Primary Care Network, or a month or two later in one of the clinics, I would have been in settings where clinicians would have been exposed to at least one of these two courses.

These two continuing education courses, if put into practice, would change how clinicians talk about eating, exercise, and weight in appointments.

1. The Health Change Associates® *A practical guide to health behaviour change using the HCA approach: Canadian edition* (herein HCA and HCA guide). The HCA methodology is a generic behaviour change support model for clinicians to implement in patient care. Developed in Australia, the course was being offered by the provincial government's Alberta Health Services at the time of my research. Eating, physical activity, and 'weight management' activities are all mentioned as core behaviour changes that the HCA approach addresses. The HCA approach is not primary care specific, nor physician centric. It came to my attention when members of one of the clinics I observed were

scheduled to do the course the following month; had I observed a month later, there could have been traces of HCA in the care provided.

2. The Canadian Obesity Network's *The 5As of Obesity Management*[™]. This network has as its core vision the reduction of the physical, mental, and economic burden of obesity on Canadians. Its home base and scientific director are in Edmonton, Alberta. The *5As of obesity management*[™] (5As) are one assemblage the Network promotes/sells to clinicians via continuing medical education and other channels to improve weight management within primary care clinics. It came to my attention through the Canadian Obesity Network's (CON) email list to members. I joined in 2010, and had previously participated in their Weight Bias and Discrimination Summit. I observed two separate CME sessions on the 5As, though I describe only one in this thesis.

Prior to attending each course, I sought out permission of those hosting to participate for the purposes of integrating the course into my ethnographic study of primary care. I attended with their explicit permission. In the introductory rounds done in the opening moments of each course, I made explicit my status as a PhD Candidate researching the course, studying different supports offered to clinicians to improve their practices, and that I would be writing notes about the course but not personally identifying details.

During the course, I wrote brief notes that linked the visual and verbal presentations, body posture and movements, learning activities, and occasionally exact quotations of comments made by either the presenter or a co-participant, when I found their comments especially striking or repetitive. Shortly after, I wrote the extended fieldnotes. In addition, I had my copies of the official documents provided by the course, and graphics available on the host

organizations' public websites (which includes most of the powerpoint slides for the 5As presentation).

For each of the continuing education courses, I reviewed all the relevant documents to develop an interview guide to use with the key informant that I or the organization identified. I aimed to fill in details about the history of the continuing education assemblages, textual and course design decisions, perspectives on what is working well and what the knowledge brokers might like to change, and future steps. I contacted the leads on the *5As of obesity management™* (Dr. Arya Sharma, and Dr. Michael Vallis) and the woman who is the driving force behind the HCA (Ms. Janette Gale), all of whom agreed to interviews. In addition, I interviewed Dr. Holly Knight, the director in Alberta Health Services who led the charge to bring HCA into the province. These interviews were conducted and recorded over the phone in spring 2014.

Key informants have consented to be identified. In the case of the *5As of obesity management™*, one of the creators was the presenter, and I have his permission to name him when describing the course presentation. I withhold the names of my co-participants, and the specific dates I attended.

4.3 Methods: Data analysis

Governmentality and Mol's logics are the two theoretical lenses through which I examine these varied data. Following Foucault and other governmentality scholars, applying a governmentality lens focuses my attention on problem definition, solutions developed, and the subjectivity claims and appeals made by patients, clinicians, and knowledge brokers observed (Foucault, 2004/2007a; Dean 2010; Cruikshank 1999). Mol's logics complement this focus, attending to how health care practices – observed or envisioned by knowledge brokers - orient to choice-logic and care-logic.

'Holding one's own' is an idiom that Frank (2010) suggests is useful in narrative analysis, and that I have applied to help analyse the data collected for the present study. The notion of 'holding one's own' refers to a set of related ideas: to maintain one's position; to be as successful or worthy as others in a given situation; to stick up for one's self; to not become weakened or diminished in status when in a trying situation. The idiom has particular relevance when studying governmental techniques, where problems are defined and solutions are enacted that mark some part of the current actor-network as in need of amelioration. Who or what is marked as a problem no longer holds its own, which may be consequential for the action that follows. Choice-logic and care-logic differ significantly with respect to who and what holds their own. In each of the different cases and settings I examined, I considered who and what maintained a positive position, and who or what was made vulnerable, weakened, or discredited. I explored *how* each of different actors came to hold their own, or fail to do so. Current primary care practices, and the Canadian Obesity Network's envisioned practices involve particular actors in the actor-network being made to hold their own, at the potential expense of others.

4.3.1 Preparing data for analysis

Specific to the observed and recorded appointments, I listened to audiorecordings, summarising parts of the visit, and identified sequences of talk to transcribe. I hired a professional transcriber to do the first draft, after which I further improved the accuracy of the transcription and integrated notes about gestures, posture, eye contact, material objects or texts used during the appointment. The same transcriptionist completed all interviews in full,

with my same review process to follow. My transcription conventions, informed by but not fully consistent with conversation analysis conventions, are described in Appendix 2.

I organised my data using NVivo 8. I reviewed my data texts – field notes and interviews - in whole, making analytic memos, and coded using both pre-determined ways to sort (e.g. exercise talk sequences; weighing) and emergent or analytic codes. I returned to whole texts or code reports iteratively, as new analytic threads arose.

4.3.2 Examining the data from the clinic

I used a number of analytic tools to help me examine the talk of clinicians and patients, looking for a range of possible intersubjective resources in use that influenced how the action unfolded. Communication happens in a given time and place to accomplish some act (e.g. ask permission, agree, or give commands) (Potter & Wetherell, 2001). Communicators mobilise various resources, such as words/syntax, discourses, or common procedures, to construct a response (Potter, 1996). Discourse analyses help illustrate communication resources used, and highlight the consequences of using different resources in specific contexts.

From conversation analysis, I identified sequences of talk on the topics of eating, exercise, and weight to analyze closely. I did so by applying conversation analysis insights about openings and closings of topics. Within the identified sequences, I considered turn-takings and attended to speech markers of preference and repair organization³⁴ (Heritage, 2009; ten Have,

³⁴ These are not private desires, or psychological proclivities; these are highly generalized and institutionalized ways of speaking (Heritage, 1984). “Preference” are those actions done straightforwardly, without delay or accounts. But when about to say something we think may be dispreferred, we signal that in advance with hesitation words, delays, and often give a reason for our deviation from giving the preferred answer (Heritage, 1984; ten Have, 2007). “Repair” refers to the ways speakers manage trouble that arises from an utterance; trouble that impedes the progress of an interaction, such as not hearing or understanding the other speaker (ten Have, 2007).

2007). The latter two speech markers help me identify moments of trouble or acceptance in the dialogue. I sought to understand the function of each turn: what the speaker accomplished. If trouble arose, I examined how it was resolved in the back and forth of the ongoing interaction. I then focused on the content of these moments of trouble or smooth acceptance.

I layered onto this an examination of what stories, interpretative repertoires, and subject positions were in play, and how they had come to be developed – including the use of material objects (such as scales) or texts (such as electronic medical record graphs). I considered these specific interpretations of moments in the dialogue within the whole of the observed visit.

Analytic questions guiding me included:

- What problems, solutions, and subjectivities were worked up in the interaction?
- What was folded in to do so (verbal resources, inscription devices, classification schemas, and the like)?
- What problems, solutions, and subjectivities were developed smoothly and ‘held their own’, and which were contested?
- What elements of choice or care logics were enacted, and how?

I looked for both common patterns across appointments, and unique or striking cases. The common patterns found are emphasised in chapter 5, and examples that help me unpack variation and different practices are in chapter 6. For the latter chapter in particular, I integrated insights from clinicians about a particular patient. These insights were sometimes in my field notes, offered immediately after the appointment, or sometimes in the final audio-elicited interview with the physician.

4.3.3 Analysing the continuing education courses

Change initiatives attempt to format a reality, to authorise a particular way of doing care. Formatting a reality, to borrow Thevenot's (2002) phrase, involves evaluations of what is important and relevant, as well as how to reach the intended recipient/audience. Knowledge broker organizations that seek to have influence on the care provided by clinicians must connect with those they seek to change. Dispersing and extending ideas, and changing the work being done in specific places, requires making new connections and may require severing others. There is action taken to connect and paraphernalia – texts, objects, and such - involved in extending reach and re-formatting a reality (Latour, 2005; Thevenot, 2002). These insights informed how I approached analysis of the continuing education courses.

Based on these core ideas about how attempts to format a reality are done, I delved into the data about the continuing education courses and (to a lesser extent) TOP's ASaP problem to examine:

- what is marked as a problem;
- how it is worked up as one;
- the desired outcome for clinical care (that is, the embedded vision of 'good care');
- what solutions are authorised;
- what is discredited, disrupted, or marked as contentious;
- how these knowledge brokers attempt to disperse and extend their influence (from subjectivity appeals, enticement of desire, to *aide-mémoires* and texts for use in the clinics);
- what elements of choice or care logics were enacted, and how?

The data I have for the continuing education assemblages include field notes, key informant interviews, and authorised texts, images, and objects. Intersubjective resources such as interpretative repertoires, narratives, subject positions apply to studying both talk and text. Conversation analysis processes do not apply to textual or material data. Visual research methods took particular salience here, given that the texts are what clinicians take back into their own environments after the course is complete. I examined the visuality of the texts – the images, formatting, and structure that simplify, foreground, and stabilise the ideas contained in the text.

4.4 Conclusion

Whether in clinical appointments or continuing education courses, visibilities and invisibilities are made while co-producing an understanding of a problem and solution. An orchestra of actors – human or not, consciously invoked or not – are involved in these processes. The rest of this dissertation delves into a) how clinicians and patients work up weight, eating, and exercise as problems (or not) and the solutions that follow, and b) how knowledge brokers offering continuing education courses authorise particular ways for clinicians to enact problems and solutions. I develop vivid, deep description of clinical and continuing education (knowledge brokering) practices to think through questions of governmentality and the logic of care.

I do so acknowledging that I am not directly capturing the ‘real world’ on the page. Both field notes and transcriptions inscribe and reduce a multi-sensory experience into a text. Neither is to be understood as a straightforward depiction of reality, but a result of purposeful focusing of attention as well as tacit perceptual patterns that are learned by being part of a

community of practice (Dingwall, 1997; Emerson, Fretz & Shaw, 2001; Grasseni, 2004). Such an understanding is consistent with Law's (2004) argument that researchers produce the reality they seek to describe. In this chapter, I have described the lenses through which I developed my data. Whether exploring the work of clinicians with patients, or knowledge brokers with clinicians, one party is actively attempting to change the daily practices of the other. I aim to make visible what is done, in service of what end, and the immediate, observable effects.

In the chapters to come, I present my work through stories, offering readers an opportunity to work out of the puzzles and problems as they unfold, before offering my own interpretation. My writing choices are similar to those in use by some institutional ethnographers (e.g. Diamond, 1995; Mykhalovskiy, 2008) and actor-network theory informed ethnographers (Mol, 2002). I develop different cases through chapters to create different visibilities, prior to putting them in dialogue with each other in chapter 8.

Chapter 5: Patient fluencies with weight-as-choice

Bodily fatness is interpreted as revealing inner truths about people: how invested they are in health; how well they manage their appetite; how well they follow healthy eating and activity recommendations. That is, the dominant discourse about weight aligns particular bodies with assumptions about values and investment in healthy body practices. In this chapter, I apply conversation analysis insights to explore how these ideas organise dialogue between patients and clinicians in primary care appointments. I seek to make visible how patients talk about their bodies and behaviours in relation to dominant biopower imperatives and advanced liberal subjectivities in circulation at present.

Foucault argued that medicine is a critical site for the operation of biopower, where the biopolitical meets the disciplinary. It is in the clinic that we can see how scientific truth is individualised. That process occurs in the interaction, a dynamic production. The governmental lens opens up a way of thinking about these conversations, where scientific discursivity and the clinical examination intersect with patients' confessions (Foucault, 1976/1990), and truths are made by the clinician and patient about a body-we-have and a person-we-are. These interactions occur in a time when the desirable subjectivity is to be an active subject who 'takes responsibility' for one's life, which involves engagement in the entrepreneurial project of ongoing self-scrutiny and improvement. The active individual is to conduct their life through calculated acts and investments that enhance their existence.

To live as an autonomous individual is to have learned these knowledgeable techniques for understanding and practising upon yourself. Hence the norm of autonomy produces an intense and continuous self-scrutiny, self-dissatisfaction and self-evaluation in terms of the vocabularies and explanations of expertise (Rose, 1993, p. 93).

A person is in continuous training, lifelong learning, perpetual self-assessment, never-ending risk management, and in receipt of continual incitement to improve one's self (Rose, 1999b).

I orient to Foucault's argument that the clinic is a space for subjectification work. In this chapter, I highlight how patients claim this subjectivity for themselves by marking weight as a norm that they care about, evaluate themselves against, and upon which they know their behaviours and personalities are judged. I highlight how weight acts as a prompt for confession, a ritual Foucault (1976/1990) describes as a speaking subject who tells a truth about themselves. Here, I attend to very common interactional practices of patients: the face-saving work they do to preserve a positive subjectivity for themselves in the face of potentially discrediting information: weight. Using conversational analysis methods, I highlight that patients do this face-saving work with fluency, and their shift into face-saving talk in relation to the topic of weight is received by the clinicians as appropriate to the topic. I aim to show that the way this face-saving is done reinforces advanced liberal notions of individual responsibility for health and morality as a function of adherence to norms. As a result, this talk preserves the dominant discourses of responsibility and health work as a site of morality.

I develop my analysis through the case of Vivian. At the time of her appointment with Dr1 (in 2013), Vivian was a 63-year-old white woman. She was recovering from a car accident, worked full-time cleaning offices (though currently doing lighter duties), and was trying to quit smoking. Vivian had recently gained weight, and her BMI at the time of the appointment (which was never spoken aloud) was 25.6, which is in the lower end of the 'overweight' classification. Vivian exemplifies many of the ways in which patients could display awareness of norms and expectations for self-governance of weight that I observed in patients across the three clinics. I

supplement Vivian's case with examples of similar behaviours with other patients across a range of body weights, BMI classifications, and weight histories.

5.1 Methods: Data collection & analysis

For this chapter, I examine the clinician-patient interactions in close detail. My core filter was to ask myself why this speaker was saying that now; what is it that has come before that spurs them to say this thing? I used conversation analysis insights about turn taking, opening and closings, preference organization, and repair to help tune into the function of particular turns.

The appointments described here are those of either the 'annual medical examinations' or a chronic disease care planning visit.³⁵ I observed all communication between the patient and a clinician, including both the medical office assistant or nurse who saw the patient first, and the physician who followed. I observed and audiorecorded ten visits with each of the three physicians, and simply observed one.³⁶ Each of the 31 appointments was booked for thirty minutes of physician time.

5.2 The clinics and the clinicians observed

Dr 1 works in a team setting, in a newer teaching clinic considered 'cutting edge' by my contacts within the University of Calgary's Department of Family Medicine. The clinic population is mixed across the income spectrum. Dr 1 – he – had been practicing for a little over twenty years at the time I observed him. The most striking demographic in his patient population is that they are older than average. He has held positions of leadership within provincial health

³⁵ Observed only in the third clinic, the one focused on senior's health.

³⁶ The exception was due to problem with my audiorecorder.

governance in the past, and leads quality improvement initiatives in his clinic. He works full-time, and supervises medical students and residents regularly.

Dr 2 works in a group practice that has nursing support, but no additional health professionals on-site. Dr 2 – she – had been in practice for more than 25 years, though has taken some leave for health problems. She works approximately half-time since her medical leave, sharing her practice with another female physician. Her patient population is financially stable, and over 90% are women. While her clinic hosts medical learners at times, she no longer supervises them.

Dr 3 works in a clinic that has a strong community service vision, integrated with other sectors to support the needs of mainly low-income seniors. That is, her patient population is 55 and older. Most have multiple and often complex medical conditions, and live on social assistance or disability/pension allowances. The clinic she works in has the most diverse range of health professionals beyond physicians and nursing staff, and it was in this clinic that I saw the most interaction among the various health professionals, both specific to patient care and socially. Dr 3 works close to full-time, but only part-time in this particular clinic. She has been in practice for just over a decade.

Dr 1 and Dr 2 work in clinics that belong to the same Primary Care Network. The Primary Care Network has a more visible presence in Dr 1's and Dr 2's clinics, than in Dr 3's. That visibility is a function of branding; Dr 1's and 2's Primary Care Network developed specific texts for use in their networked clinic (signage, magazines in the waiting room, standardised handouts for patients), which were prominent and mentioned by physicians.

5.3 The act of weighing: A potential threat to face

Appointments started with either a medical office assistant or nurse³⁷ meeting with the patient. These clinicians (all women) asked the patient a series of questions, completed a series of measures, and prepared the room and the patient for the physician portion of the visit (e.g. pulling out the various equipment needed for tasks to come, or asking the patient to change into a gown). Either during or immediately after completing the measures, the assistant or nurse would type information into the patient's electronic chart. This part of the visit was usually 6-10 minutes long.

In each clinic, the scale was in the hallway, away from the eyes and ears of those in waiting areas, but visually and audibly available to those in immediate proximity. Weight was measured in almost every appointment,³⁸ whether en route from the waiting area to the private appointment room, or after sitting and talking with the medical office assistant or nurse in the room. Height was measured in most appointments, also in the hallway. In the private rooms, other measures completed included blood pressure, and depending on the patient and the clinic, other measures might be done as well: waist circumference in clinic 1; oxygen saturation and heart rate in clinic 3.

Much of the same patterns emerged in the present study as Pillet-Shore (2006) found when she examined the talk of nurses and patients during the task of weighing using conversation analytic techniques. She examined 81 video-recorded nurse-patient interactions collected in 19 different clinics in Southern California in 2002-2003. In the present study, the act

³⁷ Seven medical office assistants and nurses consented to observation.

³⁸ The one exception: a man seated in a wheelchair in Dr1's office, who was asked to estimate his weight.

of weighing – an accomplishment of the health professional, patient, and scale – involved utterances “that go beyond that required to accomplish the immediate institutional task of weight measurement” (Pillet-Shore, 2006, p. 409) about half of the time. In the single clinic that did waist circumference, this was also the case.

In these weighing-related utterances, many patients treated the measurement of weight or circumference as a potential threat to face – as did those doing the measuring. During measuring activities, approximately half of the patients made comments that tended to either display their awareness of the desired result or norm, or demonstrate that they care about their result. These comments could come pre-emptively and/or after the result was known. Vivian did both.

5.3.1 Vivian

Vivian attended for her annual check-up, an appointment type that Dr 1 used to review overall health status and ensure guidelines for preventative care are met. The medical office assistant (MOA) met Vivian in the consultation room. She greeted Vivian, and then launched into a routine of logging into the computer, confirming Vivian’s contact information, listing the test results³⁹ the doctor will review with her today, and asking about any prescription refills needed or specific concerns the patient would like to talk about with the physician. The MOA typed, while the patient talked. After this was done, the MOA stood and asked:

Excerpt 1:

1 MOA: Can we go over your height and weight?

³⁹ In advance of these appointments, Dr 1’s patients were sent for blood/lab work. This way, current information about biomarkers was available.

2 Vivian: Sure, I will take my shoes off here.

3 MOA: Oh good.

4 (Vivian removes her shoes in silence).

5 MOA: Super. Just go down the hallway to the left.

6 Vivian: Weight's going to be higher, I know that.

7 MOA: It is?

8 Vivian: Yes. (laughs) I can tell by the pant fit. (laughs)

9 MOA: Just here Vivian. [oh] (MOA presses a button on the scale) We're gonna let it
go to zero before you step on. Just give it a sec. There you go. (Vivian steps up on
scale) That is going to be in pounds for you to take a peek at.
(Vivian looks at digital number display)

10 Vivian: One hundred and forty.

11 MOA: One hundred and forty.

12 Vivian: Oh my god, I have never weighed that much. (Vivian steps down from the
scale while the MOA touches a button)

13 MOA: And in kilograms (.) okay. (The MOA slides a vertical measure up out of the
scale, flips out arm, while saying) And then we're going to do your height.

14 Vivian: No wonder my pants don't fit. (laughs)

15 (Several seconds of silence while Vivian steps up, this time facing away from the
scale, and N lowers the arm to the top of Vivian's head)

16 MOA: Okay, you can step off.

17 Vivian: Still 5' 2"?

18 MOA: 156.4. (looks at wall-mounted conversion chart). So just under 5'2".

19 Vivian: I am shortening (laughs) and widening (laughs). That's not good. (We all walk back to examining room) ///END OF EXCERPT 1

In turn 6,⁴⁰ Vivian predicted the outcome of the weight measurement. The assistant did not speak the result aloud, but gave Vivian an opportunity to see. In turn 10, Vivian said the weight aloud, which the MOA confirmed in turn 11. Vivian then commented quite demonstratively on the result (turns 13 and 15), displaying her displeasure at her weight being higher than in the past. In the pre-emptive comment, she has predicted the outcome, and in the responses, Vivian marked this particular measure as unusual for her. Overall, Vivian evaluated the results as 'not good' (turn 24), displaying an awareness that lower weight would be better. The MOA did not participate in Vivian's construction of weight as a problem.

Similar pre-emptive and reactive comments came from people of a wide array of weights, those gaining, maintaining, or losing weight, and across the gender and age spectrum.

A smattering of other examples:

Example 1: The patient was a short white woman in her late 50s whose main concern is her ongoing knee pain. Her weight had been decreasing a bit, year after year. She was classified as having mild obesity on a BMI scale (31). The assistant asked the patient to remove her shoes. The patient sat down and said "Yep, no problem. Yeah, 'cuz these gotta weigh at least a half a pound each, right?" and laughed. The assistant reframed the issue: "We're more concerned for

⁴⁰ I follow conversation analysis convention in numbering and using the word 'turn' to refer to each unique utterance.

the height it'll add, that is at least an inch!". The patient laughed, and agreed. In this case, the patient demonstrated knowledge that an accurate – and lower – result is preferable. (Dr 1/Pt 6)

Example 2: This 51-year-old white man cracked a lot of jokes. He had high blood pressure and stable weight that the physician later told me should be classified as 'healthy', though by BMI standards, he is overweight. When seeing the weight on the scale, he noted it is 'way higher' than his own home measurement taken the same morning. They continued to talk while the nurse measured his height. The nurse noted that he's wearing clothes, and joked his jeans are heavy. He gave his home reading. The nurse asked him when he last weighed himself. This morning, and he added "I mean it might not be as accurate." She asked if he had a big breakfast? No. The topic closed after she told him his height. (Dr 1/Pt 9)

Example 3: A slightly built Filipino-Canadian woman in her early 40s - who was by all metrics healthy, with stable weight that was classified as normal - saw the weight and said "I was hoping for less, but all right". The assistant weighing her replied "You know you are after lunch". (Dr 2/Pt 3)

Example 4: A 50-something, physically active, white woman of 'normal' weight and in good health was being weighed. The assistant adjusted the manual scale, during which this woman remarked, "It's always bad when they have to go up to the next one, right?" The assistant responded pointing out that the patient is clothed, implying that clothing adds weight. (Dr 2/Pt8)

Example 5: A white Italian-Canadian man with diabetes in his 70s, and who was classified as overweight by BMI standards, stepped onto the scale saying (in his thick accent), "Oh, I might be a (.) little heavy. Maybe" and then laughed. There was a six second silence, and

then the scale display read 177.4. The assistant said, “So you’re a hundred and seventy-seven pounds, okay?” His reply latched on: “With the boots!” and he laughed. She joked back, “And the heavy watch”. “The heavy watch, oh yes”, and he laughed again. (Dr 3/Pt 1).

Example 6: On a particularly cold day, the assistant ushered the patient – a white 60-something woman with hypertension, signs of kidney failure, the most apple-shaped body I have ever seen, and a big, vivacious personality - to the consultation room, and said “We’ll get your weight. If you want you can put your stuff on the”. The patient interrupted: “Oh no, my weight! Girl! I got three layers of clothing on”. The assistant chuckled, while the patient continued “It’s not fair.” After a few more comments on the temperature, the assistant agreed that clothing “does add weight”. (Dr3/Pt5)

Example 7: A low-income, First Nations woman in her 60s who has diabetes, depression, and anxiety saw her weight and exclaimed “Oh jeez, I never lose!”, chuckling. The staff member replied “Alrighty, well come this way.” (Dr 3/Pt2)

In my informal chats and brief interviews with the medical office assistants and nurses, they commented that these kinds of patient comments during weighing were pretty common - that is, not for my benefit. They explained that they opt not to respond, or instead say something to try to make the person more comfortable. Examples of clinician non-responsiveness are Vivian, and the woman in example 7. If the clinician did make a remark, the staff member said something that saved the face of the patient. They are being measured after a meal (examples 2 and 3), or fully clothed (examples 2, 5 and 6) or their shoes and watch add to the weight (in example 5, with a joking tone). These types of comments made by clinicians functioned to mark the measure as somehow higher than a ‘true’ reading, that is, one that

would be obtained if done naked, or before eating, or a couple of weeks ago. The reframing offered by the assistant to the woman with knee pain in example 1 deflected attention from weight. In two of the thirty observed weighings,⁴¹ the clinician normalised the sentiment held or behavioural weakness confessed by the patient (e.g. eating too much over Christmas) as true of everyone. These comments preserved the notion that lower weight is preferable.

Most clinicians did not say the weight aloud,⁴² but did for height. This marks weight as a different kind of measure. If they did mention the weight, they were more likely to say it in kilograms only or only after asking the patient if they would like to know, though example 5 stands as an exception. Each clinician had a way of making weight in pounds visual – either on the scale itself, or by pointing to a number on a conversion chart attached to the wall. When I spoke with assistants and nurses alone, they noted this was purposeful, something they did out of awareness that the scale was in the hallway, and that weight is a sensitive issue for some.

Weight, a measure on a scale, was treated as important by most patients, something they knew should be low and/or lower than the measurement. They displayed knowledge of the ideal, and marked the measure as important (and therefore needing to be accurate). Patients' displays of preference for lower weight developed a subject position as one who knows the norms, and as one who wants to be lighter: 'I know the norm; I know it applies to me; I want to weigh less'. Comments that set the current result apart from what they would 'typically' weigh were used by both patients and several clinicians to preserve a more positive identity for the person – as one who weighs less if weighed more accurately (naked, before a

⁴¹ One of the 31 patients was not weighed; the clinic did not have a wheelchair appropriate scale and he was unable to stand without holding on to something.

⁴² This practice is why I do not have the weight for the women in examples 6 or 7.

meal) or who would weigh less at a more 'typical' time in their life. They displayed that they care about the measure, so much so that some (e.g. the man in example two) track it regularly.

Not every patient made these types of displays during weighing. For most of the patients who made no such comments during weighing itself, their knowledge of the potential discrediting power of weight was often demonstrated when in dialogue with the physician. That is, for most of these patients, weighing less than the measurement as a sign of 'being good' was reproduced in other moments in their appointments. Thus, patients' non-acknowledgment of weight when being measured in the open hallways may be another way to manage the threat to face, though this is hard to argue definitively.

5.4 Talking with physicians about weight

This form of 'I know the norm; I know it applies to me; I want to be normal/better' seen in weighing was observed again when patients spoke with physicians. With physicians, there were more instances of the measure and its related norms eliciting patient talk of behaviours. In their behavioural talk, whether actively solicited by questions or not, patients displayed knowledge of behavioural ideals, and evaluated themselves against these norms as well. Patients and clinicians alike participated in this talk, aligning weight with eating and exercise.

The physician portion of the appointment was less routinised in terms of order of activities. The physician would enter the room, sign into the electronic system while greeting the patient, and start talking. Some questions – what can I do for you today? – were repetitive to those asked by the nurse or assistant earlier. The rest of the appointment usually involved some combination of questions, review of measurements (done in clinic and via lab testing), review of recent consultations on file, hands-on examination, discussion of treatment options,

decision-making about the plan, giving patients documents (prescriptions and lab test forms being the most common), and the doctor recommending when the patient should next attend.

5.4.1 Vivian

When weighed earlier, Vivian expressed her discomfort with her recent weight gain to the medical office assistant. Her distress at her weight came through again when speaking with Dr 1. Each of Dr 1's patients was asked at least twice during the course of the appointment if they had any specific concerns they would like to address. Vivian had mentioned to both the medical office assistant and the physician that she gets heartburn whenever she eats or drinks. She added that she takes an over-the-counter medication recommended by a pharmacist to reduce it. As was Dr1's routine, he attended first to the concerns patients raise. It was in this discussion about her heartburn that she first expressed discomfort with weight gain to the physician.

