

Alcohol, Tobacco and Obesity

Morality, mortality and the new
public health

Edited by

**Kirsten Bell, Darlene McNaughton
and Amy Salmon**



Routledge Studies in Public Health

Alcohol, Tobacco and Obesity

Although drinking, smoking and obesity have attracted social and moral condemnation to varying degrees for more than 200 years, over the past few decades they have come under intense attack from the field of public health as an 'unholy trinity' of lifestyle behaviours with apparently devastating medical, social and economic consequences. Indeed, we appear to be in the midst of an important historical moment in which policies and practices that would have been unthinkable a decade ago (e.g. outdoor smoking bans, incarcerating pregnant women for drinking alcohol and prohibiting restaurants from serving food to fat people) have become acceptable responses to the 'risks' that alcohol, tobacco and obesity are perceived to pose.

Hailing from Canada, Australia, the United Kingdom and the USA, and drawing on examples from all four countries, contributors interrogate the ways in which alcohol, tobacco and 'fat' have come to be constructed as 'problems' requiring intervention, and expose the social, cultural and political roots of the current public-health obsession with lifestyle.

No prior collection has set out to provide an in-depth examination of alcohol, tobacco and obesity through the comparative approach taken in this volume. This book therefore represents an invaluable and timely contribution to critical studies of public health, health inequities, health policy and the sociology of risk more broadly.

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McNaughton and Amy Salmon**

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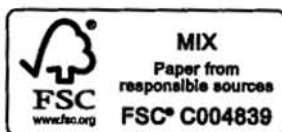
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This book emerged from a workshop held in the Department of Anthropology at the University of British Columbia in Vancouver, Canada, in July 2009 entitled *Alcohol, Tobacco and Obesity: Interrogating the New Public Health's 'Axis of Evil'*. Kirsten Bell, Darlene McNaughton and Amy Salmon co-organized the workshop with administrative assistance from Stephanie Gloyn. Funding for the workshop was provided by the Ethics Office of the Canadian Institutes of Health Research, the School of Public Health, Tropical Medicine and Rehabilitation Sciences at James Cook University in Australia, the British Columbia Mental Health and Addictions Research Network and the Department of Anthropology at the University of British Columbia, and we gratefully acknowledge their support.

Scholars writing in the areas of tobacco, alcohol and obesity from a variety of disciplinary perspectives were invited to attend the workshop. Most participants prepared papers that were distributed before the meeting and discussed in detail at the two-day workshop. In addition to the authors who contributed chapters to this book, participants at the workshop also included Peter Stearns, Rachel Eni, Leanne Joannise and Kieran O'Doherty. These individuals have made valuable contributions to the chapters contained here as discussants and critics, and we acknowledge their counsel.

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Introduction

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Tobacco use is one of the biggest public health threats the world has ever faced.

(World Health Organization 2010a)

Obesity is one of today's most blatantly visible – yet most neglected – public health problems.... If immediate action is not taken, millions will suffer from an array of serious health disorders.

(World Health Organization 2010b)

Harmful use of alcohol has a major impact on public health. It is ranked as the fifth leading risk factor for premature death and disability in the world.

(World Health Organization 2010c)

Although drinking, smoking and obesity have long been a focus of social and moral opprobrium, during the last two decades of the twentieth century they came under concerted attack from the field of knowledge and action that has come to be known as the new public health. “Lose weight!” “Avoid fat!” “Stop smoking!” “Reduce alcohol intake!” “Get fit!” is the rallying cry of the new public health (Petersen and Lupton 1997: ix). In many respects, alcohol, tobacco and obesity form the new public health's ‘Axis of Evil’ (to appropriate the rhetoric of George W. Bush) – an unholy triumvirate of ‘lifestyle choices’ deemed responsible for all manner of preventable chronic diseases, including three of the most common and costly: heart disease, cancer and diabetes.

