FATTENING UP HEALTH CARE: EXPLORING THE WAYS FAT WOMEN NAVIGATE HEALTH CARE SERVICES IN CANADA

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Abstract

This dissertation explores and documents how fat women in Canada experience fatphobia in health care settings, focusing largely on primary care. This study, which is based on interviews and focus groups with fat women, asks broadly: How does fatness act as a barrier to accessing health care services for fat women in Canada? To answer this question, I explore the following four sub questions: (1) How has fatness come to be socially constructed as a moral panic of an 'obesity epidemic', resulting in the medicalization of fatness?; (2) How does the framing of fatness as an 'obesity epidemic' impact the relationship fat women have with their bodies and themselves?; (3) With a focus on primary care physicians, how does the advice of medical professionals' impact fat women's perceptions of their bodies and their health?; and (4) How does the categorization of obesity as a disease by Obesity Canada, in the 2020 Canadian Adult Obesity Clinical Practice Guidelines, further entrench fatphobia in health care practice?

Working at the intersections of fat studies, sociology of health, and feminist standpoint epistemology, I argue that fatness is a barrier to accessing health care services in Canada. Through the experiences of my participants, I find that the framing of fatness as an 'obesity epidemic' has resulted in fat women having antagonistic relationships with their bodies, understanding their bodies as moral failures. These feelings carry over to health care spaces where practitioners often hold anti-fat bias, resulting in weight-based discrimination and experiences of fatphobia in health care. Finally, despite an abundance of research calling for health care professionals to re-consider and re-frame their approaches to fatness in health care settings, health care professionals are ignoring the research on anti-fat bias and instead are doubling down on obesity as disease.

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Introduction

As a pre-teen, a teenager, a young adult, and even sometimes now, I would fantasize about finding a really sharp knife and slicing myself into proper proportions. Fat under my arms? Slice. Hanging stomach / apron belly? Big slice. Excessive fat on my thighs? Slice. Fat around my vagina? Slice. So many parts of me to slice off, but I thought about it all the time. Just like trimming the fat off of some meat before you cook it, or shaving off meat at the deli counter. Hold out the fat, slice it away. You ordered a skinny Kelsey? Hold on, 20lbs of thigh meat coming up. (Excerpt from my personal journal).

Introduction

Being a fat woman in a thin person's world is often difficult to navigate and something I struggle with on a daily basis. Having been fat my whole life and consistently trying to be thin, making the decision to be comfortable in my fat body was not an easy one. It was, however, an important decision. Deciding that being fat was no longer a problem for me posed many challenges. Over-exposure to the thin ideal, dieting ads, pressure from family and friends, and interactions with medical professionals all act as barriers to living life as a woman who is happy in my fat body.

Of particular difficulty are interactions that occur with medical professionals. Throughout my childhood and teenage years, I have seen doctors about my weight. As I was a fat child, my weight has always been of concern to my parents, especially when my sister was suffering from anorexia and was hospitalized at a very low weight. The dominant theory at the time was that in response to my sister's rapid weight loss, I gained weight. This was never an understanding of my weight that I embraced, nor one I accept today. However, as a child I was brought to

pediatricians, psychologists, nutritionists, sleep doctors, and primary care physicians about my weight. Any medical ailment I had, whether headaches, the flu, or a sprained ankle, all were said to be rooted in my weight and the solution was always that if I lost weight I would feel better, regardless of the medical issue at hand.

My interactions with medical professionals led me to believe I was a failure. Nothing I did to try to lose weight ever worked. As a teenager, I felt that I was not trying hard enough or working hard enough to lose weight. I would consistently hear from my parents and my doctors questioning whether I was actually trying to lose weight. The underlying accusation here was that I was not working hard enough. At 18, and about 250 pounds, my doctor and my mother encouraged me to have weight loss surgery; however, only by the grace of OHIP rejection due to improperly completed forms, this was not a procedure I went through with.

As an adult, trying to get pregnant as a single woman meant fighting with multiple fertility clinics to allow me to undergo (non-surgical, non-invasive) fertility treatment to get pregnant. I had to leave a fertility clinic and try a new one when the fertility doctor told me it would violate the Hippocratic Oath that he swore "to do no harm". To him, assisting me in getting pregnant would be doing potential harm to myself and my not-yet-conceived child (see Ioannoni, forthcoming, for a detailed account of my fertility journey). After continuously advocating for myself at another clinic, I was able to get pregnant and have a complication free pregnancy.

When I reflect on these experiences, I put a lot of trust in my doctors to give me accurate information, and I believed what they had to say. I see key themes in my experiences that I further explore in my dissertation, looking at discourses of responsibilization, problematic

conceptualizations of health based on Body Mass Index, and the impact of the thin ideal on society.

When I re-frame these experiences from my perspective as a critical sociologist, I question the authority with which many doctors prescribe weight loss as a catch-all treatment for fat people when research demonstrates that yoyo dieting and rapid weight loss lead to more negative outcomes than being fat, and that the standard measures used to diagnose fat as problematic, the BMI is flawed (see Chapter 1 for a discussion of the 'obesity myth'). My frustration and anger has pushed me in the direction of critically examining conceptualizations of the fat body using obesity science and the problems associated with such conceptualizations.

The alleged obesity epidemic has created a moral panic around weight and fatness in North America that is inescapable (Campos, 2004; Gard & Wright, 2005). The body, especially the fat body, is a site of constant contestation (Gailey, 2014). The 'normal body' is understood as able, thin, light to white skinned, straight, cis-gendered, and middle class. Bodies that challenge this normative conceptualization are seen as deviant. There are many different approaches to understanding the positionality of the fat body in North America. This dissertation focuses on the fat female body and the barrier it poses to accessing health care services in Canada. The focus on access to health care is a critical one, as when women are not accessing health care services, regular health maintenance and early detection of major health problems may go unattended.

Research Questions

The primary goal of my dissertation is to address the following research question: How does fatness act as a barrier to accessing health care services for fat women in Canada?
In answering this question, I explore the following four questions:

1) How has fatness come to be socially constructed as a moral panic of an 'obesity epidemic'– resulting in the medicalization of fatness?

2) How does the framing of fatness as an 'obesity epidemic' impact the relationship fat women have with their bodies and themselves?

3) With a focus on primary care physicians, how does the advice of medical professionals impact fat women's perceptions of their bodies and their health?

4) How does the categorization of obesity as a disease by Obesity Canada, in the 2020 Canadian Adult Obesity Clinical Practice Guidelines, further entrench fatphobia in health care practice?

In using these questions as a basis for my dissertation research, I aim to get at both the contextual and historical understandings of fatness that have led to a moral panic around 'obesity', while focusing more on the lived experiences of fat women and how this moral panic negatively impacts their access to health care services in Canada.

Disciplinary Approach

My study of fat women's interactions with their doctors draws from fat studies, feminist theory, and sociology of health. I have chosen to work in this intersection because of the complexities that go along with fat bodied experience.

Fat Studies

According to Solovay and Rothblum (2009), "fat studies is an interdisciplinary field of scholarship marked by an aggressive, consistent, rigorous critique of the negative assumptions, stereotypes and stigma placed on fat and the fat body" (p. 2). The field of fat studies requires skepticism about such belief systems, and challenges the power ridden and prejudicial

assumptions of weight-based beliefs (Wann, 2009). Fat studies emerged from traditions similar to feminist and women's studies (Solovay & Ruthblum, 2009; Wright, 2009). The field of fat studies attempts to combat the dominant ideologies surrounding "obesity", a concept that contributes to the marginalization, pathologization, mistreatment, abuse and discrimination of a significant segment of the population that transcends demographic boundaries (Gard & Wright, 2005). As Pausé and Taylor (2021) explain: "fat studies is a post-disciplinary field of study that centres the fat body and the lived experiences of fat people" (p. 1)

As field, fat studies itself critically examines attitudes around weight and appearance, advocating for the equality of fat folks in society (Rothblum, 2012). Fat studies looks at the oppression and marginalization of fat people, and argues that our understandings of weight need to be situated in the context of other forms of marginalization, such as gender, race/ethnicity, sexual orientation, and socioeconomic status (Pausé, 2014; Rothblum, 2012). Cat Pausé (2014) argues that, for this reason, an intersectional approach to studying weight and fatness is crucial. Weight cannot simply be understood in isolation, and fat people are not a homogenous group; instead, fatness needs to be understood in the context marginalization and oppression, recognizing the way that weight intersects with other markers of identity (Pausé, 2014). These intersections, Chrisler and Barney (2017) note, can result in fat folks bearing a greater cumulative burden of oppression.

Fat as a Feminist Issue

The second perspective contributing to my disciplinary approach is a feminist perspective. Preoccupation with weight and body sizes has been important to social theorists, especially feminists, for decades (Fikkan & Rothblum, 2012; Orbach, 1990; Wright, 2009). The focus on the body by early feminists primarily centered on studying eating disorders and self-

consciousness, however, recent shifts in feminist thinking have pushed fatness into the spotlight as a feminist issue. As Wright (2009) notes "feminists made the link between social structures, cultural ideals, and the body, particularly in this case, the female body" (p. 6), so it is no wonder that fat is indeed a feminist issue. Historical contexts and relations shape what it means to be feminine, and this meaning has been transformed throughout history. As such, many feminists are interested in how patriarchy shapes and regulates the female body, and what the consequences are of not meeting specific standards of beauty (Gard & Wright, 2005).

Hesse-Biber (2008) notes that women are encouraged by society to see themselves as objects, and such objectification is rooted in patriarchy and capitalism and is played out through social institutions such as the family, corporate culture, the government, and the media. In directing women's focus to a preoccupation with their failure to meet societal standards of beauty, women are distracted from larger societal problems that could use their attention.

Studying fat from a feminist perspective is important, as the experiences of marginalization that fat women experience exist both at a societal and interpersonal level. Women have to contend with unrealistic shrinking beauty standards in effort to achieve unattainable standards of beauty, and these standards are often rooted in fatphobia. Women suffer disproportionately from weight bias than men, in spheres ranging from education, employment, health care, dating, and the media (Gailey, 2014; Fikkan & Rothblum, 2012). Fatphobia stems from and perpetuates the marginalized position of women, and therefore fatness is a feminist issue.

Sociology of Health

Finally, a sociology of health supplements my disciplinary approach to this dissertation. Health is often understood as having a basis in scientific medical knowledge. Blaxter (1990)

challenges this assumption. She highlights the dichotomy between a biomedical model of health and what is often viewed as a lesser, more holistic, lay model of health. Biomedical knowledge, according to Blaxter (1990) is seen as universal and as rooted in a generalizable science. This is in contrast to lay knowledge, which is seen to be unscientific and grounded in individual experiences. Blaxter (1990) and Clarke (2008) call for an understanding of both the biomedical model and the lay model of knowledge in adequately understanding health research.

As White (2016) highlights, a

> sociology of health ranges over a wide territory: how some conditions come to be called diseases; the experience of being sick or ill; the organization of the medical profession; the ways in which health policies are produced; and the workings of hospitals (p. 39).

What White (2016) is arguing is that a sociology of health allows for an understanding of health that accounts for the impact of society at large. Thus, a sociology of health does not focus on the individual, but on the wider social group that individuals belong to and the impact of that belonging on health (White, 2016).

Studying health sociologically involves complicating our understandings of health knowledge. As Bird and Rieker (1999) highlight, research on health needs to be interdisciplinary, again shifting the focus away from a strictly biomedical model of health, and this is one of the benefits of using a sociology of health approach. Interdisciplinarity in health research allows for an integrated model of the social, political, economic, and biological determinants of health. As Blaxter (1990) argues, health is not unitary, but is multi-dimensional, and the approach to studying health must be multi-dimensional as well. It is not enough to think of health as either 'wellness' or 'illness'.

Health and illness are not givens, but are constructed based on medical science that is historically and culturally contextualized (Clarke, 2008). Timmerman's (2013) furthers the value of a sociology of health by arguing that health sociology is crucial as it serves as a critical reflection of the concept of health itself. A sociology of health, then, allows us to examine health by understanding how medical beliefs are constructed, the money behind health care, allows for a de-centering of biomedical knowledge, and to look at the social mechanisms that influence health, while reframing the dominant perspectives of health.

Further, in looking at medical models of health, Clarke (2008) argues that a sociology of medicine requires us to study how the institutionalized medical system serves to construct health and illness. Health and illness are not givens, but are constructed based on medical science that is historically and culturally contextualized. The call here is for researchers to employ a critical lens.

Link (2008) argues that a sociology of health allows us to look at social factors, and these factors are important because social factors, which are under human control, have come to influence biomedical realities of health. These social factors, as Link and Phelan (2000) point out, include historical changes in life expectancies, socioeconomic status, the existence of social supports or social networks, and the prevalence of social inequalities. Socioeconomic status has increasingly become linked with disease, and Link and Phelan (2000) argue that this is because socioeconomic status embodies resources. People with low socioeconomic status lack access to resources such as knowledge, power, and prestige, which can all be used to attempt to avoid illness.

These social factors are known as social determinants of health. The Government of Canada defines determinants of health as "the broad range of personal, social, economic and

environmental factors that determine individual and population health" (Government of Canada, 2019). The Government identifies twelve main determinants of health: "1) Income and social status; 2) Employment and working conditions; 3) Education and literacy; 4) Childhood experiences; 5) Physical environments; 6) Social supports and coping skills; 7) Healthy behaviours; 8) Access to health services; 9) Biology and genetic endowment; 10) Gender; 11) Culture; [and] 12) Race / Racism" (Government of Canada, 2019).

The more access to resources and power a person has, the better their health is. Social determinants of health are further exacerbated by neoliberalism, as neoliberalism serves to reinforce inequality, which Clarke (2008) argues results in an increased stratification of health outcomes. There is a clear relationship between the social/structural hierarchy and health (Clarke, 2008). Those with resources, access, and power have better health outcomes. Social inequality plays a major role in effecting people's health, which is why a sociology of health is incredibly important. The prevalence of health and illness are linked to the social organization of a society, and a sociology of health allows for the examination of the inequality within our social structure contributing to poor health.

Bridging these fields: Using an Interdisciplinary Approach

In approaching my research, I embrace the three approaches outlined above. Questioning scientific and medical knowledge creation and the call for a sociology of health contribute to understanding fatness from a sociological perspective. The standard of appropriate body size has been in constant flux, with different body sizes being valued throughout historical eras. Critical scholars argue that obesity and fatness are not biological conditions, but socially constructed categories (Ellison, McPhail, & Mitchinson, 2016) and note that it is necessary to understand and

theorize fatness in a way that accounts for the relationship between the biological and social world (McPhail, Brady, & Gingras, 2017).

This process of othering fat people – fatphobia – is rooted in the concept of healthism, where fat people are seen as bad and as failures, as they have failed to take responsibility for their health (Ellinson et al., 2016).

As Paradis (2016) notes, we have come to adopt medical language in discussing fatness, such as 'obesity', 'morbid obesity', and other related terms. As such, it is necessary to frame these concepts in an understanding of how the social construction of fatness is framed more broadly in the discussion of medicalization, and the social, historical, and political processes that frame obesity as a moral panic.

Chapter Outlines

My dissertation is broken up into five chapter, where I explore the social construction of the 'obesity epidemic', my methodological approach to this research, the impact of the construction of the 'obesity epidemic' on participant's relationships with their bodies, fatphobia in health care and the harms caused by anti-fat bias, and finally the 2020 Obesity Canada guidelines.

In Chapter 1: *The Myth of the 'Obesity Epidemic',* I introduce key literature in the fields of fat studies and health studies that support the argument that the value, morality, and perceptions people hold around weight are socially constructed. Further, the literature discussed in this chapter demonstrates the prevalence of anti-fat bias in the health care field and provides context for the analysis of participants' data in the upcoming chapters.

In Chapter 2: *Methodology*, I highlight the influence of feminist research methods on this dissertation research and outline my epistemological approach (that of constructivism). Further, I explore the methodological approach that I undertook for data collection by outlining the steps of my fieldwork, including the recruitment stages, conducting focus groups and interviews, and my data analysis process.

In Chapter 3: *Neoliberalizing the body: The impact of the 'obesity epidemic' on embodied relationships,* I question the impact of the obesity epidemic on the relationship my participants have with their own bodies. Framing body size as pathological results in a neoliberal understanding of fat bodies as failures and creates adverse relationships with one's body.

In Chapter 4: *Fatphobia in health care: Experiences of anti-fat bias*, I argue that anti-fat attitudes held by health care professionals, especially primary care physicians, result in weight-based discrimination for fat woman in health care settings. Exploring my participants experiences, I find that continued negative experiences by fat women in health care settings (rooted in fatphobia) can result in negative or non-existent relationships with their doctors, denial of care by their doctors, or avoidance of care all together.

In Chapter 5: *A critical analysis of the 2020 Obesity Canada guidelines*, I interrogate the recommendations for health care providers dealing with "people living with obesity". Obesity Canada, a registered Canadian Charity, created these recommendations in conjunction with the Canadian Medical Association Journal. These recommendations focus largely on categorizing obesity as a disease. I argue that this categorization, and the recommendations that follow, continue to pathologies fat patients, further entrench anti-fat bias in health care, and perpetuate fatphobia and weight based discrimination.

Finally, in my conclusion I present the overarching takeaway of my dissertation: fat women in Canada face barriers to accessing health care due to their weight. In asserting this, I identify six key findings that emerge from my dissertation: 1) the impact of the neoliberalization of body size and the rise of the 'biocitizen'; 2) the ways in which discourses of responsibilization and disciplinary medicine are engrained in the practice of health care in Canada; 3) how the fat body is a space of hypervisibility, in a constant state of silent 'confession'; 4) the emergence of the contemporary health subject; 5) the negative relationship between patients and their doctors, based on their experiences of fatphobia and anti-fat bias; and 6) the entrenchment of obesity as 'disease' in health care practice.