Dr 1 asked a series of questions about what makes it worse, and what helps. Included in the questions:

Excerpt 2:

- 1 DR 1: you've not had any weight loss?
- 2 Vivian: No, ['kay] I've been gaining (giggles)
- 3 Dr 1: Uhhhmhhh, (typing) and=
- 4 Vivian: I'm hoping to get weight loss (looks at Patty)
- 5 Dr 1: Okay.
- 6 Vivian: (giggles) ///END OF EXCERPT 2

Dr 1 then asked a question about her bowel movements. That is, he did not engage with her comment about her weight gain or desire to change it, but continued in his series of questions. Shortly after, he said he would give her a prescription for a stronger medication to reduce stomach acid, and recommended she sleep semi-upright. He then asked about her alcohol consumption (none) and smoking, which elicited weight talk:

Excerpt 3:

- 1 Dr 1: Um, now, how much alcohol do you drink?
- 2 Vivian: I don't drink any.
- 3 Dr 1: Okay. And how much are you smoking right now?
- 4 Vivian: He-he. My girlfriend is passing away [*oh*] *lately* it's been at least a little over a half a pack a day [*oh, okay*]. *I* was doing really good and I was having like 4 a week.
- 5 Dr 1: Hmm. Really, wow. So almost done.
- 6 Vivian: Almost done! (laughs)
- 7 Dr 1: I'm sorry to hear about your girlfriend. That's ah, yeah=
- 8 Vivian: so I have been really stressed with that, [*yeah*] and up at the hospital [*Oh boy.*] and yeah.
- 9 Dr 1: Goodness. Um (typing) because one of the, unfortunately, one of the things that makes the, there's a few things that make the-the heartburn worse. Um alcohol, not drinking any, um so night time lying down usually would be worse [*yeah*], um smoking unfortunately relaxes the valve there a little bit [*uh huh*] and would make it worse as well so [*yeah*] as soon as *possible*

10 Vivian: *like* I was getting the heartburn before=

11 Dr 1: yes, oh absolutely [yeah] that's right [uh yeah] but it is going to help a little
bit too. [yeah] So as much as possible [*as much as possible*] (*missed word*) do not-

12 Vivian: -yeah. That's why I am gaining the weight, less cigarettes, more *weight*
[laughs]

13 Dr 1: *Weight*. And that is true. [laughs] And unfortunately with more weight, this
al-the weight also- now I've got to say your weight is actually still pretty good [oo]
but slightly up a little bit from what it was so=

14 Vivian: I think the last time I was here I was a hundred and twenty

15 Dr 1: (visually attending to the computer) So it turns out that your weight now (.) is
2 kilos, which is fourrrr, four and a half pounds more than it was 6 years ago.

16 Vivian: Really?

17 Dr: Then in between you did drop 20 lbs, almost (.) 10 kilos almost. But now it's
kind of crept up again [yeah] so it's=

18 Vivian: Yeah. Less cigarettes, more eating. (laughs and looks at observer) [okay] But
I've been trying to do stuff like celery (laughs) carrots (laughs)

19 Dr 1: Oh absolutely. That's a, that's a very reasonable thing to do. [yeah] Um how
much are you working right now?

20 Vivian: I am doing 8 hours a day, but I am still on light duties- I don't ['kay] mop or
vacuum, [okay] the only heavy lifting I do is maybe three times a day I have to
throw the garbage out.

- 21 Dr 1: Okay. Um, do you (.) exercise, like go for walks or something *or any types of exercise in addition*
- 22 Vivian: *I walk all day at work.*
- 23 Dr 1: *That's the* thing, you do.
- 24 Vivian: Yeah, I do. I must do phew, I would say 3 miles, 4 miles a day [okay] at work.
- 25 Dr 1: Yeah okay. So you are pretty active that way. Um, and then in terms of the (.) the weight (.) yeah (.) any-do you have any particular sort of thoughts about, plans about what you want to do with the weight or=
- 26 Vivian: I want to drop it.
- 27 Dr 1: Okay. Um do you have any ways of doing that?
- 28 Vivian: I am eating more salads. [okay] Less greasy foods. (*laughs*) [*'kay*]. Hubby's a junk food addict (*laughs*) [*okay, yes*] and I have been saying no. (*laughs*)
- 29 Dr 1: *That's* a great start. Um, so I mean, clearly there between 2007 and 2009 you did, and 2010 actually, you dropped a significant amount. What were you doing at that point?
- 30 Vivian: Uhhh, I was working at the ____.⁴³ [okay] And I was walking like 10 miles a day.
- 31 Dr: Okay. So you were walking even more.
- 32 Vivian: Yeah [okay] yeah. And it was more, like where I am now, it's inside a building. [yeah] When I was working at the _____, it was *outside*.

⁴³ Location withheld for confidentiality

- 33 Dr 1: *you would have been outside*. That's interesting 'cuz that was-So, so it turns out actually that if you did do some extra walking just in the evening or *something* [mm hmm] just going for some walks, so that's interesting that-that, 'cuz that seemed to help at that point.
- 34 Vivian: Yeah.
- 35 Dr 1: Changing your diet a little bit.
- 36 Vivian: Yes.
- 37 Dr 1: Okay.
- 38 Vivian: Well I have always been salads in the summer. [yeah] But hubby likes everything fried in butter [yeah] and I am saying uh!-uh! (meaning a firm no)
- 39 Dr 1: And you, and that's-that's yes indeed 'cuz that's really going to add the calories [yeah] *which* at this point=
- 40 Vivian: Like I said to him I said 'I am going for blood tests and find out what my cholesterol is!' (laughing)
- 41 Dr 1: Well and-and exactly right. That-that's part of it. Even just, I mean, the heart=
- 42 Vivian: Is it still high?
- 43 Dr 1: We'll, we'll go through it. [okay] We'll go through it. In terms of the heartburn [mm hmm] and the weight, there is actually a bit of a connection there [okay] so being aware of it and looking at the fatty foods and dropping the fatty foods is already you know [yes] And with the walking that you are doing, um I think you can probably stop the gain some and reduce it. *But* [yeah] let's see what happens

with that. If it continues to get worse, then we may need to do a bit more about it because that is one of the factors [Okay.] in the heartburn situation as well. Um (..) okay we'll, we'll, we'll have to do some stuff there. Now in terms of prescriptions
///END OF EXCERPT 3

In turn 4 of excerpt 3, Vivian created an opening to tell the physician about how she spends her free time at present – with her dying friend – in relation to a question about smoking. She accounted for what she knows is not the desired behaviour. The doctor first acknowledged the smoking result (turn 5) before expressing sympathy (turn 7), after which he refocused the conversation on the stomach symptoms (turn 9). She talked over him to gain the floor, and used it to reject the notion that smoking is the primary cause of the symptom (turn 10). He reframed in turn 11.

In turn 12, Vivian again raised her weight gain, linking it to smoking cessation. Dr 1 engaged her this time, confirming the link she has made, and offering an evaluation of her weight as “still pretty good” before reviewing her weight history over the past six years: loss, then regain and more. In turn 18, she shifted into talking about eating, noting that an increase in eating is the cause of the weight gain, and mentioning one thing she has been doing to address the problem already. In this and earlier at turn 12, Vivian developed a subject position for herself as knowledgeable that her weight is a problem, and displayed that she was already taking steps to address it. The physician agreed in general, and then brought physical activity to the table.

In turn 25, the physician solicited her thoughts on weight. Vivian latched on, and offered the preferred response: “I want to drop it”. He asked if she has methods to do so - an open-

ended question that focused on what Vivian can do that will foster weight loss. She displayed knowledge about healthy eating in response. The physician, in turn 29, asked her about what she did differently between 2007 and 2010, making a discursive link between behaviours and weight loss. She offered a ready explanation: more walking at her job in those years. In turn 33 and 35, he recommended she become even more active, and change her diet (without offering specifics on the latter). She passed the floor. He did the same (turn 36/37). She then elaborated, again displaying knowledge of what to do. The doctor oriented to calories, but she interjected (turn 40) to re-orient the discussion to cholesterol being the important factor in terms of diet (turns 40 & 42). The physician agreed to address her cholesterol in time, and then reiterated the link between weight, fatty foods, and her stomach symptoms. He noted that with the walking she already does, dietary changes should help stop the weight gain.

The appointment continued, with the doctor reviewing her current medications, her allergies, her blood work (sugar and cholesterol) and blood pressure, and her heart risk – low, over the next ten years – and results of her mammogram (“fine”). He mentioned the shingles vaccine, and the lack of coverage for cost. He then shifted the appointment into a physical exam, after which she spoke about the treatment she was pursuing for her ongoing neck pain.

At the end of the appointment, he reiterated his recommendations, including:

Excerpt 4:

- 1 Dr 1: ummm, then the weight so, yes watching what you eat um, avoiding some of the fatty stuff- maybe adding in actually a little bit more walking, say on the weekend or something like that as well [yeah] because it is interesting that that seemed to work for you in the past, just increase that actual [yeah] movement=

- 2 Vivian: Well, working at the _____, you walk that [yeah] _____ [yeah] it's 3 miles long and it is a mile long and I used to walk it at least 3 or 4 times a day.
- 3 Dr 1: Yeah so that, and that worked for the weight.
- 4 Vivian: Yeah, no kidding. (laughs) Whereas where I am working now, it's a corporate building [yeah] it's a block long and I do three rounds in that building [yeah] and then I walk a block to the other one.
- 5 Dr 1: And then yeah. So you're getting some good walking in but [yeah] if possible ramping it up some would be one of the things that might help it. Your blood pressure is looking ok still, your cholesterol– like I said that's still in a reasonable range.
- (and on he continues, summarising the results, and planned actions).
- ///END OF EXCERPT 4

Vivian responded to his recommendations to walk with first an explanation of how much walking she used to do (turn 2), followed by a statement that frames the doctor's assessment about the extensive walking at her old work as obviously helpful: "yeah, no kidding" (turn 4).

The three or four miles that she walks each day at her full-time job are not adequate, he implied, a truth based on the weight measure and the weight history. There was a recommendation, a suggestion that she notice what worked in the past, without an exploration of her interest in doing so or what might hold her back (which we know may include pain⁴⁴ and

⁴⁴ A limitation Dr1 recognized in our later interview, when we reviewed parts of the audiorecording of Vivian's appointment.

time). Other potential contributors to her weight gain that came up during the interview – stress, smoking cessation, her husband’s expectations – were not emphasised much, if at all.

5.4.2 A very common turn-taking pattern

There is one turn-taking pattern I want to highlight: that of Excerpt 3, turns 17/18. Up until this point, Vivian and Dr 1 have been talking about the outcome⁴⁵ of weight. In turn 18, Vivian linked the measure to her behaviours. We learn this link was received as appropriate in the doctor’s next turn, in that he continues to pursue the topic of her diet without any sign that the change of topic is in need of repair. This is but one example of a ubiquitous pattern in many appointments I observed: talk about measures elicited talk about behaviours from patients, with both speakers treating this shift in topic as appropriate. It happened frequently for weight, and on occasion for blood pressure and cholesterol blood test results as well.

The following examples are limited to weight. I flag for the readers that:

- 1) Patients heard a question or statement about weight as requiring a behavioural account, one that often included a self-critical evaluative comment as well.
- 2) Clinicians heard these behavioural accounts as an appropriate way to respond (ie, from conversation analysis clues in terms of ongoing turn-taking).
- 3) Patients who did this were of a variety of ages, and a wide range of body masses. Both men and women did this, though no incidences of it were found among the notably fit men.⁴⁶
- 4) It was less common with Dr 3. I develop this contrast after the examples.

⁴⁵ or in Dr 1’s phrase in an later interview, the lag measure.

⁴⁶ Something I think is worth highlighting, but I hesitate to draw conclusions about given only two of the 31 patients fit this description.

Example 8: A white man in his late 70s (Pt9) who had a heart attack years ago and has gout, attended for an annual check-up with Dr 1. He wore a hearing aid, and mumbled when he spoke. He had gained weight since his last visit, and his BMI (28.9) was classified as 'overweight'. In a later interview, the doctor noted that this patient would see benefit from weight loss specifically, given his cardiovascular history. Dr 1 then added that he is generally cynical about weight loss for most patients because it is difficult to achieve and there are other changes that would produce a better health impact, such as increasing physical activity. This appointment started by the physician asking a series of questions about his symptoms, medications, and reviewing test results.

At one point, when the physician was silent while attending to the computer, the patient mentioned that "I've gained weight though, I'm sure I have". Dr1 said he would take a look, then asked the patient if he had ever had a pneumonia shot. 'What about this year's flu shot, or the shingles vaccine?' Once done this series of questions, the doctor then turned the conversation back to weight:

DR: Uh, your weight, let me have a look. (brief pause while looking at computer) It has come up a little bit. (.)

Pt 10: Well, um, I walk, and golf a bit.

DR: Ok.

Pt 10: Fishing, part of it, but still. When this thing began I may have eaten too much I don't know. ///END OF EXCERPT

The doctor's first comment, raised during the doctor's review of measures, ended with a pause – a pass to the patient. The patient heard the pause as an invitation to speak, and offered

a comment about his physical activity. As they continued to talk (not shown), the doctor gleaned that this man was active on a daily basis. The conversation continued with the physician asking the patient to detail his usual meals.

Example 9: Dr1/Pt 10: This is the same man as in example 2 from weighing - a joking 51-year-old white man with high blood pressure, and a body mass index that was classified as 'overweight'. When I interviewed the physician, he marked this patient as a good example of when body mass index is a poor indicator, and waist circumference is better. In the appointment, when Dr 1 reviewed his measures:

DR: Um, now your, so with your weight, has basically, is always kind of the same.

Pt 9: *Yeah.*

DR: *Yeah, exactly, so=*

Pt 9: And I knew, I knew it was up, um, and that is just because I uh, for the last three weeks, I've been away two of those weeks and whenever I travel, I always eat more.

DR: Yes, *yes (inaudible)*

Pt 9: *And I just came back from a week in Vegas. (chuckles)*

DR: Oh yeah, ok, that'll, that'll do it as well. So, I mean it is kind of, you know, sort of up and down, up and down, I mean having, at least doing some of the walking is a good start. ///END OF EXCERPT

Here, the patient has marked his stable weight as higher than usual and thus a problem, a problem he links to his eating behaviours while traveling.

Example 10: A professionally dressed, white woman in her 50s who was in for her first ‘physical’ in about three years with Dr 2. She had a list of topics she would like to cover, and nervously joked that she is a hypochondriac. Over the course of the appointment, her husband’s alcohol abuse emerged as well – something the physician later told me was new information. The patient was of normal weight by BMI classification standards (24.5).

Dr2: _____⁴⁷ checked your blood pressure, which is good and then, I was noticing your weight is pretty stable (.) from last year. Like you’re up like half a pound over three years ago I guess [ok] and before you have been heavier, like 65.5 kilos?

P: I know I was thinking that, yeah, well and-and ah I am also on a bad sugar thing the last week and a half and I know my weight is coming back up ‘cuz it was down [mm] and, and I realise I am kind of waking up too hot in the night and saying ‘it’s the sugar, it’s the sugar’. ///END OF EXCERPT

It was Dr 2’s practice to comment on weight, and the pattern of weight (gain, loss, stability) routinely during the more comprehensive annual appointments. In this case, weight stability in a normal weight person after an earlier weight loss – a neutral or positive outcome – is one that elicited patient comments about her weight ‘coming back up’ and an admission that she was on a ‘bad sugar thing’. She framed the scale’s result as an over-estimation of her ‘real’ weight, at a time when she is less stressed. As the conversation continued, the physician talked with her in detail about physical activity.

Example 11: This warm and friendly white 65-year-old woman is a retired teacher. At the time of the appointment, she was in remission from a cancer that required both surgical and

⁴⁷ Assistant’s first name

pharmacological treatment. She had had both knees and one hip replaced. Her husband had a chronic neurodegenerative disease, and she was his caregiver. She was classified as mildly obese, and had gained weight since her last check-up. She was seeing Dr 2 for her annual check-up:

Dr2: Your blood pressure's good and, uh.

P: Yeah always seems to be good, so.

Dr2: And weight's up a little.

P: It is.

Dr2: About 2.5 kilos it looks like.

P: Yeah, about 5 or 6 lbs at least I was saying [yeah]. I just came back from holidays [ok] where I have done n::nothing but eat and drink and I feel it [ok] so I need to do something about that.

Dr2: Yeah, you have been higher in the past, like in 2005 you were 90 kilos, and then you- you did eventually-it goes down to 77 or 78, but now you are 81. So yeah, *maybe* [yeah] just the holiday, but.

P: It's also the (.) whole lifestyle thing. What I am doing right now is terrible [hmm] and I know that.

Dr2: Yeah [you know, so it's], so are you talking about exercise [yeah] or diet.

P: You know, not doing any exercising [yeah] because of my knee and stuff [knee, ok] it's really bad. Not that I was big on exercise anyway, but even walking I'm, (dr typing) you know, even if I went shopping I can't walk around [mm] the whole mall for an hour or two [hmm, ok] that's too much. So, um. But I do have a treadmill [ok]

that's, I can get back on it. (Pt makes eye contact with me) *[Ok, so] So I have to do that ///*END OF EXCERPT

The patient responded with a simple agreement to the physicians' first statement about weight. Dr 2 quantified the weight gain from a year ago, a statement that elicited a longer patient response. In her response (Yeah, about 5 or 6 pounds), the patient confirmed the measures aligned with her self-knowledge, before offering a behavioural accounting of the cause. The physician described her weight history, and agreed it could just be a result of a holiday. Yet, the physician ended her turn the word 'but', introducing doubt that the holiday alone was the problem. The patient then added a self-evaluation that her current lifestyle is 'terrible' – a self-evaluation that the physician does not acknowledge, neither reinforcing nor denying. The physician clarified that the lifestyle comment made referred to exercise and diet, and the patient explained her activity is limited by problems with her 'knee and stuff'.

Across these examples, physicians' talk about weight elicited behavioural accounts from patients. In some cases, weight gain was at play, and the physician had noted the gain verbally. But in other situations – weight stability or even weight reduction – patients still responded by positioning themselves as knowledgeable of their failure. Some norm of ideal weight marked their failure – even for the woman in example 10 of normal weight. The patient responses highlight the discrediting nature of the measure: the measure tells a truth to which the patient accounts.

5.4.3 The difference of Dr 3

And yet, this did not always happen. In particular, this phenomenon of patients doing work to save face in relation to weight was not as common with Dr 3. The one time it did occur

– a conversation I will detail in the next chapter, with a patient I call Darren – was the only patient I observed whose body was classified via BMI as severely obese.

But what of Dr 3's other patients? Some of this difference may be a function of her patient population. Two of the ten patients I recorded were classified of 'normal' weight from a BMI perspective, but she described them as 'cachectic'. Weight gain, rather than weight loss, was the desired outcome and topic of extensive conversation with these two patients. In addition, Dr3's patients were older than those of Dr1 or Dr2 (55+, with some observed patients in their 80s), and were living with more complex problems, including recovery from a stroke or a heart attack, managing insulin-dependent diabetes, serious mental health issues, or circulatory problems that limit activity tolerance. Many were low income, which influenced what was realistic, in terms of physical activity in particular. While walking was accessible, walking outside in winter was hazardous and other physical activities not accessible. As a result, weight loss is not an outcome Dr 3 sees as that high of a priority for her population.

She prioritised other problems that she thought would have a higher impact on their health. She spoke with people about eating or increasing their physical activity, but linked these to outcomes such as remaining independent, improving mood, or as part of a cholesterol treatment plan. In our final interview, Dr 3 noted that changing eating and exercise habits may be too hard for many of the patients in her practice:

the ones that we're expecting to make the changes are generally people who (.) have (.) um, first of all they have stable lives, and what I mean by that is that, you know, there's income, there's housing and there's some good social supports [mm hmm]. Finances is the biggest thing, it doesn't matter how motivated someone is, and, if they just don't have the finances to afford good foods, um, that will affect a lot of their issues. Diabetes, cholesterol, blood pressure issues, renal issues.

Dr3 was the one physician who spoke to me directly about how access to resources – social and financial – can impact a patient’s ability to make changes.

Perhaps the socioeconomic, age, and health status differences that distinguish Dr3’s patient roster from those of Dr1 or Dr2 means patients do not hear a statement about weight as an incitement to talk about their eating and exercise behaviour. However, my data points to something else that is potentially at work here. Dr 3 communicated differently with patients. In particular, she tended to ask more information-gathering questions before talking about results of measures. When she did talk about measures, she tended to offer an evaluation (of the ‘this is good’ variety), and occasionally she mentioned factors beyond the patient’s control (e.g. genetics or medication or complicating factors such as comorbid conditions). And when she spoke about measures, she often focused the patient’s attention in a particular direction – a trend line on a computer, for example, or asking a specific question to direct the conversation. In comparison, Dr 1 and Dr 2 tended to make a statement without an evaluative component or a method to direct the patient’s attention. Dr 3 already knew about behaviours, due to her routine way of questioning patients, while this was less often the case for Dr 1 or Dr 2.

5.5 Situating these patterns in a governmentality frame

Clinicians and patients orient to biomedical measures like weight, and calculations like BMI, as producing a truth. Patients and clinicians co-produce these truths and norms, via an intersection of examination procedures and confessional practices. I have foregrounded the ease with which patients link a particular bodily characteristic to eating and physical activity, while being weighed in a hallway or behind closed doors when talking with the physician.

Clinicians often reinforced this, treating patient slippage from weight to behavioural accounting as a relevant, appropriate response.

The truth being co-produced during the appointments depends on norms and normativity, about both preferred bodies and desired subjectivities. That is, norms are part of what patients include in responses to factual statements about their weight and/or when being weighed.⁴⁸ In clinical talk, weight is a truth not just about a body and behaviours, but implies truth about the individual, their commitment to health and taking care of themselves, and their knowledge. Most patients treated weight or BMI as implying a subjectivity, one that marks the self as abnormal and in need of remediation, regardless of whether their weight was classified as normal, stable, improving, or worsening. Patients' fluency with, and invocations of, the norms and normative values about weight and commitment to healthy behaviours was also heard as normal by clinicians. These normative assumptions are evidenced in how the turn-taking proceeded – usually without repair.

The truths told by the confession are not revelations, but confirmations of tacit knowledge. Some patient responses take the form of 'yes, I know; I know my body shows my failure'. In their accounts, patients admit their failure to conform to the norm, and/or their capacity to be someone who does the right things. To return to Murray (2009), I interpret these confessional comments as demonstrating the strength of weight and particular health behaviours as virtue discourses. Patients claim a more virtuous position by positioning themselves as one who knows and cares about the norm, even if life gets in the way of

⁴⁸ The latter being consistent with Pillet-Shore's (2006) study of nurse-patient interactions during weighing.

complete adherence to healthy behaviour imperatives. Their accounts take a similar shape to those found by Webb (2009) and Throsby (2012) in bariatric surgery clinics: the number tells a truth, and when the number marked them as not responding well to the surgical treatment, patients confessed transgressions, displayed an awareness of the rules, and articulated a desire to improve. In the present case, it is people attending primary care clinics doing this talk. And of note, it is people with a wide range of bodies and behaviours participating in these confessional practices, during both weighing and when in discussion with clinicians.

Yet the subject position of failure implied by a body evaluated as 'too heavy' (regardless of the BMI) was not wholly accepted by all the patients I observed. Several patients oriented to and then worked against the discrediting subject position implied by their weight. Patients could direct the talk to recovering a 'this does not fully apply to me' response. Vivian, who by BMI calculations is four pounds heavier than the ideal range, is occupied with a close friend who is dying, for example. This helps her reframe herself as virtuous. With other patients, pain, limited time, competing priorities, or stress functioned to help repair identity. Of note, the identity repair work often exemplified what Rose (1999a) argues is typical of contemporary confessional practices. He suggests that communicators minimise repentance for failings and instead foreground surviving hidden injuries or challenges. They resist the failure this subjectivity implies, and instead position themselves more positively. They collaborate in and in some cases lead the problematisation of their bodies, but resist the problematisation of their selves that accompany.

The ubiquity of these forms of confessional talk suggests these are socially acceptable responses to attributions of individual responsibility and control. However, this common

response perpetuates the notion that we all need to be autonomous, decision-making managers of our lives. Justifications of why the ideal can only have limited application in *this* situation, in *my* situation, do not constitute a wholesale rejection of the ideal of being a responsible, self-managing individual. Individual strategies employed to resist being judged as non-normative only apply to the person involved. They do not absolve the broader population from being responsible, self-managing people.

Weight acts as a prompt for confession, a ritual Foucault (1976/1990) describes as a speaking subject who tells a truth about themselves. The truths made by the clinician and patient are about a body-we-have and a person-we-are. Confession is, then, a technique of subjectification (Foucault, 1976/1990). Confession is a process by which patients can display their knowledge and practices of self-evaluation, risk management, and self-correction (Rose, 1993, 1999b), and thereby constitute themselves as ethical, active subjects (Rose, 1999a). In the clinical appointments I observed, patients often aligned themselves with this active, responsible subjectivity by marking weight as a norm that they care about, evaluate themselves against, and upon which they know their behaviours and personalities are judged. Patients are already fluent in these norms, examination procedures, and confessional practices. They collaborate in marking their body as an object in need of remediation, as Cussins (1998) and Heath (2006) both found. But many patients resist marking their subjectivities as an object in need of discipline.

These patterns of confessional practices will appear again in the next chapter. In some cases, patients' confessional practices that deflect blame are marked by the physician as in need of repair, creating trouble for the interaction. In the chapter to come, I focus attention on how

clinicians solicit and handle these confessions, and the interjection of weight-as-choice discourse that discredits people living in bodies deemed excessive. I do so to open up how to think about the logics of care and choice in primary care practice.

Chapter 6: Mol's logics in the clinic: Exploring care practices

Clinicians balance what patients bring into the appointment with other priorities, including biopolitical ones. The previous chapter makes visible common patterns in the subjectivity claims and confessional practices that patients bring to the dialogue. The examples developed in the present chapter add to that understanding, while orienting more to the clinician side of these interactions. The examination, with measurements, calculations, and questions, is integrated with patients' confessions in order for the actors to figure out what should be done. Understandings of the problems and solutions are developed in dialogue between clinicians and patients. Mol's (2008) logics help focus our attention to variations in these practices, and what they aim to accomplish. In this chapter, I aim to open up two threads for consideration.

Every clinical conversation I observed integrated population-based knowledge, such as norms and treatment options, into the dialogue. Population knowledge was embedded in the clinical infrastructure, such as guidelines, electronic medical record templates, and risk profile calculations. In this chapter, I demonstrate how inscriptions, population-based knowledge, and technologies are folded into practice. I highlight variation in what is made visible as possibly part of the solution to whatever problem is co-produced in the interaction. I explore what outcomes are made to matter in the conversations with patients, and how. I work through four cases, stressing how knowledge and technology were folded into clinical practice specific to the topic of weight, and to show which outcomes clinicians oriented toward. Through these examples, I highlight variations in how population-based knowledge was utilised by clinicians, aligning more with either a logic of choice or care. Through these cases, I aim to illustrate how

enacting biopower imperatives can be aligned with caring for a person as per Mol (2008), but that is not always the case.

In each of four cases I develop in this chapter, weight is worked up as a problem. In each, clinicians aim to act on patient behaviours to achieve a particular outcome. Something in the assemblage is creating the problem, and particular visibilities are made in terms of what that might be. In each, the choice-logic assumptions - that we choose our weight, and that our weight is malleable - are made present, although the extent to which the conversation maintains this discourse varies. When the dominant discourse of weight-as-choice is made to hold its own, patient choices/behaviours are identified as the problem, and physicians exclusively tinker with patient behaviours as the solution. The inscriptions of weight and body mass index speak a truth, and weight loss is the outcome to seek. Epidemiological knowledge of 'clinical targets' tends to lead the goals, and patients are recruited into committing to make the changes the evidence would suggest are in service of achieving those clinical targets. Other determinants of health are rendered invisible, and intensification of work on the self is recommended without hesitation. Three of the four examples I detail here fall into that pattern. In contrast, the final example creates space for more mediators of behaviours to come to the fore, and what may be tinkered with to make a better life is an open process of discovery with the patient. By attending to practice, we can see that pre-selected classifications and population-knowledge-based standards do not always determine clinicians' actions, and that governmental processes clinicians employ may indeed help a person craft a better life.

To build these arguments, I present each case in a summarised chronological form, including excerpts of talk and written descriptions of activities. I draw the reader's attention to

particular features and functions of the talk. I follow each case with a more explicit analytic interjection, raising questions and insights that are informed by the scholarship of others in this field and the theoretical lenses I use to focus my attention.

6.1 When weight-as-choice is maintained

6.1.1 Darren and Doctor 3

Darren was in his late 50s, and his appointment was a routinely scheduled one to monitor his diabetes. Darren had what is classified as severe obesity (BMI of 48.3). He had just completed an active weight management program. This was his first visit with his family doctor since shifting into the 'maintenance phase' of the program (a once-a-month group meeting). Dr3 told me that Darren is a potential candidate for bariatric surgery, though she has not broached that conversation with him. She added that with limited numbers of bariatric surgeries done in the province, her sense is that the 'most motivated' are the ones selected, and that the program he has just completed is a step in the process.

This appointment deviated from the usual clinic routine. Darren's appointment started while the medical office assistants were eating lunch, so Dr 3 did the measures herself. She greeted Darren at the entrance, and we three walked to a consultation room, where Darren left his coat and boots. We headed to the weighing area, in this clinic, a semi-enclosed area with a digital scale that has a ramp and weighing platform large enough for a wheelchair. The scale shared the semi-private space with a wall of cupboards and a mini-fridge that serves as medical supply storage space.

