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This chapter describes the emergence of a new species of human being—the bio-citizen. The bio-citizen is a product of an era of escalating anxiety in the public imagination about an international pandemic of overweight and obesity. A Google of the word ‘obesity’ generates millions of references that increase in number on a daily basis e.g., 32,600,000 items (3 January 2008), 33,600,000 (9 June 2008). No-one, media commentators warn, has been left unscathed by the ‘obesity epidemic’:

[m]ake no mistake: the dreaded obesity epidemic that is everywhere in the news is not restricted to any race, creed, ethnicity or slice of the socioeconomic supersized pie. As recent studies reveal, virtually every group known to democracy is getting fatter.

(Angier 2000: 1)

Medical experts have described the twenty-first century as an ‘obesogenic environment’ (Prioietto and Baur 2004), and the moral panic about an ‘obesity epidemic’ has been taken up by the disciplines, governments, and their surrogates (Campos, Saguy, Ernberger, Oliver, and Gaesser 2006). It is evident in the funding priorities of medical and scientific research; the reform agendas of social agents such as health services, education and the media; in the programs and policies of governments and national bodies such as the United States of America (USA) Center for Disease Control (CDC) and in the surveillance activities of supranational agencies such as the World Health Organisation (WHO).

The rhetoric of an ‘obesity epidemic’ has spawned a global weight-loss industry that provides diet products, programs, counsellors and advisors to help people secure the ideal of a normative body weight. Local and online diet clubs have constructed new communities whose members are joined by the shared desire to lose weight. New diet regimes and scrutiny of the weight of movie and music glitterati are the staple of popular and women’s
magazines, and internationally syndicated reality TV programs like The Biggest Loser have turned weight loss into a competitive, public sport.

Few cultural practices or organizations have escaped the growing obsession with overweight and obesity. Fast food outlets like McDonalds have succumbed and now provide customers with low-calorie foods options: no-fat muffins, ‘McLean’ burgers, low-fat milkshakes, salads and fruit. Even the World Pie Eating Championship has abandoned its tradition of eating as many meat and potato pies as possible in 3 minutes. Now competitors eat one regulation 12 cm pie as quickly as possible—and a vegetarian option is provided. According to organizers, the move was in response to ‘government inspired guidelines on obesity’ (No Author 2006c).

Scholars have challenged the plausibility of the obesity epidemic and accused the media, medical and scientific experts, and public health officials of exaggerating the negative effects of overweight and obesity on health (Campos 2004; Gard and Wright 2005; Oliver 2005). The controversy surrounding the ‘obesity epidemic’ has also become politicized. Illustrative are the campaigns by conservative organizations such as the Centre for Consumer Freedom (CCF), a non-profit, US coalition of restaurants, food companies and consumers whose goal is to oppose:

[t]he growing cabal of “food cops”, health care enforcers, militant activists, meddling bureaucrats, and violent radicals who think they know “what’s best for you” [and] are pushing against our basic freedoms.

(The Centre for Consumer Freedom 2008)

With this end in sight, the CCF has lobbied against legislation that seeks to control the eating and weight of the country’s population, in the name of protecting personal responsibility, individual autonomy and consumer choice.

UNRAVELLING THE BODY (MASS INDEX)

What has made the idea of an obesity epidemic possible is the development of a discourse of a normative Body Mass Index (BMI) as the “‘virtuous mean’ to which we should all aspire’ (Burry 1999: 610). BMI is the mathematical (re)presentation of weight that is calculated by dividing a person’s weight by the square of his or her height. Belgian statistician, Adolphe Quetelet, developed the formula for BMI in the 1800s and the idea of a prudential, BMI norm has progressively colonized the policies, practices and procedures for measuring and documenting weight. The US military first used BMI tables during the Civil War and later to exclude underweight recruits from the Korean War. In the 1980s, the World Health Organization set international definitions for BMI: underweight (less than BMI 20); average (BMI 20–24.9); overweight (BMI 25–29.9); and obese (BMI 30+). In 1998, the National Institutes of Health in the USA aligned
their weight definitions with the WHO guidelines, lowering the normal/overweight BMI cut-off in the USA from BMI 27.8 to BMI 25. BMI is now the standard benchmark used by clinical and public health offices, medical organizations, researchers and policy makers to calculate, describe and compare the weight of individuals and populations.

