

Doing Nutrition Differently

Abstract: This conversation is part of a special issue on “Critical Nutrition” in which multiple authors weigh in on various themes related to the origins, character, and consequences of contemporary American nutrition discourses and practices, as well as how nutrition might be known and done differently. In this section, authors reflect on the limits of standard nutrition in understanding the relationship between food and human health. They also focus on how nutrition practitioners are or could be creating different practices for how

nutritional information is made available, shared, and absorbed. Among the different frameworks under discussion are individualized nutrition, ecological nutrition, critical dietary literacy, feminist nutrition, and technologies of humility.

Keywords: individualized nutrition, ecological nutrition, critical dietary literacy, feminist protocols, self-help, technologies of humility.

Introduction: Julie Guthman

MUCH OF THE COMMENTARY in this special issue contains harsh critiques of nutrition and nutritionism, and readers may be left wondering what, if anything, they might do to eat well. In their edited volume, Doing Nutrition Differently: Critical Approaches to Diet and Dietary Interventions, our own Jessica Hayes-Conroy and her sister Allison suggest as a starting place to consider nourishment as something different than nutrition. Nourishment invokes a more expansive and less normative path to well-being, and “is certainly not something that begins and ends with nutritional guidelines” (Hayes-Conroy and Hayes-Conroy 2013:1). And yet, their purpose and ours is not to reinforce the “what to eat” question, but, rather, to consider how the practice of nutrition might be done differently, especially given that the field is unlikely to go away any time soon. In this section, authors focus on how nutrition practitioners are or could be doing nutrition differently. For these authors, that can mean creating different practices around how nutritional information is made available, shared, and absorbed; it can mean using different frameworks for thinking about good food; and it can mean doing science differently, as, for example, with less authority and more humility.

or what “healthy eating” means, their content should be questioned. To the extent that they express a system of social surveillance and regulation, their existence as a necessary component of public health should be questioned as well. On a strictly practical level, if the *raison d’être* of the DGA is to prevent chronic disease, they have failed; whether it is because people follow them or not is irrelevant. It has not been possible to clarify the relationships between diet and chronic disease, and the utility of national dietary recommendations has not been proven. For example, the first federal recommendations for dietary prevention of chronic disease were constructed on the premise that dietary fat (in general) causes cancer and dietary animal fats (saturated fat and cholesterol) cause heart disease (Select Committee on Nutrition and Human Needs of the United States Senate 1977). At the time, many scientists insisted that causality had not been clearly established because the science regarding links between dietary fats and these diseases was inconclusive (Pariza 1984; Glueck 1979). To this day, such links remain elusive (Hooper et al. 2011). Since the first recommendations were created — and despite changes in the American diet that are compatible with them — rates of obesity and many chronic diseases have increased rather than decreased (see Nutrition Troubles).

Individualizing Dietary Advice — Collectively: Adele Hite

To the extent that the Dietary Guidelines for Americans (DGA) express a hegemonic view of what a “healthy diet”

Given that the correlations between diet and chronic disease are uncertain and unproven, what guidance can be given to help people navigate their own variable nutrition needs in an increasingly complex food environment? While the relationship between diet and chronic disease may be

unknown, essential requirements for adequate nutrition have been established, although many questions remain in this area as well. Furthermore, people do experience better health by changing their eating patterns. Thus, rather than “imposing strict dietary rules [that] are difficult to support with evidence-based nutrition science” with the dubious promise that they will prevent chronic disease (Slavin 2012: 251), dietary guidance should be based on acquiring essential nutrition and establishing current health and well-being. Because many different dietary patterns may do this, nutrition advice ought to depend on the individual, not on government policy guidelines.

Individualizing dietary advice, however, does not mean assigning the “right” diet to an individual based on genomic, metabolic, or even cultural information. “The right dose of the right drug for the right person at the right time” is the goal of individualized medicine, but there is no corresponding analogy in food. Many American food reform circles have taken up the notion that “food is medicine” in the de-contextualized sense used by Western biomedicine with regard to pharmaceuticals; choosing the “right” ones and avoiding the “wrong” ones are all that is needed to guarantee health. *Toward Healthful Diets*, a counter-report to the 1980 DGA written by the National Academy of Sciences Food and Nutrition Board, suggested that, “Sound nutrition is not a panacea. Good food that provides appropriate proportions of nutrients should not be regarded as a poison, a medicine, or a talisman” (National Research Council [US] Food and Nutrition Board 1980: 19). Strictly speaking, food is a cure and a preventative only for diseases of nutritional deficiency, not for diseases for which the etiology is complex and unknown.