Dr3 asked Darren to remove the items in his pockets, during which he offered an unsolicited, pre-emptive account for the number on the scale: "I think I ate a little too much at

Christmas-Well, I think there is a little bit too much eating at Christmas time-“. Dr 3 interrupted to say “DR3: Always is for everyone-“. Darren interjected to agree. After weighing, she measured his height, writing both numbers down on a scrap of paper. We all returned to the consultation room.

Darren sat in a chair next to the desk with the computer. Dr3 logged into the computer, entered the information, and stated that, in addition to the blood work to review, she received a note from the pharmacy telling her it is time for Darren’s prescription refills. She then turned to Darren, and asked:

Excerpt 1

1 Dr 3: How are you doing with the weight loss?

2 Darren: Well, you know, I mean when it’s Christmas, you know what that’s like [mm hmm]. So, I would say there was not much happening with that.

(while he talks, she produces a visual trend line graph on the computer.)

3 Dr3: Well (.) I would say that at least we are on a nice downward trend. (turns computer screen so he can see graph) Look at that. (.) So here we are (.) in November [oh! ok] right [yes right] and you’ve lost about 8 kilograms, no 6 kilograms.

4 Darren: Well that is kind of strange because I know I have been eating a little too much at Christmas time so. And then when I hear, when I went on the scale here today, something (missed) did, I thought it was always about 135 or something.

5 Dr3: It was 138 the last time you did it [ok], 138.2, 130.7 today.

6 Darren: Well, if the scales were any good, well good! That’s good.

- 7 Dr3: That's good!
- 8 Darren: Yeah. (chuckles)
- 9 Dr3: 'kay! Have you managed to get out and do more activity?
- 10 Darren: Uh, some, uh, but um, actually this week I was going to go to the Y and of course start working out, but I got all these doctor appointments. Yesterday the dentist, you today [mm hmm] eye doctor on Friday. Monday I have to go back to the eye doctor [alright], the specialist, so. But anyways I still want to try to get back into, work out at the Y.
- 11 Dr3: And the Y seems like it's gonna, it's=
- 12 Darren: It's a good place, yeah. And then even if it's the treadmill, it, and on the race track [yeah] and a little bit of light weights where you are lifting.
- (During Darren's statement, the doctor clicks the mouse and a trend line for diabetes comes up on the screen; short pause).
- 13 Dr3: Ok. Um, with the diabetes, the trend ///END OF EXCERPT 1

Dr 3's question in turn 1 is about an outcome. Turn 2 is a bit ambiguous as to whether Darren was saying he expected no positive change on the outcome, or was admitting to not taking the recommended actions. Dr 3's words and visual display of the outcome show a 7.5 kilogram (ie, 16.5 lbs) loss in less than two months, an outcome that surprised Darren. He made a comment about the accuracy of the scale (turn 6) and then offered a positive evaluation, which the physician echoed in turn 7. In turn 9, Dr 3 asked explicitly about activity. His response, in turn 10, is a reiteration that he has not changed his energy intake/expenditure much. Darren cannot align the weight loss result with the 'eat less/exercise more' formula in the discourse. His

account troubles the dominant story about weight. Dr 3 does not treat this lack of alignment as a problem; the weight speaks a truth about his behaviours, even if Darren does not know or will not speak them aloud.

They continued, speaking about the diabetes measure (HgA1c), which has worsened a bit. Dr 3 changed his medications in November; she and Darren agreed that is likely the source of the problem. She asked a series of questions about Darren's home blood sugar results, and they decided to increase his current medication doses. During this exchange, Dr 3 had written the HgA1c result on the scrap of paper next to his weight. As she reviewed the new medication plan, she commented that they will monitor again after the dosing changes, and figure out next steps then:

Excerpt 2

1 Dr3: If they're coming down, that's great. If no:ot:t, the next thing would be the consideration of adding a basal insulin. But I don't think we're going to need to go there. [mm hmm] I think if you keep doing what you're doing [yeah] with um, that your diet [yeah] modifications.

(she is turned to him during this conversation. She draws an additional arrow down to the 130.7 kg # on the piece of paper while saying 'doing what you're doing, diet modification'; a gesture that captures both Darren's and my visual attention).

2 Darren: Yeah, I have to really=

3 Dr3: And if you can get into the Y

4 Darren: *And a* little activity, yeah. Yeah for the gym I have to, there's not enough activity outdoors, and you know, especially when the weather's really bad. ///END

OF EXCERPT 2

In the gesture after turn 1, Dr 3 visually reinforced the food intake link with weight loss. As the conversation continues past this excerpt, she asked him to speak about his experience with the weight loss program. Darren noted that he has just shifted into the once-a-month meeting, but the weather precluded him from attending the first session. He listed the things that he is to do, but has not yet started, such as keeping a food journal and “the calorie thing”, mentioning again that Christmas is busy.

The topic changes, to future lab work to be done, a review of the medication changes Dr 3 is recommending, and discussion of the clinicians Darren saw in the recent past (a dietician, a nurse, and an endocrinologist).

Excerpt 3

- 1 Dr3: I am actually quite pleased Darren, you are doing quite well.
- 2 Darren: Mm. (Dr stands up, and moves behind him to the blood pressure cuff hanging on the wall) Still I am suffering with fatigue, but anyways, that's.
- (9 second silence, during which time she changes the arm cuff for a larger size)
- 3 Dr3: Let's um, aim for the next one-concentrate on getting you into the activities, you might find that with the increase in activity you might-
- 4 Darren: Yeah, I am hoping the activity will help. (Dr putting cuff on his arm)
- 5 Dr3: Help with your energy level
- 6 Darren: At Christmas, before Christmas, or during Christmas time, I seemed to have a lot of energy, and really out and about and busy. (Dr inflating the cuff)
- ///END OF EXCERPT 3

In excerpt 3, turn 2, we learn of one of Darren's primary complaints, fatigue. In turn 4, the physician linked his symptom to physical activity, and Darren interrupted to agree that he is hopeful that physical activity will help.

Upon completion of the blood pressure measurement – which is good, 'as usual' – Dr 3 returned to the computer, typed for a few seconds, and then said she wanted to check "if I'm on target". She pulled up a template (I see this only once), titled *Flowsheet*. She paused, read a couple questions aloud, and made verbal note of unresolved health issues, for example, the unknown problem with his Vitamin D absorption. She re-listed the lab tests she would like done, then asked Darren if he had any questions. He did not. She stepped out of the room, selected two sheets from a hallway printer, signed each and circled certain test names on the lab requisition form. We said our goodbyes.

6.1.2 Stabilising weight as telling behavioural truths in the face of contestation

The scale and the act of measuring produce a truth that is assumed to speak about Darren's behaviours, despite that the truth is tenuous. Both speakers made the "behaviour-produces-weight" mantra relevant in multiple ways over the course of the discussion. Darren told the physician and me repeatedly that his behaviours have not changed (Excerpt 1, turns 2, 4, 10; Excerpt 2, turns 2 and 4). His comment about not yet keeping a food journal or the 'calorie thing' indicates that he was not doing what he has been advised to do. He did not accept credit for the weight reduction as being a product of his behaviour. The truth told of Darren's behaviours, represented by the measure, is not corroborated fully by Darren, but was maintained by Dr 3. This is an instance where the dominant understanding of weight as being the result of behaviours creates interactional troubles between this patient and his physician.

In this consultation, weight was understood to be a result of choices. Darren's recent weight loss implied he is making good choices. Dr 3 worked in multiple ways against Darren's positioning of himself as failing to do all that he should. From early in the appointment (Excerpt 1, turn 3), both Darren and I knew that Dr3 thought Darren's weight measures are on the right track. We heard this positive evaluation again, in excerpt 3, turn 1. Dr3 normalised Darren's comment about overeating, indicating it is a problem everyone has. She used the weight result to trump the information Darren provided about his behaviours – in showing him the trend line (Excerpt 1, turn 3), and in Excerpt 2, where Dr3 asserted Darren has made dietary changes.⁴⁹ The seeming absence of a behavioural cause of his weight loss was not left to stand as a truth; instead, the dominant weight discourse supplied a reason for Darren's downward trend. Darren must be making good changes, and his plans to start working out at the Y will only help. Because weight was going in the preferred direction, the result was celebrated and Darren was given credit and encouragement to continue what he is doing. This positive identity worked up for Darren was upheld in the face of the worsening diabetes blood test result: here, the medication change is to blame.

According to the lab value, Darren was not absorbing vitamin D, and he reported that he was struggling with fatigue; are there any explanations of those symptoms that might also account for weight loss? Has reliance on the discourse of weight-as-choice fueled the possibility of overlooking something else that is going on? The visibilities and invisibilities created here

⁴⁹ Dr3 may be pulling on prior knowledge; that is, Darren may have made dietary changes before this visit that are in the medical record. However, nothing is verbalized in this appointment that confirms that Darren has done so.

make this an example of how framing weight gain or loss as a result of behaviour consistent with choice-logic can foster neglect.

Gabriela, the next example I develop, has several similarities to Darren. Both Gabriela and Darren have problems with their blood-sugar levels. In both patients' appointments, weight is talked about before behaviours. Again, the 'eat less/exercise more' formula for weight holds, and the physician's assessment focuses on the patient's behaviours. This time, both speakers orient to it without problem. The visibilities and invisibilities produced in interaction with Gabriela highlight that the outcome prioritised by the physician is weight loss above all else.

6.1.3 Gabriela and Doctor 2

Gabriela is a 50-something, friendly, Italian-Canadian⁵⁰ woman. At the time of the appointment, she worked three days a week in a large store where she walks most of the day. Gabriela had been diagnosed with 'early diabetes', to use the physician's term. In the past, Gabriela opted to integrate dietary changes and increased physical activity to address her high blood-sugar reading. Her blood sugar levels have stabilised within acceptable limits⁵¹ in the past three measures.

Unlike the other physicians, it is not Dr2's practice to have patients go for blood work prior to annual check-up appointments, so only weight and blood pressure were current. Immediately prior to Excerpt 4, the physician reviewed the year-old blood-sugar results, and continued with her routine method of reviewing measures:

⁵⁰ A cultural identity Gabriela made salient.

⁵¹ A clinical evaluation of her blood sugar level, not my own.

Excerpt 4

- 1 DR: And your weight went up a little bit=
- 2 Gabriela: today?
- 3 Dr2: Compared to last year.
- 4 Gabriela: Yes I know. [umm] That's 'cuz I am not doing as much exercise.
- 5 Dr2: 1.7 kilos in the last year, so that's:s just over 3 pounds, so yeah the exercise
will make a difference=
- 6 Gabriela: Yes. I am a little lazy. (she makes eye contact with me while saying this).
- 7 Dr2: Ok. Is your diet pretty good?
- 8 Gabriela: Uh, I think so. I try, I watch (.) pretty much what I eat.
- 9 Dr2: Ok. And you *vary [I am very conscious] between* about 66 and a half kilos up
to 71 kilos. Today you are 70 and a half [mm hmm] so. Which is, um (.) 155.4 lbs.
- 10 Gabriela: Right. Which is (.) high.
- 11 Dr: High for you. Yeah [yes it is] your body mass index is 28.3-[yeah] that is that
height weight kind of calculation [mm hmm] we kind of want that [mm hmm] to
be 25, well, less than 25 ideally [right]. Um, so, yeah [yeah I know] so there is some
room for improvement there. And, you know, it'll affect your diabetes control too
so, um. Now are you exercising less because of your back (.)? (typing) Or?
- 12 Gabriela: (Dr typing throughout) Well I was doing a body pump class which I really
enjoyed [mm] but I find that when I do that, I do-my back is very sore after *that*
[ok] so, I think we have talked about it and you said it was ok for me to do as long
as I kept my weights low.

13 Dr2: mm hmm, *[right?] yeah*. The weights you are lifting.

14 Gabriela: Yeah *[yeah, yeah]*. So, um, so really I am just walking.

15 Dr2: ok, which is great exercise. Do you walk most days, or?

16 Gabriela: N:no, *[ok]* maybe three times a week.

17 Dr2: And how long do you walk for?

18 Gabriela: Uh anywhere from half an hour to 45 minutes.

19 Dr2: Ok *(typing)* which is a good duration.

20 Gabriela: Not bad.

21 Dr2: Yep. So you may just have to try an', try and do that every day or even, like the current (.) feeling (Dr turns from computer to face Gabriela during the 'the current feeling') is that even:n short (.) periods of exercise, like you know breaking it up into 10 minutes *[10 minutes, 15 at a time]* and at least one of them should be kind of moderate, you know, where, like you are rushing for a bus kind of walking *[yeah, yeah] yeah*, so. So just some room for improvement there.

22 Gabriela: Yes, *there is*

23 Dr2: *Of course* walking outside right now is a little touchy depending on the weather, but-

24 Gabriela: Well, I do the treadmill=

25 Dr: oh you do the *treadmill* *(burst of typing)*

26 Gabriela: *sometimes* I, if I want to just get out of the house, I will just go to the gym *[ok]* *(chuckles)* to have that (.) feel and that interaction *[yeah]* because it's boring at home *(chuckles)*

27 Dr: yeah, just ta yeah get some variety, um. (Dr turns back to computer) And are you working full-time? ///END OF EXCERPT 4

Both Gabriela and Dr2 oriented to the notion that Gabriela's slight weight gain is the result of problems with her behaviour. Eating and exercise were the only two factors made present as causal by both of them, and are both factors present early in the appointment (by turn 7 in the excerpt). It was shared knowledge that weight is a function of calories in and calories out. The physician quantified Gabriela's small weight gain, and took up the patient's attribution to exercise/laziness. We see this attribution in how Dr2 accepted the patient's comment about her diet, and then pursued the exercise topic more. The physician later offered two face-saving potential explanations for Gabriela's self-professed laziness: back pain; weather. Gabriela does not let either potential explanation stand. Both Gabriela and Dr 2 orient to this discourse, without discernable trouble doing so.

Dr 2 contextualised the current weight measure in Gabriela's own weight history, and contrasted the measure to the 'ideal' body mass (turn 11). Dr2 spoke of room for improvement in the measure, pulling on population-based knowledge to do so, and then shifted seamlessly to talk about physical activity – taking up of Gabriela's attribution of cause. In turn 15, Dr2 offered the preferred frequency of physical activity, to which the patient responded with a dispreferred answer. The physician eventually recommended Gabriela try to exercise daily, and promoted "the current feeling" that even ten minute stints of exercise will be helpful, an idea Gabriela echoed. The 'room for improvement' in the measure triggered information-giving by the physician, in the hopes that Gabriela will make additional changes to her eating and exercise habits.

As the appointment continued, more details about Gabriela's job came to the fore, in particular the extensive amount of walking involved in her three shifts a week. Listening to the conversation during the appointment I came to have doubts about Gabriela and Dr2's co-construction of Gabriela as a bit lazy, though there are no indications that Dr2 also developed doubt.

6.1.4 Which measures tell the truth of behaviours?

Gabriela's case further illustrates how the dialogue can be structured by the biomedical measures, their interpretation, and how meaning is made of them. For both Gabriela and Darren, the weight tells a truth about behaviours, more than the diabetes inscription does. The direction of weight loss or gain changes the assumptions made about behaviours. In Darren's case, the physician attributed the improvement in weight to behavioural causes, while the worsening of diabetes biomarkers was marked as a pharmaceutical problem. Darren was positioned as someone who is doing the right things for weight loss, and the diabetes outcome was a result of prior adjustment of medications. Gabriela's early diabetes was considered well controlled from a diet/activity point of view,⁵² but her weight is not. Gabriela co-operated with the physician in working up this view of the problem and the solution. The physician evaluated her as gaining weight.⁵³ With weight gain as the problem, both the physician and patient focused on the room for improvement in Gabriela's behaviours. In this case, the focus is on exercise: higher frequency and perhaps an increase in exercise intensity. The room for behavioural improvement is a function of there being room for improvement in her weight,

⁵² Despite the diabetes measure being one-year old, and arguably unreliable.

⁵³ Though arguably, it might be seen as weight stability instead; 3 pounds in a year, within her usual weight range?

when compared with the normal/ideal BMI of 25 (turn 11). Weight is trusted as telling a truth about patients' behaviours by the physicians involved in Gabriela's and Darren's care.

Gabriela co-constructed this truth, while Darren resisted it. Darren admits he has not changed his behaviours. Darren's behavioural accounting was ignored; it does not align with the truth of the measure. His numbers were going the right direction. Gabriela's appointment illuminates how the weight measure was imbued with such power that small deviations from a year ago elicited a behavioural accounting. Gabriela in some respects led this; she heard a comment about her weight as requiring an explanation, and marked herself as failing due to laziness (excerpt 4, turns 1-4).

Gabriela's case opens up a range of questions informed by the critical biomedical literature and the Canadian Obesity Network assemblage (to come). What if the stability of the diabetes measure were read as telling the truth about her behaviours? And relatedly, what if the physician had framed her weight result as 'stable' instead of a gain? How much weight fluctuation year-to-year defines stability vs. loss or gain? What if weight stability was understood to be a positive thing, in general, or for a post-menopausal woman with well-controlled 'early diabetes' more specifically? What would have happened if Gabriela's weight were in the ideal range; would her physical activity still be scrutinised or marked as inadequate? What might have happened if the focus on assessing her physical activity had started before the weight conversation; would it have been assessed to be a problem without the tie to the

measure?⁵⁴ Here, yet again, the weight discourse is made to hold its own, and the patient's choices become the object of intervention.

6.1.5 Angela and Doctor 2

Darren, Gabriela, and Vivian (in the previous chapter) have all confessed to less than ideal behaviours in response to an opening of conversation on the topic of weight. That is, all have participated in framing weight as a strictly behavioural measure. The next case, Angela, serves as a point of contrast; Angela acknowledged behavioural influences on weight, but argued behaviours are not the problem. She is already doing all she can, she argued. As with Darren, the physician ignored this. Again, interactional troubles are the result of this disruption of the dominant discourse. As shown in the next excerpt, Angela was made to confess in a way that preserves the weight = eating + exercise formula.

At the time of the observed appointment, Angela was a tall 50-year-old white woman. She worked full-time in a professional, administrative role in a fitness centre. She was in Dr 2's office for her annual check-up.

Dr2 opened the conversation by asking Angela if she had noticed any changes in her health. Angela spoke about menopause, and they discussed Angela's physical changes in some detail. Dr 2 closed this topic by turning her body and visual attention to the computer, and mentioned the need to do a PAP test. As Dr2 typed, Angela opened the topic of weight. Angela is the only person I observed who actively listed weight as one of her concerns she wanted to

⁵⁴ Sorjonen and colleagues (2006) found that proximity of talk of measures with behaviours influences the working up of lifestyle as the problem.

discuss. I have opted to annotate this continuous talk to better draw attention to what I think are key points:

Excerpt 5

- 1 Angela: um (.) oh yeah, I guess I have been struggling with my weight too [mm].
(missed phrase) I did go see that dietician [oh you did] it was hard to get in, but she didn't really (.) see anything wrong with my diet [yeah ok]. She had made a couple of little suggestions, but the diet looked pretty good on the whole. But I just noticed that, you know, working out pretty regularly the same and keeping pretty well on the diet, but the weight is starting to creep.

ANNOTATION: Before I show the rest of how this conversation formed and came to a close, I want to highlight what Angela accomplished in this opening: she proposed her weight struggle is not the result of problematic eating or physical activity patterns. She both invoked and rejected the notion that weight is a simple reflection of behaviours. However, note how the physician developed eating and exercise as problems over the ensuing exchange. To aid readers to understand what follows: Angela's weight, measured earlier by the assistant, was 83.5 kilograms.

- 2 Dr2: Yeah and it sometimes does get harder after menopause to (.) lose the weight. Although as, uh, you were down 1.2 kilos from last year [really?] which is close to 3 pounds [hmmm] which is interesting. Um, so, in the last few years, you have kind of hovered between, in the last 4 years, between 80 (.) 81.3 to 84.3, so within about the same 6 pound range.
- 3 Angela: Uh [and I know] that's better than I thought.

ANNOTATION: In turn 2, the physician offered a non-food or activity related explanation for her inability to lose more weight. She then situated today's result within the past four years, and an improvement from last year. In turn 3, Angela marked the effect of this information; her perception was worse than reality. The physician, in the forthcoming turn, could orient to Angela's adjustment or ask if she still is concerned about it, but instead, continued to talk about her weight history.

- 4 Dr2: Back when you were on, uh, Meridia [yeah] you did go down into the (.) 75 kilo range, and I think that is about the lowest you actually went. At one point you were, like back 10 years ago, you were 93.5 kilos [yeah] so you have never gone back to that [yeah]. That's around 10 kilos (..) 9 kilos higher than (.) you are now. So, you've never gone back to that (.) all time high kind of thing, but, but, you were (..) math in my head is not my strong point, sorry. Um [no, nor mine]. Um.

ANNOTATION: Turn 4 revealed Angela's successful maintenance of an approximate 10 kilogram weight loss, and her prior experience with Meridia, a weight loss medication that I later learned has been pulled off the market for safety reasons. The assemblage of Angela and Meridia altered her body metabolism, which was not sustained when the pharmaceutical was removed. However, now at 83.5 kg, Angela's weight seems to have stabilised 10 kgs below her heaviest measure of 93.5kg. Is this a positive result, in the physician's judgement? Or is weight still a problem to be addressed?

- 5 Angela: Consider I am *an accountant [that's about 74]*, that means I don't do math in my head.

- 6 Dr2: Yeah, you were, you were about 10 kilos less at one point, so about 22 lbs less [yeah]. Um, a few years ago, so um.
- 7 Angela: Which was much better for my blood pressure, and all that stuff. What was it like?=-
- 8 Dr2: 136 over 84, so it's kind of upper normal today and (.) you're often in kind of that range, 130 over 80 (.) sort of range, so, and just looking at that. Oh here we go. The-the dietician report, looks like she saw you in April or March, March, late March [yeah]. Yeah, she went over [yeah] um your history and you were using MyFitnessPal to track your intake [yeah], um, and your exercise, etc. And she's encouraging you to be accurate with portion sizes, continue to track and enter everything in MyFitnessPal and try to not eat the calories that you are, like your exercise calories, try not to eat those [yeah, yeah]. *Um*, take note of appetite changes with exercise. Be prepared with snacks for the afternoon to prevent pre-dinner extreme hunger and then, um, grains and carbohydrates.
- 9 Angela: Yeah, she didn't think I was getting enough (.) fibres, grains.
- 10 Dr2: Ok. And yeah, high intensity exercise can really increase appetite. She wanted you to have at least one serving of grains at each meal and a snack after your workouts. Um, and change your breakfast to half your regular protein breakfast smoothie and one serving of oatmeal, add Ryvita crackers, probably to add the fibre [fibre, yeah] at lunch [yeah] and pack the post workout snack, um. And she gave contact info and [yeah] email or book an appointment to follow up. So, I don't know, do you feel maybe it would be helpful to follow up do you think, or?

11 Angela: Umm (loud exhale) I don't know. I, I-I, you know, I understand the concepts she was talking about, it's not like I'm (.) not getting it or [yeah, ok]. (both chuckling) (..) I guess I haven't been super regular with keeping of that food diary thing [yeah] but uh, I am pretty regular in what I eat and I did adapt some of those pieces into my routines [yeah] so.

ANNOTATION: To recap, in turn 1, Angela noted that the dietician did not see many changes to be made in her diet. The physician verbally reviewed the dietician's report (turns 8 and 10) which did recommend some specific changes to Angela's routines, including the advice that Angela continue to use an app to track her food intake closely. Angela was put in a position of having to account for the recommendations she did not follow. Reviewing the dietician's report discredited Angela's earlier comment (turn 1). This loss of footing is reflected in how Angela started her response in turn 11, with speech markers that indicate Angela gives what she believed was a dispreferred answer. By this point in the conversation, Angela's proposed framing that her eating and exercise habits are not really the problem has been undermined. Through this, the physician oriented to Angela's weight as a problem that can be solved via more behaviour changes.

12 Dr2: Yeah, I was just at that the Mayo Clinic Nutrition Conference (Dr2 turns so her whole body faces Angela) and we had a whole day on (.) weight, weight management and one thing they said was people that track consistently really (.) do have better outcomes and then honestly tracking, like some people just conveniently forget to put down their [oh yeah (laughing)] their the big dessert

they had you know, because (Angela still chuckling) maybe I will just ignore that and not put it in my diary yeah, um. (typing)

13 Angela: That MyFitnessPal is good.

14 Dr2: Yeah, there are lots of apps now=

15 Angela: *Yeah [um]*, because you can make up your own recipes right [*yeah*] so I make a smoothie and my little Vitamix and everything [mm] and I write it all, write the recipe down and then I only have to do it once right?

16 Dr2: And then it's in there.

17 Angela: Yeah, it's so cool.

18 Dr2: Yeah, um, there is another app called Loselt um, I don't know if you have seen that one, it's a free app and then there's (inaudible word) and when you put in certain- and you can scan bar codes with that one [*oh cool*] *actually*, then it enters that food into your [*oh neat*] *your* log in and it's in there permanently with all the, you know, the (.) *calories [nutritional information]* yeah the nutrition information, etc, etc, and fibre, protein, etc. So, so, I tried that one, but again, my problem is my consistency. So, um (.. while typing) so, sounds like you can make a couple of changes. So you notice when you lose weight, your blood pressure tends to [mm hmm, mm hmm] *go down*.

19 Angela: (pause) I get healthier when I am a little lighter anyway [mm hmm] I guess I don't ever expect to be thin, but a healthier weight.

20 Dr2: Yeah, because your body mass index is 29.1. Now I know you-you work out quite a bit, so we sometimes have to, you know, not rely on BMI totally but, we say

a healthy BMI is between, well anywhere between 18 and 25-very few people are down at 18, that's almost [yeah, especially weight] almost a little too low [yeah] and you wouldn't expect that with somebody who is quite muscular and fit, so. So, um, I don't know if there is any other way, you know, we could (.) offer you any help.

ANNOTATION: By this point, Angela's eating and tracking behaviours with an app have both been flagged as not good enough by the physician. In turn 18, Dr 2 talked about her own experience with a weight loss app - a nod to her own visibly corpulent body, and to the importance of consistency of self-surveillance for weight loss. This worked to normalise the problem of consistency of self-surveillance/tracking, implying that not just Angela struggles with it. The technology, the app, was folded in as one more way that Angela can work on her eating and exercise.

Dr 2 ended turn 18 by returning to Angela's previous linking of weight loss with blood pressure (turn 7). I am unclear as to the function of Dr 2's revisiting of this link, though health psychology approaches would label this a technique to increase 'intrinsic motivation' and amplify the benefits of change. But note, the measure in question – blood pressure – is 'normal' by population standards. And 10 years ago, when 40-year-old Angela weighed less, she had a pharmaceutical in the mix.

In turn 20, Dr2 compared Angela to the 'normal' range for weight, acknowledging the limits of the measure, especially for someone as active as Angela. Yet all the talk to this point oriented to Angela's weight as a problem. Dr2's final sentence oriented to the notion of

additional help. From here, the physician brought attention to the other factor one would expect in a conversation about weight: physical activity.

21 Angela. Yeah, I don't know. (laughs in a hee hee hee hee style)

22 Dr2: Yeah, we had that talk, we should have [I mean] there's clinical appointments through the PCN, um are you still pretty physically active?

23 Angela: Yes.

24 Dr2: Ok, so it's not like you need help with physical activity [no, no, no] because through the PCN there is a physical activity (.) *resource*.

25 Angela: *I work* in _____⁵⁵, so [um] and then I cycle too, so.

26 Dr2: So this, um=

27 Angela: But you know, drinking wine goes with cycling though. (both laugh)

28 Dr2: Ok, yeah, that has quite a few calories too. (Angela still laughing) About 150 per glass, so [yeah]. And, yeah, that is another kind of rule of thumb, some people say don't drink your calories [yeah]. Avoiding juices and pop and, you know, trying to limit the [yeah] the alcohol consumption [yeah] yeah. So, this is just another thing about group classes. And then, I don't know if you have looked at the website because they have some resources on our Primary Care Network website [oh ok]. So, because I'm not-not getting the sense that you would find another appointment with the dietician that helpful really.

⁵⁵ Recreation facility name withheld for confidentiality reasons.

(when speaking about the group appointments with the dietician, she reaches for a pamphlet about the PCN Dietician, and gives it to her while saying “this is just another thing about group classes”)

29 Angela: Not really, I mean she gave me a couple of, a few pointers right? [yeah] I never realised I guess I wasn't eating enough (.)

30 Dr2: Yeah. Did she give you a copy of her letter? Like her recommendations, or, I don't know if you would find that helpful.

31 Angela: Sure that would be great, if you could /// END OF EXCERPT 5

Looking back on the whole, this conversation is one where the dominant discourse is made to hold its own, and Angela's frame of the situation is discredited. That is, Angela's initial framing suggests eating and exercise are not the problem. The physician does not allow Angela's proposed frame to stand, and Angela is held to account against the weight-as-choice discourse. Angela participates, albeit with some signs of reluctance.