At least in part, the persuasive capacity and take-up of the discourse of a normative BMI lies in its simplicity and its rhetoric of scientism. BMI deploys the language of scientific positivism to invoke an aura of truth, trustworthiness and transparency, and is easily calculated without the help of specialist tools. These tactics represent BMI as an objective fact that is devoid of personal prejudice or subjective value, and locate the discourse of BMI in the ‘science’ of the body.

But BMI is a slippery, contested creature. It is premised on the assumption that there is an identifiable ‘normal’ weight that is ‘true’ across genders and across different cultural, socio-economic and geographical groups. Yet even scientific experts who advocate the use of BMI as an epidemiological tool concede that it is an ‘arbitrary’ measure (James, Leach, Kalamara, and Shayeghi 2001: 228). BMI describes the relationship between net weight and height but it fails to take into account differences in physical frame or proportions of fat, muscle and bone mass, cartilage or fluid retention. It was this imprecision that triggered controversy when the World Health Organization (WHO) decreed the normative BMI to be between 20 and 24.9. There was an immediate outcry in Asian countries, with a call for ‘a more limited range for normal BMIs (i.e. 18.5 to 22.9 kg/m² rather than 18.5 to 24.9 kg/m²)’ because Asian populations have smaller frames and greater health risks at a lower weight than people of non-Asian backgrounds (James et al. 2001: 228).

Nor is the relationship between BMI and ill health straightforward. Genetics and activity levels are important mediating factors for good health, and British researchers warn that a normative BMI can disguise the nature of weight because many slim people can store dangerous levels of fat in their bodies that can trigger heart conditions and diabetes: ‘[p]eople shouldn’t be happy just because they look thin . . . you can have a lot of fat internally, which can have a detrimental effect on your health’ (No Author 2006d: 3).

UNRAVELLING THE VIRTUE DISCOURSE OF A NORMATIVE BMI

Nevertheless, the notion of a normative BMI has survived as a ‘virtue discourse’ that describes and defines weight, bodies and individuals. Virtue discourses are 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.

What distinguishes the work of ‘virtue discourses’ from other discourses is that they ‘configure virtue as an open-ended condition: a state
of excellence that has no boundaries or exclusions’ (Halse, Honey and Boughtwood 2007: 220). This infinite open-endedness means that it is not possible to be too industrious or too diligent about taking up the dietary practices, exercise regimes, pharmaceutical and cosmetic interventions necessary to manage one’s weight and maintain a ‘normal’ BMI.

The virtue discourse of a normative BMI is also highly moralistic because it invokes and relies on binaries that ascribe ‘opposing moral attributes to each side of the binary that seem natural, logical and fair’ (Halse 2006: 107). Thus, in societies where slenderness is idealized and desired, a low BMI is aligned with self-discipline and restraint and a high BMI (overweight or obesity) is the binary ‘Other’—the physical manifestation of self-indulgence and a lack of self-discipline and moral fortitude. Such binary constructions move beyond a discourse of healthism in which slenderness is equated with fitness and health by constituting slenderness as a necessary state of being to avoid fatness—a socially repugnant state that is a ‘metonym for laziness and ugliness’ (Halse et al. 2007: 228) and an indicator of some troubling physical or psychological pathology warranting oversight, disciplining and correction.