The authors of *Toward Healthful Diets* recognized the lack of scientific consensus and the gaps in knowledge relating diet to prevention of chronic disease, reflecting a humble approach to the complexity of this science that Aya suggests below is crucial to “doing nutrition differently.” This perspective has been lost in the ever-increasing particularities of dietary recommendations and rhetoric of scientific certainty asserted, not just in the DGA and mainstream nutrition, but in alternative nutrition and food reform movements as well. Critics of the 1977 DGA asserted that nutrition was “a young science of enormous complexity,” noting that “evidence is mounting that even atherosclerosis . . . may, after all, turn out to have nothing whatever to do with diet” (Enloe 1977: 15). Little from the field of nutrition epidemiology of chronic disease has changed since that time, yet nutrition researchers frequently go beyond the limits of the science they pursue to make pronouncements about generalizability and policy

application that are unwarranted (Menachemi et al. 2013: 616). In fact, evidence continues to mount that chronic disease may have very little to do with dietary choices; new findings from areas of research that Hannah Landecker refers to as “relational biology” — epigenetics, epigenomics, systems biology, microbiome studies, gene-regulatory network approaches, gene ecology, ecological development biology — suggest that the connections between food and health are far more complex than nutrition science had previously considered and that our notions of self are less stable and more permeable than is now assumed (Landecker 2011: 168; see also *Beyond the Sovereign Body*).

Current “nutrition literacy” efforts are designed to teach consumers how to better choose a diet predefined as “healthy” according to the DGA (Escott-Stump 2011: 979), and facile policy proposals aim to “make the healthy choice the easy choice” for consumers seen as lacking the agency to make wise choices on their own (McKay 2012; Kirkland 2011: 477). These approaches assume the links between diet and chronic disease are known and center public health nutrition policy around this assumption, with the ultimate responsibility for prevention of disease still falling on an individual’s ability to adhere to dietary rules that may or may not be efficacious. In this paradigm, the uncertainty in nutrition science, the complexity of the relationship between humans and their food, and the moral valence applied to “good” eaters who follow DGA rules and “bad” eaters who do not, remain unacknowledged.

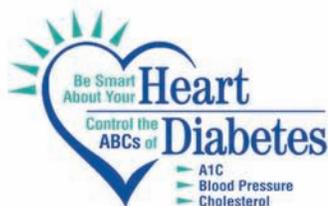
How do nutritionists and public health professionals move beyond approaches to nutrition that reproduce these assumptions and omissions? Charlotte Biltekoff has offered a radical departure from the current approach with what she refers to as “critical dietary literacy,” explained below as a way of learning to see nutrition guidance differently. The feminist work on health that Jessica describes below, although not without its acknowledged flaws, suggests a way to begin a process of creating critical dietary literacy and work toward a redefining of health knowledge. These efforts should be supported by policies that create transparency regarding the laws, political processes, institutions, science, and other social, economic, and cultural forces that impact access to nutrition information and development of sustainable systems that produce foods which support health. These efforts should also address the complexity of the current food system with the understanding that, as Kendra points out below, individual and environmental health are deeply intertwined, with both affected by concerns including but not limited to: agricultural and production practices, workers’ rights, the treatment of animals, hunger issues, food safety, genetic modification of

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FIGURE 1: Public outreach material for diabetes prevention.

IMAGE FROM THE NATIONAL DIABETES EDUCATION PROGRAM

the food supply, food additives and labeling, food advertisement and marketing, support for farmers and producers who are the stewards of our land, and the regulation of agricultural monopolies that impede fair trade and growth of alternative means of production and distribution.

The unifying framework for these efforts is an approach to food and nutrition guidance that begins with individuals and communities, as Jessica suggests, not with one size fits all recommendations or ideological pseudo-certainties. Recognizing that, as the sociologist Robert Crawford puts it, “Health meanings . . . are deeply personal and therefore infinitely varied” (2006: 404), I suggest that nutrition professionals and public health leaders have a particular responsibility to acknowledge the variety of health meanings held by private patients and by members of the public, particularly the less-privileged and vulnerable. It is our responsibility to work with individuals and communities to serve them in achieving their wellness goals related to food and nutrition in ways that move beyond “hegemonic nutrition” (Hayes-Conroy and Hayes-Conroy 2013) and in ways that make us, rather than them, accountable for the outcomes that result.