6.1.6 Intensification of work on the self, ad nauseum

Angela sustained a 10 kilogram weight loss from her maximum weight; that is, she had lost and maintained over a 10% body loss. In the last year, she had lost almost the same amount of weight as Gabriela had gained. The way Angela narrated her behaviours, she sounded much like Sarlio-Lahteenkorva's (2000; 20010) 'once-obese' informants, who show just how much work it is to sustain substantial weight loss.

When we compare Angela to Darren, we can see that her weight loss is not treated as one by the physician involved. Angela's loss was not marked as a behavioural achievement. Angela was not told she was doing something right. Instead, Dr 2 treated her much the same as

she did Gabriela, focusing on behaviours, searching for problems. Murray (2009) suggests that when patients do not confess spontaneously, physicians may solicit a confession. I interpret this physician's talk with Angela as exemplifying the predicted medical practice, where the inscriptions of weight and BMI, interpreted as non-normative and in need of correction, drive the process directed toward a patient's remediation.

Over the course of the conversation, the determinants of weight and the possible problems made visible include: Angela's consumption behaviours – both caloric quantity and food choices; Angela's physical activity; Angela's self-surveillance habits; a medication; menopause. The two latter factors mediate metabolism as well as exercise, though that was not actively foregrounded by the physician, and both were dropped quickly from the conversation.

The physician recommended more of the same: more tracking; seeing the dietician again; more physical activity; additional changes to her eating. Angela's eating, wine drinking, and failure to track her intake consistently are all potential harms. The specific solution recommended most clearly – that she reduce her wine intake to reduce caloric intake – may or may not be acceptable for Angela from the perspective of life enjoyment. The technology Dr 2 recommended Angela could use is an invitation to create even more visibility and scrutiny of her diet. Angela was expected to make new choices in the service of clinical targets.

Both Angela and Gabriela were addressed by Dr 2 as people who care about clinical targets enough to keep intensifying current and integrating new behaviours. The only solution is to choose to enact new behaviours, if her body – Angela's or Gabriela's - is to have a chance of meeting ideal clinical targets as defined by population studies. Each of these women responds to this call, at least to the extent that they will have a conversation about it with the physician.

Mol (2008) acknowledges that population-level thinking does not fall simply into choice or care logic, just as technology fails to fall into one or the other. Instead, she asks us to attend to how population-based scientific knowledge and technologies are put to use in practice. How that is done makes a difference to whether a clinician delivers services oriented more to choice or care-logic.

Mol (2008) argues that choice-logic tends to start with facts. Facts, those determined by scientific evidence or inscription devices, drive the outcomes sought. Any courses of actions recommended to patients are indicated by what the evidence indicates will help improve the measures. Patients then choose their path, and hope that the statistical odds work in their favour. In contrast, care orients to improving a life. Categorizations, inscriptions, and knowledge of what might be done are integrated in ways that orient to realistic outcomes, and in service of the goal of making a person's life better. The same inscription device, or knowledge about the effect of a medication, may be used in ways that align with choice or care-logic.

Dr 2 routinely introduced weight as a fact to open up a conversation. With Gabriela, Angela, and others not detailed here, Dr 2 situated the patient's present weight measure in relation to measures from the past several years, told the patient the ideal range for BMI, and pointed out discrepancies. She rarely interpreted⁵⁶ the measure for patients beyond invoking BMI categorizations. Instead, Dr2 let the numbers speak; she left patients to make their own meaning of the numbers before offering an interpretation. As highlighted earlier, patients slipped with ease into the notion that weight is a problem. But was Angela's weight a problem, and can it be solved?

⁵⁶ Something Dr 3 did frequently.

With Angela,⁵⁷ Dr 2 troubled the BMI categorization based on muscularity (turn 18). That is, Dr 2 offered a glimpse into how a standard categorization schema might fail to apply to a given person. The limitations of this fact *could* destabilise the assumption that more activity, more dietary changes are what is best for Angela, who is physically active, attentive to her eating, has seen a dietician, has sustained a >10% weight loss, and lost a few pounds since last year. Instead, additional weight loss remained the sought-after outcome, with an undefined sense of when Angela's weight will be 'good'. Weight stability is not enough; maintenance of a >10% weight loss (Angela) was still not a 'success' in Dr 2's interpretation. One can always choose to do more, was Dr 2's core message.

Scientific knowledge exists that would disrupt Dr 2's interpretation of Angela. Angela's sustained weight loss of >10% highest body weight surpasses the typical results of short-term weight loss only found in Wadden, Butren, Wong & Tsai's (2014) systematic review of primary care interventions. Angela could be interpreted as not at risk for health problems, if relying on the trends found in epidemiological studies reviewed in Campos (2011). Such knowledge has not made it into Dr 2's practice – despite her recent attendance at a full-day continuing education course on weight management at the Mayo Clinic. Dr 2 used the BMI to inspire change, to suggest intensification of work on the self. Over the course of the dialogue, the clinical target of 'normal' BMI drove the process, the body was treated as malleable, and patient choices were all that are made visible and acted upon.

Mol (2008) argues that clinicians' emphasis on increased self-care by patients is itself not necessarily a sign of clinical neglect. Yet, in this case, we can see how neglect might occur.

⁵⁷ And one other highly active, post-menopausal woman who is obese by BMI classification.

Mediators of weight other than behaviours are neglected in the talk. From the other inscriptions, Angela's body fell within what was designated as healthy. Mol sensitises us to ask: what unanticipated problems might follow this intensification of behaviour changes or self-surveillance? For example, what if Angela experiences guilt from enjoying a second glass of wine, thinking she is endangering her health? Is that anxiety - (a common consequence of intensification [Rose, 1999b]) - helping her craft a better life?

In addition to the silences created about metabolism and menopause, and sustained weight loss as an accomplishment, note the absence of consideration about what Angela wants. Does Angela (or Gabriela) want to further intensify her self-management practices? Perhaps, but neither we as observers nor Dr 2 know this about Angela, at least not during this interaction.

Continuing with Mol's (2008) concern that choice-logic enables neglect, I find myself asking if a physician with similar routines to Dr 2 would be able to identify a patient who is overweight or obese, and practicing disordered eating? In what situations is weight loss not *the* most important outcome? What assemblages support practices where concerns related to weight, eating, and exercise other than those worked up in these examples come to the fore?

Much of Dr 2's routines oriented to choice-logic. Normal or ideal population measures drove the process, and the possibility of risk reduction was the goal, regardless of the impact of intensification on a person's quality of life. The population-based norm was bridged into practice, and used to act on patient choices, rather than to help patients and clinicians determine what actions may help craft a better existence, as would be expected with care-logic. The possibility of realising a reduction of risk is prioritised. However, patients were not asked if

these are changes to their lives that they are willing to make. It is less a moment where a patient makes a decision, than a patient answering the physician's address, an address that assumes the patient is invested in the outcomes valued in the literature. The physician's role is to tell people what else they could add or do differently in their lives. It is the patients' choice whether to follow the advice, to change or intensify their health work practices.

6.2 Caring for populations with the logic of care

The examples of Darren, Gabriela, and Angela all orient clinical practice to targets set by population knowledge as 'good outcomes'. The conversation between Dr 3 and Ruth, detailed next, helps make visible how population level knowledge and classification systems may be folded into care in a way that aims at supporting a better life for a person. In this case, a population health improvement initiative (ASaP) guides care without over-determining the outcome. The more care-aligned interactions observed were the result of a patient who has a clear sense of her own problem(s) talking with a physician who remained open to what emerged in interaction.

ASaP stands for 'adult screening and prevention'. ASaP is a change initiation strategy spearheaded by the Toward Optimized Practice organization. This Alberta organization, currently run by Alberta Medical Association, received funding from Alberta Health (the provincial government ministry) for ASaP. The Toward Optimized Practice ASaP evidence working group developed a 'bundle' of screening and prevention manoeuvres recommended for use by primary care clinicians. These recommendations were built from a national set of cardiovascular care guidelines (C-CHANGE) and other guidelines which were 'translated' for the Alberta context. The working group updates the procedural standards as they deem indicated.

The Toward Optimized Practice group hired and trained Clinical Process Advisors who then worked with practice change leaders within Primary Care Networks and other primary care organizations to facilitate uptake of the guidelines. Dr1 and Dr3 both indicated that ASaP influenced some of the care I observed. Dr 2 worked in a clinic that has ASaP connections, but did not speak of it as an influence on her practice.

ASaP promotes opportunistic prevention and screening - that is, doing specific prevention and screening activities when one has an extra moment. Checking a patient's cardiac risk score and discussing physical activity are both manoeuvres listed in ASaP for physicians to do when the opportunity arises in a clinical appointment. Both Dr1 and Dr3 were observed calculating a patient's cardiac risk score in the EMR. At the click of a mouse, each EMR is programmed to run existing information in the chart through a mathematical calculation, and a score becomes visible. Dr3 built an active discussion around the score more frequently than Dr1. In Dr 3's use of the cardiac risk score, we see how inscriptions and population-based norms (in this case, made to hang together in a composite inscription score) can be combined with questions that open up a conversation, and enable care by tinkering with more than simply behaviours.

6.2.1 Ruth and Doctor 3

Ruth was a newer patient of Dr 3; the observed appointment was her third visit to the clinic. When I spoke with Dr 3 about her appointment with Ruth, she said this was a perfect example of how she bridged ASaP into practice.

At the time of the observed appointment, Ruth was a 68 year old white woman who lived in a suite in her son's home. This appointment was scheduled to discuss the results of

recent lab tests and a liver ultrasound. Early in the appointment, Ruth commented that she did not yet go for the ultrasound; she lost the referral. The physician re-directed the appointment to discussing the lab results, specifically some indications that her cholesterol is a problem. During this discussion, the physician explained her own unease about prescribing cholesterol lowering medications, given as-yet-unclear cause of the abnormal liver function results. She invited Ruth to pull up a chair so she too could see the computer screen. The physician clicked on the computer and a screen titled “Cardiac Risk Worksheet” appeared. The physician verbally interpreted the result as “not too bad, considering”. She explained that, based on Ruth’s cholesterol, age, weight, height; her non-smoking status; and the fact that she does not have diabetes, Ruth’s risk of heart disease in the next ten years is under 10%. The doctor pointed to a number on the screen titled “heart age”, and they said in unison that it is equal to her actual age: 68. The doctor then highlighted a second number, the calculated lowest ‘heart age’ possible if all cardiovascular risk factors were addressed:

Excerpt 6

- 1 Dr: But, but if you improve, in that you can decrease your weight to your ideal weight, so we’re looking about 60 kilograms here, right now you’re about 80, so losing some weight, um an-and improving your cholesterol levels, your heart age could be 42.
- 2 Ruth: Good! [okay] mm hmm
- 3 Dr: So you’re doing alright, but I’d like to aim closer to this (pointing at the 42). But actually doing this just told me right now, I’m not going to be as aggressive on the medication part, right now. And given the fact that we don’t really know what’s

goin' on with your liver right now, um, the first step, at least for the next three to four months, is to get you (..) doing the thing that is most important for c-controlling cholesterol and, um, even diabetes issues, but in your case cholesterol. Whaddya think the most important thing (..) would be?

4 Ruth: Getting out and getting, walking.

5 Dr3: 'k. What else do you think would be helpful for you?

6 Ruth: I don't know. I know (..) that I don't get enough exercise.

7 Dr3: Ok. How much-

8 Ruth: I have, i-i-it's like there's a barrier at the door ['k] um, I don't go out, unless I've got a good reason to go out, like you.

9 Dr3: Ok. Thank you.

10 Ruth: My granddaughter took me out shopping ['k] Wednesday. Um, if someone comes and picks me up (Ruth makes eye contact with me during "if someone picks me up"; Dr is clicking on the computer) and takes me some place, you know I-I'll go out [ok]. But otherwise, I- I-I've got this (..) like barrier.

11 Dr3: Are you afraid? (typing)

12 Ruth: I don't know. I don't know what it is. /// END OF EXCERPT 6

In this exchange, we – the patient and I - learned a bit more about one way Dr 3 uses the cardiac risk score: as a decision aid about medication. But she also used the template calculation⁵⁸ of how 'young' Ruth's heart could be (42, instead of 68) to open up a conversation. She asked two open-ended questions (turn 3 and 5), and Ruth expressed her desire to walk

⁵⁸ A capability embedded in the EMR, one made visible whether or not a clinician would like it to be.

more. Of note, Ruth responded with talk about a behaviour to Dr 3's question about what she thinks would be helpful to address her cholesterol, consistent with the pattern flagged in the previous chapter, where the biomedical measure of weight elicits behaviour talk from patients. Ruth's association of cholesterol with physical activity was received as an appropriate response. Dr 3's second question invited a second idea, but Ruth responded again talking about exercise. The physician started to ask a quantifying question, but the patient interjected and Dr 3 ceded the floor.

This exchange changed the direction of the appointment in a notable way. The physician continued to ask a series of specific questions, about crowds, going out at night, public speaking, what she does at home, her sleep routines and quality, and her mood. During this conversation, Dr 3 sat squared to the patient fully, mainly holding eye contact with the patient while clicking on the computer on occasion. The patient spoke at length in response to several questions. Dr 3 pulled up a scanned document titled "Geriatric Depression Scale", a copy of a survey Ruth completed at an earlier visit. The physician read a couple of questions, to which the patient responded at length. In time, Dr 3 asked, "Has anyone ever told you, in the times you've seen people, 'I think you might have (.) depression?'" 'Oh yeah, a long time ago.' The physician asked her to tell her more. The patient offered a lengthy story, lifting her head to the ceiling and closing her eyes for stretches of time, speaking about how she was diagnosed with depression, the medications she took, and the counselling she received. The doctor asked her the benefits she experienced of being on medications; 'what was different in your life when on medications?'. The patient described her prior social and employment activities.

Before the end of this appointment, Ruth commented that she intended to talk about her trouble 'getting out of the door' - that this conversation was a priority for her. They returned to the topic of physical activity, but as one treatment option alongside medication and counselling for the depression. The patient agreed to start taking medication, see a counsellor, and connect with a community-based, chronic disease program. Physical activity was but one way to tinker, and it is tinkering aimed at making life better, reducing depression, rather than losing weight or improving her cardiac risk score per se.

Weight loss was made visible in turn 1, but was quickly removed from the floor as a goal. The physician then asked a question (turn 3) in that could be heard in multiple ways ("Whaddya think the most important thing (.) would be?"). While the weight reduction and cholesterol related talk may have been heard as an expectation the patient talk about eating or physical activity, Ruth later stated she had intended to have a conversation about her difficulty leaving the house. She saw an 'in' to putting that on the table, and the doctor engaged with her proposed topic. A new diagnosis and a treatment plan were set on course, and the physician gained a sense of what life is like for Ruth when things are going well.

6.2.2 Caring for a patient and a population

In this appointment, we witness how a population-oriented initiative emphasising particular procedural standards (ASaP) and risk metrics (cardiac risk scores) may be folded into what is a more care-logic aligned dialogue. The physician used two different composite categorizations – a cardiac risk profile and a geriatric depression scale - as a way to aid decision-making about the best path forward. Dr 3's display of unease about how to approach cholesterol, and solicitation of the patient's perspective in the decision-making, created an

opening for the patient to share more information about her life, an opening the patient used. Each person offered information that matters to the dialogue; the patient and physician concerns were both addressed in an integrated way to figure out a way forward. The outcomes of interest ceased to be limited to weight or cholesterol; instead, the appropriate way to evaluate improvement emerged in dialogue. Dr 3 was able to care for both the population, and the patient; she created alignments between the two.

In our interview, after listening to the audio-recording of excerpt 6, Dr 3 mentioned that she approached the visit planning to take care of any ‘housekeeping’ (i.e., review of previous test results) and expected that there would be time to touch on the prevention topics included in ASaP. She added she did not enter this appointment wondering if depression or anxiety was an issue. She explained that she likes using the cardiac score to gain perspective, situating the person in front of her in a broader population. With some patients, she finds the calculated ‘heart age’ score may motivate them to make changes when she shows them how it changes if the information changes. Quitting smoking, she mentions, creates a big impact when patients see the effect it has on heart age. And yet, she foregrounded the score here primarily to aid in her own decision-making about whether to treat Ruth’s cholesterol level with a medication.

The example offered in Ruth’s appointment is helpful to highlight how scientific knowledge, inscriptions, and procedural standards alike can be activated in ways that do not over-determine the outcome. Cardiac risk score, a procedural standard recommended by the knowledge broker Toward Optimized Practice and embedded in the electronic medical record, was used to open dialogue. The calculation method embedded in the medical record software, the display of current/ideal heart age, and Dr 3’s mention of a 20 kilogram weight loss (turn 1

and 3) implied that Ruth's risk is malleable, and in particular, that obesity is reversible for this 68-year-old woman. Yet, as Dr 3 continued, she dropped weight as the goal, bringing cholesterol forward, and the patient spoke about her difficulty leaving the house. Dr 3 re-oriented the conversation about Ruth's identified difficulty, and together they developed a management plan, in an effort to make Ruth's life better. Dr 3 enacted ASaP's biopower imperative via use of open-ended questions, transparency about her own uncertainty, and willingness to follow a patient's lead. A clinician can, then, translate brokered knowledge through a logic of care or choice.

6.3 Discussion

Mol (2008) notes that technologies and knowledge do not all serve the same ends, and thus should not be a priori designated as problematic or helpful. She asks us to attend to how technologies and knowledges are brought into practice, and the effects they create.

Timmermans and Epstein (2010) echo this argument about objectification and standards. Through the examples I have developed in this chapter, the variability of practices and effects illuminate the value of these arguments.

Some epidemiological (and lay) knowledges and procedural standards limit our sense of what can be tinkered with in service of producing good outcomes. Weight as solely/primarily a function of behaviours and personal choices, and assumptions of bodily malleability, direct clinical attention and people's talk in very particular ways – ways that the current Canadian guidelines (Brauer et al., 2015) authorise. When this knowledge of weight as a behavioural outcome was enforced - as it was with Darren, Gabriela, and Angela - physicians produced silences and absences in what can be tinkered with to produce better health outcomes. Darren's

unexplained weight loss may be from another, undetected cause. Gabriela's diabetes was considered well managed by her behaviour changes, but yet still more are indicated in service of reducing her weight. Angela attempted to disrupt the assumption that her weight was determined by her behaviours, but this was rejected by the physician. Behaviours and choices are what are to be tinkered with, to produce better outcomes as defined by population health ideals. These interactions rely upon many threads of choice-logic.

A common response was for patients to highlight what makes (additional) healthy behaviour changes hard for them to make. Ruth had a "block" at the door. Angela was already doing a lot. Gabriela was tired at the end of her workdays. The indulgence of the Christmas season made starting new routines difficult for Darren. This echoes what Rose (1999b) calls contemporary confessional practices, where the focus is on hidden challenges or injuries rather than repentance.

That patients talk this way about their lives might help explain why clinicians are quick to say that patients make 'excuses' and fail to 'take responsibility' for their lives (Kirk et al., 2014; Throsby, 2007). Patients know what to do, but do not do it; they do not make the right choices despite being given the facts. But consider the effects of taking a person seriously, which is what happened with Ruth. A cardiac risk score and a couple of open-ended questions to solicit Ruth's take on her own challenges leads to management of her depression. Confession may be a technology of subjectification, but its effects are not known in advance.

The use of technologies, procedural standards, or population-based knowledge of norms or possible solutions does not determine whether practices enact care or choice-logic. The case of Ruth serves as an example of how procedural standards can be used to figure out what might

make a life better, even if the medical record calculation and visual display orient more to risk avoidance. Similarly, it is easy to imagine how the mobilisation of different epidemiological knowledge (e.g. that reviewed by Campos, 2011) could have led to interactions much more oriented to care-logic. For example, with Angela, mobilisation of knowledge of the low risks of being overweight, the value of being regularly active, and the rarity with which people sustain a >10% body weight loss would/might have led to a substantial difference in her care.

Mol (2008) suggests that epidemiology, the knowledge foundation for clinical care, is ambivalent about patient autonomy and choice. This ambivalence means that epidemiological knowledge may be re-cast through different logics. The analysis developed here highlights that the critical hinge is in the visibilities made in the interaction that are treated as important by the physician.

Of note, all of the interactions described in my research treated weight as malleable. This is one central thread of choice-logic, where our bodies are read as reflecting our choices, and where making different choices will produce different bodies. The work of the Canadian Obesity Network described in the next chapter disrupts this frame for weight, instead translating obesity into a chronic disease frame where reversibility is no longer an option. By doing so, we are offered a vision of health care practice specific to weight that incorporates more care-logic concepts than I observed in the practices of the three physicians I observed.

Chapter 7: The Canadian Obesity Network: Moving clinical practice closer to the logic of care

Obesity has been framed as a (growing) problem for several decades. Various attempts to address it have come to be considered failures by some. Dean (2010) argued that past failures to govern do not lead to abandonment of the project, but to new problematisations and solutions being assembled. This is how I understand the work of the Canadian Obesity Network (CON). In this analytic chapter, I trace the assemblage of a knowledge broker – the Canadian Obesity Network – that seeks to change care for those with obesity. I draw out the CON's constructions of problems with current care, and examine how they attempt to enroll clinicians into new practices. The CON assemblage offers a vision of weight management that aligns caring for a body and a person. I argue that the new practices they propose draw obesity management closer to Mol's logic of care than I have observed in the clinic.

I first offer a summary of the Canadian Obesity Network before offering my chronological description of the continuing education workshop I attended. The narrative description should not be understood as a straightforward or transparent description of reality, but the result of purposeful focusing of attention as well as tacit perceptual patterns that are learned by being part of a community of practice (Dingwall, 1997; Emerson et al., 2001; Grasseni, 2004). While in the course, I focused my attention on the verbal and powerpoint slide content used to persuade participants, given my particular interest in the workshop goal of changing clinician practice.

I offer a lengthy, chronological account to draw readers into the course, inviting a working out of its puzzles and problems as they unfold (Emerson et al., 2001) before offering my analysis. A few additional notes for the reader:

- For most of the chronological description, I paraphrase the presenter's comments in the tense in which they are spoken. Exact quotations are in "full quotation marks", while those in 'scare quotes' are either exact or close to exact. Sentences where I do not identify a speaker were Dr. Sharma's comments.
- I underline participant questions and comments to make it easy to look back at them when relevant in the latter portion of the chapter.
- Content in [square brackets] is an addition I have made to help the reader understand the context or an interjection of my own voice. If a longer note was indicated, I used a footnote.

In the final two sections, I describe the governmental tactics used in the 5As course assemblage (section 7.3) and then contrast the vision offered by the CON with Mol's (2008) description of care-logic.

7.1 The Canadian Obesity Network

The CON aims "to reduce the mental, physical and economic burden of obesity on Canadians" via acting "as a catalyst for addressing obesity in Canada and as a platform to foster knowledge translation, capacity building and partnerships among stakeholders" to "develop effective solutions to prevent and treat obesity" (Canadian Obesity Network, n.d.-a). Much of the clarion call of the Network (see Canadian Obesity Network, n.d.-b) is framed in the same way as most public discourse about obesity in North America: obesity is a major health problem, linked to many other diseases, and costly in the economic sense (Lupton, 2013; Saguy, 2013). However, the CON makes one much less common addition: that of weight bias,

discrimination, and stigma. On the CON's website, the "obesity in Canada" section includes the following paragraph:

The impact of bias and discrimination against people with obesity is comparable to that of racial discrimination, and it's just as common. Weight bias translates into significant inequities in employment, health, health care and education, often due to widespread negative stereotypes that persons with obesity are lazy, unmotivated or lacking in self-discipline (Canadian Obesity Network, n.d.-b)

This association made reflects an uptake/integration of a key critique about one of the challenges involved in obesity management in health services – and it is one I argue envisions weight-related health care aligned with what Mol (2008) calls care-logic.

The *5As for Obesity Management* (herein the 5As) is one of the Canadian Obesity Network's most recent offerings to realise their aim. The CON secured funds from CIHR to develop tools that would allow primary care practitioners to address obesity more effectively in the clinic (Sharma, KI). Dr. Arya Sharma is the scientific director of the Network, and leads this and other Network initiatives. For the 5As project, Dr. Michael Vallis was involved in the initial development team, and over time, came to co-lead the initiative. Dr. Vallis is a health psychologist and director of the Behaviour Change Institute at Dalhousie in Halifax. The two led the 5As development.

As a member of the CON, I became aware of the 5As via their e-newsletter in 2012. While observing in different clinics in Calgary, I learned of the clinical trial of the 5As underway in one Calgary Primary Care Network. I looked for more detail about the 5As, and was given permission by the CON to attend the course for the present study. Following my participant observation session in fall of 2013, I interviewed Drs. Sharma and Vallis as key informants early in 2014.

I first present a written description of the course, before pulling out parts of the assemblage that together aim to entice and enroll clinicians in practicing the 5As. I then argue that this assemblage and its activation by the instructor, Dr. Sharma, attempts to move obesity management closer to the logic of care. He accomplishes this, in part, by discrediting the assumption of obesity as choice so central to anti-fat bias, stigma, and discrimination.

7.2 The Canadian Obesity Network's *5As of Obesity Management*[™] course

A sunny, warm, late summer afternoon, I and twenty-three other participants trickled into a room in a public library. Fifty seats were lined up in five rows facing a wall with darkened lighting, a screen, a lectern, and a projector. At the back of the room was a table with a list of participants and *5As of obesity management*[™] materials. We each checked ourselves in, and picked up an envelope branded as the *5As of obesity management*[™]. Some participants sat together, and chatted amongst themselves. I, and many others, sat alone. Figure 1 was projected on the wall.

Figure 1: *The 5As of Obesity Management™* cover page and powerpoint slide



Figure 1: From the *5As of Obesity Management™* Practitioners Guide booklet (Canadian Obesity Network, 2012). The above title page is unaltered, and reprinted with permission as per the Canadian Obesity Network license under a [Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License](https://creativecommons.org/licenses/by-nc-sa/4.0/).

About ten minutes after the designated start time, a fellow participant stood up and turned to face us all. She welcomed us to the course, and asked that we introduce ourselves by name, profession, and where we work. Of the twenty-four in attendance, eight were dietitians, eight were nurse practitioners, and the remaining eight were from a variety of professions: social work, nursing student, pharmacist, family physician, program coordinators/directors, and

me. All but two – the pharmacist and physician – were women. The vast majority appeared white to my eye, and most would not be defined as obese.

Dr. Arya Sharma,⁵⁹ scientific director of the Canadian Obesity Network, then took the floor to lead the course, and remained alone at the front of the room for the next three hours. He brought up a slide that projected his name and three job titles onto the screen at the front of the room, formatted in a branding scheme consistent with the 5As texts in the envelope. He described his medical training and practice. During Dr. Sharma’s introduction to the course that followed, he noted that “In medical school, I didn’t learn much about obesity.” He then asked the single physician in the room ‘how much training did you get in medical school?’ “About 2 hours”, my co-participant answered. Dr. Sharma responded, ‘I learned two things about obesity when in med school’. “One, it’s not good to be fat. [Most of my co-participants laughed] Two, to tell people to go lose weight.” He added ‘telling obese people to eat less is akin to telling depressed people to cheer up. Telling people to eat less is’ “not evidence based practice. It doesn’t work”. The *5As of obesity management*[™] are a synthesis of what he’s learned to date.

He then added a second reason why clinicians might be unprepared to manage obesity. There has been ‘lots of rethinking about obesity, especially in the last 5 years’. The AMA took a “big step” when they voted to “declare obesity a chronic disease”, which makes it a medical problem. He added that he thought so all along.

He encouraged us to ask questions as they came to us, to make sure that we get what we need from the session. He then launched into the course content slides.

⁵⁹ Named here with his explicit consent.

The next slide offered a definition of 'obesities', with a self-citation. Better to say 'obesities', he noted, given that we are dealing with "heterogeneous, complex disorders with one common factor" - excess body fat. Fat is a "heterogeneous tissue", with the impact on health varying by where it is deposited as well as molecular specifics. He flagged lots of variation here in the "biological function of different fat deposits", the health impact of excess fat, and the response to treatment. Thus, there is no singular method to treat it. Obesity is "a medical problem when fat threatens someone's health...The medical, the biological – as health care professionals, that's what we worry about." Clinicians are not to concern themselves with bodily fat that is only a 'cosmetic' issue. [That is, not all obesities are of medical concern.]

Dr. Sharma told a story of how the 5As came to be. The CON secured a CIHR grant to "come up with a care path or framework to make obesity management possible in primary practices", with support from the Public Health Agency [of Canada, I assume] at a later point. The research team conducted focus groups with primary care professionals, talked with experts, reviewed the literature, examined guidelines, and did patient interviews. They sought to find out what was already happening; the answer was "not much". From patients, they learned that most have attempted to lose weight at least 10 times in the past; two-thirds said they would like to weigh less at present; and of those with BMI > 30, approximately one in five recalled speaking about a health care professional about their weight. Excess body weight is "the elephant" in the clinic. One co-participant asked what happens when it was discussed? "Never pleasant, and almost never helpful". The researchers concluded that primary care for obesity was "virtually non-existent", and that the clinicians who take it on do so as a hobby, without specialised training. Instead, patients attend commercial weight loss clinics.