The virtue discourse of a normative BMI is communicated through the images and messages of popular culture, advertising and the media; films and television programs; and the authoritative messages circulated by the weight-loss industry, health education, school curricula, and the medical profession. It permeates the pores of individuals and populations by immersion in and habituation to its terms and moral values, and through political tactics that define desirable and approved behaviour. Individuals who take up the discourse by keeping (virtuously) slender are congratulated and rewarded. They are recognized and applauded by family, friends, and colleagues; venerated by advertisers and in the popular press; and commended in the commentaries of health and medical authorities. Those who are non-compliant and overweight or obese are likely to suffer social exclusion and alienation. They are more likely to face higher health care and insurance charges, to have physical difficulty traveling in airplanes or public transport where space is confined, and to be excluded from areas of state employment. In the United Kingdom and most Australian, New Zealand and US states, compliance with designated BMI cut-offs is a criterion for admission to the armed forces, Fire Brigade, Special Constabulary, and Port Authority Police. Maintaining the required BMI cut-off is also a condition for continued employment in the army, police and fire brigades, and government sponsored health and weight loss programs have been introduced in some countries, including New Zealand, Turkey and Thailand, to help the police and firefighters get into shape (Anon. 2005a 2005b; Devechi, Gülbayrak, Oğuzönçül, and Aşık 2004).

Researchers, media commentators and medical experts also warn that overweight or obese individuals are statistically more likely to experience lower living standards, lower levels of social, economic, political and
educational understanding, and a higher incidence of social disadvantage (Burry 1999). As British research published in the Sydney Morning Herald pronounced: ‘[t]he fatter you were, the less you earned, with lower-paid clerical workers nine times more likely to be overweight (75 per cent) than those at upper management level (8 per cent)’ (Delaney 2007).

Through the operation of bio-power—the regulation of subjects by the state—the virtue discourse of a normative BMI constructs subjects who have a material investment in maintaining the discourse’s terms. For instance, the police in Queensland, Australia, have argued for the reintroduction of height and weight restrictions for police to improve the physical presence of beat police because ‘physically challenged’ police put ‘themselves and their colleagues at greater risk of assault’ (Ironside 2008). Similarly, in the USA, a succession of legal cases has upheld the right of government agencies to dismiss overweight or obese firefighters, police and other employees (Perritt 2002; Roehling 1999).

While not all individuals are subjugated at the same time or in the same way, the pervasiveness of the virtue discourse of a normative BMI shapes citizens’ self-understandings and self-techniques so that it is taken up as ‘a mode of personal self-regulation [and] internal constraint on the conduct of the self’ (Halse et al. 2007: 223). In this way, the virtue discourse of a normative BMI incorporates the ‘outside’ world (values and beliefs) into the ‘inside’ (psyche and bodily practices) of individuals. Deleuze (2000: 118–9) captures the fusion of the ‘inside’ and ‘outside’ in his notion of the human subject as the outside folded in—an immanently social, political and embedded subject:

[...] the outside is not a fixed limit but a moving matter animated by peristaltic movements, folds and foldings that together make up an inside: they are not something other than the outside, but precisely the inside of the outside.

However, the political effects of the virtue discourse of a normative BMI do moral mischief. By differentiating between those who are and are not acceptable and approved sorts of human beings within its own moral schema, the virtue discourse of a normative BMI works to ‘establish what qualifies as “being”’ (Bulter 1993: 188): thin/fat, normal/abnormal, virtuous/sinful, worthy/unworthy.

The discourse also has a more sinister effect. By deploying a mechanical, statistical procedure to calculate BMI, individuals and groups are reduced to numeric entities that become amenable to categorization and comparison. Deleuze (1992: 4) has described the effects of administratively numerating bodies: ‘[i]t individualizes and masses together [and] constitutes those over whom it exercises power into a body and molds the individuality of each member of that body’. Through mathematical reduction, the assignment/adoptive of BMI metaphorically erases the heart, soul and history of
human subjects, substituting in its place a (numeric) entity devoid of personal or social identity on which the state and its allies can inscribe a new persona—that of the (virtuous) bio-citizen.

CITIZENSHIP AND THE BIO-CITIZEN

The bio-citizen has emerged as a new sociological and biological benchmark for describing, categorising and differentiating between human beings and human societies. This new species of human being—the bio-citizen—extends Rose and Novas' (Rose and Novas 2003) theory of biological citizenship by which somatic individuality—physical ailments, illnesses and genetics—fashions relations between individuals and shapes their engagement in different political, electronic and social communities. The bio-citizen is a more complex persona because s/he has come into being by welding the body onto the social, cultural, economic and political responsibilities of citizenship and the state.