Every day more evidence accumulates regarding the purported health effects of alcohol, tobacco and fat, and newspapers are crammed with alarmist reports outlining their devastating consequences. The tone of much of this coverage is judgemental. Headlines such as ‘Drinking while pregnant risks autism in babies’ (Templeton 2007: n.p.), ‘Fatties cause global warming’ (Jackson 2009: n.p.) and ‘Secondhand smoke kills 600,000 a year’ (Canwest News Service 2009: n.p.) detail the morally suspect nature of the smokers, drinkers and ‘fatties’ who ‘endanger’ themselves and others

through their 'wanton disregard' for the unhealthy consequences of their behaviours.

One of the central objectives of this collection is to critically examine public-health policy and practice in the areas of alcohol, tobacco and obesity. Exploring this terrain, contributors interrogate the ways in which alcohol, tobacco and fat have come to be constructed as 'problems' requiring intervention, and some of the limitations of prevailing public-health wisdom regarding these three 'issues'. While it is not our intention to suggest that alcohol, tobacco and fat entail no negative consequences for health, the goal of this collection is to move beyond health (and in some cases 'against health'¹) to recognize the social, cultural and political context in which public-health policy is conceived and carried out.

From causes to correlated risks: lifestyle and chronic disease

As Petersen and Lupton (1997) have noted, unlike the old public health, with its focus on controlling filth, odour and contagion, the new public health is characterized by an intense concern with the health status of populations. Although it has brought with it a heightened consciousness of risks that are believed to lie beyond the individual's control (e.g. pollution, global warming, etc.), it has also ushered in an increasing concern with individual responsibility, self-control and lifestyle.

Despite this marked shift in emphasis from infectious disease to individual lifestyle, conceptual frameworks underwriting the 'old' public health have fundamentally informed the professional vision of the 'new' public health (Inhorn and Whittle 2001). For example, although alcohol consumption, smoking and obesity are increasingly framed through the medicalized language of an 'epidemic' (see Mair and LeBesco's chapters in this volume), the 'dangers' they represent are vastly different from those associated with the epidemics of malaria, smallpox and cholera that wreaked havoc at the turn of the twentieth century (Brandt 1997). As Crawford (2006: 403) notes:

Most contemporary dangers to health, unlike an approaching epidemic, are not immediately apparent. Disease or symptoms may not appear for years, even decades. Both the pervasiveness of dangers and their prolonged time-span require a medically informed, vigilant and sustained awareness.... Thus, to be health conscious today is to come into an understanding that one's health is in continuous jeopardy.

The transition from infectious to chronic diseases has thus brought with it a shift from tracking the singular 'cause' of disease to identifying 'risks': the social, environmental and behavioural variables statistically associated with patterns of chronic disease (Brandt 1997). In consequence, most chronic diseases are now viewed as a failure to take appropriate precau-

tions against publicly identified risks – ‘a failure of individual control, a lack of self-discipline, an intrinsic moral failing’ (Brandt 1997: 64).

Present notions of health and disease privatize the struggle for generalized well-being (Crawford 1980). Indeed, privatized risk management is a fundamental expectation of citizens under the conditions of contemporary forms of neoliberal governance (Crawford 1980; Rose 1993, 1999; Petersen and Lupton 1997). For example, the influential health economist Victor Fuchs (1998: 4–5) has observed that, ‘Every day in manifold ways (such as overeating or smoking) we make choices that affect our health, and it is clear we frequently place a higher value on satisfying other wants’. The answer, as Fuchs (1998) and others see it, is to encourage individuals to ‘choose health’² via personal lifestyle modifications: to make ‘rational’ choices between healthcare needs and scarce resources.

Yet, despite the confident predictions by public-health officials and the popular media about the imminent medical, social and economic costs if the ‘epidemic’ of tobacco use, alcohol overconsumption and obesity is left unchecked, the impacts of alcohol, tobacco and fat are far from straightforward (e.g. Jackson 1994; Gostin 1997; Campos 2004; Gard and Wright 2005; Kloner and Rezkalla 2007; Walzem 2008). As Brandt (1997) has pointed out, the early epidemiological studies linking cigarette smoking with lung cancer fundamentally transformed notions of causality. The term ‘cause’ implies a single process in which A leads to B; however, the rise of epidemiology was accompanied by an emphasis on multiple causation in explaining the roots of disease (Krieger 1994; Brandt 1997).