From this foundation, Dr. Sharma explained that the next step for the project team was to figure out how to change this widespread lack of diagnosis and management.

7.2.1 CON's key principles of obesity management

Dr. Sharma then discussed the five 'key principles', using slides that correspond directly to the booklet (visually and content-wise). Each principle had its own slide (quoted here from p. 3-4 of the booklet):

- 1) Obesity is a chronic condition
- 2) Obesity management is about improving health and wellbeing, and not simply reducing numbers on the scale
- 3) Early intervention means addressing root causes and removing roadblocks
- 4) Success is different for every individual
- 5) A patient's 'best' weight may never be an 'ideal' weight

He added these are the five key principles "we need to accept", and cross-referenced the booklet [which is matched word for word, and image for image to the projected slides]. He talked at length about the first principle, and built upon it for the four principles that follow.

The first principle is that obesity is a chronic condition, that is, lifelong and without a cure. Dr. Sharma introduced a physiological phenomenon – weight setpoint - as follows: only the rare and often memorable person maintains substantial weight loss, and only for as long as they continue their 'treatment'. If they stop doing what they are doing, the weight will "instantly come back". This is because of weight setpoint, wherein 'the brain assumes that your highest weight is what weight should be'. He added "it's why 19 out of 20 people on weight loss programs will fail." One "cannot change the setpoint, even in animal studies. Once obese,

always obese”.⁶⁰ ‘There are two groups: the treated and the untreated’. Health care sites are not weight loss clinics. Instead, clinicians are to provide chronic disease management, like that provided for hypertension, COPD [chronic obstructive pulmonary disease], and chronic pain. “Quick fix solutions clearly aren’t going to work”. He drew another parallel: Do you stop treatment when HgA1c (a blood marker specific to diabetes) or blood pressure are at target? The answer, obvious to those in the room, is no. “Put on your chronic disease glasses”, he advised. This is the second principle: orient to health instead of simply numbers on a weight scale. Weight loss clinics focus on the numbers on the scale, but we clinicians care about people’s health.

Relating to the third principle of early intervention: Obesity is not just a chronic disease, but a progressive one. He asked ‘what is the goal in any progressive disease?’ Participants offered a range of answers. He repeated one answer: ‘to halt progression’. That is another difference between weight loss and obesity management programs, he explained. The former do not see weight stability as a positive outcome. Right now, “in health care, we’re trying to make active gainers active losers”, and skipping the step of stopping progression.

A social worker interjected: one of the challenges if I promote that is that it scares the patient. Dr. Sharma said he would get to that issue in time, and then asked why preventing weight gain is much easier than preventing weight re-gain. Many voices chimed ‘setpoint’. He advised we work first at eliminating the cause of weight gain – such as binge eating disorder or

⁶⁰ Note the absence of any academic references to this theory, a theory that underpins most of the rest of the assemblage.

sleep apnea - and accept weight stability that follows as a good outcome. If the patient is still gaining, then treatment is not working.

A co-participant [unidentified profession] asked: if early intervention is the priority, when people have a BMI of 24 or 25, “are you talking to them?”⁶¹ He switched the BMI categories to 25 or 26 in his answer,⁶² and put that hypothetical patient up against another whose BMI value is 35. He may bring it up with both, Dr. Sharma said, but given the reality of eight minute appointments, he would address the one with a BMI of 35. In his practice, he orients more to secondary and tertiary prevention than primary prevention.

Dr. Sharma asked us ‘why get in early?’ A chorus of voices: setpoint. He agreed, and continued: “If I wait, I’m up against a much bigger problem”. As clinicians, we know the situations that trigger weight gain, such as starting insulin, anti-psychotics, major trauma or life events, menopause, smoking cessation. The earlier we address this, the better, which is not how we do things at present. In contrast, “health care is taking a watch and wait approach”, and the burden of obesity on Canadian adults remains unaddressed.⁶³

Dr. Sharma switched the slide to the fourth principle – success is different for every individual – and expanded his arguments on problems with how we organise care at present. In terms of the reporting metrics used in your clinic, “weight loss shouldn’t be the primary

⁶¹ Note that this person is asking if you intervene on someone designated to be of a healthy weight as per BMI classification. They did not make clear they were talking about someone who was actively gaining weight, just someone whose BMI marked them as being at the higher end of normal.

⁶² Which serves to shift this person into the overweight category as per current classification conventions for BMI. In contrast, a BMI of 24 is considered normal or ideal.

⁶³ He delineated why they are focusing on adults to start: more work orienting to prevention, especially with children, yet preventing child obesity does not necessarily mean adults will not develop “the disease”. He spoke briefly about risk factors for childhood, and two participants asked questions about interventions with children. I opt not to go into detail here because this is not part of the 5As per se.

indicator". "Weight is not a health indicator. Use health indicators" to measure impact or progress. He mentioned many. [I caught the SF9, SF36 (both quality of life measures), and measures of impact on comorbidities, such as diabetes (HgA1c mentioned), blood pressure, back pain, or speech apnea]. That is, report success by breaking into subgroups delineated by comorbidity. He warned that evaluators hate these metrics, and prefer an indicator like 10% weight loss. Administrators, health care professionals, and patients alike need to understand that the goal is to be healthier.

For the fifth principle, Dr. Sharma noted that the concept of ideal weight comes from the insurance industry. He directed our attention to the lowest mortality risk group: the population in the 25-30 BMI range. Those below 25 and over 35 have higher rates. This means that someone with a BMI of 28 may have no negative health impact from their weight. He said it is unclear why the healthy range has increased. He added that the impact of excess weight is not earlier death, but more chronic disease.

Dr. Sharma reiterated each of the five principles, and then solicited questions. I looked around the room at my co-participants, and noticed many skeptical facial expressions. The pharmacist commented 'patients don't want to hear the goal is weight maintenance'. Another asked 'if we've seen this change in the last 100 years, is it genetics or environment?' Genetics and environment, he replied. So much has changed, making it hard to isolate. For example, is the electric light the problem? It has led to us sleeping less. Is it because we are more sedentary? He offers a third example, but I miss it.

Dr. Sharma asked the group: where in Canada are the lowest numbers of obese people? Several said BC. He agreed, and added the big cities to the list: Toronto, Montreal, Vancouver. A

co-participant noted that everyone walks in those places. Dr. Sharma continued: in poorer places, obesity is an urban problem, but in Western countries, the closer people live to the downtown of a city, the lower the obesity rate. Obesity in Canada is especially a rural problem, yet our clinics tend to be in the core of urban centres, where obesity rates are lowest.

A dietician noted that this is a hard sell – setpoint, weight maintenance as goal – and asked what buy-in is like for him? The immediate administrators get it, but ‘the higher ups tend to have lay person knowledge only’, that is, “eat less, exercise more”. The problem is that these are the decision makers, and the result is underfunding, a statement he supported by giving dollar figures of CIHR funding for obesity vs. diabetes per capita. The rare policy maker who ‘gets it’ has to face a public that will ask “why am I putting money into these fat guys?” He ascribed the current situation as a function of “the whole weight bias, discrimination business”. Many hummed an ‘mm hmm’ in response. He advised us to not accept money for a weight loss centre; the results will not meet expectations, and the result will be a loss of funding.

To this point, Dr. Sharma had talked for 65 minutes. He suggested we take a break. Most of us stood, and took the opportunity to pour ourselves a cup of tea or coffee, select a snack from the fruit provided, and/or look at the 5As texts on a table at the back of the room (i.e., texts we were provided in our envelopes that were available for purchase). When we returned a short while later, Dr. Sharma launched into the more specific ‘how-to’ portion of the afternoon, working our way through the texts we had been given, each of the 5As, and the clinician actions embedded within. He spoke at length, without notes, orienting to the content on each slide – content which was an exact copy of that in the booklet provided as part of the 5As toolkit.

7.2.2 The 5As, detailed

Ask

Dr. Sharma asked if we were familiar with the 5As framework from other topics – smoking or pain, for example. Many nodded. “The 5As have been around forever”, he said, and started talking about ‘the ask’. How to ask had to be translated from a smoking to an obesity-oriented frame, one that recognises “the sensitivity issue”. You cannot ask someone “do you think you have an issue with your weight?” While weight is a sensitive issue, that is not an excuse to not talk about it. We talk about sensitive topics all the time, and are trained to do so.

The next slide was “be non-judgemental”. He flagged attitude, body language, and words used as all making a difference to the quality of care we provide. He invited us to position ourselves as patients: “what’s the natural response to being judged? To unpleasant experiences?” He answered his own question: people get defensive and so will avoid clinicians. Blame and shame generate defensiveness, period. And given that many obese people are emotional eaters, what will they do when they experience these negative emotions? “Their first stop after a negative experience in the clinic is Tim Horton’s”. He continued that we all have biases that we learn to hide, manage, not show; that is, ‘we know how to be professional’. The goal is “changing professional conduct”, and awareness of our bias is the first step.

Continuing on this theme, Dr. Sharma advised us to not make assumptions. “That’s also something I had to learn”. He offered examples of such assumptions: “probably eating too much, unmotivated, have mental health problems, don’t exercise, hate exercise”. Assumptions mean our advice will not match their needs. Obese people are likely more knowledgeable about food, exercise, and tracking than the “skinny people”, and have tried to lose weight

multiple times. He advised us to concede to patients that we do not know what it is like, but that we know it is difficult and that no one knows perfect solutions. He suggested “try something like ‘It’ll be tough. We’ll take small steps, figure out what works. We’ll work together’”. He alerted us to the possibility of people crying in our offices thanks to the acknowledgement that weight management is hard.

The next ‘ask’ slide was titled ‘readiness for change’. This is, he said, ‘no big deal’ and ‘no different for this topic than for any other’. Assess it, and accept what you learn. He asked the group why people might not be ready? He paused, and the room was silent for a moment. He asked ‘what feeds into not being ready?’. One person suggested other priorities. Dr. Sharma listed a few possibilities, including that they just lost their job, or they do not see it as a problem. Remember, it might not be a problem, or this could be denial, which is not unique to obesity. He asked ‘how many have trained in motivational interviewing?’ At least half of my co-participants raised their hands. He stressed the value of motivational interviewing for clinical work, and added he likes the scaling type questions from that tradition: On a scale of zero to ten, how ready, how confident are they to change... “Anyway, all that simple stuff”. And while on the topic of language, do not talk about fat or obesity. Use the word weight. Obesity is not a word someone with a BMI of 30 identifies as applying to themselves.

The final ask topic was creating a weight-friendly practice. He noted that to fail to create a physically comfortable and equipped office is to fail to serve 20% of your population. “Would you justify this for any other population?” He closed the ask topic by adding “the ask is all about sensitivity, so we can start a constructive dialogue”.

Assess

Dr. Sharma shifted to assessment by introducing what the research team heard from patients: “don’t give advice until you know what the problem is”. Once you have permission to talk about weight, find out what’s going on. Assessment is three-fold: assess obesity itself, health status more generally, and causes/drivers of obesity.

Assessing obesity: Dr. Sharma described the inscription of body mass index as a partial way to assess obesity. Figure 2 appeared on the screen as he spoke. He asked ‘what does BMI tells us?’ My co-participants offered a variety of answers. He echoed one: ‘right, how big someone is’. It is “not anything about health”, emphasising the ‘not’. He flagged BMI as particularly unhelpful for the elderly, who may be increasing their body fat and losing muscle mass. Within any given BMI value, there is ‘variation in the amount of fat’. For example, among women, there is 2.5 times variation in the percent of body fat within a single BMI classification. BMI at a population level likely indicates a population getting fatter, but tells us nothing about whether they are sicker. That is where the staging system comes in; that is “our response”. Health care professionals have to do tests to figure out stage.

A dietician asked: ‘how comfortable are physicians with the staging system?’ Very, he replied. It is very similar to how other diseases are classified, such as the New York heart disease classification. He gave examples of each stage, using a diabetes-related example for each of stages 1 through 4.

Dr. Sharma then showed three slides that deviated from the 5As branded set, slides that included an academic citation (which was rare during the presentation). He described the three graphs on these slides as showing the superior predictive power of the Edmonton Obesity

Staging System for mortality, a new classification system developed separately from but embedded in the 5As. After introducing the study in some detail (10,000 US adults followed for 20 years), he interpreted the results as follows: BMI does not predict survival, while the EOSS stages do. He added that we tend to think that everyone with a high BMI is “going to drop dead tomorrow. We think it’s so dangerous”. He asked us ‘what is the relative risk of heart disease for smokers?’, then answered his own question: 30 times more likely than non-smokers. He asked again, this time for lung disease for smokers? Almost 100 times, he answered himself. In contrast, the relative risk of a person with a BMI of 40 dying of heart disease? A mere 2 times. He returned to the better predictor, the staging system, drawing our attention to the graph on the slide: those who are deemed to be at ‘stage 0’ on the staging system have ‘barely a trend’ specific to mortality. Among those with BMI over 25, and over 30, there are still lots of “stage 0” people, he explained. Over 50% of those in the 25-29 BMI range are ‘stage zeroes’. He reminded us that this means they have no medical, mental, or functional problems as a result of how big their bodies are. Clinicians need to assess in ways that can recognise that.⁶⁴

⁶⁴ The lesser visual status of waist circumference on the slide is consistent with the minimal attention Dr. Sharma gave it.

Figure 2: Assessing the current state of the body

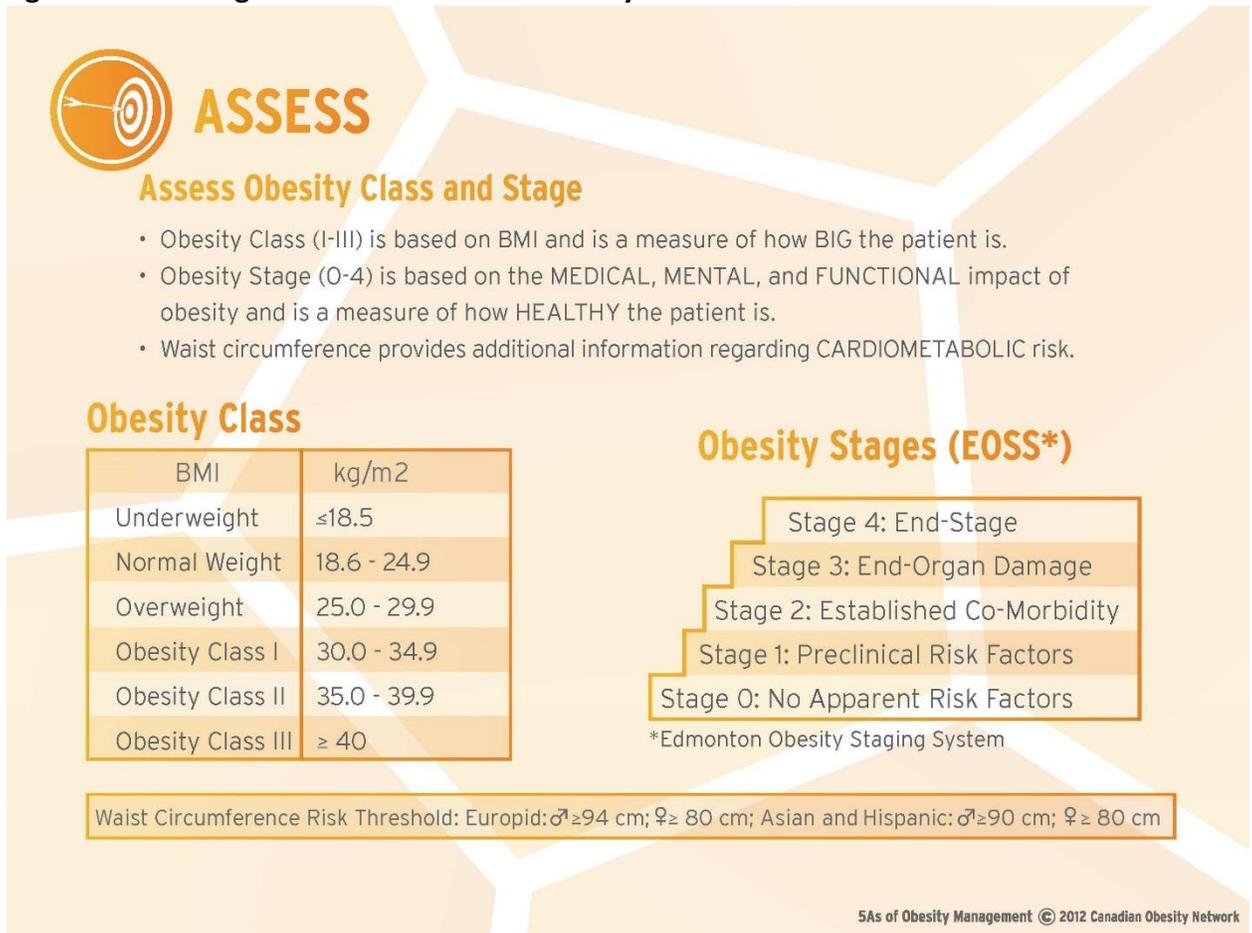


Figure 2: From the 5As of Obesity Management™ Practitioners Guide booklet (Canadian Obesity Network, 2012). The above image is unaltered, and reprinted with permission as per the Canadian Obesity Network license under a [Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License](https://creativecommons.org/licenses/by-nc-sa/4.0/).

Dr. Sharma transitioned to the next topic by asking ‘what is an assessment trying to answer?’ He listed three things: why does this person have a weight problem; how does weight affect their health; what are barriers to treatment? He brought up the next slide: assess for drivers, complications, and barriers (Figure 3). He suggested we start with the mental slice of the 4 Ms: “not because fat people are crazy” (many of my co-participants laugh) but because uncontrolled mental health problems make weight management difficult. He talked about each M in turn, and exemplified the monetary one as “you can lose your job because you’re fat”.

In his review of the 4 Ms to assess, he noted that seeing this list “puts a lot of people in shock”. They respond “I don’t have time”. He countered these imagined clinicians: “If you’re a family doc, you should already know this stuff. Take it and put it in this context.” He mentioned the superior skills of family medicine residents for this kind of assessment compared to specialist residents, who get stuck in the metabolic history for hours. This comment elicited laughter from most of my co-participants. He returned to a more serious tone: this is not additional work; this is what you need to know about all patients with a range of chronic diseases. “This is how you’re supposed to practice medicine. If they are gaining weight because of their depression, treat their depression”. The key, he said, is to ask how the 4 Ms contribute, and how to address them. He emphasised that he has not asked about eating, exercise, sleep, and the like; that is, he does not ask about behaviours during assessment. Those may come out, but start with the 4 Ms. Then, if need be, ask about behaviours if it will help you decide what treatment to recommend.

Figure 3: Assessing influences on weight and weight gain

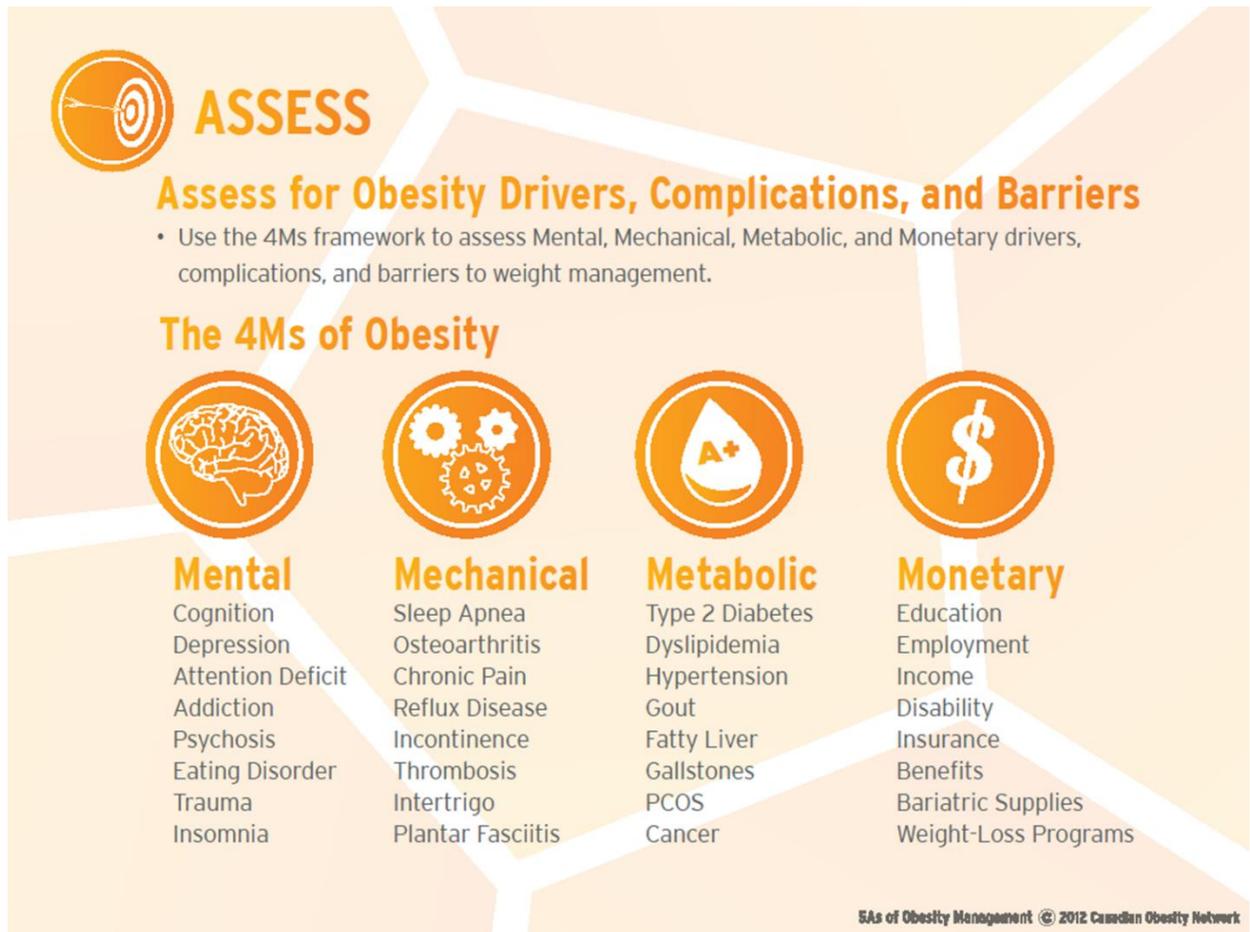


Figure 3: From the 5As of Obesity Management™ Practitioners Guide booklet (Canadian Obesity Network, 2012). The above image is unaltered, and reprinted with permission as per the Canadian Obesity Network license under a [Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License](https://creativecommons.org/licenses/by-nc-sa/4.0/).

Advise

To open this topic, Dr. Sharma noted ‘you have asked permission, and assessed well. The next step is to advise.’ Advising is three-fold: on risk using obesity stage; on benefits of modest weight loss, phrased in a way patients understand; and about the long-term nature of this strategy. For the “Advise on treatment options” slide (p. 8 booklet), he asked the group to identify what shocks his colleagues about this slide. An immediate response from a dietician:

“Three to five per cent weight loss” [the text: “Average sustainable weight loss with behavioural intervention is about 3-5% of initial weight”]. He asked us the average weight loss from bariatric surgery. The room remained silent. He answered, 25% of excess weight [i.e., not total weight, but excess].

A dietician commented: “many think they’ll be in a bikini, be a Victoria’s Secret model.”

He agreed, and added that he worries about the ones with drastic post-surgery weight loss who are “pushing the envelope”, or the ones who do not lose. The problem is that we tend to remember “the one striking case” of larger weight loss. And we should remember that “those who lose a small amount and keep it off...that patient has made big changes.” Three to five per cent weight loss may not be a clothing size, but it has a big impact on joint stress, blood pressure, and the like. We have to manage expectations, including our own [a comment that became a recurrent refrain the more we delved more into the three last As].

Dr. Sharma then reviewed a list of treatment options, each point having its own slide. He added some tips, tricks, or physiological rationales to each:

- Sleep, time, and stress management: listed first purposefully. No matter what treatment choices, time and stress management are core to any form of obesity management, and this is where clinicians need to start.
 - o Healthy eating takes 90 min/day; that is, 20 min for each meal plus some time for snacks. For those with gastric banding surgery, who eat 6 meals/day, can take up to 2 hours more.

- Exercise plans often fail because people say they are going to get up earlier. He suggested we advise against people planning to take time away from sleep; the need or desire for sleep will always eventually win.
- Dietary interventions are a sequence of tasks. Start with 'nutritional hygiene' of eating three meals a day, whatever they are eating. Hunger is to be avoided, so that patients are not in a panic when hungry. Once eating regularly, the clinician and patient can start to address what is consumed. Healthy eating involves a lot of food, which takes longer and more effort to eat. The goal is for the patient to find things they like and will sustain.
- Physical activity: "very important, but not for reason people think". Most orient to burning calories, but "that's a joke". We can eat calories burned in mere moments, and intense exercise works up an appetite, so obviously exercise alone does not lead to weight loss. But what does regular exercise do? He answered his own question: it boosts mood, reduces stress, improves sleep, etc – all of which can reduce emotional eating. He advised we suggest they choose an activity that makes them feel better, relieves stress – including low intensity options like yoga – rather than one that stimulates appetite. He called exercising to the point of vomiting, as per The Biggest Loser on television, "nonsense". And if a person is exercising and gaining weight? "They are not gaining muscle; it's a joke, it doesn't happen". They are likely eating extra calories.
- Psychological: Resolve outstanding psychological issues first. Send the person to a professional with these skills; if, for example, a patient has binge eating disorder, depression, and/or is an emotional eater, they are not patients for the dietician.

- Low calorie diets: like Optifast, which are 900 calories per day via 4 shakes. This approach is indicated only when needing large weight loss quickly for some urgent reason, like for a procedure or diagnostic test. Commercial products are necessary for this; 900 calories of 'real food' will be nutritionally deficient. This is not a permanent solution, and this is not obesity management. He added that we need to appreciate and monitor for the risks such as dehydration, kidney problems, and electrolyte imbalances. This means weekly monitoring, biweekly labs, and medication adjustments. That is, people on low calorie diets need medical management.
- Obesity medications: he made a simple comment that none are approved in Canada.
- Bariatric surgery: He asked how many of us have 'surgical patients'? A handful raised a hand. He stressed it is important to know the indications and results. He gave an overview of the changes in the surgical approaches over the past 15-20 years, as well as issues of surgical competence and the need for ongoing follow-up. Lack of follow-up is one of the major reasons 'patients fail'. He noted we should not speak of surgery as a last resort. It is better framed as the treatment of choice when >15% sustainable weight loss is "needed", and it requires monitoring for the expected nutritional deficiencies. A conversation about bariatric surgery followed.

Agree⁶⁵

We have asked, assessed, and advised. "Now the hard part – agreeing." Agreeing is, in large part, about managing expectations about weight loss held by the patient, the referring

⁶⁵ We are now nearing the end of the scheduled time. Dr. Sharma talked through 'agree' and 'assist' faster than the earlier As.

clinician, and our own. We are to facilitate the development of behavioural goals and change. ‘You all know SMART⁶⁶ goals, right? Part of a behavioural intervention?’ Heads nodded. “If I tell a patient to stop smoking or lose weight, which one is a behaviour?” Many responded quickly, decisively, and loudly: “BOTH!” After a pause, I and a few other people said ‘smoking’. A flicker of irritation flashed on his face, before Dr. Sharma responded: “Losing weight is not a behaviour and because losing weight is not a behaviour, can never be a SMART goal”. He gave a series of behavioural goal examples: eating breakfast 5 days/week; doing yoga twice weekly; improving sleep hygiene. He repeated himself: “Losing 20 lbs can never be a SMART goal”. In terms of our counselling, weight loss is never the goal, but always behaviour change. Success is behaviour change. If a patient starts to drift back to weight loss, refocus them on improved health and bring attention back to the positive changes they have already made. “You try to not be emotional about their weight loss. Never congratulate them for losing five pounds. It’s irrelevant”. A nurse practitioner commented ‘It would be very hard to not congratulate’. He responded ‘yes. I catch myself sometimes’. “They’re attached to the numbers. Don’t let yourself be the same”. The nurse practitioner said something about having a target of 5-10% weight loss. He counters: do not set it as a target. Focus on behaviours.

The conversation returned to the difficulty of not celebrating weight loss, and handling patients who do. He suggested ‘if they are celebrating, ask them why they think they lost the weight.’ Doing so will bring the focus back onto behaviours and provide positive reinforcement.

⁶⁶ SMART is an acronym for behavioural goals that are specific, measurable, achievable, relevant, and time-bound – or at least, that is how I was taught to activate the acronym. For example, a SMART goal is “In the next week, I will eat breakfast within an hour of waking on at least five days”. Whether my activation is the same as that of my co-participants in the course is unknown.