The bio-citizen is grounded in a concept of citizenship that moves beyond simplistic definitions of citizenship as a legal status and 'bundle of entitlements and obligations which constitute individuals as fully fledged members of a socio-political community' (Turner 1994: 1). Rather, the bio-citizen resurrects a notion of citizenship that had its origin in the Athenian politics of Ancient Greece. This was a time when citizenship centred on the polis, an individual's private life was considered a public matter, and the obligations of the individual were inextricably bound to the daily operation and organisation of the community. Citizenship was not merely a matter of individual rights granted by virtue of political membership to a community. Rather, citizenship was based on a set of relations between the individual and the state that involved a conscious contribution by the citizenry to improving the life and well-being of the community by actively demonstrating the moral virtues of the citizen—wisdom, temperance, justice and courage. The 'good' citizen is therefore an 'active' citizen, and active citizenship is the means by which one both commits to and becomes immersed in and part of the social world of a community.

Nikolas Rose (1989/1999) argues that this political rationality was revived during the first half of the twentieth century when the citizen was transformed from a subject with legal and constitutional rights and duties into a social being whose existence was articulated in the language of social responsibilities and collective solidarity.

The individual was to be integrated into society in the form of the citizen with social needs in a contract in which individual and society would have mutual claims and obligations. Each individual was to become an active agent in the maintenance of health and efficient
polity, exercising a reflexive scrutiny of personal, domestic, and familial conduct. (Rose 1999: 228)

While active citizenship is central to the identity of the new bio-citizen, her/his identity also derives from the disembodied, rational subject of liberal humanism, a universal ethic of justice and a notion of the common good. These ideas had their roots in the writings of Plato, Aristotle, and Cicero but their contemporary meanings were developed by philosopher John Rawls (1971/1999) who argued that the common good involves an implicit social contract (agreement) between individuals and the state that equal access to certain general social conditions advantages all members of a society. This social contract was necessary to serve the common good and construct a well-ordered society in an increasingly complex, interdependent world (Andre and Velasquez 1992). In this schema, what counts as virtuous, moral actions are those that serve the interests of the individual and all others in any society. Thus, for the bio-citizen, failure to control one’s weight makes one a ‘bad’ citizen by ignoring the interests of the common good needed for a well-ordered society.

THE BIO-CITIZEN, THE COMMON GOOD AND THE WELL-ORDERED SOCIETY

The first obligation of the bio-citizen to the common good is to take personal responsibility for the physical care of oneself. Maintaining one’s weight within the BMI ‘norm’ is crucial to meeting this goal. Burry (1999: 610), for example, enunciates this philosophy when he instructs, in the Journal of the Australian Medical Association: ‘[c]ontrol of weight, no matter that some have a genetically determined potential to acquire and retain more weight in comparison with others, remains a matter of self-control and personal responsibility’.

Media and consumer groups have latched onto the messy matter of weight as a personal responsibility. In Australia, for instance, The Age newspaper has decreed: ‘[a] healthy diet and exercise regime is an individual responsibility’ (No Author 2006b). In the United States, the Journal of the Diabetes Association of America, reporting on the flurry of unsuccessful litigation against fast food companies for producing flavoursome food without adequate health warnings of the dangers of consumption, cited medical experts who cautioned: ‘personal responsibility is still the key to diet and exercise and other positive health activities’ (No Author 2006a). At an international level, key questions examined by the 18th International Congress of Nutrition in Durban in 2005 included: Is the global obesity pandemic the responsibility of the individual or governments? Who is to blame? Who should be responsible for reversing the trend?
Reconfiguring personal responsibility as a social responsibility ratchets up the burden on and accountability of the individual for the well-being of society, but becoming a (virtuous) bio-citizen involves more than taking responsibility for ensuring that one’s weight stays within the BMI ‘norm’. It is a responsibility to care for oneself in order to care for one’s offspring and family—including any unborn children. For example, scientists warn that overweight mothers put their unborn children at risk because maternal obesity transmits the ‘obesity gene’ to offspring and is linked to miscarriage, pre-term birth, stillbirth and neo-natal deaths (BBC 2008). Similarly, anti-obesity campaigners argue that ensuring ‘we can get women at the right weight at pre-conception’ means that ‘we can prevent this whole obesity issue’ (Hagan 2008). Aspiring mothers are also urged to stay slender to defend their children against the future possibility of being overweight because ‘obesity is more likely in offspring if parents are obese’ (Burry 1999: 609).