Chapter 1: The Myth of the 'Obesity Epidemic'

Introduction

This chapter examines key literature on changing cultural and societal values on weight throughout different historical periods that have led to what is contemporarily known as the 'obesity epidemic' by looking at the rise of the obesity epidemic, the use of obesity science, and the prevalence of discrimination in health care spaces. From this literature, I argue that the obesity epidemic is a social construction fueled by the medicalization of fat bodies and the moral panic that comes from this social construction of fat bodies as 'epidemic', and a problem in need of a solution, contextualizes my analysis throughout this dissertation.

The Rise of the Obesity Epidemic

The standard of appropriate body size has been in constant flux, with different body sizes being valued throughout historical eras. As Klein (2001) notes, much like trends in fashion, body ideals cycle in and out, and this is evident looking historically at trends with thinness, fatness, and varying body sizes. Such shifts in cultural values around weight demonstrate the way in which the values around weight, as many researchers such as LeBesco (2004), LeBesco (2009), and Gard and Wright (2005), are social constructs. Boero (2012) describes the 'obesity epidemic' as a post-modern epidemic, as obesity is not contagious, and is not a discrete disease entity. Instead, obesity relies on the processes of medicalization – the use of a medical framework to examine something that is not, in and of itself, inherently medical – to bear disease status (Boero, 2012; Paradis, 2016; see also Murray, 2008;). As Murray explains "obesity, then, is less a biological infection of the tissue and cells, than one of moral standards of Western bodily aesthetics" (p. 16).

In her book *Revolting Bodies*: *The Struggle to Redefine Fat Identity*, Kathleen LeBesco (2004) argues that contemporary understandings of fatness are framed by historical, economic, and political positions. Looking at fat images in Ice Age Europe, and the Hellenistic period of Greece, LeBesco (2004) asserts that "fat is a fluid construct that has been used to serve dominant economic and cultural interests, to the detriment of not just the fat people" (p. 17). This is demonstrated through shifts in historical time periods, impacting the availability of food and resources.

Many of the statues found from the late Ice Age are figures of human bodies, specifically the female body. The most famous figurine that LeBesco (2004) discusses in her book is the "Venus of Willendorf" sculpture from the Ice Age period, found in 1908. This figurine represents a woman with a large stomach, ample breasts, and large hips (see Figure 1.1 below). At this time, LeBesco (2004) notes, resources were incredibly scarce, and these Venus statues, worn by women as pendants for good luck, represent the way in which body fat was a luxury. In fact, as Klein (2011) notes, many of the figurines found from this period, around twenty thousand years ago, were overly fat and abundant. Klein (2011) supports LeBesco's (2004) argument that the Venus figurines, especially the famous "Venus of Willendorf" sculpture, are indicative of the way in which beauty was viewed during this time. Oliver (2005) further argues that throughout history, body fat has represented wealth and power, and this is evident, he says, through historical accounts of fat glorification such as the "Venus of Willendorf" statue.

Figure 1.1

Venus of Willendorf Statue

Both Klein (2011) and LeBesco (2004) shift from discussing portrayals of fat in the late Ice Age to discussing fatness in the Hellenistic period of Greece. Representations of bodies from this period, according to LeBesco (2004), were abundant and would be considered overweight or obese in contemporary times, especially the statues of goddesses, philosophers, and athletes. Klein (2011) states that large bodies, bodies that would be considered obese by today's standards, were socially acceptable in the Greek times, prior to the rise of Christianity.

LeBesco (2004) notes that there is some controversy over the meaning of the abundant statues (both in the Ice Age and in Greek times). Some historical researchers suggest the statues were meant to exalt an idealized person and represent their status. LeBesco highlights that others, however, argue that these representations of fatness are emblematic of cultural ideals during these time periods.

Klein (2011), LeBesco (2004), and Oliver (2005) note that the shift in attitudes about weight and fatness following the Ice Age and Greek times are consistent with the rise of Christianity. LeBesco (2004) attributes the stigma associated with fatness to the rise of Christianity, as manifestations of fatness were seen as dirty and came to represent sloth and greed during Biblical times. Oliver (2005) positions ambivalence towards fatness as evident in

the medieval Catholic Church, which associated corpulence with sin and gluttony. Klein (2011), drawing on researchers such as Clark (1956), says that the triumph of Christianity over Paganism led to the body being viewed as a space of shame and humiliation. The statues that came before the rise of Christianity, in Greek times, were now viewed as sinful and luring people to the devil. Nude statues of Adam and Eve, Klein (2011) notes, looked shameful and humiliated. Fatness became associated with being dirty and unclean, which LeBesco (2004) notes is seen as unclean or ungodly in Christianity. The power of religious institutions to construct fatness as polluted or unclean contributes to the early marginalization and stigmatization of fat people (LeBesco, 2004).

Shifting forward in history, Eric Oliver (2005), in his book *Fat Politics: The Real Story Behind America's Obesity Epidemic,* highlights the way in which fatness has always been political. Oliver (2005) shifts from discussing the influence of the Church to deconstructing the influence of the Industrial Revolution on fatness. Fatness, he argues, lost its cache around the time of the Industrial Revolution. Oliver (2005) argues that in order to understand why the symbols of fatness and thinness changed, it is necessary to understand the relationship of these constructs to class politics. At the time of the Industrial Revolution, access to resources became less difficult and food became less scarce. As such, no longer was self-restraint necessary as a form of survival, and fatness as a sign of wealth was no longer the ideal (Oliver, 2005). Instead, Oliver (2005) suggests that the Protestant reforms in the 1800's instilled the ideals of social control and self-regulation in the lives of citizens. If people came to believe they were in control, then they were morally accountable for their failings. While it is evident from Oliver and LeBesco that fatness has lost its cache, the path for marginalization of fat people become more clear, as the shame associated with being fat increased. Bordo (2003) similarly argues that

through historical changes in the understandings of the body, the symbolism of the body changed as well. Body size, whether fat or slender, demonstrated the capacity of the individual to engage in impulse control and self-restraint (Bordo, 2003). As such, fatness came to represent a lack of self-control and self-restraint, and arguably this message of self-control and self-restraint is visible in the neoliberal ideology supporting 'health' 'wellness' and the 'thin ideal' seen today, further discussed in the next chapter.

Oliver (2005) notes that as the nature of social class changed, thinness came to represent a new marker of social status. Being fat, or having excess body weight, was seen as personal inadequacy and failure (Bordo, 2003; Oliver, 2005), and presented challenges to upward mobility, as those who were fat were seen as lazy, lacking discipline, and unwilling to conform to societal standards (Bordo, 2003). Similarly, Nurka (2014) notes that being thin or slender was essential to bourgeois femininity. Slenderness represented moderation, and moderation and responsible management of the body, the family, and capital were essential for women's access to entitlements, like the middle class, femininity, and belonging (Bordo, 2003; Murray, 2008; Nurka, 2014). The prevalence of the media, advertisements, and the diet industry later propped up this ideal (Lupton, 2017; Oliver 2005). With shifts in society away from factory work, exercise was no longer required in order to aid in employed labour, and therefore, Oliver (2005) argues, through its scarcity, exercise gained value.

According to Oliver (2005), the diet and weight loss industry prop up contemporary values of thinness and the new standards of beauty. In her work on the diet industry, Pat Lyons (2009) notes that since about 1994, the way in which the diet and weight loss industry has capitalized on American's concerns about weight and status has pushed this industry into the center of American's lives. She notes that the diet industry has majorly increased their profits

and their social influence without actually increasing the effectiveness of their products or treatments. Lyons (2009) highlights some key trends in the mid-to-late 1900s, arguing that whether it was through amphetamines and diuretics in the 1950s, Weight Watchers and Atkins in the 1960s and 1970s, Phen-Fen in the 1990s, recent history appears to show that weight reduction at any cost is a priority. This is supported, she argues, by the astronomical profits seen by the diet industry, noting that as of 2004, 46 billion dollars annually was spent on weight loss products, and most weight loss is not sustained.

The obsession with diet products, reflected in the profits seen by the diet industry, rest on the intense anxiety of becoming or remaining fat. Oliver (2005) argues that the source of fat hate is fear and that "the ideology that underscores [fat prejudice] is an ethos of individualism and self-reliance" (p. 73). Hesse-Biber (2008) highlights how the regulation of weight has become a tool of capitalism in contemporary times, arguably capitalizing on this fear of fatness. Health concerns mask profit motives for the weight loss and diet industry, who are often funding the research that promotes these health concerns (Gard & Wright, 2005). As Hesse-Biber (2008) notes, this adds up to huge profits for these companies – "as we divide up our bodies and spend, they conquer" (Hesse-Biber, 2008, p. 66).

The diet industry is further propped up by the media, which routinely represents fat bodies in gross or monstrous ways (Owen, 2015; Friedman, 2015) and the media relies on the assumption that obesity, as an epidemic, is scientific fact (Boero, 2012). Fat bodies are held up in the media as failures that warn others of what can happen if you do not take care of yourself (Owen, 2015). Fat bodies, then, are portrayed in the media as failures, as a mascot of what not to become and as a site of what Owen (2015) refers to as "horror, marginalization, and shame" (p. 2). Similarly, Lupton (2017) notes that with the continued rise of the 'obesity' in the 1990s, there

was a shift in the way fat bodies were represented in the media. Just as Owen (2015) had argued, Lupton (2017) demonstrates how fat bodies are seen by the popular media as "grotesque, uncontained, destined for ill-health and an early death, and a burden on the public purse" (p. 120). The fascination with the 'obesity epidemic' relies on the sensationalization of fat bodies as out of control and in need of intervention (Boero, 2012). For example, this sensationalization can be seen in the way that fat people are portrayed in media, such as the 'headless fatty' (Cooper, 2007), where portions of fat bodies are shown in the media, depersonalizing the subject by only showing their abundant bodies, or by portraying fat bodies in gluttonous situations, like eating large quantities of unhealthy food.

Approaches to understanding fatness are also more multi-faceted than simply studying the diet industry. In her piece *Quest for a Cause: The Fat Gene, the Gay Gene, and the New Eugenics*, LeBesco (2009) takes a different angle at understanding fatness since the 1990's. She looks at the implications of research on a supposed fat gene, a biological etiology of fatness. In doing so, she looks at research done by Davenport, the so called 'father of eugenics', and how he researched eugenics as a solution to keep the unfit from reproducing.

In the mid 1990s, obesity and homosexuality were seen as undesirable conditions with no clear etiology, and discourses of fat and gay genes blew up in the media. Great enthusiasm was expressed for a biologically determinist answer to the alleged problem of obesity and homosexuality, especially by the people who occupied these categories. This research is significant as the implications of a fat gene are high; the recognition of fatness as genetic and rooted in biology shifts the blame off those who are fat and from the social construction of fat stigma to a biological problem, one in need of a cure. The quest for a genetic cause of fatness factors heavily into public policy, civil rights, and legal protection. The implication of a

biological basis of fatness implies that the biomedical model can solve this alleged problem. LeBesco (2009) notes that it is important to understand that while biology plays some role, fatness is a far more multifaceted and socially constructed issue**.**

Similarly, Fox Keller (2002), in her book *The Century of the Gene*, argues that mapping out the human genome has demonstrated that there is a large gap between genetic 'information' and the impact of this information on biological meaning. She notes that the term 'gene' has become entrenched in our culture, even though it is ambiguous and often reductionist (Fox Keller, 2002). However, using the rhetoric of genes and genetics, or 'gene talk', is a powerful way to persuade and influence an argument, especially in promoting an agenda, securing research funding, and marketing products in the bio-tech industry (Fox Keller, 2002).

Dominant discourses of fatness are problematic as the science in which they are built on, according to Gard and Wright (2005), is flawed. In their book *The Obesity Epidemic: Science, Morality, and Ideology*, Gard and Wright (2005) examine the way in which scientific research is used dubiously to push forward a specific health agenda. Gard and Wright (2005) argue that the core principles of science on obesity currently is that obesity and overweight are bad for health, and that too much food with too little exercise is the cause. As evident above, at particular historical junctures, different threads of thinking about weight converge to produce new understandings of the value of weight (Gard & Wright, 2005; Klein, 2001; LeBesco, 2004; LeBesco, 2009; Oliver, 2005). Obesity science, according to Gard and Wright (2005) is trapped in its primary interest of understanding body weight through a biological etiology, ignoring other factors. As LeBesco (2009), among others, have noted, weight is a far more complex social construct then biological etiology.

Medicalization and Obesity Science

The construction of obesity as a social problem occurs from many different perspectives, such as through the government, scientific research, and more specifically the medical community. The way in which weight is constructed as problematic by medical professionals has great influence on the lives of fat people. This section outlines some of the ways the medical profession bolsters claims of an 'obesity epidemic' by looking at the use of obesity science.

A key tool of this science is the BMI (body mass index) scale. It was developed over 150 years ago, and is now used as the main way to measure fatness (Gard & Wright, 2005). It is calculated by dividing a person's weight in kilograms by their height squared (in meters). What constitutes overweight, per BMI standards, has changed throughout the years. Prior to 1999, a BMI score of 29 was considered overweight (Boero, 2012; Berg, 2017; Gard & Wright, 2005). This was then reduced to a BMI of 27, and soon after a BMI of 25, which is the current standard used to indicate the upper limits of the 'normal' weight category (Boero, 2012; Berg, 2017; Gard & Wright, 2005).

The use of the BMI scale as a measure of fatness is problematic. For example, BMI does not correlate with the levels of fat people have; according to Gard and Wright (2005) at best, BMI accounts for 60-75 percent of body fat variation in adults and is completely inaccurate for measuring body composition in children. BMI fails to account for ethnic diversity or variation in body composition (Boero, 2012; Donoghue, 2014; Gard and Wright, 2005; Satinsky & Ingraham, 2014). Gard and Wright (2005) call for extreme caution in understanding statistics on obesity levels and their relation to diseases. They argue that

> To summarize: obesity is defined as excess fat that impairs health and is routinely measured using height and weight to calculated a BMI … The classification of obesity

> depends on the BMI … that appear to relate to increased occurrences of various non-communicable diseases. As both BMI and girth measures are problematic, all statistics on the levels of obesity in human populations need to be interpreted with a great deal of caution to avoid science fiction being represented as science fact (Gard & Wright, 2005, p. 94).

For example, many athletes would be considered 'overweight' or 'obese' based on the measure of BMI. Regardless of their health or fitness level, the muscle mass of a large number of athletes would push them into the 'unhealthy' ranges of BMI ('overweight' or 'obese'). In a study of 173 athletes, 72% of participants were incorrectly identified when using BMI to measure body size (Canda, 2017). While their BMI would put them in the 'overweight' or 'obese' range, their fat percentage indicates a 'normal' range for health (Canda, 2017). This discussion has played out in the media as well (see, for example, NPR's *If BMI is the test of health, many pro-athletes would flunk* or New Scientist's *Overweight Olympians: Guess the BMI of top athletes)*.

Brown and Ellis-Ordway, drawing on the work of Cox (2020), and Springs (2019), argue that another key problem with BMI as a tool for measuring health is that it is inherently racist. BMI as a tool is based on Northern European standards around body size, which means that it is not reflective of racial and ethnic communities (Brown & Ellis-Ordway, 2021; Cox, 2020; Springs, 2019). As Cox (2020) argues, for racialized people ""[t]he fear and shame of living in a fat body come dressed in the same racist, fatphobic bullshit the West has been selling for centuries" (p. 19).

In his book *The Obesity Myth: Why America's Obsession with Weight is Hazardous to your Health*, Paul Campos (2004) demonstrates some of the major contradictions and flaws in the medical discourses surrounding the obesity epidemic. Campos (2004) argues that the case for

obesity as a medical problem is threefold: fat kills, thin is better for your health, and getting thin will deal with the fact that fat kills. In debunking this claim, he argues that the standard for measuring fat, BMI, is flawed. A BMI greater than 25 is typically claimed to be the cause of many deadly conditions, and therefore people need to get their BMI lower then 25 at any costs. However, Campos (2004) argues that the negative effects of a BMI greater than 25 are not supported in evidence. He highlights research that demonstrated that mortality rates are actually higher in those considered underweight according to BMI. Campos (2004) concludes that in almost all large-scale epidemiological research studies, there is little to no correlation between weight and health for the majority of the population.

Further research on BMI, obesity, and mortality demonstrates the problematic nature of using a BMI of 25 as a standard on the upper limits of 'normal'. In a 2005 study conducted by Flegal, Graubard, Williamson and Gail, researchers looked at the importance of adjusting for confounding factors, like smoking and age, when studying obesity and mortality, as these factors influence the outcomes of the study. Using data from the National Health and Nutrition Examination Survey (NHANES), Flegal and colleagues aimed to examine all deaths related to weight ('underweight', 'overweight', and 'obese') in the US in 2000. The results showed an increase in mortality in both the categories of 'underweight' (BMI <18.5) and 'obese' (BMI ≥ 30). The results, however, are lower than previous estimates of weight related mortality in other studies. Specifically, in reference to obesity they found obesity to be associated with a modest increase in relative risk. They found that being in the 'overweight' (BMI 25 - <30) category was not associated with any increased risk to mortality.

In a subsequent study by Flegal, Kit, Orpana, and Garubard in 2013, the authors found similar results and further explored this previously mentioned modest increase for those with a

BMI ≥ 30. In this study, Flegal and colleagues examined existing analyses of BMI and all-cause mortality that have hazard ratios for BMI categories. These categories are stratified by 'underweight', 'normal' weight, 'overweight', 'obese', and 'grades 1 – 3 obesity'. Flegal et al., (2013) found that in the US 40% adult men and 30% adult women, and in Canada 44% adult men and 40% of adult women, have a BMI between 25 – <30, making them categorically 'overweight'. Flegal and colleagues (2013) argue that, in comparison to the 'normal' weight category of ≥18.5 - <25, 'overweight' is associated with significantly lower mortality rates. Flegal et al., (2013) report that 36% of adults in the US and 24% of adults in Canada have a BMI ≥ 30, making them 'obese'. However, those who are 'grade 1 obese' (BMI 30-<35), did not have significant excess mortality. This suggests that findings about the increase in excess mortality for those who are 'obese' occur in 'grades 2 – 3 obesity' (BMI ≥35).