“That’s a professional counselling skill muscle”. The pharmacist asked “do people eventually let go?” [i.e., of the weight loss focus]. Yes, it becomes ‘less and less acute’ the more you reinforce the benefits. When they are discouraged, remind them of the benefits of what they have already accomplished, and comment ‘but weight loss? This is not a weight loss centre’. A nurse practitioner noted that ‘women are particularly fixated on that number. They think they’d be happy if they lost weight’. Dr. Sharma noted that weight loss does not fix crappy relationships, and added “This is your counselling skills. If you’re emotionally invested, they’ll continue to be, period.” A dietician commented that people with eating disorders are also invested. Dr. Sharma refocused the talk on obese patients and agreeing on behaviour change: ‘remember and remind them that you cannot guarantee a behaviour will produce a particular outcome. But you can guarantee they will get healthier. So, agree on the treatment plan. Remember that big results require big steps. All the successful people made big steps. Maybe not overnight, or all concurrently, but cumulatively big.’

Assist

Dr. Sharma described assisting primarily in terms of arranging patient access to appropriate education and resources. He started by emphasising the value of group sessions, something supported by ‘the evidence’. ‘You lose influence by trying to do this one-on-one with patients. Obesity, and many of its related key causes, are common problems, so can find others pretty easily. A physician with a roster of 2000 can certainly find some people with common challenges.’ The group became more vocal at this point. Some agreed with Dr. Sharma, while others challenged or questioned him. They challenged his interpretation of the value of groups, in that groups make it harder to individualise care. They expressed concern that it is unfamiliar.

They asked questions about how best to do these. What is the ideal group size? What degree of structure is needed for group discussion? He responded to each in turn. He then introduced the notion of choosing the right provider - all are specialists and limited resources in the current health care system, so choose wisely - and arranging ongoing follow-up, 'just like you would with your diabetics'. See them often enough to keep things on track and catch problems early.

So that, he concluded, is the framework. 'It's not a cookbook. It doesn't tell you have to diagnose or manage depression, for example. There are other resources for that. It's a framework, a pathway to follow. And we now have the first data to show this works.' He mentioned that a pre/post study of 5As framework in a Calgary primary care network had been done, and described the intervention as a 'low-level' one, with distribution of the toolkits and a 20-minute video.

In the final moments of the workshop, he invited and fielded questions from the group. All questions were related to specific assessment and treatment issues, such as interpreting low Vitamin D levels and gestational weight. The woman who introduced him at the start of the afternoon stood and thanked Dr. Sharma for his 'excellent' presentation. People started moving around, standing up, talking amongst one another. A few made their way to the front of the room to ask him questions. I stayed, and once the crowd around him thinned, I offered him a ride to the airport, noting I was also going there.

7.3 Governing clinicians in the service of a biopower aim

The CON attempts to build a new reality for obesity management in primary care through its presentation of the 5As. Building a reality is difficult, costly work, and involves managing a range of pre-existing contingencies (Callon, 1986; Latour & Woolgar, 1986; Latour,

2005; Timmermans & Berg, 2003). An actor – in this case, a knowledge broker (Meyer, 2010) – trying to insert itself in a locale makes connections and displacements to reassemble relations, such that the new can fit (Callon, 1986). These re-alignments retain some, but not all, of the original (Callon, 1986). These insights guide how I think about the work done by the CON.

The CON 5As texts and presentation shifted the focus of clinical activity from weight to health. The governmental pathway the CON promotes involves acting on clinicians, so they in turn act more effectively on the biopower-defined object of interest – obesity – in new ways. The knowledge brokers involved – the working group members, assistants, and graphic designers involved in de- and re-assembling knowledge into the 5As texts, and Dr. Sharma as presenter - try to insert the 5As into clinics by reordering relations among actors already on the scene. I first describe how the 5As translates obesity from a simple reflection of eating and exercise choices to a more complex chronic disease. I then trace four major, specific strategies taken by this knowledge broker to govern clinician action specific to obesity: making visible how it is that clinicians make a difference; a pedagogical approach that mobilises expertise and narrative; mobilising the familiar; the use of simplifications and *aide-mémoires*. Together, these alignments created in the brokered knowledge assemblage are those the CON and Dr. Sharma believe will assist with the smooth passage of the 5As into clinical practice.

7.3.1 The biopower object, re-framed: Obesity as chronic disease and multiplicity

In our interview, Dr. Sharma noted that recasting obesity as a chronic disease and as obesities – a purposeful plural – is foundational to improving obesity management. This translation of obesity from choice to chronic disease, he added, is the point that elicits the most resistance from clinicians and patients. He stated that this is why he emphasises it early, and

repeatedly orients back to the idea through questions and making links. He explained to me that re-casting obesity in a chronic condition frame creates openings into understanding that many 'driving factors' need to be addressed, and that weight stabilization is success.

The CON and Dr. Sharma used many strategies to dissociate obesity from the dominant discourse and created new associations with chronic disease. During the course, Dr. Sharma developed a narrative of obesity and obesity management that includes far more than what is contained in the texts distributed to participants. He folded in scientific rhetoric (visual and the discourse of evidence) and analogies to other diseases to translate obesity into a multiplicity and a chronic disease:

Well a lot of it is about the narrative right. So there's, sort of, our presentation itself doesn't actually contain a lot of data or studies. But it's the narrative, it's, it's, it's telling people or reminding people that the evidence shows (.) how ineffective obesity treatments actually are and how you are dealing with the setpoint and how you are dealing with a situation that yoyo dieting is really the rule and not the exception. So you know the story telling aspects that (.) convinces most people [ok] using very specific examples and then citing the literature. (Sharma, interview)

This narrative formats a reality, to borrow Thevenot's (2002) phrase.

Setpoint theory is used by Dr. Sharma to trouble the common explanation that people just need to eat less and exercise more to weigh less that is central to disparities produced by weight bias, stigma, and discrimination in care. He invoked the physiological theory of setpoint to reinterpret why sustained and substantial weight loss is difficult. Dr. Sharma repeatedly foregrounded physiology through evoking setpoint and outlining mediators on metabolism. This repetitive and recursive use of physiological theory in the course has the effect of overwhelming and undermining the dominant discourses about body weight and composition being a simple reflection of eating and exercise behaviours and malleable. In sum, part of how the brokered

knowledge translates obesity into a chronic disease is by *adding* physiological science to the epidemiological problematisation. This addition functions to challenge the over-simplified risk factor frame produced and justified by epidemiological ways of knowing and acting upon body weight.

Dr. Sharma also invoked the rhetoric of scientific evidence for effect. The new narrative for obesity offered, one that includes setpoint, is touted as better explaining the results of clinical trials of interventions to reduce people's weight. Decades of research has demonstrated that sustained weight loss is rare (see Wadden et al., 2014 for a recent systematic review). Dr. Sharma drew our attention to the powerpoint statement (reproduced in the booklet) that the average weight loss sustained from behaviour change alone is three to five per cent, an uncited use of statistical rhetoric to persuade. He marked telling people to lose weight as not evidence-based. These examples among others in the course are moments where the term 'evidence' or scientific rhetoric links to the currently-dominant expectation that clinicians are committed to evidence-based practice.

Making analogies to other diseases is another tactic used by Dr. Sharma to translate obesity into a chronic disease frame. He pointed out that other bodily conditions we call chronic diseases, such as diabetes, may be managed with long-term treatment but not cured. He noted that if treatments are discontinued, then the biomarkers of disease status (and perhaps quality of life) worsen, as is true of diabetes or blood pressure treatment. In this brokered assemblage, this pattern - of biomarkers worsening in absence of treatment - is presented as true of obesity as a result of weight setpoint. Dr. Sharma reminded participants that like other diseases such as addiction, biases need to be distanced from care provision. Dr. Sharma encouraged participants

to wear ‘chronic disease glasses’, an incitement to bring a familiar and general model for care to bear here. Through analogies, Dr. Sharma translated obesity into a chronic disease through associations with other disease-management practices already in the clinic.

Dr. Sharma’s talk and the 5As texts promote an additional way to know the body. The Edmonton Obesity Staging System, included in both the texts and the presentation, was made visually equivalent to body mass index. The staging system differentiates obesity into non-pathological through to palliative forms. I would expect this new way to categorise the body – this change of how to know the body - to generate different enactments of obesity, via more targeted material practices of obesity management. This categorization system, if put into practice, would extend the way in which obesity may be understood as a multiplicity.⁶⁷

In the presentation, it is a scientific register used to persuade participants of the value of the new categorization scheme. The powerpoints included scientific-looking graphs that deviate from the branded slides to present information published in a journal, which Dr. Sharma interpreted verbally as displaying the staging system’s superior predictive utility to that of body mass index. Obesity as a multiplicity is promoted further via tables and diagrams in the texts and workshop powerpoint slides as well. The assessment mnemonic the 4 Ms (Figure 2) outlines a wide range of causes, complications, and barriers that must be addressed to manage obesity. The diagram that followed instructs clinicians to diagnose the ‘root cause’ of obesity as one of food intake, reduced activity, or impaired metabolism. The energy balance model typically understood as calories in and calories out is portrayed as insufficient. Obesity may be

⁶⁷ I choose the word ‘extend’ purposefully. Throsby (2012) has developed the argument of obesity as multiplicity in her study of care in bariatric surgeons’ offices. Surgical obesity, and patient enactments of obesity-as-loose-skin are but two of the examples she develops.

behavioural, but may also be metabolic. Obesity may or may not be unhealthy. Different obesities exist, and yet are still all labeled obesity, coordinated in a manner than holds these various heavy bodies together.

Both the physiological theory of setpoint and making obesity a multiplicity destabilise weight loss as the primary goal of health care for all with the disease. Weight is no longer a proxy for health in this model. Weight may never change, and that may be appropriate. Health may improve dramatically without a change of weight. Obesity management is about fostering health. While critics have argued the existence of non-pathological forms of fatness – Campos (2011) and Gard (2009) being recent examples - the staging system explicitly supports an enactment of a non-pathological obesity in the clinic, if used as intended.

Contrasting enactments of obesity – obesity-as-choice, where bodies are malleable versus several obesities as chronic diseases – are part of how the CON justifies the need for governmental activity focusing on clinicians. By reconfiguring the object of obesity and the objectives of clinical management, the CON offers a health care approach distanced from weight loss, which, to date, health care has failed to produce. Obesity management is marked as a clinical task, given health care is where chronic disease management takes place. In the next four sections, I highlight governmental strategies the CON uses to attempt to get health care professionals to offer clinical services better aligned with the reconfigured obesities.

7.3.2 Foregrounding how clinicians make a difference to outcomes

The social interaction between clinicians and patients was presented as consequential for patient outcomes. The focus on the clinical relationship was also purposeful, according to Dr. Vallis in our interview: “In the behavioural field we have to remember that the effective

ingredient doesn't happen by swallowing. The effective ingredient is in the relational, it's in the words that are exchanged." Dr. Sharma framed the status quo of primary care obesity management as a troubled clinical relationship between clinicians and patients with obesity.

Dr. Sharma started to develop a 'troubled relationship' problem frame in the first five minutes of the course. He argued that clinicians are underprepared, and then absolved them of their limitations; he was once 'just like us' and the field has changed rapidly over recent years. If (and only if) clinicians change their own practice to be more evidence-based and less biased, will they be in a position to help persons with obesity enhance their health and quality of life. This talk highlighted two positions for clinicians: failing or succeeding to deliver evidence-based care at present.

During the course, Dr. Sharma continued to develop this frame. We were told that patients bring what we should expect them to bring, given that they live in a body that is misinterpreted in a hostile social world. The troubles in this relationship reflect unrealistic expectations both clinicians and patients bring to bear on health care, and clinicians' failure to manage obesity well. Dr. Sharma developed the argument that psychologically, people with obesity are just like everyone else. They are no more likely to have a mental health problem than the general population. They react in ways common to each of us. They get defensive when blamed or shamed; just like "we" do. They may not be ready to change for various reasons, like having other priorities or not seeing it as a problem, which occurs across people living with chronic diseases. Their expectations are shaped by the social world, which in this case is one that delivers an onslaught of critique. They live in a society that assumes that making change and attaining ideal weight will be easy. They are often emotionally invested in

weight loss, but with a track record of failure in this regard despite often being very knowledgeable about food, exercise, and tracking. Dr. Sharma reminded participants that patients, like most of the rest of us in this same society – clinicians included – misread fat bodies as reflecting a failure of willpower.

Dr. Sharma linked desired clinical actions with appeals to an ideal clinician subjectivity, and aligned both with the 5As. In the *ask*, clinicians are to respect a patient's decision to opt out of talking about weight altogether, recognising the history of negative or harmful health care experiences patients may have had in the past. Enacting the 5As means clinicians are sensitive when the situation calls for it, rather than avoiding the conversation about weight. Clinicians are to acknowledge that obesity management is difficult and complex. He advised us to concede to patients (and by implication, to ourselves) that we do not know what living with obesity is like, but that we know it is difficult and that no one knows perfect solutions. Clinicians are to be professional, which he linked to managing biases, just like when working with people with addictions. Clinicians *assess* to gain an understanding of what is causing and making the disease harder to treat – “this is what practicing medicine means” - rather than make assumptions that limit the effectiveness of their care. When *advising*, clinicians keep risks in perspective. Goals *agreed* to by patients and clinicians are to be behaviour specific, and weight loss is not a behaviour. Professionals do what is effective when working with their patients; they do what is evidence-based (and the 5As framework was pitched as evidence-based). If what professionals are doing is not working, they change their methods to better serve their patients. And when comments or questions from my co-participants marked obesity management as difficult

because of patients' unrealistic expectations,⁶⁸ Dr. Sharma turned the focus back on clinician actions to manage expectations better. Through both planned and spontaneous content, Dr. Sharma highlighted the need for change, and specifics about how to change one's own actions so that one may better care for patients. Becoming the ideal clinician was marked as consistent with being professional, evidence-based, more consistent with the practice of medicine, adaptive to patient needs, collaborative, and compassionate.

Dr. Sharma offered absolution for past clinical actions. Clinicians were underprepared, unsupported; the science has changed rapidly; bias runs rampant. The future, however, could be different. The implied argument is that it all comes down to what providers do in their clinical practice from this point forward. If, for example, they continue to judge, enact the 'eat less/exercise more' repertoire by offering overly simplistic advice and failing to assess well, or continue to foreground weight loss rather than health as the goal, they are providing neither obesity management nor enacting professionalism. If they take up the charge, if they put into practice that which they have learned in the course, they can transform the lives of their patients for the better. The implied challenge he issued to the audience: What kind of clinician are you going to be tomorrow, now that you have better knowledge and tools to help you?

7.3.3 The pedagogical approach: the accessible expert and the narrative

The pedagogical style – lecture, questions, responding to comments from the participants – was partly a result of the Network doing what they could with the resources they had. However, it was also somewhat purposeful to use 'the expert' presenting information in didactic format. Dr. Sharma activated the texts verbally, integrating the texts' resources with

⁶⁸ See the underlined statements in the earlier section about the 5As course.

additional content and new emphases, and responding to participants' questions or comments. Compared to the 5As texts, Dr. Sharma offered physiological rationales, expanded upon tips and tricks for communication and assessment, made visible what clinicians can do that is problematic vs. what is helpful, and actively questioned the audience to engage and persuade clinicians of the need for change and that the 5As is the best approach. Dr. Sharma made salient and accessible the preferred clinician subjectivity while delivering the course content.

In our interview conversation, Dr. Vallis noted the value in having Dr. Sharma lead the courses at present (at 'this stage of dissemination'). Dr. Sharma has "a really great reputation as, sort of the guru". Dr. Sharma's credibility is an asset to be used to help transport the 5As into primary care practice. While perhaps not the 'workshop' method they would have chosen had the Network had the anticipated financial support for dissemination, it is one that allowed Dr. Sharma to set the frame for the conversation, tailor comments for known points of friction, and respond to participants' questions and comments.

7.3.4 Translating the 5As counselling theory: Mobilising the already known and in use

The *5As of Obesity Management*[™] is an adaptation of a familiar mnemonic for many clinicians, best known for smoking cessation counselling. In our interview, Dr. Sharma told me the Working Group quickly settled on this particular frame for their primary care clinical tool because of the familiarity, the ease of remembering the 5As (ask, assess, advise, agree, assist), its linearity ("it does take you to a certain sequence in how you would do the assessments" – Sharma, interview), and the flexibility of the framework to include all actions that Dr. Sharma noted were components of obesity management. Dr. Vallis' take on this choice:

when it comes to supporting behavioural change, you know there are multiple theories, there's multiple methods of understanding human behaviour and of trying to address

behaviour change. As it turns out, *the 5As* was kind of one of the very first ones out of the block and then it, it-it got identified and then it got promoted. Um, and so you know, it's that sort of expression, give a kid a hammer and everything they encounter is a nail. (Vallis, interview)

Dr. Vallis noted the 5As has credibility as a model due to endorsement by organizations such as the World Health Organization as an evidence-based approach to counselling patients with chronic disease. The adaptability of the 5As framework to the full range of actions the CON promotes for clinicians also supported its use, according to Dr. Vallis.

This hammer, the 5As framework, has the advantage of being a 'minimal intervention', according to Dr. Vallis:

primary care docs for instance would say 'I'm not good at this, I have never been trained, and it takes too much time to actually support either the understanding of the problem or the solution to the problem.' So *the 5As* is sort of offered as kind of a minimal intervention, a minimal intervention meaning time, so you have to put minimal resources into this. And also to address the competency issue by making it fairly straightforward in terms of its sequences. (Vallis, interview)

In the course, Dr. Sharma addressed the anticipated problem of clinician time constraints directly and proactively. See, for example, his mention that seeing the assessment rubric (the 4 Ms) puts people in shock, prompting them to say "I don't have time". At that moment, he suggested this is not extra work for primary care practitioners, but a process of organising existing information through a different lens. And yet, the time issue seemed to carry an inherent tension over the duration of the course.

In the key informant interview, Dr. Sharma noted that approaching obesity as a chronic disease will take time and resources. In our conversation, Dr. Sharma noted that the time problem is the one consistent bit of negative feedback the Network has heard about the 5As from clinicians. Dr. Sharma attributed this complaint in part to a misunderstanding: the 5As can

be completed over a series of visits, but sometimes people fail to understand that. Later, he explained that obesity is a complex problem without an easy solution. If it falls under the purview of health care,

you're gonna need to spend as much time on it as it deserves or as it takes. You know, you would do the same thing with your diabetes, I mean you wouldn't say, well you know the health professionals shouldn't spend time managing diabetes because diabetes is so complex to management, or takes up so much time or takes up so many resources (Sharma, interview).

When the time feasibility argument faltered, Dr. Sharma used an analogy to another disease to make an ethical argument instead.

7.3.5 Textual rhetoric, materiality, and *aide-mémoires*

In the methodology chapter, I highlighted arguments of Chaplin (1994), Fyfe and Law (1998), and Spencer (2011) who argue that the visuality of texts influences interpretation, reflecting cultural orders that operate on a pre-reflective level. The visuality of the 5As texts, and their content, promote certain readings and activations.

The 5As texts have a coherent visual branding with respect to colour, font, background pattern, succinct wording of content, bulleted lists of content written in incomplete sentences, memorable emphasised mnemonics, and visual graphics that tie words to a specific action or idea. All the texts have the Canadian Obesity Network logo visible. In our interview, Dr. Sharma explained that the Working Group wanted the texts to appeal and have “solid brand recognition”, a desire that led them to hire a commercial design firm. His co-lead on the 5As project, Dr. Vallis, spoke more about the branding cohesiveness: CON continues to work to establish itself as the reputable and reliable ‘go to’ source of information on obesity

management. The *5As of obesity management*[™] texts are meant to further communicate that brand to clinicians.

Beyond branding, the textual choices reflect the CON's interpretations of clinicians' preferences and the broker's hope of a literal presence for the 5As in appointment rooms.

Regarding clinician preferences,

largely the feedback from providers saying that they didn't want (.) a long, complicated guideline. They were more interested in-in, you know, something that would help, uh, bullet points, really serving as a reminder and, uh, materials like the checklists. So, you know, we made a very conscious decision not to-not to include detailed guidance on any of the topics (Sharma, interview).

The booklet, a short and simple read, is for clinicians' reference when learning the 5As processes specific to obesity management. The three other texts in the package, all in the same visual branding schema, were developed to be used in the clinic appointment rooms:

- 1) 'obesity facts' patient handouts: a double sided 9" x 4" page. One side lists the five 'key principles' as per the first two pages of the clinician booklet, and the other has a list titled "Resources". There are three headings on this page:
 - a. "Public Health Agency of Canada" (described in a sentence that follows).
 - b. "Information on other obesity related health problems can be found at" (with a list of 15 different medical conditions and a website for each).
 - c. "Other useful links" (with six titles that are profession or behaviour-specific with links to mainly professional association websites).
- 2) checklist/charting document: a two-sided 8.5"x11" notepad. One side lists each of the 5As with checkboxes below linked to a series of tasks, plus spaces designated for patient name, notes, date, and provider signature. The other side contains three graphics

(Figure 2, Figure 3 and one that lists 'root causes of weight gain') that are also in the booklet.

- 3) a 3-dimensional 'desktop tool': a dodecahedron made of cardstock that requires assembly, was designed to occupy space more noticeably than a poster could on a wall; to act as an object of both patient and clinician attention. The 3D cardstock object was to be, in Dr. Vallis' words, "a little sexy" tactile conversation piece that places this work, quite literally, in the primary care (scope of) practice. In contrast, a flat text would be likely to be buried among other papers, Dr. Sharma noted.

Each of these texts is offered by the knowledge broker to reinforce the 5As at the point of care delivery. The patient handout and desktop tool may be taken up by patients or clinicians in appointments. The checklist is designed/intended to be used for charting, which in turn can function to communicate care processes completed with colleagues, such as primary care team members also involved in care for the specific patient.

This visual cohesion, repetition, and texts developed to be placed in appointment rooms all work as *aide-mémoires*. This is also true of the mnemonics: the 5As, the 4 Ms. The textual rhetoric, materiality, and memorable mnemonics are meant to work on clinician action in ways that do not require wholly conscious attention by the clinician.

7.4 The 5As in Mol's Logics frame

The Canadian Obesity Network has pulled together a mix of texts, materials, inscription devices, subject positions, interpretative repertoires, statistics, physiological theory, and more to improve obesity management in primary care. In this section, I situate the detachments made and re-alignments forged in the 5As through the logics filter developed by Mol. Consistent

with Mol's (2008) articulation of the logic of care, the CON invites clinicians to tinker, to doctor – or to use the CON's frame, to provide chronic disease management.

Mol's (2008) text implies a series of ways to look at health care practice and explore the logic(s) in operation. To review, care-logic practice aims to help craft a more enjoyable life for the patient who is living with a chronic disease. Care-logic orients to the question of which outcomes are preferred by the patient and realistic, given the current situation. Care-logic practices fold scientific knowledge and measurement/classifications in to help patients and clinicians decide what path is best to pursue. Technologies that may help achieve that outcome are used. The clinician and patient work together, remaining aware that the results are not guaranteed, and new problems may emerge from the changes made. Figuring out what to do is an ongoing process of tinkering with whatever works, dealing with new twists and turns as they appear. In the section to follow, I will explore these ideas separately, though their effect is cumulative.

7.4.1 What is 'the good' that care is meant to produce? How to realise this good?

What good might be done? Mol (2008) argues health care practice in the logic of care orients to helping individuals craft more satisfying existence while living with chronic disease. What is characterised as 'good' is emergent, and never settled. Clinicians and patients pick a place to start, do their best, and address challenges that emerge. These ideas are echoed in the *5As of obesity management*[™] as presented in the 2013 workshop.

The *5As* reconfigures the outcome sought from obesity management. Two of the key principles developed in the *5As* presentation and texts state explicitly what comprise good outcomes: 1) "Obesity management is about improving health and well-being, and not simply

reducing numbers on a scale”; 2) “Success is different for every individual”. Health, well-being, and success in the 5As are based on the question of what makes life better. What makes a life better is something figured out via dialogue and comprehensive assessment of the causes, complications, and barriers to obesity management. Health is co-produced by collaborative action with patients, using clinical expertise to address concerns of and risks to each individual living with the chronic condition of obesity. Ongoing follow-up care helps identify when things do not turn out as planned, or new challenges arise - that is, when something else is indicated to help make life better.

Mol (2008) describes care-logic as caring for that which can be cared for, and letting go of the illusion of control, instead recognising that not all that makes a difference to a patient’s life can be tamed. Obesity management in the 5As method is not driven by stoking patients’ desire to lose weight. Instead, the key is what is possible, helpful, and sustainable, which may not actually match patients’ desire for thinness. Participants were told that body weight cannot be tamed, at least not yet. The physiological theory of setpoint means that body weight is not significantly malleable; neither individual action nor a whole orchestra of actors can change setpoint, at least not yet. And thus, there is no clinically defined ‘ideal’ that clinicians expect patients to achieve, the fifth of the key principles. Instead, weight targets are set by what is sustainable and provides a good quality of life for the person. Good is what is achievable in practice, not determined by unrealistic desire to be thin or statistical studies that define ideal weight through associations with disease biomarkers.

7.4.2 What may be tinkered with to achieve these ends?

Care-logic in Mol's description starts from a recognition that a wide range of factors make a difference in a person's life, such as skills, habits, technologies, resources, relationships, and more. In care-logic, clinicians and patients decide what actions to take or adjust to try to make life better for the person living with a chronic disease. Clinicians have an imperative to change whatever it takes, including themselves. Failure is not an invitation to blame within care-logic, but a reason to try something new.

The dominant interpretative repertoire for weight is that individuals can tinker with two things to make a difference: what they eat, and how active they are. In the 5As, the dominant mantra that fat people need to eat less and exercise more is put in its place, literally. A place is created for those ideas, but only as two of many possibilities in terms of obesity management. Patient eating and exercise behaviours are not the only cause or lever for change.

The 5As assemblage makes visible and reinforces a range of mediators of body weight that either influence behaviours directly, or act through a different mechanism altogether: metabolism. The *assess* section of the 5As highlights a wide range of factors at play. The effects of diabetes or anti-psychotic medications, for example, influence bodily adiposity independently of calories eaten or expended. Poor sleep may be causal, and what causes poor sleep? That, in itself, is a long list. What about stress? In Dr. Sharma's verbal presentation, the effect of stress – including that produced by judgement by clinicians and others – has its own influence on our bodily composition, as well as our behaviours. In the *advise* section, Dr. Sharma presented and justified the long list of treatment options in the 5As. Patient behaviours may be tinkered with,

but such action is only appropriate if it addresses the root cause and works with patient readiness to implement change.

Health care professionals' expectations, knowledge, and behaviours are to be adjusted as well. The status quo of offering generic 'eat less/exercise more' advice, provoking guilt or shame, or reinforcing unrealistic weight loss expectations are clinician behaviours marked as failing to realise the good that is desired, and producing negative side effects. Clinicians are to transform their communication behaviours and methods of organising care to manage their biases and help adjust patient expectations, in the aim of improving obesity management.

7.4.3 How well do measurements and classification systems care for people?

Mol (2008) suggests that a measurement or classification is useful only if it helps take good care of patients. As noted in the literature review chapter, the central way through which obesity is known and classified is through a measure of mass – the BMI. Critical scholars have flagged multiple problems with the measure, and its usage and interpretation (Campos, 2004; Lupton, 2013; Nicholls, 2013). I agree with these critical scholars that the BMI does not help clinicians care well for patients – and my analyses support this critique.

The 5As marks the BMI as an inadequate way to know the fat body. As argued earlier, the 5As assemblage extends the notion of obesity as a multiplicity. A heterogeneous collection of obesities – from non-pathological to palliative - is made to hang together under one disease name, but substantial variations in fat distributions and molecular differences mean that fatness per se is not the problem. In the 5As, more must be known before a fat body is considered a risky body, or a diseased body. If supporting health is the outcome of interest – the meaning of

which is to be worked out between patients and clinicians – then the information leading into a decision of what might be done must orient to health.

In the 5As, obesity is to be classified through a measure that recognises different health impacts of fat, including the possibility of no impact at all. The current categorization method for bodies – body mass index – is de-emphasised visually in the text, and verbally in the course as inadequate if used alone. The text of the booklet and powerpoint slides notes BMI indicates only how ‘big’ someone is; the BMI is not a measure of health. One can be categorised as ‘obese’ by body mass index standards, and yet be healthy. If obesity is a chronic disease, then the body mass index as a categorization fails to differentiate those who are healthy from those who have a disease. Of note, this active destabilising of the BMI is coming from medical and public health insiders.

The decentring of the BMI in obesity management is furthered through *addition*. The Edmonton Obesity Staging System is the additional categorization tool presented, pitched as better predicting mortality than the BMI. The visual presentation in the 5As booklet and powerpoint slides generates an equivalence of the measure to body mass index, and the accompanying text frames the classification as that which orients to health. The knowledge broker presented the staging system as aiding clinicians to provide better care by shifting the clinician’s attention to the question of what might be best for a person living with obesity. This argument aligns well with Mol’s logic of care, but whether the argument holds when the classification is put into practice is an empirical question.