Healthy Food in Health Care: Kendra Klein

While Adele makes the case that food is not medicine by pointing to the complexity and instability of linking particular diets to material health outcomes, a growing movement within the healthcare sector in the United States is arguing that food can play a key role in disease prevention. The focus, however, is not on individual consumption. Within what can be called the *healthy food in health care* (HFHC) movement, a growing coalition of nonprofit organizations, doctors, dietitians, and other health professionals argue that healthy food is determined not only by the quantity and quality of what we eat, but by how food is produced, processed, and distributed. In other words, “doing nutrition” requires looking up from the traditional nutrition science microscope focused on vitamins, antioxidants, and isoflavones to take into account health outcomes associated with the entire agrifood system.

HFHC actors draw on scientific evidence connecting agricultural practices like pesticide use with material outcomes like birth defects, asthma, neurodevelopmental and reproductive disorders, and various cancers (Sutton et al. 2011). They cite routine use of antibiotics in animal agriculture, overuse of synthetic fertilizers in crop production, and toxics used in food packaging as contributing to health problems such as antibiotic-resistant bacteria (Smolinski, Hamburg, and

Lederberg 2003), blue baby syndrome (Ward et al. 2005), and endocrine disruption (Dougherty et al. 2000). In addition to these direct health impacts, they argue that the dominant industrial agrifood system undermines the material basis of our existence through water contamination, soil erosion, and greenhouse gas emissions while degrading the physical and economic vitality of farm workers, family farmers, and rural communities (Cohen and Mikkelsen 2004; Harvie, Mikkelsen, and Shak 2009). From this *ecological nutrition* perspective (see also *Beyond the Sovereign Body*), which places the health of human bodies and communities within the context of agrifood systems and ecosystems, doing nutrition differently means creating and legitimizing alternatives to the dominant agrifood system. Within the HFHC movement, this represents powerful new alliances between alternative agrifood movements and healthcare institutions with deep pockets and cultural clout.

Through the efforts of HFHC advocates, an ecological nutrition discourse is being taken up within the mainstream healthcare sector in the United States. Riding the wave of health care’s mounting concern about diet-related diseases, and helped along by the growing conception that health care should not only treat sickness but should prevent disease and preserve wellness (APHA 2012), a coalition of nonprofit organizations under the banner of Health Care Without Harm are finding that hundreds of hospitals and clinicians are receptive to redefining “healthy food” along ecological lines. Since 2005, over 480 hospitals and health systems have signed onto their *Healthy Food in Health Care Pledge*, which states that “for the consumers who eat it, the workers who produce it and the ecosystems that sustain us, healthy food must be defined not only by nutritional quality, but equally by a food system that is economically viable, environmentally sustainable, and supportive of human dignity and justice” (HCWH 2006).

This ecological nutrition framing has spread dramatically within the healthcare sector. It has been endorsed in policy statements issued by the American Medical Association, American Public Health Association, and American Nurses Association, among others, and it forms the basis of the *Healthy Food Challenge* of the Healthier Hospitals Initiative developed in 2012 by thirteen of the most influential health systems in the country (HHI 2013). Even the American Medical Association, rarely a radical agent for change, urges hospitals to “become both models and advocates of healthy, sustainable food systems that promote wellness and that ‘first do no harm’” (AMA 2008).

In putting their ideals into action, hospitals participating in the movement are seeking out food that is local, organic, whole rather than processed, produced by family farmers, and free of a host of agricultural technologies such as antibiotics,



FIGURE 2: Luis Vargas, Procurement Manager for Nutrition and Food Services at University of California at San Francisco Medical Center, receives a shipment of organic Satsuma mandarins from local family farm, Capay Organic, as part of the Farm Fresh Healthcare Project.

PHOTOGRAPH BY MARYANN BOOSALIS © 2013

growth hormones, and genetic modification (Harvie, Moore, and Brook 2008; Sirois and Gottlieb 2013). These are developments of no small consequence for alternative food movements given that healthcare institutions spend \$12 billion in the food and beverage sector each year (Harvie 2006), and a single hospital may have an annual food budget of \$1–7 million or more (FSD 2011). Even small shifts in foodservice budgets could represent substantial new markets for alternative food supply streams.