Underlying multiple causation theories and the sophisticated techniques used to map them (e.g. computer-generated multivariate analyses) is a hidden reliance on a framework of biomedical individualism (Krieger 1994). As Brandt (1997: 67) notes, ‘The irony is that the process of pathogenesis is so complex and overdetermined that discussion of “cause” necessarily becomes a socially constructed and often contested domain.’ Paraphrasing Austin (1999), a central contention of this collection is that current assessments of the state of evidence regarding the health ‘risks’ attached to alcohol, tobacco and fat should be viewed as an ideological project as much as an empirically driven one.

Clean-living movements: the Victorian roots of the contemporary lifestyle crusade

Although we appear to be at a juncture in which lifestyle factors have acquired a unique prominence in public-health policy and practice, many of the contemporary claims about alcohol, tobacco and fat have historical precedence. Indeed, the Victorian era witnessed a sustained attack on all three substances that bears a striking resemblance to many of the claims made against them today (Engs 2001; see also Brandt 1997).

Temperance movements gained mass support in a number of countries in the nineteenth century, particularly amongst the middle classes (Aaron and Musto 1981; Gusfield 1986; Engs 2001). As is now well-documented, temperance reformers perceived alcohol as the root of social, moral and physical decay, linking it to familial violence, crime, poverty, insanity and a litany of other social evils (see Aaron and Musto 1981; Gusfield 1986; Levine 1993). At its height, the temperance movement was highly influential in countries such as the USA, the UK, Canada and Australia,³ leading to a variety of alcohol restrictions and culminating in the USA's failed experiment with alcohol prohibition between 1920–1933.

The anti-tobacco movement similarly gained strength in the mid-to-late-nineteenth century. Like alcohol, tobacco was linked to various health issues, but of greater concern to social reformers was its association with the corruption of innocence and a host of other medico-moral issues that were the mainstay of Victorian medicine, including insanity, idleness, hysteria and impotence (Hilton and Nightingale 1998). Interestingly, smoking and drinking were often teamed together 'as an evil partnership threatening to undermine physical and moral health' (Aaron and Musto 1981: 176; see also Engs 2001). Thus, the UK and US anti-tobacco movements gained support from many of the same people who supported the temperance movement (Hilton and Nightingale 1998; Tate 1999; Engs 2001).

The history of the dieting movement also exhibits strong connections with the temperance movement. Many temperance leaders were also concerned with other so-called 'evils' such as gluttony (Schwartz 1986; Engs 2001); for example, Sylvester Graham was an American temperance lecturer who also became preoccupied with diet and lifestyle more broadly (Schwartz 1986; Engs 2001). The rise of 'Grahamism', where ardent followers pursued a healthy lifestyle through abstinence from alcohol and tobacco, restrictive vegetarian diets and regular exercise regimes, was notable for the way in which health reform was turned overtly into a moral crusade (Engs 2001; see also Warner 2009 for a discussion of evangelical Christian physiologists).

Clearly, although the strength of these three reform movements and the personnel involved differed across issues, temporal periods and locales, they were part of a larger Protestant-infused 'clean living' movement that ascribed moral value to self-restraint and self-regulation, and condemned 'pathological' excess (Engs 2001; Warner 2008; see also Coveney, this volume). Although the present public-health attacks on lifestyle are cloaked in the language of science rather than morality, they manifest considerable continuity with earlier claims. As Crawford (1980) points out, underlying the lifestyle emphasis of contemporary understandings of health is the assumption that what people are really suffering from is over-indulgence of the good society that must be checked.