7.4.4 How are scientific knowledge and technologies folded into care?

To review Mol (2008), knowledge of risk based on population studies, and intervention research on the impact of certain treatments and technologies, may help clinicians and patients decide what is to be done. In choice-logic, the evidence knows best, pre-determining the outcomes sought, the measures of progress, and the paths taken to get there. The unpredictability about whether the relationships found in population studies will be realised for a particular patient is forgotten or ignored. In care-logic practices, the question becomes whether the outcomes prioritised in the research evidence align with what is achievable, realistic, and desirable for the specific patient in question. What is achievable and desirable for a given patient helps the clinicians filter what knowledge and technologies to bring to the fore as possibilities. In care-logic practice, clinicians and patients both recognise that the effects of such changes are never guaranteed, and that making changes in lives can create new and unintended consequences that must be addressed.

The CON's 5As assemblage exemplifies Mol's (2008) argument that enacting care-logic is not a rejection of evidence or technology. Dr. Sharma justified the 5As with a wide variety of quantitative evidence, including studies highlighting:

- current care is problematic in that it is biased, judgemental, not helpful and sometimes harmful;⁶⁹
- intervention trials have shown that the average, sustained weight loss from behavioural changes is three to five per cent of original body weight;

⁶⁹ This recognizes that interventions can have unintended – and initially, unstudied – effects, a feature Mol (2006; 2008) highlights as well.

- a number of pathways lead to increased body fatness;
- categorization methods should be able to predict health outcomes, or they fail to be health measures;
- physiological research on metabolism.

Technologies such as behavioural tracking methods or acid reflux medications are welcomed in the 5As. The key delineation is whether the knowledge and technologies mobilised improve a person's health and quality of life, something which is known only in time and with ongoing tinkering.

7.4.5 How to understand how patients and clinicians work together? What are their roles?

Clinical relationships rooted in choice tend to orient to fostering patient independence (Mol, 2008). In choice-logic, clinicians are experts who give patients the facts, or salespeople who incite desire. Patient-experts then make their choice by filtering the facts through their own values, or patient-consumers call the shots. The patient making a choice marks the end of the relation. In contrast, care-oriented practice is open-ended, addressing problems as they emerge. Independence is not the goal; dependencies within the collectives that shape our lives may extend our capacities and make for better living. The care-logic relationship is one that fosters patient resilience, tenacity, adaptability, and perseverance while they strive for health in the face of unpredictable disease. Both involve meddling in lives, but for different reasons: for the moralistic reason of promoting autonomy, or in the aim of improving a situation.

Some features of choice-logic as per Mol's differentiation appear in how Dr. Sharma's talk and the 5As texts present roles and clinical relationships. The 5As uses the dual expert language, in what I hear as an echo of Mishler (1984). The assemblage preserves room for

patient choice at different points in the pathway. Respect for patient autonomy and choice has a place of particular prominence: the first A is 'ask'. This privileged moment in the 5As, when a clinician asks permission to speak with a patient about weight, reflects the need to recognise that weight is indeed a loaded conversation. Given existing stigmatization of people living in large bodies, including that done by clinicians, this moment of choice allows the patient to opt out. This choice, then, may be an expression of respect. Similarly, the 'A' of agreeing to goals creates an opportunity for patients to decide on a course of action. These uses of patient choice sound more like features of choice-logic than that of care-logic.

Mol (2008) suggests that there may be situations when hybrid practices incorporating both care-logic and choice-logic elements are helpful. I think the purposeful use of patient choice in the 5As may be one such example – if put into practice – for three reasons. First, these patient choices are located in a care-logic frame. The choices made by patients along the way are not meant to perpetuate the notion of body weight malleability; the CON does not promote an illusion of complete control of body weight. In addition, these are not choices pre-defined by the evidence. The choices in the 5As function to build trust and ensure any goals set are achievable and important to the person living with obesity. Second, patients making their choice does not mark the end of clinician involvement; care continues in the follow-up format expected of primary care chronic disease management. Finally, the 5As locates the disease of obesity in a life lived, not just in the body. During the course, Dr. Sharma developed subject positions of persons with obesity through biological, psychological, and social lenses. By foregrounding physiology – especially setpoint - and framing obesity as a heterogeneous condition with many causes, much of Dr. Sharma's talk repositioned patients as living in bodies

that are not under simple control by willpower alone. Their experience of living in an obese body in our society has influenced their knowledge, confidence, and experiences in some unique ways, including some negative ways. The subject position developed is of an emplaced person, influenced by social relations and physiological realities that are well outside of their control. Within this frame, it is clear that the moments carved out for patient choice and autonomy in the 5As recognise not all outcomes flow from choice. Instead, patient choice is used to ensure that care activities produce treatment plans that are appropriate for the specific person, dislocated from the illusion of mastery or independence. The vision of the relationship promoted is one of partners working together to define the problems that are to be addressed, and decide how to do address them.

7.5 Who and what holds their own in the governmental assemblage of the 5As?

The 5As workshop is a governmental assemblage that aims to act on clinicians. In pursuit of a method to improve obesity management in primary care, the Canadian Obesity Network has pulled together a mix of texts, materials, inscription devices, subject positions, interpretative repertoires, statistics and more. This is done through producing synergies and alignments to attempt to facilitate integration, as well as actively severing some current associations. Some actors in the envisioned care practices hold their own – that is, are framed in positive ways – while others are weakened and discredited.

A number of the synergies created in the 5As framework operate through medicalising obesity in two particular ways: as a chronic disease, and a multiplicity. Chronic disease management is a common interpretative repertoire in health care, one that comes with a set of familiar roles, responsibilities, and goals. Chronic diseases are those which are without a cure,

but are not immediately terminal. Such a frame insists that clinicians understand obesity management as a long-term activity, one aimed at improving quality of life and health outcomes rather than being driven by the expectation that people can cure themselves if they just work hard enough. And the multiplicity frame connects adiposity to a range of potential causes and complications, which are to be determined before a course of action is put into place with the patient. The multiplicity frame medicalises most, but not all, obesities.

Translating obesity into a chronic disease frame via new associations is not all that is done in this assemblage. The actor-network actively destabilises some current actors in clinical care. Body mass index as a measurement and its current classificatory system are both de-emphasised as the primary way by which obesity should be judged. Being big is not itself a problem; this argument has been made for decades, though it has had difficulty gaining traction in a systematic way within health care. The BMI fails to make visible the range of metabolically healthy people who are obese. The CON argues that doing obesity management well requires a better classification system. The CON offers one they argue is better, to be used in addition to the BMI.

The CON assemblage undermines epidemiology and clinical trials as the primary knowledge foundations for clinical practice. This is accomplished by re-interpretation of epidemiology and clinical trials results, and by addition of physiological theory and traces of psychology- and sociology-based arguments about human behaviour. The physiological re-framing of weight⁷⁰ discredits particular simplifications about weight gain and obesity, ones long

⁷⁰ A theory that is described in practical terms, but without referencing or any indication of the degree of acceptance of this theory among academics or medical specialists. In this sense, Dr. Sharma's description and repeated references to the theory of setpoint allows the concept to 'hold its own'.

dominant and often assumed or implied in epidemiological and clinical trials about weight and health: that bodies are completely malleable, under individual control; that blaming or shaming people for their weight or weight gain will produce the hoped-for results; and that weight is a stable, unmediated reflection of calories consumed and expended. Each of these discursive simplifications is marked by the CON 5As assemblage as producing 'bads' when enacted, in part by inclusion in the new narrative that marks each as producing problems. In the 5As assemblage, failing to appreciate setpoint and obesity as a chronic disease means not meeting people's needs, and perhaps adding distress into their lives. Psychological and sociological threads are also bridged into the assemblage, used to help re-interpret people with obesity and their lives. Patients with excess body fat are like everyone else, psychologically. They are no more likely to have mental illnesses. They may have psychological distress as a result of stigma and discrimination based on their body weight, which makes their health and lives worse. The methods they use to cope with continual blaming and shaming, such as avoidance of health care or certain social situations, may also worsen their health or quality of life. The additions to the knowledge foundation about weight offered by the CON contribute to the unraveling of the dominant discourses about obesity.

Undermining the dominant discourses about weight also undercuts the notion of individual responsibility for health. Health is, instead, something co-produced by collaborative action of clinicians with patients, together addressing concerns of and risks to each individual living with obesity. The 5As assemblage presented in this course attempts to sever clinical care from anti-fat interpretative repertoires and stigmatising practices. This medicalized, and more

individualized, relational approach to obesity management undermines expressions of choice-logic.

Clinicians may or may not hold their own as a result. The subject positions developed by talking about bias discredits those who enact bias, and commends those who manage their bias. Evidence-based care is a second way by which clinicians' actions may be evaluated. The implied argument is that if they put into practice that which they have learned in the 5As, they can transform the lives of their patients for the better. If clinicians do so, they can then claim a positive identity for themselves on the grounds of being both evidence-based and managing their biases. The 5As is framed as a passage to claiming oneself a professional. These subjectivity appeals mobilise both desire and responsibility.

Of note, the subjectivity appeals to be a certain kind of professional involve abandoning particular ways of positioning patients as failures. The CON assemblage rejects the kind of patient positioning developed by the surgeons studied by Throsby (2012), who attributed poor weight loss outcomes after bariatric surgery to failures of the patient. In the 5As, success and failure are both the result of the actions of different actors distributed over time and space. Clinicians are to meet patients where they are, figure out together what might be helpful, and tinker in service of making life better. Clinicians are to manage obesity in a frame much more consistent with Mol's (2008) logic of care.

Destabilising some actors on the primary care scene, and adding others: the designers of the 5As offer replacements for that which they take away. The CON 5As workshop and texts develop a new narrative for obesity, and a new set of practices and subject positions to enact in obesity management in the clinic. The texts produced and presentation given aim to make that

easier, but realising this vision of care depends, crucially, on clinician action. Whether that action follows after clinicians attend the workshop, and the effects of such action, is yet to be seen.

Chapter 8: Conclusion

I started my exploration of primary care management of eating, exercise, and weight by reviewing the literature about the discursive strengths and stigmatising effects of framing weight as a threat to health and as a reflection of personal choices. I observed practice in three primary care clinics in Alberta, examining how the topics of weight, eating, and exercise are handled in annual medical appointments or chronic disease care-planning visits with adults. I participated in a continuing education course for the *5As of obesity management*[™] offered by the Canadian Obesity Network, a course that sought to change clinical practice. I focused my attention during data collection and analysis using methodological principles from ethnomethodology, conversation analysis, visual research methods, narrative analysis, discourse analysis, and actor-network theory to explore the assemblages that comprise current practice. I applied theoretical insights of governmentality and Mol's logics framework to consider clinical interactions and continuing education practices.

To conclude my dissertation, I review and emphasise some key insights from the previous chapters, and offer additional interpretations that emerge from putting in-the-clinic results beside the CON 5As assemblage and the work of other scholars. I present an informed imagining of how translations of the 5As in clinics may proceed, based on my knowledge of existing research and my ethnographic findings of what makes a difference (actors that spur other actors to act) to primary care practices specific to the topics of eating, exercise, and weight. Finally, I offer my reflections on using governmentality and Mol's logics in relation to one another.

8.1 In-the-clinic: Weight as discrediting

One aspect of weight management I have made visible in this dissertation is of the discourses and subject positions patients made salient in the clinic. In Chapter 5, the **patient fluencies** chapter, I explored how most patients invoke the dominant frame of obesity – that is, eating and exercise as problem and solution – in ways that mark the topic of weight or the act of weighing as (potentially) discrediting. Weight was treated by patients and clinicians as telling a truth about the body, and also about the person. Patients invoked dominant discourses about weight: weight-as-malleable, and weight-as-choice, particularly the result of eating and physical activity behaviours. Clinicians treated patient associations of weight with eating and exercise as relevant and appropriate, similar to Pillet-Shore's (2006) study of weighing and Sorjonen and colleagues' (2006) study of lifestyle-related talk. In the appointments I observed, both patients and clinicians were fluent in the dominant frame. The dominant discourse about weight, and its implied subject positions (that heavy bodies reflect people who do not take care of themselves) makes a difference to talk in the clinic. This is, in essence, a confirmation of what others using conversation analysis methods have found (Pillet-Shore, 2006; Sorjonen, Raevaara, Haaraka, Tammi, & Perakyla, 2006), and what Murray (2009) predicted. The strong discursive association between the bodies-we-have with the people-we-are influences how clinical care proceeds.

However, the discourse was not wholly deterministic. The difference it made to the action in the clinic depended on how the dialogue unfolded - a second contribution to the existing field I make in this dissertation. The extent to which this discrediting frame influenced the dialogue depended on both speakers. Some patients professed normative concerns with weight, while claiming a more positive identity for themselves by foregrounding their hidden

challenges. Angela's appointment, reviewed in Chapter 6 (the **logics in the clinic** chapter), serves as a key example. She invoked the frame in part through explaining why her eating and physical activity habits are not the cause of her 'excess weight'. Angela's account was not accepted by Dr 2, who instead continued to talk with Angela in ways that reinforced the notion of body malleability and the 'eat less/exercise more' interpretative repertoire. Dr 2 persisted in this repertoire despite Angela's recent small weight loss and maintenance of a >10% weight reduction over the past several years. But at other times, physicians did disrupt the dominant discourse about weight. To continue with Angela, Dr 2 noted that the BMI has to be taken with 'a grain of salt' in muscular, active people. As noted in the patient fluencies chapter, Dr 3 occasionally offered non-behavioural explanations directly to patients (such as genetics) to account for their weight. In the clinics I observed, both patients and clinicians introduced less discrediting frames to account for weight, though there was no guarantee the other would accept it. It was more often the case that physicians maintained the weight-as-choice and body-weight-as-malleable discourses that exemplify what Mol (2008) calls choice-logic, where our bodies are interpreted to be the results of our choices, and we are each to act on our choices to bring ourselves in line with the norm.

If weight was deemed an issue and the dominant discourse that physical bodies reflect our choices upheld, only eating and exercise were made into salient topics for conversation specific to weight management. This is the case for Darren, Vivian, Gabriela, and Angela. The case of Ruth offers the counter-example: weight was removed from the conversation as the important outcome of interest. Instead, Dr 3 created an opportunity for Ruth to talk about her biggest challenge at present. The result was a diagnosis and management plan to address Ruth's

depression. Ruth's appointment was the most care-logic aligned interaction I presented in this text, and it was accomplished by moving weight to the background and centring the dialogue around Ruth's own understanding of her health and life.

By examining clinical practice in close detail, I have made visible some of the ways in which clinical activities are formatted in advance. What is to be known and done by clinicians is embedded in the digital and material infrastructure. Each clinic had at least one scale, and tape measures in each clinic appointment room. Nursing staff have routines that involve weighing, and in one clinic, measuring waist circumference. The electronic medical records have a designated spot for weight on the main page. Each electronic medical record has calculations coded into the computer software to generate the BMI and composite risk scores. On Dr 2's EMR, the BMI always shows at the top banner, the only text in red font on the page (even if the BMI is deemed 'normal'). Dr 3's risk score calculator shows how low one's 'heart age' could be if the patient's weight and other indicators were in the ideal range. In Dr 1's EMR, the 'population alerts' page has a specific flag that displays if the BMI is above a pre-designated threshold. These each serve to reinforce the notion that weight is something to be known and acted upon.

8.2 The CON 5As of *obesity management*[™]: A vision of clinical weight management

In primary care clinics, I highlighted how patients tried to deflect blame and judgement, with or without agreeable physicians. Patients tended to disrupt the discrediting discourses about weight by highlighting how their personal situation presents unique challenges. These unique challenges imply a need for recalibration of expectations for this *particular* individual. The *5As of Obesity Management*[™] workshop also deflected blame from patients, but through a

different mechanism: recalibration of expectations about weight loss for the entire population of people deemed to have excessively high BMI values.

The recalibration developed by the CON contains the over-simplification about obesity causation in a new narrative. This new narrative emphasises how scientific knowledge about metabolism has changed and continues to evolve. The physiological explanation offered for body weight – setpoint – makes sense of the rarity and difficulty involved in maintaining even small reductions in weight. In the narrative used by the CON, the fat body is a result of a range of influences, of which eating and exercise are two. The fat body may or may not be a diseased one. This new narrative of fat bodies reinterprets weight maintenance as a positive outcome, and marks a sustained body weight reduction of five per cent or more as atypical. The physiological knowledge helps translate some presentations of obesity into a chronic disease that can only be managed, never cured. If clinical care practices take up this new narrative, enactments of overweight and obesity will become more of a multiplicity within primary care than they are at present. Metabolic pathophysiology, medications, concomitant medical conditions, mental illness, sleep, stress, probabilities, norms, and more may all be folded in to different clinical enactments.

In the 5As narrative, people do not 'fail'. Assemblages fail. Assemblages are the provisional and temporary linkages of heterogeneous elements that, together, bring about the whole in a particular time and place. The 5As framework recognises a range of actors that influence the body, such as mediators of metabolism, psychological stresses, social experiences, and behaviours. The medications in use may mediate metabolism in a way that changes what goals are realistic. Physiological mechanisms of the body may push back, a resistance to

reductions in weight that is independent of eating or exercise. Experiences of stigmatization in or outside of health care can worsen the health of a person with obesity. The patient and their body then meet a clinical assemblage that includes clinicians' communication practices, norms, epidemiological studies, and clinical trial results. Clinicians may communicate in unhelpful ways. The norm may not apply well to a given person. The statistical odds of improvement may not break the patient's way. The point of breakdown in the 5As narrative is not necessarily a person or their willpower. Fatness no longer reflects a lack of investment in taking care of one's self, in the CON 5As. The result is that the 5As envisions clinical practices for weight management in a way that is much more consistent with care-logic than was observed in primary care clinics.

8.3 An informed imagining of translation of the 5As into primary care practice

In the chapter about the 5As, I highlighted alignments made by the CON with existing practices. Through these alignments, the CON attempts to create traction for the promoted obesity management practices in primary care clinics. To use Callon's (1986) description of translation that has been taken up by Meyer (2010), I have highlighted the problematisation, *intéressement*,⁷¹ and some enrolment processes which may or may not help the 5As translate as intended into primary care. Continuing with Callon's description of translation processes, I imagine points of friction or resistance that could influence future enrolment and mobilization of the 5As in clinics. These potential points of friction are based on my knowledge of primary care clinics and my analyses of influences on care provision. I present this by separating out different actors I observed. The relations among these different actors in the network, and the

⁷¹ The processes used by the knowledge broker to interest actors in taking up the role designated for them.

effects that may result, are harder for me to imagine, and are worthy of empirical study in the future.

8.3.1 Persons who are classified as overweight or obese

How might a person react to the news that sustained, significant weight loss is not an achievable goal, or that they have a chronic disease called 'obesity' that is without cure? There is good reason to think that the clinicians participating in the 5As courses who flagged patient investment in thinness as a potential problem are raising a relevant issue. Much of the scholarship described in the literature review demonstrates the association of thinness with virtue and of fatness with ignorance, laziness, and irresponsibility. Lupton (1995) argues

in the interests of health, one is largely self-policed and no force is necessary. Individuals are rarely incarcerated or fined for their failure to conform; however, they are punished through the mechanisms of self-surveillance, evoking feelings of guilt, anxiety and repulsion towards the self (p. 10).

Engaging in body shaping practices, especially if successful in achieving the socially-valued physique, marks one as a successful, moral, disciplined citizen in advanced liberal societies (Murray, 2005).

Numerous authors demonstrate the investment people have in weight and weight loss. This investment is reflected in how people who are labeled obese structure their narratives and accounts about weight (Boero, 2010; Throsby, 2007), the shame and self-blame they experience (Earnshaw & Quinn, 2012; Murray, 2005; Scrambler, 2009), and the numerous attempts they make to lose weight (Kirk et al., 2012; Kirk et al., 2014). Chapter 5 presented several examples of patient displays of investment in thinness and health, displays that patients used to position themselves in favorable ways. Patients distanced themselves from the stigmatising, dominant discourses about weight, implying that the stereotype applies to other people, but claiming a

more virtuous position for themselves. Dr. Sharma offered suggestions of how clinicians can help people invested in weight loss to switch their focus, an acknowledgement that this does present an issue in clinical care. The desire people have to be thinner influences clinical practices.

Clinicians may change the way they talk, but they will still be working with people who are well-versed in the dominant discourses about weight and health behaviours. I envision new interactional troubles emerging between clinicians and patients, where a patient will be repeating the patterns observed in Chapter 5 while the clinician tries to shift the frame. This is not insurmountable, and some patients may embrace clinicians who offer practical advice and support that considers a patient's history of past efforts (Kirk et al., 2012; Malterud & Ulriksen, 2011) even if the advice and support does not orient to weight loss. Consider the example of Angela in Chapter 6: how different might her appointment have been if the physician told her that weight stability was a positive outcome, and that her weight was not a health concern or a risk?

However, I imagine patient investment and desire for thinness, or at least weight reduction, will not be easily ameliorated. Murray (2005) explores how the "collective knowingness about fat" limits the Fat Acceptance movement. 'Obesity acceptance' is a different enactment of acceptance of corpulence than that promoted by Fat Acceptance activists in that it involves accepting the diagnosis of obesity as a chronic disease, but it may offer a productive starting point for the current task. Murray (2005) notes one cannot simply change one's mind about one's body, yet that is what the Fat Acceptance movement assumes. Instead, those practicing fat acceptance have experiences of living in a fat body that are always multiple,

contradictory, and ambiguous. One cannot place one's self outside the discourses that constitute us as subjects (Murray, 2005). Changing clinical care to orient to weight stability or modest reductions of weight (at most) asks people to continue living in bodies that generate internal feelings of revulsion, shame, anxiety, or guilt (Lupton, 1995; Scrambler, 2009). Fat bodies are marked as threats to the health and economic wealth of the nation in media and policy reports (Canadian Institute for Health Information & Public Health Agency of Canada, 2011; Saguy, 2013), and attract judgement from others on a daily basis (Lewis et al., 2011; Seacat, Dougal & Roy, 2014). The 5As alters the discursive resources available to patients in ways that reduce stigma and discrimination, but will not be accepted by many people these patients find themselves interacting with.

The translation of obesity into a chronic disease may take hold in (some) clinics, but that does not assure widespread uptake. This has implications for patients' experiences of health care services. The 5As offers persons with fat bodies new resources for biographical coherence, and for claims to a positive identity, at least while in the company of what Goffman (1963) called 'the wise'. It is ill-advised to assume that all will be 'the wise' within a given clinic; it is unlikely that all who do patient care will attend a 5As training course or enact the disruptions of dominant weight discourse proposed by Dr. Sharma. When a patient is referred to another clinician, the CON conceptualization of obesity as a chronic disease, and causation as being a function of more than willpower and behaviour are likely to be met with the disbelief of clinicians. Multiple previous studies have demonstrated the tendency of clinicians to foreground willpower and behaviour as the causes of obesity - see Boero (2010), Kirk and colleagues (2014), Malterud and Ulriksen (2011), and Puhl and Heuer (2009) for examples. Patients may find

themselves working with clinicians who follow other methods to organise care, such as the new Canadian guidelines (Brauer et al., 2015). The alternative orderings may or may not be consistent with the 5As approach to obesity management. The multiplicity of enactments may proliferate, with patients caught up in and needing to respond to notably different enactments of weight management within health care settings.

8.3.2 Clinicians and the primary care environment

As noted earlier, the 5As course assemblage could make it harder or easier for clinicians to hold their own. Part of why it may be harder is that the 5As course developed a subject position that could discredit clinicians. Dr. Sharma marked many common practices (e.g. telling people to eat less and exercise more) as unethical and failing to be evidence-based. He offered an absolution of sorts, but, to recycle Sharma's own argument about patients, how might clinicians react to being blamed or shamed? Aphramour and Gingras (2011) note that the scientific rhetoric of evidence-based practice obscures recognition of the embodied and emotional nature of clinical practice. They also flag the possibility of dieticians experiencing shame and reacting defensively to suggestions that their current practices are harmful. I imagine that other emotions clinicians experience may also make a difference to how the 5As are translated into practice (if translated at all). Disrupting dominant discourses about weight and health shifts those who are interpreted as virtuous into more ambiguous terrain, and those who are stigmatized onto less judgemental ground. Clinicians are people, and virtue discourses about weight and health may shape their own narratives of self. Emotional responses of clinicians, which I would expect to vary in part based on clinicians' own body weight and degree of corpulence, may prove to be influential in the translation of the 5As into primary care.

In addition, some of the specific tasks embedded in the 5As but also used in other assemblages have known translational difficulties. Consider the example of the 'agree' portion of the 5As. 'Agree' includes patients developing behaviour change goals, such as eating breakfast daily. Behavioural goals are not a new concept. And yet, in the 5As course, it became clear that many clinicians lack familiarity with core ideas about behavioural goals. When Dr. Sharma asked course participants which of quitting smoking or losing weight was a behaviour, most of my co-participants confidently shouted "BOTH!" Self-management support activities, of which behavioural goal setting is a component in the influential Chronic Care Model (Wagner et al., 2011), have proven to be difficult to translate into clinical practice (Johnston, Liddy & Ives, 2011; MacDonald, Rogers, Blakeman & Bower, 2008). This is reinforced by Rueda-Clausen and colleagues' (2013) evaluation of the pilot study to implement the 5As in a Calgary Primary Care Network. The authors found that only 'assess' and 'advise' activities increased significantly from baseline.

Biomedical measures form a big part of how clinicians know the body. In Chapter 6, the **logics in the clinic** chapter, I highlight moments where the biomedical measure is assumed to tell a truth about the body that overrules the account offered by the patient. The 5As booklet lists a range of possible causes of weight gain, and a number of treatments. I flag here the lack of inscription device and quantification possible for some of these causes and treatments. Stress pathways, and stress management offer an illustrative example: there is no biomedical measure that can confirm that stress is indeed a problem. That which cannot be measured but is instead known only through patient accounts, and for which there is no specific location on a chart for a value, seems less likely to be foregrounded in clinical care.

The 5As will enter clinics where the digital infrastructure is not oriented to its use. The digital infrastructure reflects the work of many who have come before. The BMI has a prominence in the electronic medical records of each of the clinics I observed, a prominence that will take active effort to work against or disrupt. The software could be updated to include diagnostic codes based on the staging system. Similarly, a digital template could be made based on the 5As checklist. Embedding the 5As in the electronic medical record software will require the initiative of a person or group of persons with the technological skills to do so, and user skills in navigating new templates. Absent that effort, it is possible that the CON-provided charting checklist will be scanned into some electronic medical records. From what I observed, scanned documents get quickly left behind, not capturing attention as time passes. That which is not easy to do will be less likely to be taken up in practice. This matters because the electronic medical record is used to communicate with other clinicians and organise future care activities.

The use of templates should not be assumed to ensure enactments of the 5As will retain the envisioned care-logic quality. The use of templates and computerised checklists in routinised ways can introduce new interactional difficulties (see Blakeman, Macdonald, Bower, Gately & Chew-Graham [2006] for an example relating to self-management template use) and detract from more relational care practices (see Rhodes et al. [2006] for a diabetes-specific example). Templates, standards, and checklists can create troubles, changing more than they were intended to when used in practice.

The Canadian Obesity Network is not the sole knowledge broker seeking to order how clinicians care for bodies, people, and/or the population. In this dissertation, I made note of two others: the Alberta Medical Association organization called Toward Optimized Practice, and the

Canadian Task Force on Preventative Health Care. The latter released a new clinical practice guideline specific to obesity assessment and management in primary care in early 2015 (Brauer et al., 2015). There are other knowledge brokers trying to get into primary care clinics to act on clinician action about weight, eating, and exercise, and many who had come before. Primary care is a site of dense relations - a highly networked space. This means that in clinics, the 5As will co-exist with other ways of ordering clinical practice. Certain orders may seem easier to achieve or require fewer resources. For example, the new guideline released by the Canadian Task Force on Preventative Health Care (Brauer et al., 2015) recommends primary care clinicians offer or refer patients classified as overweight and as having high risk of developing diabetes, and all obese patients, to structured, behavioural management courses. Offering courses may be time and resource-intensive for the clinic, but a one-time referral to a community program is a notably less involved activity for a primary care clinician than is taking on the lifelong, chronic disease management promoted by the CON in the 5As.

In the 5As course, and in my interview with Dr. Sharma, clinician concerns about time were raised. While Dr. Sharma provided pat answers to reassure clinicians, the experience of trying to put the 5As into practice may prove more intensive. The misalignment of expectations with experience, and existence of competing priorities in the clinic, may influence how the 5As translate into care practices. While policy documents point to primary care as a site where obesity is to be managed, there may be a lack of incentives or resources to take on these changes.