Health Care Without Harm also leverages another form of healthcare currency—the moral and cognitive authority associated with healthcare credentials. The coalition works to bring the voice of doctors, nurses, and other health professionals into policy debates. In April of 2013, they submitted a letter to President Obama and the Food and Drug Administration (FDA) signed by nearly 800 clinicians demanding a ban on the use of medically relevant antibiotics in animal agriculture; they also delivered 530 clinician comments to the FDA expressing opposition to the approval of genetically

engineered salmon. This approach shifts the moralization implicit in alternative food discourse, which others in this issue have critiqued, from individual eaters responsible for making “good” and “ethical” food choices to a set of more powerful actors. The onus is not on patients, for example, to eat well, but on hospitals to provide better food and on health professionals to lend their weight to changing the policies that shape the food system in the hopes of making “good” food the norm.

In the HFHC movement, the body and its disease or well-being are at the center of contestations over the agrifood system, right use of the landscape, and appropriate use of agrifood technologies. Speaking for diseased bodies, HFHC advocates can be understood as seeking to reembed the agrifood system within its ecological context through transformation of food commodity networks, public health and agricultural policies, and cultural notions of what constitutes healthy food.

Practicing Feminist Nutrition: Jessica Hayes-Conroy

The ecological nutrition model that Kendra discusses above has important connections to the way that I approach the question of how to “do nutrition differently.” For me, the idea that nutrition might need to be re-practiced emerged initially out of my scholarship on school garden and cooking programs (Hayes-Conroy forthcoming), which are both healthy eating initiatives (that is, interested in questions of healthy diet) and instruments of the alternative food movement (that is, interested in questions of healthy agroecosystems and communities). While both projects are certainly laudable and important, they also frequently tend to be taken up as mechanisms of what I call “hegemonic nutrition” (Hayes-Conroy and Hayes-Conroy 2013), the tendencies of which I outline in *Nutrition as a Project*. As a result, I have come to critique healthy/alternative food intervention as ineffective for a variety of reasons, including inattention to embodied cultural difference and social inequality, promotion of expert knowledge regimes that masquerade as apolitical truths, and the elevation of white, Western, upper-class modes of eating as morally superior to other ways of eating and knowing food. To be clear, none of these critiques are meant to counter concerns about pesticide use, or deny the impacts of the industrial food system on the material body and environment. Rather, they should be read alongside these concerns, as intersecting and coalitional calls to attend to the material-semiotic mechanisms through

which different bodies become variously attracted to different foods and food ideas (Hayes-Conroy and Hayes-Conroy 2010).

Detailing a critique of hegemonic nutrition is crucial, but equally important is articulating how best to move forward. Because I have discussed this critique elsewhere, here I want to discuss nutrition *practice* more directly in an effort to think through how practitioners, and eaters at large, might conceive of and enact nutrition in more effective and empowering ways. In searching for better models of health intervention, I believe that one place from which important lessons have emerged is the history of feminist health activism in the United States. I do not think that feminist health activism is the *only* or the *best* frame for re-practicing nutrition, but simply that it is valuable because it seems to address many of the critiques that have been launched against hegemonic forms of nutrition. However, one small disclaimer is needed. In what follows, I do not wish to over-romanticize feminist health activism in the United States, which many have shown to be complicated and implicated in a number of ways—for example, by sometimes overlooking race and class differences (Morgen 2002), or by privileging Western-centric logic, or favoring the individual (Davis 2007). These critiques are important, and continue to be debated. My contention, however, is that what feminist health activists sought to do, and how they sought to do it, has salience—both in the recognized achievements and the scholarly critiques—for a re-practicing of nutrition. There are at least three reasons why I believe this to be so.

The first reason has to do with a focus on the practices or protocols that are involved in doing health differently. This focus importantly shifts attention from the end product or goal of intervention to the complex processes (and politics) of intervening. In Michelle Murphy's recent book, *Seizing the Means of Reproduction*, she explores the concept of “protocol feminism,” or what she broadly describes as “politicization at the level of technique” (Murphy 2012: 29). To Murphy, the protocols of feminist health activism became the “transmissible components” (ibid.) of feminist healthcare practice, through which the complex relations of healthcare intervention were to be scripted. In other words, a protocol established how to *do* something—how to put in motion the technologies, subjects, exchanges, affects, and processes that make up a moment of (alternative) healthcare practice. In this way, good health was something to be enacted collectively and continually rather than achieved individually. For example, in the feminist health movement of the 1960s and '70s, the self-help clinic was more than a space for individual wellness in the same way that *Our Bodies, Ourselves* (Norsigian 2011)

was more than a text for personal perusal. They were both a set of mobile ways of doing health differently that influenced both the production of knowledge about health and also healthcare practice itself.