The moral imperative to care for one’s weight in order to care for others does not abate after the birth of children. Medical experts and the media urge parents ‘to shape up’ by eating healthy foods, exercising and watching their weight because they are ‘role models’ for their children (Hagan 2008; McDowell 2008). Parents are advised to set ‘a good example by sitting down to breakfast’ because ‘the more often an adolescent [has] breakfast, the lower the BMI’ (Bakalar 2008). Parents can draw on a bevy of paediatric dieticians, medical specialists, advisers and counsellors for support in helping their children lose weight. Or they can go online where sites such as ‘My Overweight Child’ offer ‘tips, strategies and guidance for parents of overweight kids’ (No Author 2008a). If these strategies fail, the Surgeon General of the United States recommends a ‘family-centric weight management program’ with nutrition lessons, exercise sessions and mandatory parental involvement (Hunter 2008). Similarly, the medical profession—including the esteemed Mayo Clinic urges parents to ‘[m]ake weight loss a family affair’ to beat childhood obesity (Mayo Foundation for Medical Education and Research 2006; Priorietto and Baur 2004). As a last resort, parents can secure their children’s future by sending them to ‘weight-loss boarding school’ so that they learn ‘to eat right, exercise more and fight the genetics that have placed them among the millions of children who struggle with obesity’ (Bompey and Wilson 2008).

Recalcitrant parents who fail to control their own weight and that of their children leave themselves open to being ridiculed, blamed and decried as ‘bad parents’. Or they are punished by the state with the loss of child custody and parental rights, as in the case of 3 year-old Anamarie Martinez-Regino. Weighing in at 54 kilograms, the 3 ft 6 ins tall Anamarie was three times heavier than an average 3 year-old; and she was removed from her parent’s custody by the government of New Mexico, USA, ‘because they could not control her weight’ (No Author 2002).

The responsibility of the bio-citizen involves more than a social contract to care for one’s own weight and the weight of one’s family. It is a
responsibility to care for the health and economic well-being of others in the community and the nation. The idea that overweight and obesity causes economic damage is so widespread that it has become conventional wisdom (Gard and Wright 2005). Medical authorities and the media warn that failing to care for one’s weight by becoming overweight or obese can cause a litany of potentially avoidable health problems, including sleep disorders, high blood pressure, diabetes, heart disease, stroke, arthritis, cancer, and poor reproductive health. These undermine the ‘healthy functioning of the general community’ (Burry 1999: 610) and place an unwarranted strain on a nation’s health-care system (No Author 2006b). The overweight and obese also require expensive, super-sized equipment that place additional burdens on the finances of governments and health agencies. For example, the State government of New South Wales, in Australia, recently:

had to buy three additional super-sized ambulances, at $150,000 each, in order to cope with those people who are so fat they cannot fit inside a standard ambulance. They are designed for people who weigh at least 180 kilograms. Moving these patients can take up to 5 hours, and require the assistance of the police, fire-fighters, and SES volunteers . . . and hospitals are being forced to purchase special hydraulic lifting equipment to transfer obese people onto hospital beds. Extra large medical examination machines are needed, such as Computerized Tomograph (CT) and Magnetic Resonance Imagers (MRI), as the obese do not fit into the standard ones.

(Smith 2008)

Because of the crisis caused by an overburdened health care system, ethicists have urged society to replace the current “ethic of individual rights” with an “ethic of the common good” (Andre and Velasquez 1992). But failing to care for one’s weight is also blamed for causing nations other, unnecessary financial burdens. The Australian government has placed the financial cost of obesity in the region of $3.7 billion per year (Obesity Commission 2008) but a study commissioned by Diabetes Australia estimated the cost of increased expenditure on health plus the loss of economic productivity due to weight-related ill-health costs the community approximately $20.7 billion per annum (Uhlmann 2006).