Alcohol, tobacco and fat: convergences and divergences

Although alcohol, tobacco and fat have been a central focus of medico-moral crusades over the past two centuries, the historical and contemporary differences between these movements should not be elided. For example, for much of this period the anti-smoking movement was far smaller in membership and influence than the temperance and dieting movements, although it experienced a substantial reversal of fortunes in the mid-to-late-twentieth century as the epidemiological studies linking first smoking and then passive smoking with lung cancer emerged. Stearns (1997) argues that the turn-of-the-century campaign against fat differed greatly from the later wide-scale attack on smoking, despite their similar moral overtones, because medical evidence clearly set the stage for a transformation in public attitudes towards tobacco. Whereas, 'in the case of fat, Americans assimilated a new understanding that overweight could be a health risk that on the whole simply substantiated and justified a belief that had already taken root' (Stearns 1997: 25–26).

Another key difference was that tobacco use successfully escaped the 'rediscovery of addiction' (Levine 1978) that characterized attitudes towards alcohol in the early-to-mid-twentieth century. Indeed, the influence of addictions discourses was far more pronounced in the dieting movement during this period than in anti-smoking propaganda. For example, Esther Manz created the first national dieting association in the USA, 'Take Off Pounds Sensibly', after she was exposed to Alcoholics Anonymous (AA) messages, leading to her epiphany that her substance of choice was food rather than alcohol (Schwartz 1986: 25). AA provided a direct model for Overeaters Anonymous, founded in 1960, and the manifold other dieting organizations that followed, such as Weight Watchers, which has continued to retain a focus on public confession and mutual aid meetings integral to the AA model (Schwartz 1986: 204).

Tobacco resisted the realm of addiction for so long because the central defining feature of this concept as a cultural category is the idea that its use causes intoxication and behaviours that would not otherwise be manifested in the user (Room 2003; see also Keane 2002). Unlike recreational drugs such as alcohol, heroin or cocaine, tobacco's main advantage is its compatibility with the requirements of everyday life (Sullum 1998; Keane 2002).⁴ As Berridge (1998) has shown, smoking therefore emerged as a policy issue through a different route from alcohol or other drugs – concerns came out of chest medicine, cancer and epidemiology rather than psychiatry.

Important differences between policy responses to alcohol and tobacco continue to exist. Today, the emphasis on austerity and self-restraint evident in temperance discourses on alcohol has been displaced by the perceived virtue inherent in moderate consumption and easy-going compliance (Aaron and Musto 1981; see also Room, this volume). Interestingly, this shift is also evident in the transition from 'dieting' to 'healthy eating'

discourses since the 1990s (Chapman 1999), where the virtues of austerity and self-deprivation have been replaced by ideologies about the sensuous pleasures of beautifully presented ‘gastroporn’ foods made from natural ingredients and consumed in an unhurried (if restrained) way (see Probyn 2000). Conversely, the idea of moderate consumption is almost entirely missing from contemporary discourses on tobacco.⁵ Nicotine is now often labelled ‘more addictive than heroin’ (Nicotine Anonymous 2010) and the concept of the ‘social smoker’ is now understood largely to be a transitional category rather than representing a sustainable relationship with tobacco over time (see McCullough, this volume).

Who’s the baddest?

Clearly, the valuations placed on alcohol, tobacco and fat also differ substantially. As the WHO quotes at the beginning of this introduction suggest, in most circles tobacco presently holds the distinction of being considered the most dangerous substance in the new public health’s ‘Axis of Evil’. The tobacco industry’s dubious victory as the number-one ‘merchant of death’ is satirized in the novel *Thank You For Smoking* when an argument breaks out between the central protagonist Nick, a tobacco lobbyist, and Polly, an alcohol lobbyist, about whose substance kills more people. As Nick says:

Look, nothing personal, but tobacco generates a little more heat than alcohol.... I’ll put my numbers against your numbers any day. My product puts away 475,000 deaths a year. That’s 1,300 a day.... So how many alcohol related deaths a year? A hundred thousand, tops. Two hundred and seventy something a day. Well wow-ee.