Following this idea, I want to consider what it would look like if the kinds of feminist protocols that produced the book *Our Bodies, Ourselves*—the most famous and popular feminist health text to emerge from 1970s health activism in the United States—were drawn into the production of nutrition knowledge and practice. According to Kathy Davis, one of the key reasons why *Our Bodies, Ourselves* has continued to thrive across both time and space is not so much in regard to the static information that it captures, but in the process through which this information has been produced, critiqued, and reproduced through various iterations of the book (Davis 2007). That is, from the beginning it was always more about the protocols of authorship than the end product. This privileging of process is and was not new to feminism, but it remains radical today in terms of how we define health medically and how we produce (knowledge about) health scientifically. Therefore, it is worth asking about the transmissibility of such protocols of authorship for the re-practicing of nutrition, and particularly for how we practice the production of nutrition knowledge. Of course, as the authors of *Our Bodies, Ourselves* recognized, any such questions of knowledge production are simultaneously questions of health enactment, especially since, in the case of much feminist health activism, knowledge production itself depended upon women's collective acceptance of the invitation to re-practice health care in their own hands (Morgen 2002).

As Davis's (2007) work helps bring to light, the Boston Women's Health Book Collective (BWHBC), which initially authored *Our Bodies, Ourselves*, enacted the following policies in regard to authorship: First, the book was to be co-authored by a variety of “lay” voices (later, the group insisted on diversity of race, class, gender, sexuality, age, and other forms of difference, though these were not originally primary concerns). Second, the book was to provide a space to detail individual experiences of health and health care. The BWHBC not only considered these experiences important in their own right, but they also felt that such narratives would function *productively* to invite the reader to become active in the production of knowledge about her own body. Thus, third, the book was to encourage active readership by urging the reader to consider her own unique narratives. Fourth, the BWHBC was also to be committed to critically engaging with the production of scientific/medical knowledge, including through questioning the processes of normalization and standardization, as well as the lack of medical knowledge about

certain bodies. Later, this questioning also included the medical industrial complex at large, including the pharmaceutical industry. Fifth, the group was to be dedicated to each other and to the readership at large. The authors maintained an insistence on group (rather than individual) responsibility by encouraging such practices as reading and responding to every letter that the BWHBC received from readers (Davis 2007). Sixth, the book was to synthesize social and biological processes in the definition of bodily health. That is, biological processes were not to be privileged over social forces in outlining paths to better health and well-being. And, finally, the book was to be translated and/or rewritten for different countries, cultures, and languages by enrolling geographically situated authors (in many different countries around the world) to determine the relevance of different health topics, to weigh word-choice decisions, and to seek out new emergent narratives. In other words, the translation protocols for *Our Bodies, Ourselves* operated under the assumption that health knowledge was never universal, but rather always geographically and temporally situated (*ibid.*).

In terms of the production of nutrition knowledge—out of which emerges an invitation to practice nutrition differently—I would venture to say that many if not all of the above protocols of authorship within the BWHBC have relevance to the practicing of critical nutrition (and, for that matter, the practicing of science more broadly, as more democratic and community based; see Aya’s discussion below). For example, many food activists and academics have called for a questioning of expertise, and also of the homogenous voices within nutrition science and practice (Rodriguez 2013; Harper 2013). Partly in response to such calls has come the development of peer-based nutrition groups that focus more on storytelling (Williams et al. 2012), and that edge us toward more active forms of participation in the production of nutrition knowledge (Alkon 2013). There is certainly much more to do in pursuit of this goal, but the BWHBC model of multivocal authorship is an important directive. Also notable along these lines is the parallel emergence of critiques of nutrition *science* (see Adele’s account above), as well as of the food system at large, including increased calls for nutrition science, and its consequent practices, to become more committed to issues of social justice and environmental responsibility (as Kendra describes above). Heeding these calls is undoubtedly a multifaceted project, but it is encouraging to see the emergence of such concerns in scholarship on alternative food and healthy eating (for example, in descriptions of the complexities of economic inequality, geographic access, and mobility in recent food desert literature; see Shannon 2013; McClintock 2011). Further paralleling the protocols of BWHBC