The implications of the 2005 and 2013 studies by Flegal and colleagues are incredibly important and controversial. They found in both studies that those in the category of 'overweight' (BMI 25-<30) were at significantly lower rates of mortality then those in the 'normal' BMI range. This finding suggests that being 'overweight' is not bio-medically problematic; in fact it appears that being 'overweight' is healthier than being in the 'normal' weight category, when looking at mortality risk. Subsequently, their research also suggests that being 'grade 1 obese' (BMI 30 - <35) has no difference then the 'normal' weight range. The BMI scale is used as a standard in measuring a healthy weight however this research, which is a review of much of the existing research on weight and mortality, shows that the negative health consequences, in relation to mortality, do not occur for at least 10 points higher on the BMI scale then what is used as the cap for 'normal' body weight (BMI 25).

Despite the results of these studies being accepted by the CDC (Flegal, 2021), obesity researchers have been attacking Flegal and colleagues' work since the day it was published in 2005. Flegal (2021) shares how immediately following the publication of the 2005 article, many obesity researchers attacked the findings by writing papers attempting to argue that the findings by Flegal et al. (2005) were wrong and even holding symposiums with the sole intent of criticizing the study and the researchers behind it. These attacks continued for years, despite other researchers (like a group of Canadian researchers in 2010) finding similar results (Flegal, 2021). Despite continuing attacks to discredit their work, Flegal and colleagues (2013) carried out the second analysis and found similar results to their 2005 study.

All of the above research leads to the question: Why do we continue to use the BMI scale as a standard? If fat is a problem, even when studies suggest differently, what is the solution? As Campos (2004) notes, the popularized solution to the argument that fat kills people, is to be thin, as thinness is better for your health. Fatness is said to lead to disease and increase the mortality rates for people who are considered obese. Campos (2004) examines research on obesity as causing disease, and challenges conclusions that obesity has a causal relationship with heart disease, diabetes, or cancer. In fact, he argues, there are many diseases and conditions, including cancer, that are less likely in those who are fat.

Similar to the case Campos (2004) argues that is made for obesity as a medical problem, O'Reilly and Sixsmith (2012), drawing on O'Hara and Gregg (2010), argue that beliefs around the 'obesity epidemic' can be distilled into three main tenets, which they refer to as a 'weight centered paradigm'. First, a person's weight is associated with the amount energy they take in and put out. Second, being fat or 'obese' is associated with medical problems and early death. Finally, weight loss will result in improving the quality of life for those who are 'obese'.

It is evident in the research discussed in this section that obesity science is problematic. According to Gard and Wright (2005), obesity science is trapped in its primary interest of understanding body weight through a biological etiology, while ignoring other factors. The core principles of science on obesity are that being overweight is bad for health, and that too much food with too little exercise is the cause. The scientific literature on obesity assumes the body functions mechanistically, focusing on energy in and energy out (Gard & Wright, 2005). This assumption fails at accounting for variables outside of food intake and physical activity, ignoring social determinants of health such as socioeconomic status, race, culture, the environment, or the government, as well as holistic body models that are common in Chinese, holistic, and homeopathic health practices. When racial, ethnic, or socioeconomic factors associated with weight are documented, they are often left out or misinterpreted by scientists as indicating that people in these groupings have insufficient understandings of health (Gard & Wright, 2005). As Campos (2004) highlights and Gard and Wright (2005) address, many studies have found the link between body weight and physical activity to be either inconsistent or unsubstantiated.

Looking at obesity from a genetic perspective, Friedman holds a similar perspective regarding the ability of folks to simply lose weight and not be obese. Friedman argues that the heritability of obesity is similar to that of height and weight, and that the increase in folks with obesity is due to the way genetics interact with environmental factors (Friedman, 2003). Despite this, he argues, society does not readily accept the role of genetics in the rise in obesity the way they accept the role of genetics in differences in stature (Friedman, 2003). He concludes that "obesity is not a personal failing … the obese are fighting a difficult battle … against biology" (p. 858). Yet, despite all this research that contradicts problematic assumptions about body size,

obesity science is still used to support public health and public policy on regarding weight and health.

Obesity Science

Contrary to popular belief, science is not objective nor does science represent a universal truth (Clarke, 2008). Instead, science and scientific medical knowledge are human products, created by people in a specific time and place (Clarke, 2008). As such, Clarke (2008) notes that science is socially constructed and is not objective as external social forces influence it. Yet, the consequences of this socially constructed knowledge greatly impacts marginalized communities, specifically in this case, fat individuals. Scientific facts often serve as the basis for creating policy, funding future research, and overall have great influence on the way health is dealt with from a policy perspective.

Obesity science is no different and is used to inform public health policy (Berg, 2017; O'Reilly & Sixsmith, 2012; Satinsky & Ingraham, 2014; Seeman & Luciani, 2011) and the implications of public policy on the lives of fat people can be immense (O'Reilly & Sixsmith, 2012; Seeman & Luciani, 2011). Public health, as described by Satinsky and Ingraham (2014), measures "body size to assess, describe, and predict the health of populations" (p. 143). The medicalization of fatness has resulted in fat bodies being conceptualized as 'obese' and in need of intervention (see Chapter 5 for further discussion on such intervention). As noted previously, medicalization is the process through which language and the practice of medicine are applied to complex social problems, which Boero (2012) uses to describe obesity as a post-modern epidemic. Medicalization is the result of the application of a medical framework to a social problem that is not inherently medical (Boero, 2012). Medicalization, as a process, is done by a

range of actors, from doctors to the media, to big pharma (Boero, 2012). The result of this process can be medical intervention, and the medicalization of obesity renders it a problem in need of a treatment or cure (Boero, 2012). For example, in 2013, obesity was considered for inclusion in the upcoming Diagnostics and Statistics Manual (DSM), to be included as a mental illness, but was eventually withdrawn from consideration (Caplan, 2012).

Obesity policy, as Seeman and Luciani (2011) note, is used to shame, punish, and humiliate fat folks. Yet, interestingly, these public health approaches to body size, rooted in obesity science, are often seen reflected in weight loss programming (Satinsky & Ingraham, 2014). No wonder weight loss is a vicious, ineffective cycle (Berg, 2017; Campos, 2004; Lyons, 2009; O'Reilly & Sixsmith, 2012).

Satinsky and Ingraham (2014) argue that a social justice informed measure of body size would be beneficial for public policy, as it would allow for an understanding of the realities of living in a fat body. A public health approach to body size does not account for the lived experiences of people in fat bodies, the way a fat studies approach to body size would (Satinsky & Ingraham, 2014). Current public health approaches, they argue, have a "tendency to flatten, reduce and essentialize the lived experience of fat people" (Satinsky & Ingraham, 2014, p. 151). Similarly, O'Reilly and Sixsmith (2012) call for public policy on weight to be framed in a way that is weight neutral, suggesting that public policy can take up the language of Health at Every Size (HAES), discussed later in this chapter. Consequently, a public health approach to body size often results in health care providers holding anti-fat bias towards their fat patients, impacting the quality of care that they receive.

The Fat Body in Health Care Spaces

Many scholars have conducted quantitative research on the attitudes of health care professionals towards overweight and obese patients, and ultimately concluded that the weight of the patient impacts the perception of the patient by the provider and the care they may ultimately receive (Alberga et al., 2016; Amy et al., 2006; Balkhi et al., 2013; Brown & Flint, 2013; Chrisler & Barney, 2017; Donoghue, 2014; Foster et al., 2013; Hebl & Xu, 2001; Kasardes & McHugh, 2015; Miller et al., 2103; Puhl et al., 2014; Schwartz et al., 2003).

The stigma associated with fatness does not disappear in health care settings. The stigma towards overweight and obese patients is prevalent among health care providers (Brown & Flint, 2013), resulting in fat individuals being less likely to seek medical care than their thin counterparts (Balkhi et al., 2013; Donoghue, 2014; Ellis-Ordway, 2021b). This stigma contributes to the differential care and treatment received by fat patients by their health care providers (Balkhi et al., 2013; Chrisler & Barney, 2017; Donoghue, 2014). In research done by Balkhi and colleagues (2013), they found the health care providers – physicians, nurses, and medical students – held negative attitudes towards fat patients, viewing them as unpleasant and unsuccessful, and noted a discomfort in working with fat patients to provide care. This discomfort, according to the work of Balkhi et al., (2013), results in health care providers ordering less or outright omitting certain tests or treatments, which Chrisler and Barney (2017) describe as micro-aggressions. The discriminatory treatment of fat patients by health care providers can result in problems such as: less time spent with the patient, the over or under dosing of prescription medications, and the complaints of patients not being taken seriously (Chrisler & Barney, 2017). Hebl and Xu (2001) found that the heavier the patient, the less time the physician spent with them. This discomfort also results in health care providers not taking

their fat patients seriously. Puhl and colleagues (2014) found that 36% of health care providers in their study believed that obese patients would not be compliant with treatment they prescribed (see also Hebl & Xu, 2001). This belief is rooted in the assumption that fat patients are unwilling or unable to follow the recommendations of health care professionals, or that they are non-compliant patients (Puhl et al., 2014).

Miller and colleagues (2013) examined weight related bias in medical school students, finding that medical school students have a significant weight related bias. They argue that teaching medical students to recognize their weight related bias and mitigate this bias is crucial to combatting weight-based discrimination in health care (Miller et al., 2013). Yet, as Alberga and colleagues (2016) found, there is a lack of comprehensive interventions to reduce weight bias among either students or health care professionals.

The stigma and anti-fat bias toward obese patients are prevalent across the spectrum of health care providers, even in fields that specialize in assessing and treating weight related pathologies. In research on health care professionals who focus on eating disorders, Puhl et al., (2014) found that similar to other health care providers, there is a significant weight-based bias. Additionally, Schwartz et al., (2003) looked specifically at health care professionals who do obesity work and found that even obesity specialists exhibit a significant anti-fat bias. They hold similar stereotypical views of fat patients as other health care professionals, viewing them as lazy, stupid, and worthless (Schwartz et al., 2003; see also Teachman & Brownell, 2001).

Recognizing that weight-based discrimination by health care providers can result in delayed access to care, screenings, and treatment, it is important to note that most weight related concerns are initially addressed in a primary care setting (Brown & Flint, 2013; Foster et al., 2003). Primary care physicians are critical of their obese patients, and this critical view can result in

negative and discriminatory behaviour towards the patients (Foster et al., 2003; Hebl & Xu, 2001). The heavier the patient, the more negative the opinion of the primary care provider, and ultimately the size of the patient largely influences the quality of care they receive (Foster et al., 2003; Hebl & Xu, 2001). Hebl and Xu (2001) found that the heavier the patient, the more likely the physician was to find that they were unhealthy, and the physician would think they were unable to take care of themselves, they had less self-discipline, and that they were in need of stricter medical advice. Yet, the physicians predicted that the heavier the patient was, the less likely they were to follow this advice (Hebl & Xu, 2001).

In research conducted by Foster and colleagues (2003), they found that physicians tend to view obesity as a behavioural problem, and nearly half of the physicians believe that psychological problems contribute to obesity as well. Foster and colleagues (2003) also examined the attitudes of physicians towards their fat patients, finding that 30% indicated that their obese patients are lazy, less than half of the physicians felt competent to prescribe weight loss programming to their obese patients, and less than half thought it was even possible for their obese patients to lose a significant amount of weight. Yet, weight loss is still the primary prescription by health care providers for fat patients.

Donoghue (2014) advises that negative discussions of weight and fatness are often used to motivate fat people to be 'healthier', and not be complacent in their fat bodies. Yet, this motivation is actually stigma masked as assistance, and the stigmatization of fatness comes at the expense of the health and well-being of fat folks (Donoghue, 2014). The stigmatization of fat bodies, according to Donoghue (2014), can contribute to feelings of shame, self-loathing, depression, and social avoidance.

Even the perception of discrimination impacts access to health care for fat patients; if a fat patient believes their health care provider is discriminating against them, then the physician - patient relationship becomes fraught (Balkhi et al., 2013; Chrisler & Barney, 2017; Miller et al., 2013; Phelan et al., 2005). Patients who do not trust their health care provider and who experience discrimination and sizism are reluctant to return to their health care provider, resulting in long-term health consequences such as incomplete follow-ups, delays in cancer or other important health screenings, and an absence of care (Chrisler & Barney, 2017; Kascardes & McHugh, 2015; Phelan et al., 2015; Schwartz et al., 2003). For example, Amy and colleagues (2006) found that 60% of women in their study who had a BMI of 55 or higher delayed accessing health care services because of their weight. They also found that 73% of the women in their study indicated that they experience at least one size related barrier to accessing care (Amy et al., 2006). The percentage of women experiencing size related barriers increased as their BMI increased, meaning that size related barriers to accessing health care disproportionately affect larger women (Amy et al., 2006; see also Foster et al., 2003; Hebl & Xu, 2001).

Chrisler and Barney (2017) argue that negative attitudes about fat people and their health are rooted in healthism, and the idea that body weight can be a predictor of chronic illness and ill health. Healthism then provides health care providers a space to justify their medical fat shaming, and the use of shame in effort to motivate fat patients to lose weight (Chrisler and Barney, 2017; Donoghue, 2014). This construction of fat bodies as in need of change, and the subsequent fat shaming fat people experience in health care settings has resulted in fat people and fat activists pushing back against this shaming. Instead, fat activists push for the normalizing of fat bodies, especially in these health care spaces.

Reconceptualizing and Challenging Discourses of Health

Gard and Wright (2005) argue that the risk of trying to attain the thin ideal are high, and can result in the marginalization, social isolation, and social undesirability of women. When women normalize these messages of risk, they become self-regulating, in that they work hard to not violate social norms of thinness. It is difficult to resist the internalization of blame and shame around weight. Gard and Wright (2005), drawing on LeBesco (2004), argue that fat activism and the Internet are good tools in reconceptualizing and revaluing fatness. Fat activism focuses on normalizing the fat body, and recognizing fatness as a social and political issue, not an individual issue (Boero, 2012).

LeBesco (2004) argues that current understandings of fatness are constructed through our historical, cultural, and economic positions. Fat activists have been challenging the marginalized understandings of fatness for over forty years, and LeBesco (2004) argues that fat is "a function of our historical and cultural positioning in a society that benefits from the marginalization of fat people" (p. 16). The internet has been an ever growing space where size acceptance – a political movement focusing on fat liberation, fat acceptance, and fat pride (Davenport et al,. 2018) – has been able to flourish (Davenport et al., 2018; Webb et al., 2019). Online there are forums, blogs, shopping spaces and more that have popped up to reject the thin ideal, to build community amongst fat folks, and to campaign for size acceptance (Davenport et al., 2018).

One of the primary ways community has developed online is through the cybercommunities, specifically the 'fatosphere'. Cybercommunities, according to Smith, Wickes, and Underwood (2015), are "a distinct forum for community building and identity management, and … are embedded in daily life. Unlike social network sites like Facebook or Twitter, which are structured for the development of personal networks, cybercommunities are

those that emerge around topics where members may or may not reveal their identity" (Smith et al., 2015, p. 951). These communities provide folks the space to manage their identity and understand their marginalized and often stigmatized identities (Smith et al., 2015). These communities, like the Fatosphere (which is most relevant for this discussion), they argue, are significant for folks who would be otherwise socially isolated offline due to their marginalized social identities as they provide space for fat folks to explore their identities and come to terms with their fat bodies (Smith et al., 2015). They found that: "The FA [fat acceptance] … communities allow the self to be affirmed and witnessed by other members, which may assist in stabilising an identity; something that may not be achieved through self-definition alone" (Smith et al., 2015, p. 957).

Webb et al. note how the efforts of fat content creators (like web bloggers) have inspired the 'fatosphere', space online for fat folks to find inspiration and community, along with body acceptance. Similarly, Lewis and colleagues (2011) conducted a study looking at the types of information sought out by fat people online. They found that this information took two different forms: searching for weight loss and diet material and searching for connection with others experiencing fatness as a stigmatized identity, culminating in finding fat acceptance spaces or the 'fatosphere' (Lewis et al., 2011). Finding the fatosphere, they argued, provided participants with a place of empowerment, support, and acceptance, providing an alternative framework to diet and weight loss that is not characterized by shame (Lewis et al., 2011).

The fatosphere is often a space where fat folks are exposed to radical reimaginations of bodies and size. One example of a radical reimagination of fatness is the Health at Every Size model (HAES). The HAES can provide a look into the ways that the fat body can be destigmatized and accepted in fatosphere spaces through the promotion of health improvement

without a focus on weight loss (Webb et al., 2017). This perspective differs from conventional constructions of health and focuses on healthy day-to-day practices and positive self-acceptance. This model challenges understandings of health, specifically in relation to Body Mass Index (BMI). The health at every size model, according to Burgard, "defines health by the process of daily life rather than the outcome of weight" (Burgard, 2009, p 43).

Shifting the discourse of health as intrinsically related to weight to a discourse of health as related to a set of practices is important to fat studies scholars. The language of the "obesity epidemic" and the use of BMI as a measure of health are problematic, and many scholars argue for a shift to a HAES perspective (Bacon & Aphramor, 2011; Burgard, 2009). In their 2016 study, Frederick, Saguy, and Gruys found that exposure to fat rights and a HAES perspective on health resulted in a decrease in the perceived risk of fatness, supporting the argument that a HAES perspective helps to combat weight stigma.