(Buckley 1995: 128)

Complicating alcohol’s status as a public-health ‘evil’ is the so-called ‘French Paradox’ (Simini 2000): the reduced prevalence of coronary heart disease in countries where red wine is regularly consumed alongside of a diet high in saturated fats. Although the health benefits of moderate alcohol consumption remain contested (Hamajima *et al.* 2002; Koppes *et al.* 2005; Tolstrup *et al.* 2006; Saremi and Arora 2008), it has therefore been more difficult to condemn as an unhealthy poison than tobacco.

There are signs, however, that obesity is beginning to encroach upon tobacco’s reign as the number-one ‘killer’. Obesity, the popular press tells us, is the ‘new tobacco’. A recent examination of media comparisons of obesity and tobacco (Rosen and Smith 2008) found that tobacco tends to be treated as an issue that has been successfully dealt with – a waning problem or a ‘war that has already been won’. In contrast, obesity is portrayed both in the popular press and public-health circles as a growing concern poised to supplant tobacco use as the leading cause of preventable

death. Notably, the economic costs of obesity are often highlighted – and described as likely to soon ‘eclipse’ the financial burden posed by smoking (Rosen and Smith 2008).

Significantly, tobacco control is increasingly being touted as a successful model for combating obesity (e.g. West 2007). In public-health circles the assumption seems to be that fatness (an embodied state) can be treated the same way as tobacco or alcohol consumption (embodied practices). Despite the existing critiques of the inputs/outputs model of obesity (e.g. Campos 2004; Gard and Wright 2005), evident in such approaches is a semantic slippage between obesity and overeating – with the latter used as a synonym for the former and implying a causal relationship between the two. Therefore, suggested public-health interventions include: the provision of information about how to avoid overeating, providing treatment for overeating, regulating certain types of foods (through price increases or restrictions on availability) and reducing the social acceptability of overeating or eating too much of particular kinds of food (West 2007; see LeBesco, this volume, for a critique).

Such approaches directly mirror established tobacco and alcohol controls, from ‘sin’ taxes to restrictions on how, when, where and to whom food may be marketed and distributed. West’s (2007) call to reduce the social acceptability of overeating also parallels the tobacco ‘denormalization’ campaigns that have become a core feature of global tobacco control policy over the past decade. Here, stigma is endorsed as a legitimate public-health tool (see Bayer 2008; Bell *et al.* 2010).⁶ In this respect, developments in tobacco and obesity policies appear to have learned few lessons from alcohol and other addictions, where it has been recognized that *destigmatizing* substance use is crucial for encouraging timely access to healthcare and improving health status, particularly among groups already experiencing multiple forms of disadvantage (see Bell *et al.* 2010).

Punitive responses and disproportionate impacts

The implementation of tobacco denormalization policies and similar proposals to stigmatize obesity speak to the increasingly aggressive nature of public-health policy relating to alcohol, tobacco and obesity. As we have previously documented (Bell *et al.* 2009), where there are deemed to be harms to children or foetuses, proposed legislation is particularly punitive. Thus, women who give birth to alcohol-exposed infants are increasingly being criminalized, doctors are being exhorted to report parents who smoke around their children as a form of child abuse and childhood obesity has been labelled an indicator of child neglect. In all three instances, this rhetoric of risk is mediated by, and reliant upon, historically rooted discourses that position women of colour and poor women as ‘bad mothers’, justifying the removal of children from their parents’ care (Swift 1995).

Punitive public-health responses have also informed the framing of 'lifestyle issues' in primary care, where recent debates have emerged about whether smokers, drinkers and fat people deserve the same access to healthcare as other groups. Indeed, there are a growing number of instances in Canada, the USA, Australia and the UK of doctors choosing to withhold treatment from those who drink to excess, smoke and who are overweight (Hall 2005; Kohler and Righton 2006; ABC News 2007). Health professionals who have taken this stance highlight the 'self-inflicted' nature of mortality and morbidity associated with drinking, smoking and fat (Hall 2005), and the growing demands placed on healthcare systems where resources are already spread too thin (Kohler and Righton 2006). These developments speak to the pervasiveness of neoliberal discourses in public health, which disguise the unequal impacts of public-health policies and interventions across the population.