The CON offers a vision for health care that *may* allow clinicians to hold their own in the future. In a health care system that is taking up performance measurement and pay-for-

performance methods in the name of accountability, the indicators used to measure performance now and in the future may make a difference to how the 5As are taken up in practice. The methods by which health care knows itself are mainly quantitative, and often focus on biomedical outcomes rather than effects on lives (Mol & Law, 2004). In the case of the ASaP checklist promoted by the knowledge broker Toward Optimized Practice, completing a task – promoting physical activity, checking a cardiac risk score – is the indicator of good performance. But if patient health outcomes are the measure of success, how weight is included or excluded from indicators would be something I would pay attention to as a potential influence on how care proceeds. I doubt that performance metrics promoted by provincial organizations will take up 5As tasks as indicators in the near future, but recognise the possibility of a specific clinic doing so via the quality improvement committee. If the latter were to happen, the work done by the quality improvement team to change care could prove to be a catalyst for mobilization of the 5As model in clinics. The particular methods used to evaluate care practices could change how the 5As framework is taken up in care.

8.3.3 The knowledge infrastructure of clinical practice

Epidemiology currently serves as the primary knowledge foundation by which health problems are defined and modifiable objects identified. Much of the epidemiological work conceptualises weight as a modifiable ‘risk factor’, one that can and should be reversed (Campos, 2011). Mediators of metabolism, such as sleep or weight cycling, remain excluded from most epidemiological models (Campos, 2011). The same is true of how epidemiology was translated into health policies targeting lifestyle; lifestyle was deemed modifiable rather than existing in relation to social and physical environments (Larsen, 2011). Choice-logic relies on the

notion that we choose our bodies, and can change our bodies by making new choices. This is reflected in most epidemiological work on weight – the models used, the variables included, the interpretations of the statistics. Epidemiology creates visibilities and invisibilities that provide a sense of what is to be acted upon, truncating comprehension of the social (Mol & Law, 2004; Rich, Monaghan & Lee, 2011; Shim, 2010) and physical environmental mediators (Guthman, 2011) of our bodies. Epidemiology is not neutral on what makes a difference to the health of the population. The tendencies of epidemiology to conceptualise weight and lifestyle as malleable limits capacity to translate weight into care-logic.

In the Canadian Obesity Network's assemblage, the current science of populations is marked as inadequate if the goal is to care for people, individually or collectively. In the 5As course, Dr. Sharma made the argument that clinicians need to know bodies as physiological entities, and people as psychological and social beings to care well for people living with obesity. Both the 5As course assemblage and critical weight scholars (e.g. Campos, 2011) argue that aligning what is at least potentially good for bodies and individual people depends on a more inclusive knowledge foundation than what epidemiology offers, at present, on weight.

The CON attempts, at least rhetorically, to align caring for bodies, individual people, and the population on the topic of weight. Aligning care for multiple objects can be difficult and precarious (Law, 2010). The CON tries to achieve this by foregrounding health as the object of interest and folding in other knowledge sources. However, as long as reduced weight remains the biopolitical imperative for those with higher levels of adiposity, the CON assemblage will not suffice. If improved health, considered broadly, is the sought-after outcome, then the CON 5As *might* succeed, though the actual health impacts of using the *5As of Obesity Management*[™]

method have not yet been published. Publications evaluating the effects of the CON assemblage have only demonstrated change in clinical processes (Rueda-Clausen et al., 2013). This is consequential in a time and place where care for populations is justified by use of epidemiological models and study.

8.3.4 The tenuous medicalization of obesity

The CON assemblage creates opportunities for many obesities to be enacted in clinical practice. This is in part a reflection of the new classification system embedded in the model. Obesity as defined by the BMI is *sometimes* a chronic disease, once re-classified in the staging system. Many elite athletes are obese by BMI standards; the staging system creates a category that can account for these bodies and for those who live in fatter bodies without health problems. Yet, these people are called 'Stage 0' and obese, marked as almost-patients in the staging system. If people categorised as Stage 0 get a joint injury from participation in sports, for example, would this shift them into Stage 1? Misattribution of problems to weight – a problem flagged by Malterud and Ulriksen (2011) as stigmatising - may persist with use of the staging system. This could act as a potential point of friction or resistance that impacts how the 5As model is translated when transported into primary care clinics.

The new classification system promoted in the 5As workshop and texts relies entirely on the co-presence of a psychological problem, a functional limitation, or a disease. That is, obesity is to be classified from a 'healthy' version (Stage 0) through to a palliative version (Stage 4) by having high body mass and a concomitant problem. These problems may or may not relate to the high body mass. If mental illness is no more common among those with obesity, as Dr. Sharma stated, then why would having a diagnosed mental illness shift a person into Stage 1 or

2? Treating obesity is, in the CON conceptualization, primarily treating the co-existing problem. The primary issue here seems to be lack of adequate treatment of psychological, functional, or biological problems that cause weight gain. While laudable in terms of addressing one of the problems that produces health disparities, this is shaky grounds for medicalization.

On the surface, the staging system seems to address the critique that the BMI is not health-centric, and thus cares better for patients. I see the staging system as likely to produce improvements in this regard. However, I also recognise that a range of ad hoc processes develop around the use of any new standard, the effects of which are not known in advance.

8.4 One knowledge broker in a field

The introduction of a new standard into practice is not straightforward. Translation attempts may have no, minimal, or substantial intended impacts, and may change more about clinical care than was intended. A number of ethnographies help us understand that order is not ours to dictate in any complete sense (Callon, 1986; Latour & Woolgar, 1986; Lee & Stenner, 1999; Timmermans and Berg (2003). Consider Callon's (1986), Latour and Woolgar's (1986), and Timmermans and Berg's (2003) close descriptions of the work involved in building realities. Such work is difficult, costly, and involves managing a range of pre-existing contingencies. Creating and maintaining associations and relations come at a cost, and that which is Othered, banished, or rendered invisible can push back against our attempted mastery (Callon, 1986; Lee & Stenner, 1999).⁷²

⁷² I interpret the failure to achieve the biopower goals about weight loss through these ideas: pre-existing contingencies may not be managed well, and that rendered invisible pushes back against the practices that assume malleability of the body and emphasize individual responsibility to eat less, exercise more in the name of risk reduction.

The densely networked terrain of primary care helps us understand why the CON, like other knowledge brokers, uses a range of strategies to try to gain a foothold in care. Their strategies include identity and narrative appeals, folding in new knowledge to re-interpret existing epidemiological studies and clinical trials, and making the new model of care materially accessible in the clinic (e.g. the charting checklist and dodecahedron), among other tactics. The CON carves out the space for its own assemblage by active associations and dissociations with that which is already accessible to the clinicians attending the course. This glimpse helps us understand why embedding any new procedural standard into care is messier than is often imagined (Timmermans & Berg, 2003). Any stabilization of practices is a temporary accomplishment, one that is subject to change, in part because a number of knowledge brokers are swarming toward the clinic and trying to re-order practice.

The knowledge brokering work involved in trying to insert a particular set of care practices into clinics helps illustrate how no single actor determines the outcome. The problem is not any single actor; it is the assemblage that, when enacted, produces the problem. Recalling the literature review, the problems at present are multiple, including: the heavy reliance on the BMI; limited ways in which obesity causation is thought; stigmatization and discrimination in health care. And even just changing one aspect of the assemblage – such as introducing a new classification system to know obesity – will involve more than good will of clinicians. To the extent that any one knowledge broker addresses the problems that generate neglect of those deemed excessively fat in health care, the effects are neither assured nor entirely predictable. In particular, the CON is working to disrupt a solidified set of practices that direct clinical attention

to eating and exercise interventions to produce weight loss – a set of practices the new clinical practice guidelines for Canadian primary care practitioners reinforce.

In this glimpse into practices, there are many knowledge brokers trying to get a proverbial foot in the door, and change is a constant in clinics. For this reason, I think there is particular strength in using methodologies that are as open as possible when looking for what influences contemporary clinical practice, and the effects of translating brokered knowledge into clinical practice. Using methodologies that are open to a wide range of actors making a difference, that study translations as they occur, are especially relevant given the limits to the present method-assemblages of epidemiology and clinical trials, which have difficulty accounting for relational influences on outcomes and may miss many actors in the assemblage that made a difference to the outcome.

8.5 Thinking with governmentality and Mol's logics

In this project, I used two theoretical lenses to explore current and envisioned primary care clinical practices geared to the imperatives of weight and health: governmentality, and Mol's logics. I applied insights from each of these theoretical lenses to data produced through methodologies and methods that focused attention on actions and interactions. In the present section, I revisit the two theoretical lenses to highlight contributions of each, and contrasts between the two.

8.5.1 Governmentality

I think using governmentality in the present study brought two particular strengths. The first relates to how it focused my attention analytically. The second relates to how my work contributes to a field of research.

Subjectivity, especially the subjectivity idealised in advanced liberal rationality, is a core interest of governmentality scholars (see Cruikshank [1999], Dean [2010], and Rose [1999a] for examples). Their work on subjectivity offered an important anchor for my analysis of in-the-clinic talk about weight, eating, and exercise. I used forms of discourse analysis to attend to how speakers position themselves and others in talk, and how speakers work to preserve positive identities for themselves in face-threatening situations. The integration of governmentality scholars' work on advanced liberal forms of subjectivity, where active, entrepreneurial subjects are the ideal, helps make visible why it is that weight serves as such a threat to face for so many patients (across body sizes). Understanding such talk through a governmental consideration of advanced liberal subjectivity allows for a deeper understanding of why changing clinical practices about weight may be difficult.

I relied on a different focal point when analyzing the CON 5As assemblage with governmentality. Here, my contribution to the governmentality literature is more in the form of description of small, mundane techniques used to act on the actions of clinicians. My tracing out of a series of governmental tactics the CON used in hopes of acting on clinician action contributes to a bigger governmental project not undertaken here, where more theoretically-oriented governmentality scholars consider how these small, mundane techniques comprise a recognizable rationality.

As I look forward to future publication, including governmentality in my theoretical framework helped contextualise mutating attempts to address rising body mass in the population. Previous attempts to govern fat – to produce a new order – have proven unsuccessful. Fat bodies have not, en masse, become thin, yet the project has not been

abandoned. Rather, new problematisations and solutions have appeared, as Dean (2010) notes is common. Governmentality allowed me to add a more robust frame to studying the work of knowledge brokers than that offered by Meyer (2010). Meyer (2010) focused on translation, in Callon's (1986) sense. I find this helpful, but limiting. Meyer's (2010) frame does not make sense of why the surge of knowledge brokers exists in health care, a trend that governmentality can help interpret.

The primary limitation governmentality poses to the current project is a function of its neutrality and non-teleological orientation. My project is driven, in part, by a concern about the production of health disparities in health care practice, disparities produced by governmental practices that interpret fatness as a failure to enact the idealized subjectivity. I sought to contribute to the dialogue about stigma and discrimination in care in ways governmentality is not equipped to do.

8.5.2 Mol's logics

Mol's logics offers a teleological foundation to engage for the current project, one that Mol (2008) argues is not consistent with critical approaches, but is not neutral either. By mapping out local, situated actor-networks specific to eating, exercise, and weight talk in primary care, my proposed research may be considered an engagement in ontological politics (Mol, 1999). Highlighting common patterns of assemblages can open up dialogue about whether these are 'good' enactments, wherein 'good' is a concept to be developed rather than assumed a priori (Mol, 2002). In a world where nothing is fixed but instead a movement in need of continuation, foregrounding the practicalities and materialities involved in the crafting of action can help open up a dialogue about which realities might be best to bring forth (Law,

2004; Mol, 2002). Without over-assuming but instead describing, we can wonder when and where we might do better. We can make it easier to see that things might be done differently, because they are already are (Mol 2002). We can ask instead ‘what reality should we live in?’ (Mol 2002); we can focus on goals or end points or goods we seek.

I am not neutral about the value – the good produced – of decreasing bias, stigma, and discrimination on the topic of weight. Applying Mol’s (2008) logics frame has allowed a lens through which to create and present vivid distinctions between different ways of approaching talk about weight, eating, and exercise in the clinic. Mol offers a sophisticated foundation for ethnographic work, directing attention to a range of actors that contribute to enactments of choice-logic and care-logic, while recognising that the effects of enactments are what matters and that interferences of choice-logic and care-logic may produce better ways of living with disease.

Part of the strength of Mol’s frame is that it is one that can engage clinicians. I think Mol is onto something when she argues that the logic of care has lacked a language. She suggests that clinicians agree with choice-logic when presented with it, but then often tell stories of the times choice-logic fails in practice. As I work to translate my results for clinician audiences, the resonance aids my ability to engage that audience. Contrasting Vivian’s care with Ruth’s through Mol’s logics, for example, opens up dialogue about which care practices are ‘good’ ones, dialogue relevant to clinicians in their everyday work.

Of note, Mol (2008) argues specifically about the goods care-logic practices produce for those living with chronic disease. While the CON argues obesity is a chronic disease, I am agnostic about whether that is an accurate description. Working with Mol’s framework, I have

come to think that care-logic may apply well to any particular bodily characteristic that is not easily ameliorated yet is considered a medical object.

Mol's model has limits, certainly. She stays close to practice, and like actor-network theorists and ethnomethodologists, focuses attention on what is observable in those specific practices more than linking to more all-encompassing rationalities such as advanced liberalism. Using Mol's logics model leaves much unaddressed, such as issues raised by Lupton (2013) and Guthman (2011) regarding the contradictory pressures in advanced liberal societies to consume and also self-discipline consumption. Here is where a theoretical articulation with governmentality helps.

8.6 Concluding thoughts

Law (2004) argues that any research project helps produce the knowledge it describes. As researchers, we interfere in the world in ways that can make a difference. The problem then becomes how to engage? Which visibilities and interferences are good ones? Which messes are good to create (Mol 2002)?

My thesis makes visible existing orders and standards relevant to primary care management of weight, eating and exercise, and some of the effects that follow. It was common and observable in the clinic to position patients with excess fat on their bodies as failures – a positioning I mark as a 'bad' in terms of the effects that follow. When the weight-as-choice and body-weight-as-malleable are maintained by the physician, certain invisibilities are sustained in interaction that may make a patient's life worse. The work of the CON seeks to shift obesity management into a frame that locates failure – that is, fat bodies read as a problem - in a much broader assemblage, and in doing so, creates a space to envision an enactment of the logic of

care specific to weight management. To return full-circle to Mol's (2008) introduction to *The Logic of Care*, my dissertation offers one more example of how care is not force, but is also not well-served by limiting care to patient choice among pre-determined care pathways.

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Appendix 1: Patient Case

Description/rationale for case

The core reason to use a standardised patient periodic health exam in this study is as an elicitation device. The aim is that the case, completed in the physician's own office at the outset of his or her participation, will provide an opportunity for the researcher to ask questions about what is being observed while it is underway. Questions such as:

- what are you doing?
- Why are you doing that? (And why now?)
- How will you use the information from that?

These are, for the most part, inappropriate to ask during an actual periodic health exam in practice; doing so would lengthen and notably disrupt the appointment, risking that it will not meet patient needs.

Once this is completed, the information gathered will provide something of an orientation point for future conversations (e.g. I noticed this was different than with the demo periodic health exam). The idea is not to push for or demand consistency – given the case is of a particular type of patient, and not some sort of a universal - but to explore variations.

The goal is a case that does not drive a clinician to managing a particular medical condition, but one in which some might find reasons to discuss eating, exercise, and/or weight. In discussion with Dr. Maeve O’Beirne, the case is to be a person who would be classified as a “Stage 1” on the Edmonton Obesity Staging System: “Patient has obesity-related subclinical risk factor(s) (e.g., borderline hypertension, impaired fasting glucose, elevated liver enzymes, etc.), mild physical symptoms (e.g., dyspnea on moderate exertion, occasional aches and pains, fatigue, etc.), mild psychopathology, mild functional limitations and/or mild impairment of well

being.” (Dr. Sharma’s Obesity Notes, n.d.). The usual first response with this will be lifestyle counselling, Dr. O’Beirne said.

Purposeful features of the case included:

- mild obesity as per BMI standards. Request to Medical Skills Centre that this woman be heavier and one with some visible fat on her body.
- a couple cardio-vascular risk factors: family history, borderline elevated blood pressure on this and the previous visit, ex-smoker.
 - Re: borderline high blood pressure: first line of hypertension management is diet
- sedentary job
- knowledgeable at a basic level about what it is that is recommended (not eating fried or salty foods, knows to eat more vegetables, etc)
- married with children still school aged, so she is kept busy caring for others
- normal pregnancies and deliveries (ie, no history of gestational diabetes or hypertension)
- birth control: vasectomy, so that hormonal birth control methods cannot become a focus of intervention for the high blood pressure.

Notes for standardised patient⁷³

Lisa Martin is 43 years old. She is new to this doctor; her former one moved away. This is her second visit; the first was a 'meet & greet' where the doctor took her past medical + surgical history, family history, and reviewed her smoking and alcohol intake. At that time, the doctor recommended coming in for a periodic health exam, and ordered her to get blood work completed before the visit. That blood work has been done. Personal life:

- married to husband, Darrin (aged 46), for 16 years
- together they have two sons, Benjamin (9) and Riley (7). Delayed pregnancies by choice
- lives in Silver Springs, in a home they own (http://www.calgary.ca/CSPS/CNS/Documents/community_social_statistics/silver_springs.pdf)
- works as an administrative assistant in the human resources department of a large oil

⁷³ All details of the case - the names and other details - are fictional.

company. Has a certificate from SIAST in Regina.

- Moved here when she was 23, met Darrin soon after.
- Darrin is a high school science teacher at Sir Winston Churchill School
- The boys are in hockey during the winter, and soccer in the spring/summer. Their sports schedule keeps the whole family pretty busy. The one thing she does for herself is a monthly book club.

Health:

- no past health conditions: an occasional cold or flu, but nothing serious.
- Laparoscopic gall bladder removal 4 years ago
- Hospitalizations: pregnancies and surgery above
- childbirth: both vaginal deliveries, no gestational diabetes (and related, if asked, no 'big babies') or high blood pressure, no complications in delivery
- medications: none, but takes liquid Vitamin D supplements (2 drops) and a multivitamin daily
- birth control: husband had a vasectomy five years ago

Weight history (to offer if asked):

- never a skinny person, but not overly heavy either
- never really took the extra 15 pounds of her second pregnancy off, and has had a slow weight gain since
- aware that she could stand to lose a few pounds, but pretty busy with the family activities.
- Has tried dieting a couple of times, lost 10-15 lbs each time, but always came back. If asked how, cut out junk food, and ate salad one meal a day.

Diet (to offer if asked):

- does most of the cooking at home
- “We eat pretty balanced meals”. If asked what that means: “I make an effort to include vegetables”. If asked how often, say 'I usually put some raw vegetables in our lunches, and then include one vegetable dish at supper'.
- More of a meat and potatoes family; it's what Darrin and the boys seem to like best
- If asked about salt intake, say “not too bad”.

- If the physician probes: I put salt on my fries, and eat chips once in a while.
- If asked how often eats fries and chips, about once a week or every couple weeks, either when getting lunch out or when at a hockey tournament with the boys
- Not a pop drinker
- Typical day:
 - orange juice + toast or cereal for breakfast;
 - sandwich (varied: tuna salad, ham + cheese, etc) + raw veggies for lunch on workdays. Eats at her desk or in the lunchroom with coworkers, depending on how busy it is.
 - hot lunches on weekends (soup or stew if at home, usually made in the slow cooker; if at a hockey arena, either brings her own lunch similar to workdays, or buys a burger or something similar)
 - Supper: one glass of 1% milk with meat, potatoes or rice or pasta (usually not things like Sidekick pasta, though will do that when rushed for time), and one veggie side dish. Dessert a couple nights a week: ice cream, pudding.
 - Other: 2-3 cups of coffee + water throughout the day. Not usually flavoured or specialty coffees, though sometimes enjoys about 1x/week

Activity (to offer if asked):

- “I don't have a lot of time for exercise”.
- If pressed for detail, sometimes goes for walks with Darrin on the weekend, if they can get away from the boys for a while and it's not too busy
- In the past, has tried Curves and Zumba at different points, but fell out of the routine when life got busy
- Drives to work, and has parking on site

Alcohol (to offer if asked):

- has a glass of wine or two with supper once in a while
- if pressed, this happens about once or twice a month

Sleep (to offer if asked):

- “decent”. If pressed for detail, gets about 7 hours/night, though that depends on how busy they are.

Menstruation (to offer if asked):

- regular cycles, about 26 days. Heavier flow since she had her sons, but not too bad.

General demeanour and appearance:

- looks neat but casual: clean clothes (jeans, sensible walking shoes, t-shirt or sweater), hair and skin clean; hair styled in a low-maintenance manner
- friendly, comfortable, but not overly gregarious

Case documents given to physicians

Lisa Martin is a 43 year old woman, in your clinic for the second time. The first visit, 2 months ago, was a 'meet & greet'. She presents today for a periodic health exam. Between this and the former visit, you sent her for blood work, the results of which are attached.

Medical history:

- no known medical conditions
- Sx: laparoscopic cholecystectomy 4 y.a.
- Hospitalizations: cholecystectomy + pregnancies
- Pregnancies: G2P2; vaginal deliveries, no gestational diabetes or high blood pressure, no complications in delivery
- medications: none.
- Over the counter medications: occasional Advil for tension headaches; takes Vitamin D supplements (2000 IU) and a multivitamin daily
- no drug allergies
- birth control: husband had a vasectomy five years ago
- last PAP: one year ago; all results reported normal to date

Family history:

- father b. 1940; mother b. 1944
- father: MI at age 63; high blood pressure
- mother: arthritis
- siblings: two brothers, no known conditions

Social history:

- married to Darrin (46) for 16 years; mother of two healthy boys, Benjamin (9) and Riley (7)
- administrative assistant in a large oil company. Husband: high school teacher

Smoking and alcohol:

- ex-smoker; quit 9 years ago when pregnant; smoked ½ pack/day x 8 years
- 1-2 drinks, once or twice a month

Previous visit (2 months ago)

Height 5'3" Weight 189 BMI: 33.5

HR: 78

RR: 15

BP: 140/88

This visit:

Weight: 190 BMI: 33.7

HR: 72

RR: 12

BP: 142/90

Lab Report

Martin, Lisa

98765432* AB (healthcare number)

7208 61 Ave NW

Calgary, AB T3B 3W8 (primary address)

15-Dec-1969 (43), F (birth date (age), gender)

(403) ***-**** (primary phone #)

ESTIMATED GLOMULER FILTRATION RATE

Order request status: Final

Collected date: 8-Nov-2013 08:22:00

Received date: 8-Nov-2013 11:14:00

Last Update Done: 8-Nov-2013 13:25:00

Order Accession #: 11-238-005939

Performed by: CALGARY LAB SERVICES

Assigned Patient Location: 0101,0101

Patient Class: C

Filler Number: .384938837101LA

Ordered by: ****, ****

Attending Provider: ****, ****

TEST NAME	RESULT	FLAG	UNITS
ESTIMATED GLOMERULER FILTRATION RATE	>60		mL/min/1.73m2

Chronic kidney disease is defined by estimated GFR which is persistently <60 mL/min/1.73 sq. m (see www.AKDN.com for more information)

LIPID PANEL

Order request status: Final

Collected date: 8-Nov-2013 08:22:00

Received date: 8-Nov-2013 11:14:00

Last Update Done: 8-Nov-2013 13:25:00

Order Accession #: 11-238-005939

Performed by: CALGARY LAB SERVICES

Assigned Patient Location: 0101,0101

Patient Class: C

Filler Number: .384938837101LA

Ordered by: ****, ****

Attending Provider: ****, ****

TEST NAME	RESULT	FLAG	UNITS	REFERENCE
CHOLESTEROL	6	(H)	mmol/L	3.80 - 5.20
TRIGLYCERIDES	1.1		mmol/L	0.60 - 2.30
HDL CHOLESTEROL	0.87	(L)	mmol/L	>=0.91
TOTAL: HDL CHOLESTEROL RATIO	6.9			

Assess hours fasting: The guideline is > 9 hr. Assess CV risk group. Primary treatment targets for high and moderate CV risk patients are: LDL-C < 2 mmol/L or 50% decrease. Can J. Cardiol 2009; 25: 567-579.

LDL, CALCULATED	3.90	(H)	mmol/L	2.00 - 3.40
HOURS FASTING	11.5 hours			

Lab Report

GLUCOSE FASTING

Collected date: 8-Nov-2013 08:22:00
Received date: 8-Nov-2013 11:14:00
Last Update Done: 8-Nov-2013 13:25:00

Order request status: Final

Order Accession #: 11-238-005939
Performed by: CALGARY LAB SERVICES
Assigned Patient Location: 0101,0101
Patient Class: C

Filler Number: .384938837101LA
Ordered by: ****, ****

Attending Provider: ****, ****

TEST NAME	RESULT	FLAG	UNITS	REFERENCE
GLUCOSE, FASTING	5.1		mmol/L	3.9 - 6.1

Hours fasting guidelines: >8 hrs Can. Diabetes Assoc.
Hours Fasting 11.5 hours

COMPLETE BLOOD COUNT

Collected date: 8-Nov-2013 08:22:00
Received date: 8-Nov-2013 11:14:00
Last Update Done: 8-Nov-2013 13:25:00

Order request status: Final

Order Accession #: 11-238-005939
Performed by: CALGARY LAB SERVICES
Assigned Patient Location: 0101,0101
Patient Class: C

Filler Number: .384938837101LA
Ordered by: ****, ****

Attending Provider: ****, ****

TEST NAME	RESULT	FLAG	UNITS	REFERENCE
HEMOGLOBIN	138		g/L	120 - 160
HEMATOCRIT	0.41		L/L	0.36 - 0.48
RBC	4.3		10E12/L	4.0 - 5.6
MCV	93		fL	82 - 100
MCHC	339		g/L	320 - 360
RDW	12.1		%	11.0 - 16.0
PLATELET COUNT	213		10E9/L	150 - 400
WBC	5.9		10E9/L	4.0 - 11.0
NEUTROPHILS	3.3		10E9/L	2.0 - 9.0
LYMPHOCYTES	2.0		10E9/L	0.5 - 3.3
MONOCYTES	0.4		10E9/L	0.0 - 1.0
EOSINOPHILS	0.2		10E9/L	0.0 - 0.7
BASOPHILS	0.0		10E9/L	0.0 - 0.2

Lab Report

CREATININE, SERUM

Collected date: 8-Nov-2013 08:22:00
Received date: 8-Nov-2013 11:14:00
Last Update Done: 8-Nov-2013 13:25:00

Order request status: Final

Order Accession #: 11-238-005939
Performed by: CALGARY LAB SERVICES
Assigned Patient Location: 0101,0101
Patient Class: C

Filler Number: .384938837101LA
Ordered by: ****, ****

Attending Provider: ****, ****

TEST NAME	RESULT	FLAG	UNITS	REFERENCE
CREATININE, SERUM	55		umol/L	35 - 100

TSH

Collected date: 8-Nov-2013 08:22:00
Received date: 8-Nov-2013 11:14:00
Last Update Done: 8-Nov-2013 13:25:00

Order request status: Final

Order Accession #: 11-238-005939
Performed by: CALGARY LAB SERVICES
Assigned Patient Location: 0101,0101
Patient Class: C

Filler Number: .384938837101LA
Ordered by: ****, ****

Attending Provider: ****, ****

TEST NAME	RESULT	FLAG	UNITS	REFERENCE
TSH	1.21		mIU/L	0.20-6.00

IRON STUDIES

Collected date: 8-Nov-2013 08:22:00
Received date: 8-Nov-2013 11:14:00
Last Update Done: 8-Nov-2013 13:25:00

Order request status: Final

Order Accession #: 11-238-005939
Performed by: CALGARY LAB SERVICES
Assigned Patient Location: 0101,0101
Patient Class: C

Filler Number: .384938837101LA
Ordered by: ****, ****

Attending Provider: ****, ****

TEST NAME	RESULT	FLAG	UNITS	REFERENCE
FERRITIN	50		ug/L	13-375

Appendix 2: Transcription conventions used

The transcription conventions used in this dissertation borrow from the Jefferson method used in conversation analysis research. My study is not conversation analysis in its full form, and I did not have access to the funding and transcription skills necessary to use the complete Jefferson notation method.

Action	Transcription method
Overtalk	words are <i>italicised</i> and indented to show where the overlap begins
Strongly emphasised word	<u>underlined</u>
Rising or falling intonation	indicated as question mark or period, even if not the end of a sentence
Latching speech or interruptions, where the second speaker speaks immediately after a word spoken by the first speaker	= attached to the last utterance of the first speaker
Brief interjections by the 'listener' that do not cause the speaker to cede the floor	The brief interjection is in square brackets; e.g. [mm hmm]
Stutters or speech by one speaker that latches onto a word but changes the trajectory of the sentence	hyphen e.g. that's-that's-that's is a stutter
Word removed for confidentiality reasons	_____ with a footnote to explain
Slight pause	Comma
Significant pause clues - either the length of a significant pause in seconds	Period (.) indicates notable pause. If long enough to measure in seconds, the length is indicated (7 seconds)
Elongation of a word, the stretching out of particular sounds	::: e.g. I wa::nted to go
Marking a missed word	(inaudible)
Non-verbal actions done at that particular moment	(she turns back to the computer)