According to Burgard (2009), the HAES approach "differs from a conventional treatment model in its emphasis on self-acceptance and healthy day-to-day practices, regardless of whether a person's weight changes" (p. 42). Challenging societies obsession with thinness is key in this perspective, as the HAES model disentangles weight from health. Bacon and Aphramor (2011), in their article *Weight Science: Evaluating the Evidence for a Paradigm Shift*, call for a model of health that focuses on intuitive eating and promotes reliance on internal body cues: Health at Every Size. This model disentangles weight from health, as the two are not conflated together. The Health at Every Size model instead focuses on creating healthy behaviours instead of promoting weight loss. Bacon and Aphramor (2011) argue that weight-focused paradigms of health do not turn people into thinner or healthier versions of themselves, so adopting a Health at

Every Size perspective provides more benefits than the traditional weight-loss model, shifting from a health management model to one of health promotion.

The Health and Every Size model is not without criticism. For example, as noted by Brady and Gingras (2016), the health at every size model is still rooted in healthism, as it assumes everyone should be working toward this notion of 'good' health. Healthism, they note, means that we are preoccupied with personal health, and that personal health has become a primary way to define well-being (Brady & Gingras, 2016). They are skeptical about the notion of health at every size because it does not contribute to an emancipatory future from healthist discourses. They also argue that the health at every size model overlooks intersections of oppression, like gender, sexuality, and ability. Brady and Gingras (2011) question the commitment of health at every size to social justice, as this model does not question the links between health and morality, and as we discussed earlier, the fat body is often seen as immoral.

Even one of the co-authors of the original article on HAES, Lucy Aphramor, has critique of the article they wrote over 10 years ago. In their 2021 article, Aphramor reflects on the way that the original article by Bacon and Aphramor (2011) has become a go-to "repository of all the biomedical references you need to launch an informed attack on anti-fat healthcare" (Aphramor, 2021). Despite this, she notes that in the original HAES article, she and co-author Lindo Bacon mistakenly led people along the same path that is traditionally used around weight loss, but re-packaged as a new and radical approach (Aphramor, 2021). Despite thinking that they were providing a counter-cultural approach to thinking about fatness and health, Aphramor (2021) reflects that their HAES did not challenge the deeply held belief that health and weight are the responsibility of the individual, since the focus of HAES is still on behaviour change. She also notes that the original article on HAES does not challenge the way Eurocentric values are

presented as neutral and HAES upholds structural oppression and colonial, white supremacist ideals of the body (Aphramor, 2021).

Additionally, the presence of HAES discourses in the fatosphere are not without consequence either. Webb and colleagues note that despite the growing popularity of HAES themed posts on social media, they still portray a specific acceptable fat lifestyle, that of a healthy fat person. In their study of Instagram posts that use #fatspiration, #fatspo, and/or #healthateverysize (or #HAES), Webb et al. found that the underlying messages around fat acceptance differed based on the hashtag. For example, Instagram posts that used #fatspiration or #fatspo often endorsed fat acceptance more than posts using #healthateverysize. Posts that encourage 'fatspiration' typically showed fat folks as unapologetically fat and embracing fatness and fat identity in a way that is consistent with previous research on fat bloggers posting in the Fatosphere (Webb et al., 2017). Posts made using #HAES or #healthateverysize, however, tended to promote a weight neutral approach to fitness and health promotion (Webb et al., 2017), embracing the idea of being fat and fit simultaneously.

Conclusion

The literatures presented in this chapter support the argument that the value, morality, and perceptions around weight are in fact social constructs. Perceptions and understandings around the meaning of certain bodies have varied by time, place, and social groups, and could be dependent on the socio/cultural/historical conditions in which they exist. These perceptions are not neutral; they influence the lives of fat people socially, culturally, and institutionally. For this dissertation, the primary focus is on the health care system. As such, from this literature, I argue that the social construction of body size as an 'obesity epidemic' has resulted in the

medicalization of fat bodies. As demonstrated above, doctors bring with them bias, specifically anti-fat bias, and this effects the care received by fat patients, and this has led me to do research on the specifics of how this bias is acted out.

Chapter 2: Methodology

Introduction

In recognizing that fat is a feminist issue, this dissertation draws on work done by feminist scholars around a sociology for women[1], highlighting the value of understanding the lived experiences of women – specifically, fat women. Dorothy Smith (1987) made the early argument that feminist theorists participate in constructing a sociology for women. The goals of a sociology *for* women, opposed to a sociology *of* women, is one that focuses on the interests of women, centres their experiences, and is emancipatory (Acker et al., 1991). The focus of a sociology for women must see as a priority the eventual end of conditions that oppress women, prioritizing an equitable and free society (Acker et al., 1991). Feminist research, and feminism both in theory and in practice, must then include a commitment to producing knowledge with the goal of improving women's lives (Letherby, 2003), serving this emancipatory function (Acker et al., 1991).

Feminist research cannot lose sight of the fact that women actively construct and interpret the processes that shape their lives. It is important in feminist research to highlight that the personal is indeed political. As such, understanding women's perspectives is paramount to a sociology for women. As Stanley and Wise (1990) note, sociology, and indeed a sociology for women, is not neutral, nor is it impartial. It is the production of knowledge that is located contextually and comes from the people giving voice to such knowledge. Women's research is not conducted in a political vacuum; instead, it is intertwined with the political goals of the

[1] As noted in my recruitment texts (see appendices A and B), when using 'women' as a category, I welcomed all women who wanted to participate in my study, whether they area cis-gendered women, trans women, non-binary but assigned female at birth, etc. My use of the category of women is one that is not rooted in biology, but one that is inclusive and self-selected.

women's movement (Acker et al., 1991), and issues of sexualities, racialization, class, and other forms of marginalization.

Letherby (2003) notes that knowledge in academia has largely held a masculine focus. Women have been ignored in traditional approaches to knowledge and knowledge production, and where they have been included it is typically in relation to men (Letherby, 2003). Women, then, are seen as the 'other' to men (de Beauvoir 1974; Letherby 2003). Men were the dominant group, the model of what was considered 'normal', whereas women represent the 'other', a deviation from men. A feminist sociology then, as DeVault (2004) notes, must go beyond standard topics of inquiry and build more on what we share with respondents as women than what we share with our academic discipline, centering women's experiences in research and in knowledge production.

In this chapter, I explore the methodological approach I took to conducting my research. First, I outline my epistemological approach to creating knowledge about fatness and health care by embracing a constructivist approach, employing the tenets of trustworthiness, and grounding myself in feminist standpoint theory. Next, I examine my own positionality in relation to my research by reflecting on how my research topic came to be and the role I played in data production as a fat, female researcher. I then highlight the steps I took in engaging in fieldwork by discussing my recruitment strategies, the demographics of my participants, and the adoption of interviews and focus groups as data collection methods. I end this chapter by discussing how I analyzed my data and laying out the significant and implications of this dissertation work.

My Epistemological Approach

In this section, I explore how I came to adopt a constructivist approach to creating knowledge. In addition, I look at the tenets of trustworthiness, determining that these are appropriate measures of rigor for my dissertation. I conclude this section by entrenching myself in a feminist standpoint perspective.

Employing a constructivist lens

This dissertation takes up a constructivist approach to undertaking research, recognizing that feminist research embraces the experiences of women and centers these experiences in the research process and analysis. In choosing this epistemological approach, I reviewed the tenets of a positivist and objectivist approach and determined that a subjective, constructionist approach was better suited to my research.

For positivism, there is a focus on objectivity. As Sprague and Kobynowicz (2004) argue, the way we know is not in fact objective. Research does not take place in an unbiased, apolitical vacuum, and is instead expressions of different world views (Sprague & Kobynowicz, 2004). Similarly, objectivism, as Harding (2004) notes, limits attempts at objectivity as it rejects the task of critically identifying the context and history shaping the agendas and results of science, much the same way that context, history, and social processes contribute to the shaping of people's experiences. In contrast to understandings of objective science, as Bhavnani (2004) states, knowledge is a historical production, and as such one of the prevailing challenges against positivism for differing epistemologies, such as feminist theories, is to centre the historical relationship between science and society.

Other academics, such as Hanson (2008; 2015), and Seale (1999) highlight the ways in which objective and subjective are not polar opposites. Hanson (2015) notes that the same arguments made for subjectivity in research can be applied to objectivity as well. The debate

around the two concepts is not philosophical or theoretical, Hanson (2008) argues, but is political. Objectivity and subjectivity, she argues, both derive from the larger question of the place of humans in knowledge legitimation. Both paradigms, she argues, can be seen as aspects of constructivism. This argument is rooted in the idea that humans participate in knowledge making, and this knowledge creation is rooted in philosophy of excluding the role of deity in understandings of the world (Hanson, 2015). As such, both subjectivity and objectivity are part of constructivism, and are parallel concepts instead of opposites (Hanson, 2015). Positivism at its origin, Hanson (2015) argues, was focused on legitimizing human knowledge production. She calls for recognition of subjectivities and objectivities, dependent on one another, instead of a focus on object and subject.

Seale (1999) argues the importance of recognizing the consequences of specific methodological choices for researchers during a study. Similar to Hanson (2015), he argues that it is possible to understand positivist methodology as incorporating an understanding of science as a human construction through the outlining of techniques used to demonstrate truth claims, with openness to falsifiability.

For female sociologists, the relationship between being a working woman and the world is at the centre of their experiences; the same cannot be said for male sociologists. This centering of women's experiences challenges the claim of sociology to objective knowledge, according to Smith (2004). In a socially constructed world, the only way to create knowledge is from within, and this knowledge is subject to the social constructions that inform its creation. Hesse-Biber and colleagues (2004) argue that the nature of knowledge is partial, situated, power laden, and relational, and therefore feminist research cannot maintain the objectivity desired by feminist

empiricism. Instead, they acknowledge the contextual atmosphere in which knowledge is created leads to feminist objectivity (Hesse-Biber et al., 2004).

Employing Rigor in the Research Process

In taking up a constructivist approach, my research does not follow the methodological approaches to objective rigor. One of the key debates in qualitative research addresses the question of whether qualitative research can be as rigorous as its quantitative counterpart. Rigor in qualitative methods differs from that of quantitative methods, as the goals of reliability, validity and generalizability are not necessarily the priority of qualitative researchers. As such, my research takes up Lincoln and Guba's (1986) trustworthiness approach to rigor.

Lincoln (1995) notes that, in discussing rigor, it appears as if scholars are trying to make explicit that qualitative inquiry is not second-rate scientific inquiry. Instead, there is a focus on highlighting emergent criteria to validate the research relationship between researcher and participant (Lincoln, 1995). She argues that through understanding research positionality, we can recognize that research is always partial and incomplete, and that it can never represent the full truth.

In examining ways to ensure that qualitative research is rigorous, Goodwin and Horowitz (2002) address key concerns regarding rigor in qualitative research. They highlight concerns around rigor and the generalizability of findings by qualitative researchers. Goodwin and Horowitz (2002) posit that these concerns are not as problematic as suggested. Despite differences in techniques for research, qualitative research works to capture and represent depth and detail on specific and important social issues (Goodwin & Horowitz, 2002). This type of research, Goodwin and Horowitz (2002) argue, is more conducive to building theory as

qualitative research allows for richness in data. While this data is not always generalizable, it still provides key in-depth analysis and interpretation of prominent social issues, building on the past and filling in the blanks on complicated issues (Goodwin & Horowitz, 2002).

Additionally, Seale (1999) addresses concerns around the issue of validity. Validity, according to Seale (1999), simply means the truth. This, however, does not discount the necessity of qualitative research. Qualitative study allows for the explanation of phenomena based on case studies and specific examples, which provide a broader base of knowledge for understanding social problems (Seale, 1991). Seale (1999) draws on Lincoln and Guba's notions of trustworthiness in qualitative research,

Instead of using tenets of positivism to strengthen generalizability in qualitative research, Guba and Lincoln (1986) suggest the paradigm of trustworthiness, through dimensions of credibility, transferability, dependability, and confirmability (Guba & Lincoln, 1986; Shenton, 2004). Undertaking these strategies in qualitative research allows for similar standards of rigor that are required in quantitative research. The idea is that the four dimensions of trustworthiness parallel the dimensions of conventional scientific research undertaken with a quantitative method (Guba & Lincoln, 1986). As it is intended to parallel scientific standards of rigor, the four dimensions of trustworthiness are offered as qualitative counterparts to their positivistic partners (Guba & Lincoln, 1986; Shenton, 2004). In carrying out my research and analysis, I employed the strategies of trustworthiness: credibility, transferability, dependability, and confirmability.

Credibility addresses the congruence between the researcher's findings and reality (Shenton, 2004). Lincoln and Guba (1986) argue that credibility is one of the most important aspects of ensuring trustworthiness. The use of appropriate research methods as well as employing triangulation of research methods strengthens the credibility of research findings

(Guba & Lincoln, 1986; Shenton, 2004). Transferability addresses the idea that if other researchers believe their context and situation to be similar to the one described in another study, they can relate the findings of the other study to their own position (Shenton, 2004). Therefore, Guba and Lincoln (1986) and Shenton (2004) highlight the responsibility of the researcher to ensure that there is sufficient contextual information about the research process in order to enable another researcher to make an assertion of transferability.

The third dimension in ensuring trustworthiness in qualitative research is dependability. In effort to address dependability, as much information as possible about the research process must be shared (Guba & Lincoln, 1986; Shenton, 2004). Dependability is not concerned with necessarily gaining the same results but allowing another researcher to follow the same process and methods that were conducted in a study (Shenton, 2004). Finally, confirmability occurs when the researcher takes steps to ensure that the findings of their work are the result of the experiences and ideas of the participants, and are not informed by the biases, characteristics, or preferences of the researcher (Shenton, 2004).

Qualitative methods provide a unique opportunity to uncover in-depth analysis of social phenomena that is not available through the use of quantitative methods. Using qualitative methods allows for the production of critical scholarship. As Kobayashi (2001) argued, critical scholarship provides the opportunity to understand social consequences of the phenomena being studied and allows researchers to uncover what tensions and contradictions exist for the people involved in the research process. Viewing qualitative methods through a critical lens, she argues, provides the space for challenging dominant viewpoints and analyzing what contradictions contribute to increasing social inequalities and marginalization. Kobayshi (2001) notes that using feminist methods, more specifically, allows for discussion to go beyond a contextual

understanding and instead provides the opportunity for critical research. This contributes to, what she refers to as, the "potentially transformative nature of qualitative research" (p. 4).

Feminist Standpoint Epistemology

This dissertation is methodologically rooted in feminist standpoint epistemology, which places women at the centre of the research project (Brooks 2007; Hartsock, 1983; Haraway, 1988; Letherby, 2003). For feminist standpoint epistemology, women's experiences are the starting point in which all knowledge is built. Brooks (2007) highlights how women are key to research because they have what is called 'double consciousness' (taking up this concept from DuBois, 2004), which means that they are aware of their own lives, but also the lives of the dominant group – in this case, men – as well, and therefore provide a crucial starting point for knowledge production. This type of research, Letherby (2003) notes, employs the use of reflexivity and a recognition of the ways in which the personal is political.

Dorothy Smith (1987), a key feminist academic in the area of standpoint theory, proposes a sociology from the standpoint of women, one that challenges the dominant standpoint of men as central location for research. From this perspective, even the very beginning of a research process – the identification of a research question – is rooted in women's lives and experiences (Hesse-Biber et al., 2004). Women are the starting point for knowledge and their knowledge is valued. Women hold a unique position in knowledge creation because they are connected to their lives as oppressed women, but they also understand and are intertwined with the dominant lives of men (Hesse-Biber et al., 2004). Starting from the standpoint of women, according to Smith (1987), does not universalize a particular experience, but allows for researchers to fill in the actual experiences of women speaking from the actualities of their everyday lives. Women, then,

are embodied, active subjects in the research process (Smith, 1987). This type of research, Brooks (2007) argues is objective – or employs 'strong objectivity' – as the representations of reality from women themselves are more unbiased and objective than other representations, which often, as also discussed in Letherby (2003), represent the standpoint of men.

The research that I engaged in for this dissertation is strongly rooted in feminist standpoint theory. The very creation of my research question and my project emerged out of my own negative experiences with the health care system and my participation in online fat-positive communities, where women repeatedly ask for advice on seeking a body positive doctor. Here, women discuss their negative experiences with the health care system, specifically their primary care doctors, and ask for other women to share their experiences with their own doctors. The goal here is to create a list of fat positive, or at least not fat-shaming, doctors around the greater Toronto area, accessible to those in the online community (in this case, different Facebook groups). Seeing these experiences, coupled with my own, inspired, motivated, and validated my drive for this project, coupled with the lack of qualitative research specifically on the experiences of fat women with health care. While I focus on women in this dissertation, it is important to recognize that not all women are the same, and that there is not one experience shared by all women.

Problematizing the Universal Category of 'Woman'

Reinharz (1992) argues that feminist research must recognize the plurality of women, that there are women's ways of knowing, opposed to a singular woman's voice. Early feminist research failed to account for the diversity of women themselves and women's experiences (Collins, 2000; Crenshaw, 1991; Hesse Biber & Yaiser, 2004; Letherby, 2003). In response,

feminists such as Collins (2000) and Crenshaw (1991), among others, began writing and researching marginalized women's lives, problematizing the universal, essentialized category of 'woman'.

Is there a universal, shared experience of subjugated women? Crenshaw (1991) highlights that often discussions of identity politics ignore intra group differences, assuming a universality of experiences. This contributes to tensions inside groups, for example with the category of women. Racialized women, poor women, women of different sexual or gender orientations, likely have different understandings of what it means to be a woman then, for example, a middle-class white woman. Crenshaw (1991) argues that race and gender cannot be separated from each other; the experiences facing women of colour are often the product of the intersection of racism and sexism.