It is also contended that failing to care for one’s weight represents a threat to national security. According to a study by the US National Academy of Sciences and the Subcommittee on Military Weight Management, the increase in obesity in the USA:

decreases the pool of individuals eligible for recruitment into military services, and it decreases the retention of new recruits. Almost 80 per cent of recruits who exceed the military accession weight-for-height standards at entry leave the military before they complete their first
term of enlistment. This in turn increases the cost of recruitment and training. These issues threaten the long-term welfare and readiness of the US.

(Subcommittee on Military Weight Management and Committee on Military Nutrition Research 2004: 1)

Through such political strategies, the virtue discourse of a normative BMI constructs a moral universe in which being and being recognisable as a virtuous (bio) citizen requires active, demonstrable care for one’s own weight and the weight of particular and generalized ‘Others’ in society (see Benhabib 1987). As Samantha Murray discusses in this book, controlling one’s weight is constituted as the ethical responsibility to society of a virtuous (bio) citizen.

Thus, in contrast to the lazy, inert, self-absorbed subject—the ‘bad’ citizen implicated in the social and political rhetoric of an obesity epidemic—the model bio-citizen is a public-minded, socially responsible individual who is concerned about the common good and well-being of society. S/he adheres to the social contract between the individual and state by renouncing irresponsible weight-related behaviours as an active demonstration of care for the health and economic well-being of self, family and nation.

THE BIO-CITIZEN AND THE NATION STATE

The emergence of the bio-citizen (re)configures the relationship between individuals and collective social groupings. While the rhetoric of the obesity epidemic may not ‘differentiate between particular social groups’ (Gard and Wright 2005: 19), the effects, practices and technologies entangled in the virtue discourse of a normative BMI do differentiate and deliberately and actively seek to do so by elevating BMI to a descriptor and definer of human difference across social, cultural, political, economic and geographic axes.

This phenomenon is explicit in the obesity league tables that are gathered and circulated by government bodies, health authorities and social agencies, and periodically reproduced by the popular press. Across the globe, obesity league tables serve as a proxy for the health and economic well-being of local, national and international populations. At the local level, for example, in Australia’s most densely populated state, New South Wales (NSW), media reports of the Tenth Annual Health Report told of the increased risk of premature death ‘due to potentially avoidable causes’ of overweight and obesity, and were accompanied by maps that highlighted the geographic and socio-economic regions where the average BMI was above the norm.

At a national level, the third annual report of ‘The Trust for America’s Health’, entitled F as in Fat: How Obesity Policies are Failing America
(Trust for America’s Health 2007) ranked obesity by state using data from the Centre for Disease Control and Prevention. Colorado had the country’s lowest rate of obesity (16.9 per cent) but the survey identified the most economically disadvantaged, poorest areas in the South as home to nine of the country’s 10 most obese states, with Mississippi (29.5 per cent) in first place followed by Alabama and West Virginia (Trust for America’s Health 2007).

At the supranational level, the Noncommunicable Disease Surveillance (NCD) program conducted by the WHO collects national information about weight and develops country-based, comparative profiles as part of a global surveillance strategy to track country-level trends. How countries fare in the international weight stakes inevitably triggers national and international publicity and scrutiny, with journals like Forbes Magazine eager to profile the ‘World’s Fattest Countries’ and to distribute national shame (Streib 2007).

While statistical surveillance of the population’s weight through obesity league tables appears innocent—monitoring the weight of populations to improve the health of individuals and communities—they function as a sort of modern-day panopticon. Medical authorities, for example, have applauded the use of BMI to standardize classification of those who are overweight and obese because it enables ‘comparable analysis of prevalence rates worldwide’ and the gathering of ‘comparative data from different countries, to depict secular changes in the epidemic, and, as noted, to help prepare a scheme for clinical management’ (James et al. 2001: 228–9).