As Petersen and Lupton (1997) note, the enforcement of state-imposed health regulations tends to be exercised upon the most stigmatized and powerless groups, such as immigrants and the poor or dispossessed. For example, in the context of North American and Australian alcohol policy, it is the drinking patterns of the poor and indigenous peoples that are generally problematized – a pattern that has continued from the Gin Epidemic in eighteenth-century England (Warner 2002) to North American FASD prevention policies of the present (Salmon 2004; see also Salmon's and Keane's chapters in this volume). Similarly, obesity has increasingly been framed as a 'disease' of the poor and non-white, and people of colour and the poor bear the burden of public-health scrutiny (LeBesco 2004; see also LeBesco and McNaughton's chapters in this volume). The unequal distribution of public-health attention is even clearer in relation to smoking, which is today most prevalent amongst those on the lowest rungs of the social ladder (Bayer and Stuber 2006).

Accordingly, by positioning smoking, drinking and obesity as 'diseases of the will' (Valverde 1998) made manifest through overindulgence, hedonism, ignorance and excess, the new public health draws on tropes historically associated with the poor and racialized groups, while in turn valorizing moderation, restraint and responsibility (attributes most historically intertwined with white, Protestant, middle-class values) as fundamental to achieving goals of healthy living.

Overview of chapters

This collection attempts to bring together some of those who are currently studying alcohol, tobacco and obesity. It explores recent developments in public-health policy and practice in these three areas in comparative, international and interdisciplinary perspective. Several key questions have informed the conceptualization of the chapters in this volume. How are smokers, drinkers and fat people constructed as 'problem citizens' within

relevancies of the new public health? Are smoking, drinking and fatness equally totalizing or abject? How and why do some substances become defined socially as inherently 'unsafe' or 'addictive' while others become so only in particular quantities and circumstances?

Part I deals with the way in which public-health research and policy are produced, focusing on the social, cultural and political context of scholarship and intervention. In the opening chapter, Michael Mair outlines the means through which the 'new public health' constructs its objects. Using tobacco as an example, Mair shows how contemporary tobacco-control research re-conceptualizes a complex social practice (cigarette smoking) as a non-rational behaviour amenable to forms of causal explanation loosely modelled on those found within the biological sciences.

This section continues with Kathleen LeBesco's examination of neoliberal governance as a means of conceptualizing the relationship between the state and the individual around issues of fatness. Illuminating the tensions between the injunctions to consume less and spend more, LeBesco discusses state efforts to enlist individual citizens in the 'war on obesity' and the more aggressive measures increasingly being implemented for those who 'fail' to self-police. Through this analysis, she illuminates the limitations of contemporary conceptions of obesity and the 'obesogenic environment' and their damaging consequences for those who dare to wear the proof of 'excessiveness' on their bodies.

Themes of excess and individual responsibility also run through Robin Room's examination of the contradictory exhortations of late-capitalist societies to promote both excessive consumption and personal restraint. Through an examination of conceptions of alcohol embedded in temperance ideologies, 'alcoholism' and the contemporary retreat from alcohol control, Room demonstrates the continuities between the contemporary emphasis on 'moderate drinking' and Puritan ideals, which simultaneously serve the interests of those promoting neoliberal free-market ideologies.

An attempt to crystallize underlying ideological conceptions is a core focus of Michael Gard's discussion of obesity scholarship. In this account, positioned as both an observer of and combatant in the 'obesity wars', Gard constructs an anatomy of the obesity controversy. Moving beyond standard representations of the two 'sides' of the debate, he provides a complex account of the disparate groups who comprise the obesity 'alarmists' and 'sceptics'. As his chapter convincingly demonstrates, in the context of debates about obesity, nothing could be more irrelevant than the 'truth' of fatness.