Extending Crenshaw (1991) and Collins' (2000) critique of a universalized 'woman's' experience, there is similarly no universal 'fat' experience. Fat women experience their bodies differently, as their fatness intersects with other markers of identity such as body size, race, socio-economic status, sexuality, ability, and gender identity (Pausé, 2014; Rothblum, 2012; Wykes, 2016). As Wykes (2016) notes, the regulation of fat bodies is used as a way of maintaining and supporting other forms of oppression. As such, the data produced from the interviews I conducted do not put forward simply one narrative, but multiple narratives. It is clear from the interviews that experiences living in a fat body are not universal, but varied and complex. My participants vary in age, race, and even in size/fatness (in the fat community, there is much debate around the concept of 'fat', embracing terms like 'small fat' or 'super fat' to denote how fat a person is, and many of my participants use this language in their interviews).

As such, this dissertation takes up Collins' (2000) understanding of the importance of intersectional feminist theory. She, like Crenshaw (1991), calls for an understanding of the oppression faced by different women, whether by race, class, gender. She also critiques feminist theorists that focus on a universal woman, which predominantly focuses on the issues of white women. But importantly, what she highlights is a call for recognition of research and knowledge done by oppressed women, and a recognition of the validity of their knowledge.

Knowledge Creation

Intersectionality is not just the accounting for of race and gender, but also the creation of knowledge by oppressed groups. Specifically, Collins (2000) discusses the rich history of Black women intellectuals and how they have laid the foundation of a strong African American women's intellectual tradition. She argues that by suppressing the knowledge created by oppressed groups, the dominant group continues to rule as it looks like the subordinate group is not dissenting their victimization. This, however, is inaccurate as there is a plethora of knowledge created by women in oppressed groups, as Collins (2000) indicates. What she is arguing for here is social theory that is created by women in oppressed conditions, so that social theory will reflect the lived experiences of women with intersecting oppressions.

This notion of creating social theory from the experiences of oppressed groups impacts the creation of scholarship. In terms of creating scholarship, Collins (1991), drawing on the position of Black feminist scholars, notes that these types of researchers are considered an 'outsider within'. For her, Black feminists are inside the feminist movement, but outside the scope of the universal woman, which tends to represent middle class white women. With this outsider within status, Collins (1991) argues that Black feminist scholars offer a distinct

intellectual position, and a standpoint with much to contribute to understanding marginalization, through Black feminist thought. Black feminist thought, according to Collins (1991) relies on clarifying the standpoint of and for black women and focuses on the interlocking nature of oppression.

Fat scholarship then, I would argue, is in a similar position in terms of creating new knowledge around weight, fatness, and 'obesity'. In Chapter 1, when establishing the discipline of fat studies, I noted that Solovay and Rothblum (2009) describe fat studies as "an interdisciplinary field of scholarship marked by an aggressive, consistent, rigorous critique of the negative assumptions, stereotypes and stigma placed on fat and the fat body" (p. 2). Fat studies as a field of scholarship focuses on critiquing power ridden and prejudicial assumptions around weight and body size (Wann, 2009) and is often responding to the moral panic around 'obesity' fueled by the medical sciences (Gard and Wright, 2005).

Medical and health research often promotes the dominant discourse of the 'obesity epidemic' and, as pointed out in Chapter 1, the idea that fat is dangerous to your health and can kill you, being thin is better for your health, and getting thin will deal with the problems associated with fatness (Campos, 2004). Campos (2004) tells us that the medical industry has built obesity as a problem on mistaken assumptions, however these assumptions about weight support the multi-billion-dollar industry that has been created around weight, and this industry is not deterred by flimsy science. What is interesting to note here is that Campos (2004) highlights how drug and pharmaceutical companies fund much of the production of obesity research, and the conferences on the obesity epidemic. Further, Lyons (2009) highlights the relationship between researchers and physicians that influence the supposed war on obesity, that she dubiously names "Obesity Inc.". The typical approach for researchers and physicians, she argues,

is to upsell apparent problems associated with fatness and downplay the ineffectiveness of treatments they are selling. This is problematic as these researchers and physicians hold power in informing public health and public policy (Lyons, 2009). Equally problematic is that the diet and weight loss industries, specifically drug and pharmaceutical companies, fund the research on health that is propping up claims of an obesity epidemic (Lyons, 2009). This further exacerbates the moral panic around the obesity epidemic as the drug and pharmaceutical companies stand to gain from the war on obesity, as they make billions of dollars a year on the sale of weight loss products. The war on obesity, Lyons (2009) concludes, is about profit, masked as health concern.

If the medical industry and pharmaceutical companies produce the dominant discourse around weight (specifically, the discourse of the 'obesity epidemic'), then fat studies exists to combat these dominant discourses, aiming to challenge the pathologization, mistreatment, and abuse of fat people, who arguably exist as a marginalized group (Gard and Wright, 2005). Fat scholarship then, like Collins' (1991) argument about Black scholarship, relies on the knowledge and experiences of fat women, who exist in this category of 'oppressed group', or as Collins (1991) notes, 'outsiders within'. I, as a fat scholar creating scholarship on fatness, am an outsider to the dominant group creating knowledge on weight but bring with me my experiences of weight-based marginalization and oppression to my research.

Reflexivity: Positioning myself in relation to the research

Adopting feminist standpoint epistemology led to the use of a feminist framework in the undertaking of this research process. Hesse-Biber and colleagues (2004) argue that the importance of a feminist framework is the way in which women's experiences can be highlighted. Feminist research, they argue, takes a critical approach to traditional knowledge

claims regarding the idea of a universal truth, and instead focuses on difference, social power, resisting traditional scientific knowledge and oppression, while committing to emancipatory actions of political activism and social justice for women. Challenging the notion of universal truth, Hesse-Biber and colleagues (2004) recognize the importance of multiple truths, and therefore multiple feminisms.

There are many expectations by feminist academics with respect to the requirements of research to be truly feminist. Feminist research, according to Letherby (2003) must: be reflexive with respect to gender; challenge objectivity; recognize the value of the personal as a form of knowledge; use non-exploitive research relationships; and place value on emotion and reflexivity as a source of knowledge. Similarly, Harding (2004) argues that feminist methods must: use women's experiences; construct a social science for women; and explicitly locate the researcher's positionality. Feminist methodology, DeVault (1996) notes, is distinctive from other social science methods in that it shifts the concern from primarily androcentric to concerns that highlight the locations of women (DeVault, 1996). Additionally, as DeVault (1996) notes, feminist research seeks to minimize the harm to women throughout the research process, like Letherby's (2003) notion that feminist research must be non-exploitive; and similar to Harding (2004), must support research of value to women and contribute to change and action (DeVault 2004). Essentially, feminist research must be for women, non-exploitive, and emancipatory.

Reflexivity is key to a feminist framework in qualitative research. Hsiung (2008) describes reflexivity as a process by which the researcher examines how her own experiences, perspective, emotions, and social location influence her research. From this perspective, Hsiung (2008) sees the researcher not as a neutral party, but as an active participant in knowledge creation. By examining the role of the researcher as an active participant in the research process,

Hsiung (2008) notes we understand how qualitative methods are interactive and result in the co-construction of knowledge.

In doing feminist research, Letherby (2000) argues that we must provide the reader with 'accountable knowledge', so they have the information to critically assess the context of the research presented, locating the researcher as part of the process. Similarly, Clandin and Connelly (2000) argue that experience should be the starting point of all inquiry in the social sciences. Further, Kreiger (1985) highlights the need for researchers to understand not only their data, but to also understand their own experiences as part of the community under study. In understanding my role as a fat woman doing research on other fat women, I explored the way my position in the community makes me an 'insider'.

Insider status

Doing research on a social group in which the researcher is a member poses special challenges to the research process. As fat woman studying the experiences of other fat women, this was a methodological challenge I faced throughout the research process.

Asselin (2003) examines some of the key issues around conducting qualitative research in a setting in which the researcher belongs. This insider research, where the researcher is a member of the community being studied, can result in the researcher bringing with her certain biases and issues that challenge the trustworthiness of the research (Asselin, 2003). Asselin (2003) argues that the researcher can bring with her understandings about the culture she is studying, such as taken for granted assumptions, or a belief that she knows the culture of the community. To counter this, Asselin (2003) suggests it is best for the researcher to assume nothing. Asselin (2003) highlights how, with insider research, role confusion may occur. This

confusion occurs when the researcher responds to or analyzes data from a perspective other than that of researcher. Similarly, Asselin (2003) highlights issues around objectivity, as the researcher may have expectations of what experiences their participants may have. Continual self-reflection, she argues, can help address this issue.

Further, Letherby (2000) outlines some of the risks associated with doing research where the researcher is an insider to the problem. Focusing on the incorporation of the self into research, Letherby (2000) argues that the self is always present throughout the research process and cannot be separated out. This influences the choice of the research topic, the theoretical perspective adopted, and the interpretation and presentation of the findings. While recognizing the way in which our participant's knowledge is situated contextually in different structures and discourses, it is also important to recognize that as researchers we are also situated in the social (Letherby, 2000).

In conducting research with other fat women, I am certainly an insider to this community. I cannot hide either my body size or gender presentation – I am a visibly super fat woman – and as Asselin (2003) notes, I may bring with me my biases and issues, which could pose a problem to the trustworthiness of my research. In efforts to combat this, Asselin (2004) suggests that as a researcher studying her own community, the researcher should assume to know nothing. Letherby (2000) notes though that the researcher is always present in the research process and cannot be separated out. She argues that it is important not just to understand the context and location of the participants, but of the researcher as well (Letherby, 2000). This succinctly describes the situation in which I found myself. Separating myself out, as Asselin (2004) suggests, was very difficult in practice; I could not separate myself and my experiences from the discussions I was having with participants. I found however that sharing my experiences with

participants opened them up to a more thorough discussion about their own experiences. It created a space where we co-constructed our knowledge of problems within the health care system by drawing on and sharing our individual experiences.

Auto/Biography

In understanding that I cannot separate my experiences as a fat woman from my research on fat women, I explored the methodological approach of auto/biography to incorporate my experiences into the research process and understand my experiences as data, in addition to my participants. Letherby (2000) argues for the importance of doing auto/biographical research in feminist theory as this form of research recognizes the emotional and personal involvement of the researcher to the process. Stanley (1993) describes auto/biography as challenging the binary assumptions of self/other, subject/object, and public/private by disputing the distinction between biography and autobiography. Using reflexivity, from this perspective, requires an understanding of the self as a subject of intellectual inquiry (Stanley, 1993).

Stanley (1993) highlights the use of the 'auto/biographical I' in doing sociological research. According to Stanley (1993), the auto/biographical 'I' is a sociologist who is concerned with constructing, opposed to discovering, sociological knowledge and social reality. By using 'I', the researcher is recognizing that sociological knowledge, according to Stanley (1993), is situated, contextual, and specific, and can come out of personal experience. The use of the auto/biographical 'I' allows sociologists to analytically account for their own intellectual product through examining the labour process of doing research and recognizing that knowledge is related to the location of the knowledge producer (Stanley, 1993). Essentially, as noted previously in the importance of feminist research, the researcher cannot be disentangled from the

research process. Auto/biographical writing, as Letherby (2003) notes, is the use of the researcher's experiences as data.

This process of auto/biography was inescapable in my research. Throughout the interview process, I found that my interviews were more of a guided discussion then a formal interview, in that my participants and I both shared our experiences with each other. We laughed together, in some instances we cried together, but ultimately, we bonded over our shared experiences of fatness (inside and outside the health care field) and the trauma that can come from living in a fat body. I could not and would not want to separate myself from this research. My interest in this research project stems out of experiences I have had as a fat woman in the health care system, and these experiences have produced trauma that is re-visited each time I interview a participant.

Reflecting on the onset of my project, I did not anticipate how emotionally draining it would be to hear the negative experiences of my participants time and time again. I often found myself leaving my interviews upset and angry, and I found myself carrying with me the experiences of my participants into my own interactions with the health care system. I frequently find myself explaining to doctors what research I am conducting, and sometimes sharing with them troubling stories I have heard from my participants (without any identifying information).

In conducting this research and carrying out the analysis, I adopted an auto/biographical approach, in efforts to understand my experiences as a part of the research process and to provide what Letherby (2000) referred to as 'accountable knowledge'. Distancing myself from this research would have been impossible, if not for the only reason that I have no option but to 'come out' to participants as fat, as fatness is a visible marker (see the previous discussion around hyper(in)visibility from Gailey 2014). Accounting for my experiences, however, provides space for accurately contextualizing my research and ensuring that my position as researcher is

adequately represented. Both through the interview process and self-reflection, I have incorporated my experiences as data.

Conducting Field Work

The following section explores the way I undertook research for this dissertation. It outlines my recruitment strategies and the effectiveness of these approaches, as well as the demographic information of the participants that I recruited. I conclude this section by discussing my use of interviews and focus groups to collect data and exploring the challenges that came with both of these methods.

Recruitment and the Operationalization of Fatness

Recruiting fat participants for my research posed the question: what constitutes fatness? Operationalizing fatness in fat studies research is difficult, as conceptualizations of fatness vary in fat studies as a discipline, and to the individual fat person. There are a few different approaches I thought through in effort to operationalize fatness in my research: the BMI scale, plus size clothing sizes, and self-identification.

The use of the BMI scale to identify fatness is rooted in a problematic biomedical model of health that is critically challenged in fat studies research (Campos, 2004; Flegal et al., 2005; Flegal et al., 20013; LeBesco, 2004; Gard & Wright, 2005). As such, I immediately chose not to use the BMI categories of 'overweight' or 'obese' in identifying fat participants.

Similarly, using plus sized clothing is problematic as the sizes associated with 'plus size' have been shrinking. By this, I mean that smaller sizes on the clothing scale (such as sizes 10-14), have come to share the 'plus size' label, with clothes that range up to a size 32 in many plus

size stores. As such, adopting the language of 'plus size' to recruit participants was not something I was comfortable with.

Ultimately, I chose to use self-identification as a means of recruiting fat participants to my project. In recruiting fat women for both focus groups and individual interviews, I created two posters that I posted as an image on Facebook (in fat positive Facebook groups) and postered around the city at TTC stops. I also posted flyers on Craigslist and Kijiji and relied on snowball sampling using friends and previous participants as informants.

In employing self-identification to recruit participants for interviews, I put the following text on my posters (virtually identical text, switching interview for focus group, was used for the second poster – See Appendix B: Recruitment Focus Group Poster).

> Do you identify as fat?
>
> Have you been told you are 'overweight', 'obese', or 'fat' by health care professionals?
>
> I am looking for fat identified, female identified participants who are interested in taking part in an interview to discuss weight, fatness, and health care. You are invited to share your experiences of interacting with the health care system, specifically with primary care doctors, with the researcher, who is also a fat-identified woman. (See Appendix A: Recruitment Interview Poster)

While I relied on self-identification of individuals in identifying as fat, I provided the language of 'overweight' and 'obese', specifically in reference to health care providers, to try to target the population of women I was aiming to study. Not all fat women identify using the term fat, they may simply use the medical language ascribed by their doctors to understand their body size, but I was still interested in recruiting them. I hoped that in providing multiple ways of

describing body size, I would capture a wide array of participants. Ultimately, most of my participants were recruited through Facebook and snowball sampling. I interviewed 30 women and held two focus groups (one with two women, one with three women), talking to a total of 35 fat-identified women.

Pseudonyms of Research Participants

In doing this research, all participants were given a pseudonym. To assign pseudonyms, I went to an online list of names and chose a name from each letter of the alphabet in effort to avoid similar sounding pseudonyms and help keep the reader on track. The only exception here was that one participant specifically requested I give them a South Asian pseudonym, so they provided me a name to use. Below is a list of the pseudonyms of the folks whose stories you will hear throughout this dissertation:

Amelia	Imogen	Paula	Xia	Faith
Brenda	Jane	Rachel	Yasmin	Gina
Cheryl	Karen	Sabrina	Zoe	Mia
Danielle	Laurel	Tanya	Ariel	Krista
Emma	Madison	Ursula	Brielle	Ajooni
Gillian	Natalie	Victoria	Kristina	Lisa
Hannah	Olivia	Wendy	Demi	Charlotte

Reflecting on Recruitment

Drawing back on the previous discussion of auto/biographical research, I thought it was important to make clear to my participants that I myself am a fat woman. Personally, I would be frustrated as a fat woman to do an interview about my body size with a researcher that did not identify as fat, as I would be less comfortable sharing my experiences with someone who I did not think could relate or understand on a personal level. Indicating to my participants that that I

am an insider to their community, a fat woman, was an important part of my research design as I believe it gave me credibility to speak about fat issues.

One aspect of insider status that I did not account for until after my interviews were completed is my status as a woman, doing research on women specifically. Prior to conducting my research, I had not accounted for how my womanness is an aspect of insider status, and the impact that had on what data came out of my interviews. Reflecting on the impact of my gender on my interviews, I can see how this allowed for a space where my participants could feel more comfortable talking about the gendered nature of their bodies; for example, in many interviews our discussions veered towards sex and sexuality and the interplay between body size and their sex lives.

Similarly, I did not account for my 'outsider' status, in that prior to conducting my research, I did not think through the way my whiteness and my cis privilege might impact who felt comfortable participating in my study. While there were a few non-white and non-cisgendered folks in my study, it would be reasonable to assume that folks may not have felt comfortable talking to a white, cis woman about their experiences in their fat and marginalized bodies the same way that I would not feel comfortable talking to a thin researcher about my fat body. I assumed going into this research that I was an insider in this community, without recognizing the nuance of my own identity and how that could still position me as an outsider to folks inside the fat community. I reflect further on the need for more research on race, fatness, and health care in the final chapter of this dissertation.

Recruitment Troubles: Studying Elites

In addition to interviewing fat women, I had originally set out to talk to primary care doctors as well. As such, I briefly explored literature about studying elites, as studying elites poses different challenges than studying those affected by fatness. Odendahl and Shaw (2002) acknowledge that social sciences frequently reference the elite, but often the elite are studied less frequently, as researchers opt to study people without influence who are affected by the powerful. 'Elite', according to Odendahl and Shaw (2002), is typically linked to people with power and privilege. This can apply to those who are considered 'professional elites', such as scientists and physicians. In terms of studying fatness and the 'obesity' epidemic, these professional elites have great impact on conceptualizing fatness and 'obesity' as problematic.