Moreover, the technology of national and international weight surveillance has spawned a new transnational class of organizations that are devoted to sustaining the disciplinary regimes of the virtue discourse of a normative BMI. These include: the International Association for the Study of Obesity (IASO) and its policy arm, the International Obesity Task Force; the Global Prevention Alliance; and HOPE (Health Promotion through Obesity Prevention in Europe).

Far from dissolving social, cultural and economic differences, obesity league tables reshape how geographical spaces are conceptualized, defined and described, thereby reconfiguring understandings of local, national and international difference. Asserting a ‘truth discourse’, that a BMI outside the statistical ‘norm’ constitutes a social, economic and/or health problem, legitimates the intervention, disciplining and control of individuals and populations by states and their surrogates. Direct intervention and control by the state—as in the case of Anamarie Martinez-Regino—is evident in a number of domains and is symptomatic of what Deleuze (1992) described as the progression from disciplinary societies to societies of control. In the USA, for example, at least eight states have banned trans fats from schools (No Author 2008c); North Carolina, Florida, and other states have legislated to make physical education mandatory for all elementary school students (No Author 2007a 2008b); and federal legislators in the House
of Representatives have advocated including physical education in the No Child Left Behind (NCLB) Act (2001):

The bill would add physical education to the multiple measures for determining accountability under NCLB, offering schools another way to meet their adequate yearly progress while promoting physical activity and nutritional education for students. States would be measured on their progress toward meeting a national goal for required physical education recommended by the Centers for Disease Control of 150 minutes per week in elementary schools and 225 minutes per week for students in middle and high schools. School districts and states would also be asked to report on students’ physical activity and help promote healthy lifestyles.

(No Author 2007b)

In short, obesity league tables function as a bio-political line of force in the armoury of bio-power—a regime of knowledge and authority over the physicality of individual and collective human vitality that is considered ‘desirable, legitimate and efficacious’ (Rabinow and Rose 2003: 2) by the governments and supranational agencies. The irony is that obesity league tables deploy a homogenising logic of sameness—the virtue discourse of a normative BMI—yet they work to make collective differences visible and distinct by grafting BMI onto the geographic and socio-economic profile of nations in ways that define and differentiate between populations by aligning weight with the social, racial, cultural and/or economic profile of a nation-state.

THE BIO-CITIZEN AND THE FUTURE . . .

As a result, citizenship is no longer coterminous with nationality but with the bodily practices of communities within the geographic boundary of the nation-state. Conflating responsibility for BMI with national geography positions the bio-citizen in the corporeal practices of identity. It grafts the body onto politics by physically differentiating between citizens along local, national and international geographical and political planes. The United Nations’ Declaration on the Elimination of All Forms of Racial Discrimination (1963) banned discrimination by race, class or gender, and this principle has been enshrined through government legislation and laws in the majority of liberal, democratic societies. In contrast, the emergence of the bio-citizen represents a conceptual continuation of the eugenics movement of the eighteenth and nineteenth centuries that defined and differentiated between individuals and groups according to their physical characteristics, race, phrenology and/or genetic lineage.
Because governments and their agents have committed intense political energy and considerable financial resources to constructing the bio-citizen, the virtue discourse of a normative BMI is not an innocent bystander in choreographing the future. But what has been buried in the jetsam and flotsam of its wake are bigger, more difficult issues: hunger; poverty; physical abuse; lack of fresh water, medical care and education; discrimination and inequalities; social and economic disadvantage. A cynic might wonder if this is a stratagem—a bio-political ruse—by governments and their agents to deflect the citizenry’s attention from the social justice issues that continue to blight the lives of individuals and the well-being of communities and nations. Whether this state of affairs is by design or circumstance, what remains unclear are the sorts of political strategies that will effectively subvert the virtue discourse of a normative BMI, rectify its effects and fracture the logic and identity of the bio-citizen.

However, even the act of thinking and naming the bio-citizen is a transgressive and potentially transformative act. As Deleuze reminds us, thinking involves the violent confrontation with reality that makes it possible to rupture the control of reality, to alter what we think is possible, and to become different sorts of human beings and citizens (Deleuze 1992).

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