authorship, many of us in this section and issue have also called for engagement with both the social and biological aspects of healthy eating, insisting on a view of healthy eating as more than just metabolic processes (or at least as a more complex metabolism, as Adele notes regarding Landecker’s 2011 work). Of course, one logical outcome of this biosocial view would be an insistence on the embeddedness of any nutrition knowledge in particular social and material contexts, and thus an insistence on the changeability of this knowledge over both time and space—in other words, counter to the idea that nutrition is a universal science. As nutrition *knowledge* becomes recognized as more situated and emergent, practitioners can, like the BWHBC, begin to identify the kinds of mechanisms and labors (at the levels of both body and landscape) that are needed to produce such alternate forms of knowledge. In this way, the production of critical nutrition knowledge becomes itself an alternative material practice.

Getting back to my overall task of specifying the value of the feminist health movement to critical nutrition practice, the second point that I will make (more quickly) is that the work of activists was not only discursive but also simultaneously material, and perhaps especially affective. To explain by example, beyond inviting women to explore and discover their own bodies, Michelle Murphy reminds us that one of the most well-known practices in feminist self-help was the vaginal self-exam. Women health activists quite literally traveled the country trying to convince other women that it was righteous, and not shameful, to look at their own cervixes. As Murphy points out, this production of what she calls an “immodest witness” involved quite a bit of affective labor (2012: 74). In fact, a lot of what happened within feminist “self-help” was not actually about the self-in-isolation but instead about understanding the relational, affective economies through which women became enrolled in caring about the self and others. That is, feminist self-help was a process of teaching (certain) women to feel at ease, or proud and in control of their bodies, in connection with other (particular) proud women and their own bodies. It was, at its core, a collective material endeavor.

In regard to healthy eating, then, the main question for critical nutrition is: what would it mean for nutrition practice to be engaged critically and reflectively in relational, affective labor? First, I would argue that this practice must necessarily involve recognition that nutrition is *already* engaged in affective labor. Thus, part of the practice would need to include an interrogation and discussion about how affective experiences of food and nutrition knowledge *already* impact one’s behaviors and experiences of eating. For example, how do feelings of guilt, disgust, and shame, as well as comfort, pleasure, and

pride, influence eating practices? In addition, such a practice would necessarily involve discussion about the affective economies that *unevenly* produce these experiences, highlighting these experiences as social and political rather than individual (Hayes-Conroy and Hayes-Conroy 2010). Further, such a practice might also require thinking through how to encourage the production of new and more empowering visceral imaginaries; that is, how might practitioners facilitate the imagining and enacting of *new* affective selves (like the “immodest witness,” perhaps) that can help to produce the kinds of empowerment (and resistance) that is needed? And, what sorts of arrangements or protocols would be necessary for creating the kinds of group solidarities that could produce these new affective economies and outcomes? To be sure, there is no single blueprint to discover in answering these questions, but encouraging practitioners to see and understand the operation of affect is certainly a first step.

The third and final point to make here in regard to feminist health is to specify the meaning of self-help and DIY (do-it-yourself) logic as it existed through the feminist health movement. I want to do this primarily because of the understandable concerns regarding the relationship between individualism and neoliberal subject making that make a lot of people nervous about DIY and self-help (Pudup 2008; Harris 2009). As I mention above, self-help was never really about “the self” in feminist health activism. Actually, self-help was instead always placed within a broader framework of group solidarity and responsibility that, while not unproblematic, did not take the position that individual empowerment comes purely from self-reliance. To the contrary, self-help emerged out of concerns about lack of access to knowledge and resources, as well as concerns about structural discrimination and injustice. Of course, a lot of these same issues arise in the context of local food activism, as well as healthy food access. But they also link to food and nutrition in terms of how bodily health and weight are often attributed problematically to personal responsibility and individual deviant behavior (Guthman 2011; Evans 2006). So, what the legacy of feminist self-help lends to critical nutrition is an idea about how to articulate a sort of person-driven nutrition practice that does not bolster the command of individualism-as-neoliberalism.