Interviewing the elite allows for a perspective in social science that focuses on power and access that is not achievable from studying only those without power (Odendahl & Shaw, 2002). However, interviewing elites is not without challenges. For example, accessing professional elites who are willing to discuss social problems with the researcher is difficult. This certainly was a challenge I faced in conducting my research, and ultimately did not overcome.

In conceptualizing how to approach interviewing doctors, I considered circulating a recruitment ad at different medical practices, posting an ad on Facebook or other social media sites where there are physician specific groups, and snowball sampling after obtaining one or two participants. I wanted to speak to doctors who have been identified as 'fat positive' (or even 'not horrible') to discuss how they are able to practice that perspective in the face of a fatphobic medical system. Ultimately, I decided the best way to figure out who to recruit was to comb through fat positive Facebook groups, focused on the GTA, and list all the doctors that were suggested. This produced a list of 22 doctors, of which I hoped to interview 10. I reached out via email and phone and did not hear back from any of the doctors I contacted. This proved to be a

difficult set back. In consultation with my supervisor, Dr. Hanson, I decided to move forward without interviewing doctors and instead focus on the experiences of fat women. Instead of interviewing 10 doctors, I proceeded to interview an additional 10 women (changing my goal of 20 women interviews to 30).

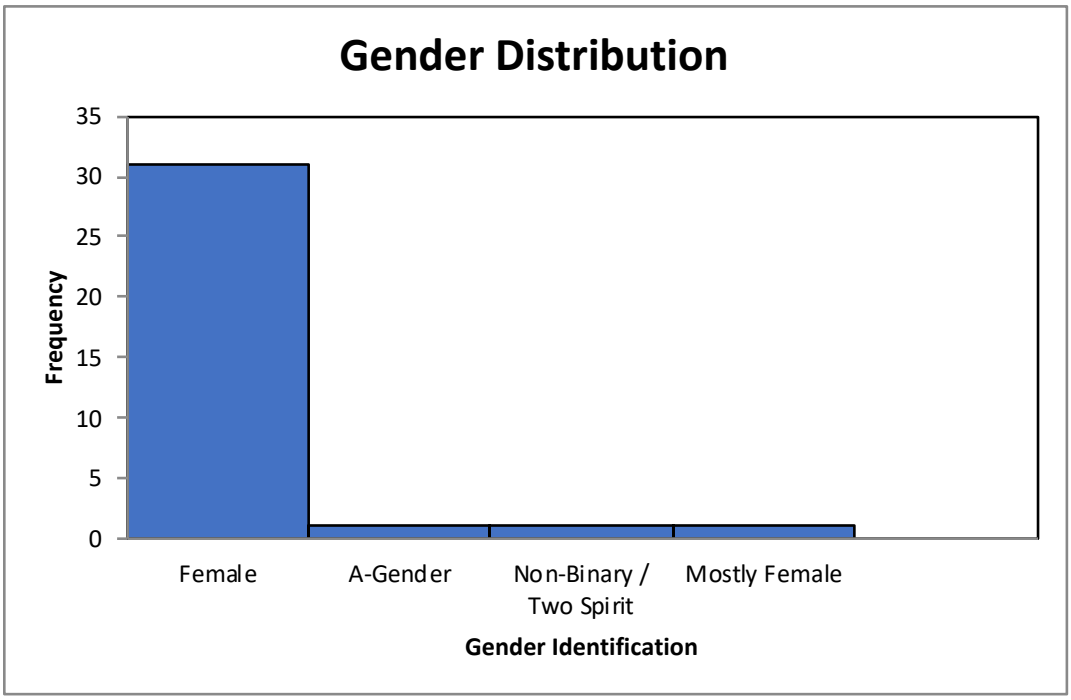
Participant information: A snapshot of my sample

In conducting this research, I spoke with 35 women. In the case of one participant, they did not fill out the demographic form prior to the interview, so the following demographic information reflects 34 of 35 participants. The following demographic information comes from participant's voluntary answers to Appendix C: Demographic Survey, that was administered prior to the start of each interview.

Not all my participants identified as cisgender women; there were varying gender identifications. Figure 2.1 shows the distribution of gender identities in my sample. In my sample, 91% of my participants (31/34) identify as female, 3% (1/34) identify as a-gender, 3% (1/34) identify as non-binary/two spirit, and 3% (1/34) identify as 'mostly female'.

Figure 2.1

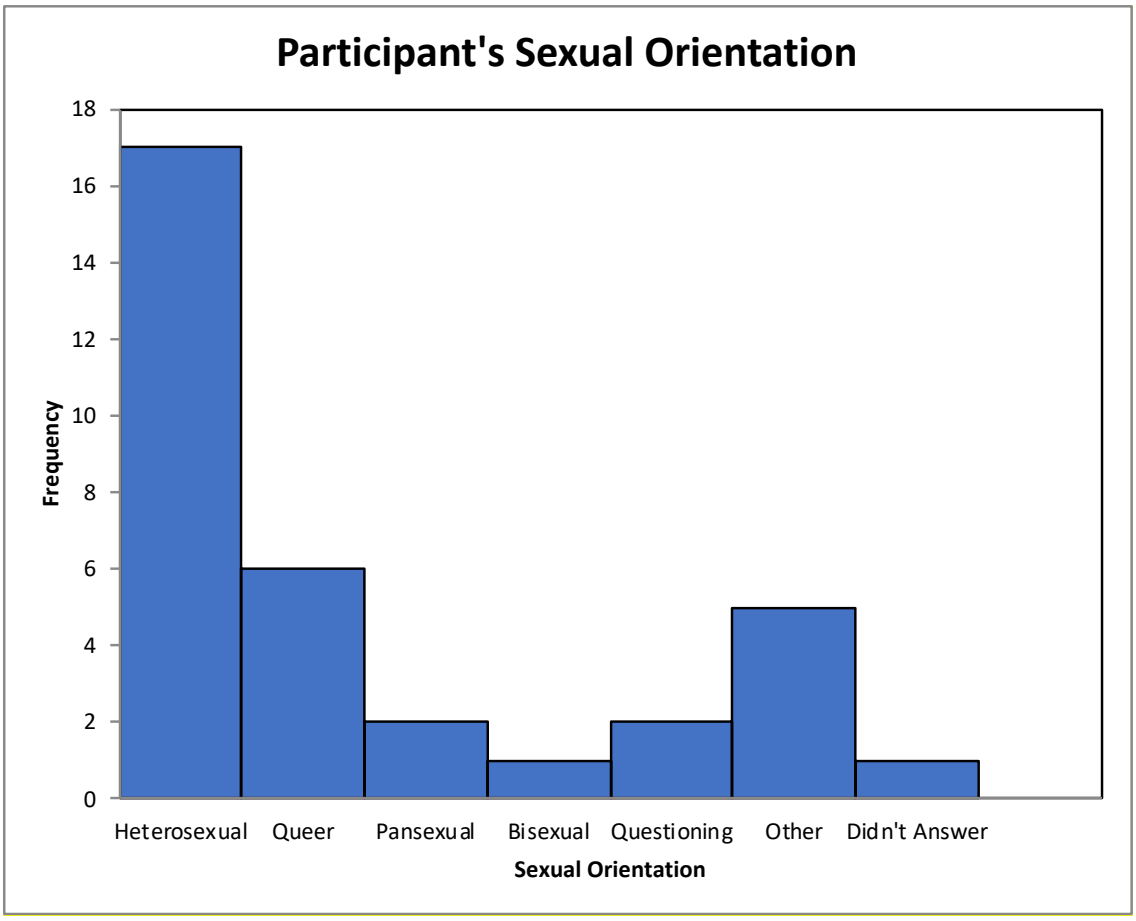
Distribution of Participant's Gender Identity



Additionally, my sample of participants spanned a variety of sexual orientations (see Figure 2.2 below). Half of my participants (17/34) identify as heterosexual, 18% (6/34) participants identify as queer, 6% identify as pansexual (2/34), 6% (2/34) identify as questioning, 3% (1/34) identify as bisexual, and 3% (1/34) did not answer the question. The remaining 14% (5/34) provided an answer that I categorized as 'other'. In this category, people provided mixed or multiple answers. The following answers provided by participants were categorized as 'other', as they did not fit into the other established categories: bisexual/pansexual; straight/bisexual; queer/bisexual; queer/two-spirit; and married to her husband.

Figure 2.2

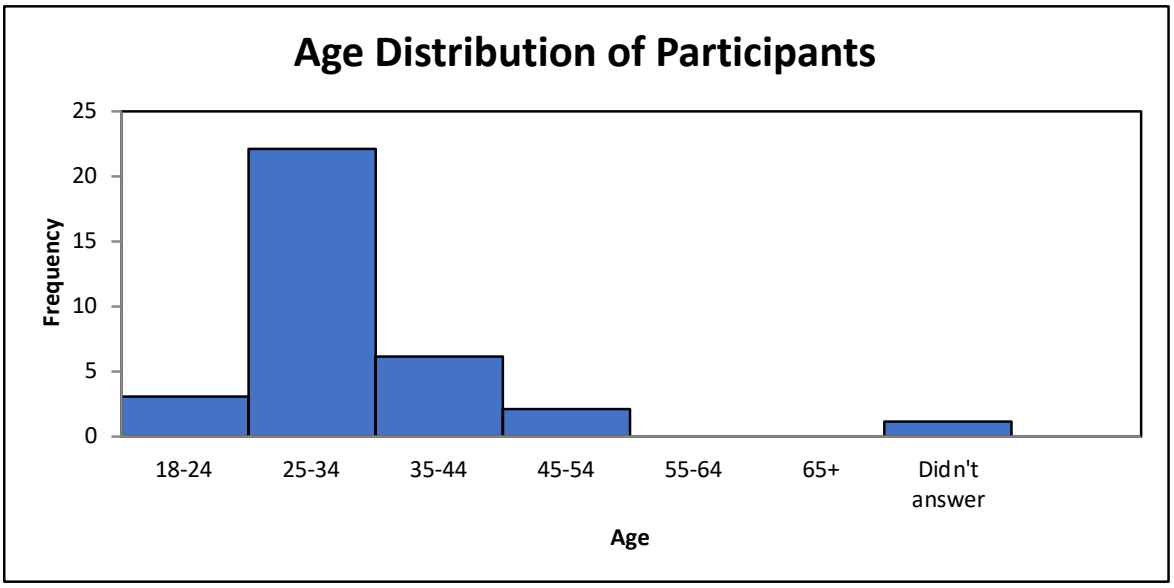
Distribution of Participant's Sexual Orientation



My participants vary in age (Figure 2.3) and ethnic identification (Figure 2.4). The majority of my participants (65% or 22/34) were between the ages of 25-34, 9% of participants (3/34) were between the ages of 18-24, 18% (6/34) were between the ages of 35-44, 6% (2/4) were between the ages of 45-54, and 3% (1/34) did not answer the question. I did not have any participants over the age of 55.

Figure 2.3

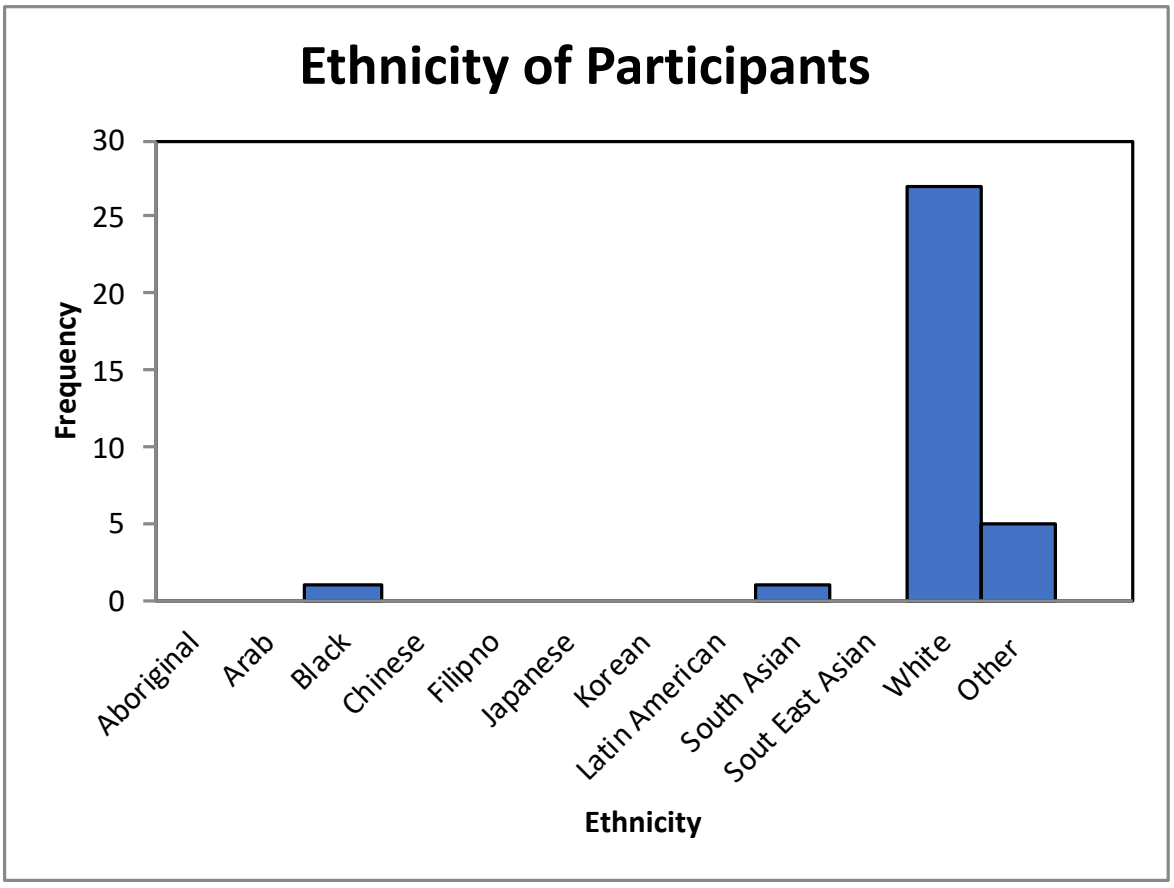
Age Distribution of Participants



In asking the ethnicity of participants, I used the ethnicity categories employed by Statistics Canada on the census. These categories can be seen in full in Appendix C: Demographic Survey and have been truncated in Figure 2.4. In hindsight, if I were to create this form again, I would have left ethnicity blank and allowed participants to write in their answer, like how I asked about gender and sexual orientation. My sample was overwhelmingly White (80% or 27/34 participants); 3% (1/34) participants indicated their ethnicity as Black, and 3% (1/34) identified as South Asian, and the remaining 14% (5/34) identified as 'Other'. Similar to the breakdown of sexual orientation, the 'other' category here contains participants who either wrote in their answer or chose multiple answers. The identifications under the category of 'other' contained the following responses: mixed ethnicity; Portuguese; bi-racial South Asian and White; Aboriginal, Black, and White; and unknown ethnicity.

Figure 2.4

Ethnicity of Participants

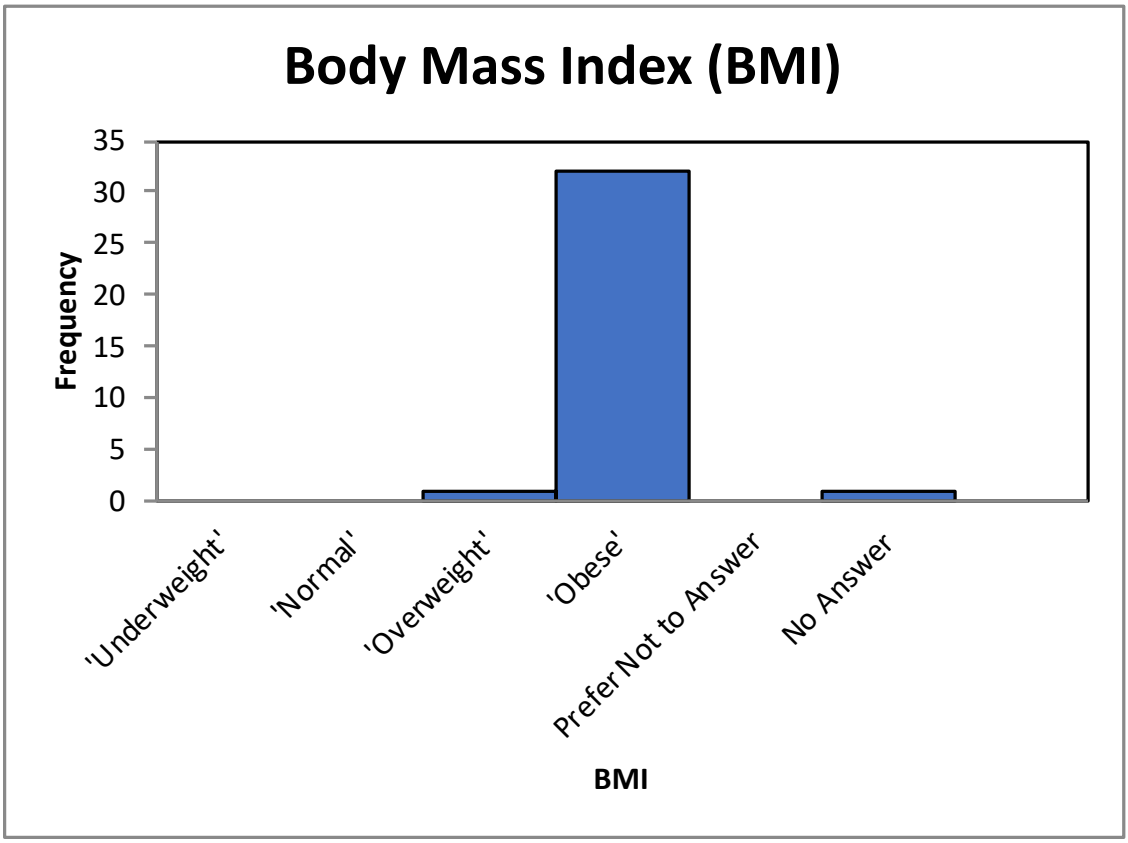


The final piece of demographic information I collected addressed participant's BMI (see Figure 2.5). For this, I asked participants to indicate how their body mass would be described, based on the medical model of BMI, and provided them the categories used by the BMI to describe body size ('underweight', 'normal', 'overweight', and 'obese'). Unsurprisingly, 94% (32/34) of participants indicated their bodies would be described as 'obese'. One participant (3%) indicated their body would be described as 'overweight', and one participant (3%) chose not to answer the question, instead they indicated they do not calculate their BMI. I debated whether or not to ask this question at all in the survey, as the calculation of BMI and its

subsequent use in health care is incredibly problematic; however, I felt that it was useful information in understanding how the folks in my sample would be categorized by their health care professionals and I thought they may be more comfortable indicating that indirectly on a survey opposed to being asked that question in our interviews.