Kirsten Bell comes to a similar conclusion in her examination of research and policy on second-hand smoke. Exploring why this topic has been such a central focus in tobacco control and public health policy, she argues that the 'truth' of second-hand smoke is far less relevant than its cultural attributes as a liminal substance that dissolves the boundaries between bodies.

Part II of the book examines the ambivalent place of pleasure in public-health discourse on alcohol, tobacco and obesity. Central to the chapters in this section is an attempt to explicitly conceptualize and document the sensuous pleasures associated with embodied social practices such as drinking, smoking and eating, and to move beyond rationalist public-health accounts of consumption. Robin Bunton examines the ways in which pleasure is conceptualized and organized under the conditions of contemporary consumer capitalism. Using binge-drinking as an example, he turns his attention to pleasures deemed to be troubling from a public-health perspective via some reflections on the ambivalence and contradiction in contemporary consumer capitalism regarding the intoxicated body.

Helen Keane takes up further the topic of alcohol's pleasures through an explicit engagement with the typology of pleasures Bunton outlines in his chapter. Using the Australian National Alcohol Strategy as a case study, her analysis reveals the ways in which intoxication is reduced to its harms in public-health discourse, resulting in a radical disjuncture from the everyday experiences of drinkers, where intoxication is a form of bodily pleasure.

Writing from a phenomenological perspective, Simone Dennis outlines a similar disjuncture between public-health discourses on tobacco and smokers' experiences, particularly the centrality of sociality, corporeal connection and rupture that are central to the practices of smoking. She demonstrates the ways in which smokers resist the moralized dimensions of state efforts to regulate their bodies and the profoundly corporeal dimensions of smoking as an embodied practice. Lucy McCullough also highlights the intrinsic sociality of smoking, examining the ways in which contemporary tobacco-control policies have attempted to use the sociality of smoking *against* the smoker via social 'de-normalization' strategies. Her chapter considers smokers' responses to attempts to stigmatize this complex social practice – which often have the effect of reinforcing rather than reducing smoking as an embodied social practice and identity.

Finally, John Coveney explores the 'problem' of excess and its emergence as a central project in public health. Using examples drawn from public-health nutrition, he argues that there is currently an explicit and organized backlash against the so-called good life and the 'consumptogenic' environment it is seen to produce. Tracing the historical roots of our concern with unregulated pleasure, he demonstrates the ways in which contemporary discourses draw on centuries-old Christian values that abhor waste and hubris, and, in so doing, he highlights the pleasures that hunger itself entails.

Drawing on critical perspectives detailed in earlier chapters, Part III examines the groups being targeted in public-health discourses on alcohol, tobacco and obesity. It asks the question about who is being singled out as 'risky', 'unhealthy' or in need of intervention in policy and practice around the new public health's 'Axis of Evil'. As the chapters in this section reveal,

women's bodies in general – and mothers' bodies in particular – are especially singled out as key sites of risk production, although the effects of such discourses appear to be strongly mediated by class and ethnicity.

Focusing on conception, pregnancy and reproduction, Darlene McNaughton argues that, although the true impact of obesity on conception or the health of foetuses is unknown, core assumptions at the heart of obesity science have been taken up uncritically in medical arenas. This has created new opportunities for the surveillance, regulation and disciplining of 'threatening' female bodies and the affirmation of certain moral, neoliberal ideas and values.

Drawing on research with Canadian families, Svetlana Ristovski-Slijepcevic explores how mothers respond to nutritional discourses that encourage them to monitor, assess, educate and discipline their children with respect to eating and food choices. She simultaneously takes a critical perspective on the lack of consideration given to the broader political, social and historical dimensions of people's food choices.