Finally, in terms of thinking through what individual agency means in the context of self-help, it is also important to recognize that the actions of the agent were never, and could never be, entirely innocent. That is, to the extent to which the self is conceived as embedded within a broader social and political context, individual acts within feminist self-help could not work purely against the dominant system.

For example, many feminist self-help clinics sent their pap smear slides off to medical labs, knowingly connecting their work to the work of the (then-male-dominated) medical industry (Murphy 2012). Similarly, scholars and practitioners of nutrition might do well to recognize that not all of the current self-help initiatives within food activism necessarily or primarily concern themselves with the purity, innocence, or accuracy of their eating practices, but rather with creating broader mechanisms of food provisioning and valuing that can open new possibilities for collectively renegotiating the inequitable food system. For all of the above reasons, as I learn more about the history of feminist health activism, I continue to be inspired by the transmissibility of these concepts and protocols to critical nutrition practice, and I hope that these connections can help to inspire scholars and activists to begin to investigate and instigate on-the-ground practices of critical nutrition.

Seeing Nutrition Differently: Charlotte Biltekoff

I think it is important that we learn not just to do nutrition differently, but also to see nutrition differently. As I discuss in *Interrogating Moral and Quantification Discourses in Nutritional Knowledge*, nutrition is fundamentally both empirical and ethical; it provides rules about what is good to eat and guidelines through which people construct themselves as certain kinds of subjects (Coveney 2006). The dual nature of nutrition is always there, but it can be very difficult to keep in focus. The seemingly empirical nature of nutrition tends to obscure its ethical aspects, leading both producers and consumers of nutrition and dietary advice to engage uncritically with the moral precepts, social values, and ideals of good citizenship that are embedded within it. The same is true in the inverse. The discourse of alternative food is overtly ethical. Its empirical aspects—normalizing rules about what and how to eat that lie behind the celebration of eating as an ethical act—are obscured.

Learning to “see” nutrition differently, to engage actively and critically with both its ethical and empirical aspects, is in many ways similar to learning media literacy. It is a reorientation to something familiar and ubiquitous that involves acknowledging the constructedness of messages and thinking about the particular circumstances and consequences of those constructions. The goal of “dietary literacy” is to enable both producers and consumers of messages about dietary health to consciously and critically assess the values that those messages express. Practicing dietary literacy means asking questions like: What social concerns might be driving this nutritional crisis?



FIGURE 3: *Eating habits carry with them an assumed moral and social significance.*

PHOTOGRAPH BY REBECCA FEINBERG © 2011

What qualities and characteristics are associated with eating right? What qualities and characteristics are imputed to bad eaters? Who stands to lose or gain in relation to the definition of a “good diet” being advanced by this message? How might different people react to this message differently? The alternative food movement has taught many American consumers to be more conscious about where their food comes from and what values it expresses. Should not contemporary consumers be just as concerned about the origins of their dietary advice, and the social and moral ideals it expresses?

Dietary literacy is about seeing nutrition and dietary advice differently, but it also entails rethinking the meanings that eating habits accrue. Having eating habits that align with prevailing dietary ideals is an unexamined social privilege that is much like, and also very much related to, thinness and whiteness. Being a good eater may seem like a natural expression of virtue and responsibility but it is also a result of social processes that have been obscured. Likewise, “bad” eating habits, often perceived as the result of ignorance, irresponsibility, or indifference, are also produced through social processes that have been obscured. Dietary literacy means being very careful about the social and moral significance assumed to be inherent in both “good” and “bad” eating habits.

I hope that using the concept of dietary literacy to think differently about diets and dietary advice will help people to become more conscious of the moral forces at play, and their very real social consequences. But I also hope that it will lead to some even bigger questions about Americans’ increasingly obsessive focus on diet as a source of biomedical health and social well-being. What are the results of the obsession with diet as a proxy for health? The late twentieth-century expansion

of the social significance of eating right reflects the growing emphasis on individual behavior. But the role of dietary discourse may also be to further inflate the sense of an individual’s capacity to control his or her biology and to take responsibility for that body’s productive potential or, conversely, its potential as a drag on public resources. Diet talk too often obscures structural and environmental stresses, constraints, exposures, and inequities, while naturalizing the dubious redefinition of health as a moral virtue and an individual responsibility.