Figure 2.5

Participant's BMI



Using Interview Methods in Feminist Sociological Research

Early interview methods in social science research were rooted in scientific assumptions of uniformity and objectivity. Using a specific question-response method, the technical interview

focused on repetition and generalizability. Standardizing interviews in effort to create generalizable results has failed, according to Mishler (1991). The results of these efforts to standardize have meant that researchers are avoiding the central issues of context, meaning, and discourse. As such, the standard interview method of question-response has failed and does not serve its methodological value.

In contrast, Mishler (1991) argues the need to examine the assumptions and implications of how interviewing as a method has come to be defined. Many standard definitions of interviewing, he argues, are too technically focused and obscure the central issue of discourse. These definitions, according to Mishler (1991), assume a focus on behaviour rather than language, while excluding the recognition of how talk is situationally and culturally relevant. Using technical definitions of the interview, Mishler (1991) argues, negates the relationship between discourse and meaning that emerge from interviews, by relying on a question-response pattern of interviewing. Survey research then strips the interview of its context by focusing on a question-response method (Mishler, 1991). The application of this method assumes cross-cultural and trans historical context of the interviewee, which is one of Mishler's (1991) main criticism of the technical interview.

In effort to address this criticism, Mishler (1991) focuses on the importance of understanding interviews as a speech event. This, he highlights, requires understanding the social relationships in creating speech, such as the relationship between the researcher and research participant. It is important, Mishler (1991) argues, to remember that the actual speech of the interview is what is important to study, the transcript is not the object of study. Similarly, according to deMarris and colleagues (2003), interviews are a space where the researcher and

participant co-construct data for a specific project. This data provides authentic interactions with the realities of the lives of participants.

In using interviews as a research tool in feminist research, it is important to recognize the relationship between the researcher and the participant. According to Smith (1987), the relationship between knower and the object of knowledge is a social construction. Knowledge itself, she argues, is a social accomplishment created through social relations between researcher and researched. A sociology for women understands that the subject of study is both the knower and an actor, not a woman transformed into an object of study but a woman with active presence (Smith, 1987). Smith (1987) argues that discourse is a primary medium through which society is mediated. Women, she notes, have historically been excluded from the production of such discourse, resulting in the standpoint of men to be recognized as universal. By documenting women's lived experiences, we can use feminist research to challenge ideologies, structures, policies, and conditions that oppress women (Hesse-Biber & Leavy, 2007). Through this documentation, we can aim to empower and emancipate women.

Mishler (1991) notes that both the researcher and the participant jointly construct the discourse produced through the interview. This was certainly the case in the interviews I conducted. Using individual interviews allowed me the opportunity to go in-depth with my participants and, as Mishler (1991) notes, co-construct the discourse produced by the interview.

In conducting individual interviews, I employed a feminist approach, similarly to that identified by Anderson and Jack (1991). In their work, they talk about how feminist interviewing is like oral history. The use of oral history, as noted in Anderson and Jack (1991), allows for the refining of methods used to probe into women's experiences through listening to the different levels of their responses. Minister (1991) argues that feminist oral history is the kind of

interviewing that is intuitive for women interviewing other women. This technique encourages the researcher to account for the pauses, discomfort, reluctance, and unwillingness of the respondent to address certain questions. By exploring the language and the meaning women use in describing their personal experiences, Anderson and Jack (1991) argue this will highlight the conflicting social factors affecting women's lives. Key to this is remembering that the researcher herself is an active participant in the discussion.

As discussed several times in this chapter, I was embedded in the research project start to finish, including the interview portion. I would describe my interviews as being more of a structured but open discussion, in which I was an active participant, opposed to a discussion where I simply asked the participant a question and did not actively participate. When I set out to do my interviews, I had this assumption that I would be able to have some distance from my interviews and that I would be able to, as Asselin (2003) suggest, assume nothing, and not take my biases or personal history with me into the interview. This was an incredibly naive assumption on my part, and it was very clear after the first interview that I would be embracing more of an auto/biographical approach (Letherby, 2000) and employing interview techniques more consistent with oral history (Jack and Anderson, 1991), opposed to traditional approaches to interviewing. Ultimately, I found this approach strengthened the data I got from my participant interviews. For the most part, my participants and I were able to build off of each other's experiences, which I believe created a space where my participants could feel more comfortable to be vulnerable and share their histories.

While I tried to make sure my participants were comfortable throughout the research project, there were a few interview situations where I myself did not feel comfortable. In a handful of interviews, when I met the participant, they were not what *I* would consider 'fat',

even though they categorized themselves this way. For these participants, weight loss and dieting were key to their health care journey in a way that was different from my other participants. Where, for most of my participants, weight loss and dieting were harmful, these participants celebrated their weight loss journeys and the extreme ways they achieved weight loss. They had previously been 'obese' but would not qualify as 'obese' anymore. I struggled with these interviews, both as a researcher and a fat woman. As a researcher, I was hesitant to include voices of participants who are not 'fat'; this was an easy hesitation to overcome, as these women had previous experiences of fatness and health care that were incredibly useful to this research project. As a larger fat woman ('super fat'), this was more difficult to overcome. While I was able to put aside my feelings during the interviews, extensive diet and weight loss talk is incredibly difficult for me and brings up a lot of negative emotion. These feelings were easier to deal with when my participants also shared that perspective but listening to some participants celebrate weight loss and extreme dieting was sometimes quite difficult.

Using Focus Groups in Feminist Sociological Research

In addition to conducting interviews, I held two focus groups. Focus groups, as Barbour and Kitzigner (1999) note, are group discussions that aim to explore a specific set of social issues with multiple participants. Using group discussion allows for data to be generated based on group interactions. Barbour and Kitzinger (1999) highlight that focus groups provide the benefit of exploring how perspectives are both constructed and expressed, eliciting different experiences and concerns from the participants. In using focus groups, statistical representation is not a primary concern; instead, focus groups allow for the inclusion of demographic diversity resulting in diverse group interaction (Barbour & Kitzinger, 1999).

Wilkinson (2004) notes that focus groups are informal discussion between participants about a pre-selected topic, identified by the researcher. Focus groups are best used for exploratory and multi-method research (Wilkinson, 2004). According to Wilkinson (1999), focus groups are a contextual method of importance to feminist research, as feminist researchers emphasize the significance of understanding social context of both their participants and their research. Focus groups provide an interactive social arena where researchers can observe the process of meaning making by their participants, as focus groups are a social context in and of themselves (Wilkinson, 1999; Wilkinson 2004). Similarly, according to Morgan (1996), focus groups allow for the collection of data through group interaction, based on a topic laid out by the researcher. In contrast to individual interviews, Morgan (1996) highlights how focus groups are different, as you cannot separate out the group context from the research data, and this is a key theme that occurs throughout discussions of the use of focus groups in sociological research.

Additionally, focus groups provide a more dynamic setting for my participants to discuss issues around health and fatness. The focus group setting can be empowering (Wilkinson, 1999; Morgan, 1996), and can serve to legitimize participants' experiences, encouraging them to share more and build off what other participants are saying. The relationship between fatness and health is a private one and can often be isolating with respect to feeling like an experience is unique to you. For example, as a fat woman I am involved in many social media groups where other fat women talk about their experiences with life in general. When it comes to health, the sense of community and relief built around one person's admission of an issue and the subsequent response and confirmation by others that they experience the same issues was something I hoped to replicate in a focus group setting.

While focus groups provide the opportunity for rich dialogue among diverse participants, Farquhar (1999) raises the issue of focus groups and sensitive topics. There is potential that researchers will raise strong feelings or opinions of their participants in group discussion. To combat this, Farquhar (1999) suggests inviting participants to establish the ground rules of the focus group prior to beginning discussion, to determine how to deal with strong reactions to sensitive topics. In further exploring these sensitive topics, focus groups provide researchers the opportunity to address the social construction of sensitive issues (Kitzinger & Farquhar, 1999). The group dynamic allows for unpacking sensitive moments further with participants. These moments may be identified through explicit comments, shock, surprise, defensiveness, among other reactions.

My focus groups posed a lot of challenges. The first major challenge I had was recruitment. Similar to my interviews, I recruited on Facebook, on Kijiji, and with physical posters around the TTC. I did receive a lot of interest, especially from Kijiji. However, ultimately, I ended up with two focus groups, one with 2 participants and one with 3. While I originally had 5-6 people register for each, for various reasons they either cancelled or did not show up. A few participants indicated to me they had thought the focus group would provide payment (even though it was indicated in the ad and via email that it was voluntary). The three participants who cancelled for this reason all indicated to me that they do focus groups together as a form of income.

The location and time of the focus groups also impacted my ability to recruit. I held my focus groups at the Qualitative Research Lab at York University, which is in the north end of Toronto and requires a bit of a commute to get to. In addition, the Qualitative Research Lab is only open during business hours, so my focus groups were held during the day. I chose to use the

Qualitative Research Lab as it is equipped to record focus groups and is a nice facility for this type of research. However, I think the location and time of these focus groups limited my ability to effectively recruit participants.

The second major challenge I faced was that my focus groups did not go as planned. Originally, I had intended to employ Farquhar's (1999) suggestion of establishing the ground rules with the participants at the beginning of the focus group. In both focus groups, when I tried to do this, there was no interest in either group to establish any boundaries. In hindsight, I wish that I had suggested some potential ground rules to try and elicit some more discussion around this topic, because when a sensitive issue did arise, neither I nor my participants were prepared to deal with it.

Kitzinger and Farquhar (1991) note that sensitive issues may arise in the focus group setting and that this space should be one where these issues can be discussed. As a researcher, I failed at dealing with a particular sensitive issue that occurred during my first focus group. The first focus group I held was the first bit of fieldwork I conducted; it had two participants. During the focus group, one of the participants mentioned how in one of her medical appointments, she was uncomfortable with the size of the gown and the behaviour of the male technician conducting her ultrasound. She felt he was touching her inappropriately. In response, one of the other participants asked her if the male technician was attractive. I was thrown off by this response and instead of trying to address it, I tried to change the conversation. In hindsight, I wish I would have pointed out that regardless of attractiveness, the technician's behaviour was inappropriate. I wish I had spoken in defense of the participant instead of changing the conversation. After the focus group, I spoke with the participant via email, where she expressed

her discomfort at that comment, and I apologized for how it was handled. I took that experience forward with me in the following focus group and in my interviews.

Analysis

Van Den Hoonaard (2012) notes that analysis begins as soon as you start to collect data, which is why memo-ing throughout the research process is important. In memo-ing, I recorded things like preliminary ideas, references to literature I have read, questions raised, connections I have made between ideas, as well as personal/reflexive observations. Consulting my memos throughout the research process helped to flesh out key ideas and in understanding my data (Van Den Hoonard, 2012) and to prepare for the rest of my interviews.

In analyzing my transcripts, I read through the transcripts multiple times, focusing on a different aspect with each read through, and memo-ing while I do so; these different aspects go on to form themes in the research. In her work *Do Men Mother?* Andrea Doucet (2007) highlights her approach to reading transcript data, suggesting an initial pass through of the data to understand what story her participants are trying to tell, followed by 'reading herself' into the data and determining her own reactions, and finally a reading where she focuses on what the participant says about him or herself. I like this approach to understanding interview data, as it allows for both an understanding of the participant's story and a reflection of the researcher on the participant's story, consistent with the auto/biographical approach I have adopted. Additionally, I used thematic analysis and codes in analyzing my interview and focus group data, in effort to group key themes and similar stories together, using the software program Dedoose. Coding, using a thematic analysis, provides a systematic framework for analyzing data. By examining and identifying patterns in the data that relates to the identified research questions

(Braun & Clarke, 2014). These themes then provide the opportunity to use the data in a descriptive way to highlight the emergence of patterns (Braun & Clarke, 2014), for example the uptake of certain discourses.

Bischoping and Gazso (2016), in their work *Analyzing Talk in the Social Sciences,* highlight the work of Kitzinger (1994) and Wilkenson (1998), who argue that focus group data should be analyzed as Petri dishes, meaning that the focus group is the unit of analysis, not the individual people in the focus group. Focus groups can be used to understand how knowledge is constructed in that particular group setting (Bischoping & Gazso, 2016). In analyzing my focus groups, I looked for the ways participants construct common ground, relate to one another, are different from one another, what stories emerged from the focus groups, and the impact of the group setting on knowledge creation.

Significance and Importance of this Research Project

The goals of a sociology for women, opposed to a sociology of women, is a sociology that focuses on the interests of women (Acker et al., 1991). According to Acker and colleagues, a sociology for women must be emancipatory. The focus of a sociology for women must see as a priority the eventual end of conditions that oppress women, prioritizing an equitable and free society (Acker et al., 1991). As Letherby (2003) notes, feminism itself is both theory and practice. Feminist research, then, must include a commitment to producing knowledge with the goal of improving women's lives (Letherby, 2003), consistent with Acker and colleagues (1991) proposition that a sociology for women must be emancipatory.

In doing my research, I aim to contribute to knowledge creation around weight and health that can be emancipatory and challenge the existing stigma and marginalization faced by fat

women. While the primary focus of my dissertation is on the ways in which fatness serves as a barrier to health care, understanding ways fat women resist institutionalized fatphobia, specifically in relation to their health care, is important to me. Feminist research focuses on the lived experiences of women but should also serve as a space to empower and emancipate women (Harding, 2001; DeVault, 2004). Similarly, Wilkinson (1999) argues focus groups are a space for consciousness raising and can be a form of action research, and this is an area of feminist research that is important to me.

In conducting my interviews, I knew that the data that would come from them would result in findings that could be used to challenge fatphobia in medicine and the marginalization of fat women. One thing I did not fully consider was how my participants (and myself) would find the interviews to be a space of empowerment. Many of the women I talked to shared how much they appreciated having the opportunity to share their experiences and to have their voices heard. One participant, Ariel, explained it this way:

> I think we need to start these conversations-- Like I really don't see a lot of talk or any kind of like movement or social change around improving how women's experiences with health care if they're really- there's really not a lot of going around. So, when I saw this I was like, you know, maybe this is my chance to tell more people my story. Because I always tell people my story but I want more people to hear it and I want this to change for us. Because I'm not the only fat woman and I'm not going to be the only fat woman and like this isn't going away, right? I'm not a disease.

Implications

The field of fat studies is an emergent, burgeoning field providing interdisciplinary research on the consequences of stigmatization and marginalization of fat bodies, and fatness as a space of oppression. As a sociologist, the research in this dissertation contributes a critical perspective on the way fatness poses a barrier to accessing health care services for fat women in Canada to this developing field.

Examining the fat body from a feminist sociological perspective allows for the understanding that the experiences of marginalization that fat women experience exist at both a societal and interpersonal level. Women must contend with unrealistic beauty standards to shrink in size in effort to achieve unattainable standards of beauty, and these standards are often rooted in fatphobia. Fatphobia stems from and perpetuates the marginalized position of women, and this form of marginalization has rippling consequences. This dissertation highlights one of the major consequences of fatphobia, and that is fatphobia in medicine and health. Fatphobic discrimination can discourage women from accessing primary health care services which, in and of itself, has consequences on the long-term health of women. If women are not receiving regular health care checkups, early detection of current or future health problems is not possible. Women may not receive the necessary care or referral to see health care specialists if they are not accessing primary health care. Additionally, if women are facing fatphobia in a primary care setting, they may be discouraged from using health care services of any kind in the future, again leading to possible poor health outcomes.

This research has implications far beyond the individual level. The "obesity epidemic" is one of the most powerful discourses that influences the way in which health and bodies are conceptualized. Wright (2009) argues that the alleged 'truths' about the "obesity epidemic" have been reconceptualized by government policy, health promotion initiatives, online resources, and

in-school practices that influence the way in which young people come to understand themselves. Children and young people come to know themselves in ways that have been constructed by claims makers. Using notions of biopower, Wright (2009) conceptualizes this construction of knowledge as a range of biopedagogies, which reflects the "normalizing and regulating practices in schools [that are] disseminated more widely through the web and other forms of media, which have been generated by escalating concerns over claims of global 'obesity epidemic'" (p. 1). The medicalization of obesity, and its subsequent construction as a disease, has influenced the way in which people are under constant monitoring and self-surveillance.