Turning her attention to tobacco-control policy, Rebecca J. Haines-Saah critically explores tobacco-control policy representations of female smokers. Haines-Saah identifies a number of recurring tropes in these images, in particular, the gendered symbolic violence of anti-tobacco messaging. Drawing on research with young female smokers, she examines how representations of smoking as 'unfeminine' and 'unacceptable' are reproduced and resisted in everyday practice and in women's narratives about smoking.

The collection concludes with Amy Salmon's chapter on foetal alcohol spectrum disorder (FASD). Drawing together many of the strands examined in this volume, Salmon's chapter provides a critique of some of the more problematic undercurrents in FASD prevention initiatives, through an analysis of how neoliberalist, anti-colonial and public-health agendas are enacted by the state (directly and indirectly) on the bodies of Aboriginal women and their children.

In collecting the chapters in this volume, we have sought to locate contemporary public-health policy and practice within its broader social, cultural and political context, as well as highlight some of the more worrying consequences of recent developments in the new public health and the paths along which it is being currently pursued. In bringing together critical perspectives from a range of scholars, we aim to expose and flesh out some of the fascinating convergences and divergences between the three health issues under examination here.

Of course, there is much more to be said than could be produced in a single text and there are a number of other areas that could have been productively explored in this collection. First, in light of the emphasis on sexual behaviour and drug use evident in the public-health crusade against 'lifestyle diseases', we might have conceptualized public-health policy in terms of a 'Quintet' rather than an 'Axis' of Evil. Second, given the

growing focus on corporate culpability for lifestyle diseases, it might have been useful to compare constructions of the alcohol, tobacco and fast-food industries in public health and popular accounts. Given the burgeoning number of lawsuits against these industries (especially the fast-food industry), future efforts would be well-served to explore how these fit with the arguments advanced in many chapters in this collection about the neoliberal and individualist orientation of much public-health discourse.

Finally, although individual contributors are differently positioned in terms of the degree to which they treat alcohol, tobacco and fat as problematic, the chapters in this volume take, to varying degrees, a social-constructionist perspective on these topics. We feel that this approach provides a necessary corrective to prevailing representations, helping to expose the social, cultural, economic and political roots of contemporary public-health discourses. However, we also recognize that social-constructionist approaches may be accused of ‘problem deflation’ (Room 1983), and failing to engage with the biological impacts of alcohol, tobacco and obesity on the human body. Thus, there are challenges that lie ahead in terms of navigating a middle path that simultaneously recognizes the moral, economic and political underpinnings of contemporary public-health discourses on alcohol, tobacco and fat, whilst recognizing that they can also present problems with real consequences for individuals and their communities (Madsen 1983; Moffatt 2010). Our hope is that other scholars will choose to pick up where this volume leaves off and that the chapters contained in this anthology will spur further comparative research into alcohol, tobacco and obesity (and their comrades in ‘harm’) and the ways they have been taken up as social and medical issues, as well as examining solutions to their problematic aspects that do not merely replicate the limitations of existing policies and practices.

Notes

- 1 *Against Health* is the name of a new anthology (Metzl and Kirkland 2010) that critically examines the moral assumptions underpinning the concept of health.
- 2 *Choosing Health* is the name of an influential white paper produced by the English Government (Department of Health 2004) that typifies this approach.
- 3 Harry Levine (1993) has argued that countries that developed large temperance cultures had two things in common: they were primarily Protestant and they had a cultural preference for drinking distilled liquor.
- 4 Of course, these features of tobacco are culturally and historically specific – a notable feature of tobacco use in South America was its use as an intoxicant to facilitate a bridge between the human and spirit worlds (Wilbert 1987).
- 5 Although it does emerge in representations of cigar smoking, where casual consumption is commonly depicted as a viable option, and sports and film stars are often photographed with celebratory cigars.
- 6 On the one hand, West notes that obesity is already highly stigmatized and so ‘there would be little point in focusing on this’ (2007: 149). However, his call to reduce the social acceptability of overeating amounts to the same thing, given the cultural potency of obesity as a sign of excess (see LeBesco 2004, and this volume).

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