Toward Humble Nutrition: Aya H. Kimura

In different ways, all of the above authors have discussed the question of “doing differently” as it is asked particularly of nutrition. I want to start by pointing out that this question of different practice is also a question within broader scientific communities as well. More specifically, the assumption in nutrition science that science is best left to “experts” is being questioned in other fields. Science and Technology Studies (STS), for example, has pointed out a broad cultural understanding of a lay-expert divide that sees laypeople as incapable of understanding technical issues, and such a divide as a result of “boundary work” that tries to demarcate between science and nonscience (Gieryn 1995). Many scholars who study society-science interfaces have argued for a more democratic practice of science. Similar to Jessica’s discussion of authorship practices above, various participatory forums such as science cafés, citizen juries, and consensus conferences have been conducted to involve laypeople in knowledge building (Kleinman 2000).

At the core of such undertakings is the realization that science involves an exercise of judgment and is founded on implicit normative assumptions. Scientific disciplines have different epistemic cultures (Knorr-Cetina 1999) and often involve tacit knowledge that is not officially codified (Collins 1992). The history of the discipline and its conventions restrict science’s frameworks and its approaches to any policy issue. STS scholar Sheila Jasanoff has argued for science to strive for what she calls “technologies of humility” (Jasanoff 2003). She points out that experts’ humility in seeking the voices of citizens is necessary, as science often fails to consider issues that fall outside the conventional framing of a particular discipline.

While STS has amply shown that science is nonlinear, disjointed, and fragmented, the public face of science is far from making such an honest admission. Particularly when it comes to public health issues, experts’ (and perhaps the general public’s) preference is for an uncomplicated sound bite as a guide for lay citizens. But nutrition science is like any

other science—as Adele also points out, there are a lot of knowledge gaps and disagreements among experts. For example, obesity is usually seen as a hallmark of bad health caused by bad food, but some experts argue that obesity itself might not be a health threat. For instance, proponents of “health at any size” point out that stress, poverty, and marginalization might be stronger triggers for diabetes than weight per se (Bacon and Aphramor 2011).

Nutrition messages tend to be sanitized and stripped of these complexities and knowledge gaps. However, honest recognition by scientists is important. Without experts being forthcoming about ambiguity and knowledge gaps in science, it is difficult to have a democratic forum where laypeople engage in dialogue with scientists. When prevailing nutrition programs are not working but experts hold on to an unproblematic façade for the discipline, laypeople would need a lot of courage to criticize nutritional policy and programs. Because women have historically been considered irrational, emotional, and weak on technical/scientific issues, they suffer from “general marginality from epistemic credibility” (Olson and Gillman 2013: 74). The stakes are higher for them to confront nutritional science’s public face of knowing the unwavering truth. In connection to Kendra’s discussion of ecological nutrition above, this struggle for credibility also has been true of women who call attention to environmental issues. Indeed, one has only to look as far as Rachel Carson’s famous treatise on DDT to recall women’s struggles for epistemic legitimacy.

Feminist historian and philosophers have provided important analyses of knowledge gaps and ignorance. While acknowledging that ignorance could be socioculturally structured to privilege the existing power relations (Tuana 2004, 2006; Schiebinger 2005), some have argued for a positive evaluation of ignorance as the basis of “epistemic responsibility” (Townley 2006). We ought to realize that science is not individualistic, but done in a community. Feminist philosopher Cynthia Townley argues for a reevaluation of ignorance, reasoning that epistemic actions need trust and empathy, both of which require humility about one’s limits of knowledge and ignorance (ibid.). Scientists becoming honest about the lack of scientific unity and consensus is the necessary first step.

Of course, humility in nutritional science risks fostering naïve individualism (experts cannot decide, so it is up to you what to do with your body). One’s right to be uncertain needs to be coupled with meaning making that is collective and situated. The term “epistemic community” is typically understood as a network of traditionally credentialed scientists, aimed at the production of universally applicable

knowledge. But a more inclusive epistemic community that involves both scientists and laypeople can help society make sense of knowledge gaps and disagreements in nutrition. As Jessica describes above, the women’s health movement helped to illuminate ignorance on women’s health issues and exposed patriarchal and capitalist structuring of biomedicine. Another, yet often underrecognized, contribution was to provide a space for women to come together and make sense of these issues. Knowledge and ignorance were not only made evident, but their meanings were debated and acted on collectively. Perhaps what we need now is such space for collective meaning making in relation to knowledge and ignorance in nutrition. ❁

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