This research also provides a sociological perspective on patient care for future doctors, specifically targeted at medical school training. In my interviews, I asked all my participants what they would want doctors to know about dealing with fat bodies. Many of my participants simply want doctors to see them as people, and not as a problem. In my interview with Yasmin, she noted that she thinks:

> doctors often aren't trained to see patients as people. They see them as cases, as problems to be solved. I think humanizing the patient is important, and taking a listening posture, as opposed to, "I know all the answers to all the medical questions," type approach. Whoever is sitting in front of you, that you just step out of your own situation in life, turn off your thoughts and just listen to what the person has to say. I think affirming their humanity, whoever's sitting in front of you, gay, straight, trans, male, female, black, white, brown, whatever, that listening to their story, and I think this is even when it comes to understanding other people's perspectives, specifically as white people, it's important we listen. We need to learn to listen and to shut the fuck up. I think doctors need to do the same.

I intend to write a journal article or publish my dissertation as a book in the future, and the findings of this research can then be used in patient care curriculum. Changing the way fatness has been medicalized contributes to efforts to change the marginalization and oppression faced by fat women in the health care system, and this is a key goal I have in producing this dissertation.

Chapter 3: Neoliberalizing the body: The impact of the 'obesity epidemic' on embodied relationships

Kelsey: When was the first time you think you dieted?

Xia: Kindergarten.

Kelsey: Kindergarten?

Xia: For sure. I was the biggest kid in the class. I loved tuna sandwiches for lunch. One day one kid was, "Well that's why you're fat," and so I didn't want tuna sandwiches anymore.

Introduction

The social construction of the 'obesity epidemic' has far reaching consequences in the ways that fat women[2] live in their bodies. While obesity research focuses on the potential impacts of high BMI on the body and potential subsequent health outcomes, this research neglects the impact of constructing the fat body as problematic and as a site for intervention on people actually living in fat bodies (see Chapter 5 for further focus on the problems of intervention and *Obesity Canada* Guidelines).

When I set out to undertake this research, my primary objective was to understand the impact of body size on accessing health care services. However, one of the major themes that emerged from the interviews I conducted dealt with the ways in which the moral panic around the 'obesity epidemic' is in fact an embodied experience for fat women. In this chapter, I take up the question: How does the framing of fatness as an 'obesity epidemic' impact the relationship fat women have with their bodies and themselves?

I found that the social construction of fatness as an 'epidemic' has resulted in adverse

[2] The social construction of the obesity epidemic greatly impacts fat men as well; however this research focuses on those who identify as women or were assigned female at birth

relationships with oneself, their body, and their position in the world around them. I argue that these antagonistic relationships are rooted in neoliberal understandings of individual failure to be thin and are influenced by the expectation to perform 'good health' and conform to the stereotype of the 'good fatty', the uptake of extreme dieting and disordered eating practices, and exposure to harmful portrayals of fat women in the media.

Throughout my interviews, participants shared how they experience shame around their body size and how this shame comes from their individual failure to be thin. In this chapter, I share my participant's experiences of the 'obesity epidemic' and how the neoliberal discourses around body size result in society viewing them as failures (and, through the lens of biocitizenship, bad citizens). Internalizing messages of failure results in many participants attempting to appeal to the 'good' fatty archetype, an archetype that represents a fat person who is fat despite engaging in 'acceptable' health behaviours.

Other ways participants describe experiencing their fat body as a bad body is through the prevalence of bullying in their childhood, which often resulted in the undertaking of extreme and dangerous dieting behaviours in attempt to reach the thin ideal. This dieting ranged from extreme calorie counting, excessive exercise, formal dieting through weight loss programs, and starvation.

Finally, in this chapter my participants detail the impact of the media on their relationships with their fat bodies. The media fosters negative feelings and attitudes about fat bodies, and my participants describe how the prevalence of attacks on fat bodies and constant weight loss advertisements foster dissatisfaction with their own bodies. This dissatisfaction contributed to their desire to change their body.

The Neoliberalization of body size: "I'm not supposed to be big, it's my own fault that I'm big, and I'm the one who has to fix it"

Fat women internalize understandings of their bodies as overindulgent, as representing lack of self-control, and as individual failure. The risks of not attaining beauty ideals are high, and can result in marginalization, social isolation, and social undesirability (Gard & Wright, 2005). When women normalize messages of the thin ideal, and the risks associated with not meeting this standard, they become self-regulating in attempts to prevent violating social norms. Gard and Wright (2005) argue these messages are difficult to resist. There exists an assumption that body size is indicative of individual behaviours, and this assumption has contributed to the pathologization of weight (Gard & Wright, 2005; Jutel 2009). As LaMarre and colleagues (2017) note, moralizing messaging around health contributes to the way bodies learn to be productive biocitizens, and the biopedagogies that contribute to this moralization are built on the neoliberal assumptions of health that argue that fatness is individual responsibility and individual failure.

Public health often portrays obesity as resulting from individual behavioural failures, yet also argues that obesity is an 'epidemic' (Boero, 2012). This represents what Boero (2012) calls the normative / pathological duality. Similarly, Murray (2008) argues that when 'obesity' is represented as disease and framed from a medical perspective, the 'cure' is for the individual to adopt 'health' behaviours and to change their lifestyle. Murray (2008) refers to this as medical normalization, arguing that this is a form of disciplinary medicine – "institutional discursive shifts that reveal the perpetuation of fundamental assumptions that construct and (re) produce us as (normal or pathological) subjects" (p. 15). Murray (2008) argues that medical knowledge is actively involved in the disciplinary process of making the fat body deviant, as medical knowledge contributes to the pathologization and the ascribing of the deviant label. The

disciplinary function of medicine is that it then reproduces both social understandings of the fat body and the perpetuation of supposed 'truths' around obesity (Murray, 2008). An example of the function of disciplinary medicine is the 'epidemic'. Murray (2008) notes that when a community is experiencing an epidemic, it is incumbent on them both personally and civically to control the disease. It is their responsibility to act in accordance with controlling the epidemic. The term 'epidemic' functions to scare people into acting responsibly, drawing on and employing medical discourses to do so (Murray, 2008).

The medicalization of fatness and the moral panic around an 'obesity epidemic' often neglects larger systemic contributors to body size (such as social determinants of health, access to affordable 'healthy' food, general ethnic and racial variability in body size, for example) and instead place the blame (and shame) of having a large body on the individual living in said body. In talking with women for this project, feelings of failure and individual responsibility were prevalent in our discussions. Danielle noted that "in general, from such a young age, you're told, 'it's your fault, you're eating too much, you're not exercising enough'", regardless of the effort being put into trying to attain the thin ideal. This sentiment reverberated throughout my interviews, and the sense of individual failure was often wrapped up in feelings of shame. Yasmin attributes this shame to her own failure to lose weight and to 'fix' herself: "The fact is I'm not supposed to be big, and it's my own fault that I'm big, and I'm the one who has to fix it. It's shameful that I haven't done it already … it's my own fault anyway so I hang my head in shame".

The neoliberalization of weight also impacts the view outsiders have on people in fat bodies, influencing their assumptions of fat people's behaviour. These assumptions are often then internalized by fat women who then further normalize these supposed betrayals of the thin

ideal. Yasmin expressed her frustration with assumptions made about people in fat bodies, describing them as unfair.

> **Yasmin**: It makes me angry because there's assumptions made, I think, about fat people which are unfair.
>
> **Kelsey**: What do you think these assumptions are?
>
> **Yasmin:** That we're lazy, weak maybe, undisciplined, not as valued as other members of society, that people should feel sorry for them [fat people], that there's a pity that should be extended to them. Also a shame. 'Look at that. If you'd just lose weight, you could get married. You could find a husband.'

The assumptions around failure to lose weight transcend concerns around health and are often about aspects of social life that cannot be achieved (supposedly) when violating the social norms of appropriate body size. In Yasmin's case, her inability to lose weight manifested in concerns about her romantic desirability. For others, concern was expressed around, among other things, their ability to participate in daily aspects of life such as walking long distances or biking, participating in sports, making friends, or advancing in their career. The common denominator of concerns around body size that were unrelated to health is that being fat prevents a full and enriched engagement in the social world.

When body size is understood to be in flux and in a state of constant change based on individual effort, an inability to reach a desired size can be traumatizing. Fatness, then, is seen as individual choice and personal failure, and this failure is worn on the body for everyone to see. Gard and Wright (2005) argue that fat women internalize messages of blame and shame, which

are difficult to resist as these messages come from the stigmatization and blame that are placed on fat bodies. The internalization of the thin ideal can result in women believing that they have brought discrimination and unfair treatment onto themselves, as they have failed to meet society's expectations of how they should look (Chrisler & Barney, 2017; Prohaska & Gailey, 2019). And as Gailey (2014) notes, women are stigmatized by their fatness, and they wear this stigma for everyone to see (see also Murray, 2008). Their fatness makes them hypervisible (Gailey, 2014) to the world, as they are unable to hide their violation of social norms around appropriate health and size body. As Madison explains "it's overly frustrating because there is always this assumption like, 'Well, if they just tried harder, they wouldn't be [fat]', whatever".

Yet fat women are also hyperinvisible (Gailey, 2014) in that their experiences, struggles, and realities are often ignored and delegitimized. Feelings around living in a fat body and the internalization of shame and failure are present from an early age. Yasmin shares: "I think there's always been, since I was a child, a sense of disconnect from my body, that it wasn't a good body because it didn't meet certain standards". Similarly, Ursula's internalization of shame around her body size directly influenced her perspective on her worthiness to be in a romantic relationship.

> **Ursula**: For a very long time, I felt like, "Well, no guys want to date me, no guys want to be with me, because of my size. I'm not attractive to men." For a long time, I was like, "Well, whatever," and I was like, "Well, then I don't want to date." Then I was like, "Well, whatever. If they don't like me for who I am, then I'm not going to bother."

Danielle was similarly concerned that her inability to lose weight influenced whether or not she would be loved: "I was internalizing fat phobia. I was convinced that no one would ever love me if I was fat so I needed to fix that".

The stigma associated with obesity has resulted in overweight people being seen as lazy, lacking willpower to control their bodies, and overall blaming their moral character (Ellison, McPhail, & Mitchinson, 2016). The understanding of one's body size as being connected to their individual behaviour was prevalent among interview participants. Amelia, for example, expresses how these assumptions make her feel, especially in regard to assumptions around self-control. She shares an experience of leaving a graduate studies class where her body is "hyper(in)visible" (Gailey, 2014).

> **Amelia:** I experience those moments when I am confronted with the way that people view fatness as a kick in the gut. There is never a moment where those things happen where it does not become rooted in my understanding of self. I remember on Wednesday, I was leaving my Feminist Theory class, and one of my friends had brought candy and put that on the table. As they were leaving … one of them turned back to the table and grabbed the snickers bars, one of the fun-sized ones and was like, "what is it with these people putting unhealthy shit out on the table, when I am trying to lose weight, it is not like I can control myself." Took the bar, and walked away. It had absolutely nothing to do with me, aside from existing in that space, but it was entirely about me because it portrays weight with morality of being able to control it yourself and all of those discourses that come into play that immediately position me as not welcomed and invisible, in the most visible way possible.

The neoliberal context in which fatness is understood demonstrates the responsibilization discourse that positions fat people themselves as problematic. In the example above, Amelia is

hyper(in)visible (Gailey, 2014). Fat people are seen as responsible for their bodies and are expected to self-police in order to attempt to reach the thin ideal. Gailey (2014), drawing on Foucault, argues that fat people are expected to become docile bodies, which means that they are expected to self-police and self-regulate their behaviours based on normalizing and regulating discourses. The stigma associated with hypervisibility of fat bodies, then, acts as discipline, as people are expected to abide by social norms for the good of society. The reaction of Amelia's colleague to the mere presence of "unhealthy shit" in the classroom is a demonstration of feelings of shame and a perceived lack of self-control, motivated by aspirations of the thin ideal (i.e., "I am trying to lose weight"). For a variety of reasons, including the internalization of fatphobia and stigmas associated with fatness, one of the primary ways in which the responsibilization discourse is embodied is through dieting.

The 'Good' Fatty: "Yes, I'm fat, but I'm following the rules. Please treat me with respect"

While being fat is seen as an unacceptable condition (or, in health care spaces, a disease), there are behaviours that fat people can undertake in order to lessen their embodied transgression and appease the moralizing discourse around being 'healthy'. In the previous section, I discussed the individualizing and responsibilizing discourses around body size; if you are fat, it is your responsibility, and in fact, your duty, to work hard until you are no longer fat. You, as a fat person, must be working towards societally acceptable notions of 'health', as a fat body cannot be a healthy body. These moralistic and healthiest discourses often result in fat folks trying to demonstrate that, while fat, they are working hard to shed themselves of both the weight and stigma. In 2014, fat activist Stacy Bias created a comic blog post (similar to an infographic) explaining the difference between 'good fatties' and 'bad fatties', where she describes 12 'good

fatty' archetypes. The good fatty, according to Bias, is one "who is trying or at least *believes* they should NO LONGER be a fatty … for the most part, each 'Good Fatty' archetype that exists is basically an argument or justification for inclusion in society's spheres of privilege" (Bias, 2014, original emphasis). As Cameron (2019) notes "the good, or acceptable, fat body is either fat because it is diseased, or remains fat despite proving itself to be physically active and healthy" (p. 260). The 'good fatty' exists only in opposition to the 'bad fatty' – a fat person who is unacceptably fat, cannot justify their fatness, or is not interested in change (Bias, 2014; Cameron, 2019; Gibson, 2021).

The need to fit into an archetype of 'good fatty' was prevalent throughout my discussions with participants across topics. The desire to be seen as 'worthy' of respect popped up in discussion arounds peer groups, romantic relationships, and health care situations. Fat folks felt a strong desire to be seen as respectable and 'good', and this was done through the performance of health behaviours. LeBesco (2004) refers to this behaviour as "the will to innocence", where fat folks "seek to relieve them[selves] of responsibility for their much maligned condition" (p. 112).

> **Xia:** We want to make sure that people know that you know that, "Yes, I'm fat but I'm following the rules. Please treat me with respect. Please, I'm dieting. Please, I know that I'm too big, I know that." The more you can put out that message, it almost feels like a layer of protection. The first layer of protection is making sure that you just look pleasant and nice. Then, the second layer of protection is like when you are at work, and everyone's going out to eat at lunch, you're getting chicken and a salad and sparkling water. Yes, those fries do look good, but you will need to make sure that no one is looking at you and being like, "She's fat because she ordered fries at lunch even though

almost everyone else at the table has fries." What the hell is that? [chuckles].

Laurel: It's awful. Again I know so many people who are like, small or like straight size who like do way less than me, way less physically active, eat foods like deemed very unhealthy like all the time, high in calories, low in like nutrients and are not criticized or watched in what they do in public, never have a doctor say anything to them and sometimes they're the ones going to the doctor and be like, "Maybe I should move more" and the doctor is like, "Yes, you could. You don't have to." Then you go to the doctor it's like obviously you have the flu because you're fat. If you weren't fat, you would never have any flu. You'd just be fine.

This type of health performativity is what Bias (2014) refers to as "the work in progress" fatty, where a fat person is working to become "not-a-fatty" (Bias, 2014). Here, participants are engaging in health behaviours that they understand to be consistent not only with 'good health', but with good citizenship (Halse, 2009; Harwood, 2009). By appealing to acceptable behaviours around health and actively trying to change their body size, the work in progress fatty is trying to portray that they have the self-discipline and restraint (Halse, 2009) that is consistent with 'good' 'healthy' people, even if they themselves have not reached an acceptable body size.

While Bias (2014) refers to these behaviours as consistent with good fatty archetypes, Halse (2009) discusses similar behaviours in relation to the concept of the biocitizen (Halse, 2009). Citizenship for the biocitizen, no longer tied solely to nationality, ties individuals' private lives and bodily practices to their citizenship rights (Halse, 2009). Specifically, the good citizen is an active citizen, and therefore a thin citizen. In contrast, failure to control weight makes a bad

citizen, as a fat citizen is violating what is considered the good of society, by failing to take care of themselves and their weight (Halse, 2009). Weight then is symbolic of a social contract between citizens, and being fat violates this social contract, potentially producing negative consequences for society as a whole. These consequences include potentially negatively impacting the economy, burdening the health care system, and violating the common good. It is therefore the personal responsibility of the biocitizen to ensure that they are not violating this social contract, and a personal failure when a citizen is fat (Halse, 2009). You can see this in Xia's plea for respect, appealing to her health behaviour and indicating that she uses her health performance as a layer of protection against the outside world; she is trying to foreground herself as a good biocitizen. Xia further shares how she tries to ensure she is not violating social norms in her fat body:

> **Xia:** That's the other thing. I also put a lot of stock into the jolly factors; I'm fat but I'm funny. I love you. I'm caring about you. I make some jokes here and there but they're snarky and they're about someone who's not you. They are about our shared enemy and that's very much a persona that I've built for myself. Everyone has their own mask that they've built for themselves but I think as fat people there's this extra dimension of adhering to one social norm to make sure the other social norm isn't applied. If I'm the jolly fat person, then I'm not the gross fat person or I'm not the angry fat person or I'm not the slob who isn't trying. I am trying and look at how nice I am to everyone.

Healthy behaviour was not the only societal norm that participants felt they had to meet in order to be deserving of respect or to be seen as respectable as fat folks. Wykes (2016), in *Why*

Queer Fat Embodiment, argues that compulsory heteronormativity regulates the fat body, much like it regulates other 'deviant' bodies. Jones (2016), in *Performance of Fat*, notes that the regulation of the fat body is a part of a larger system of regulation, and fatness is used to maintain categories of difference that are informed through other systems of marginalization, such as race, class, sexuality, gender, and ability. The intersection of fatness with larger systems of oppression has been underserved in fat studies literature, often essentializing the experiences of fat women (Friedman, Rice, and Rinaldi, 2019; Jones 2016; Wykes, 2016). The entanglement of race, socioeconomic status, gender, and sexuality appeared frequently in discussion with my participants.

> **Cheryl**: It's exactly that. The fact that our bodies-- Obviously we're talking here about women's bodies, it's gender women's bodies, but trans-women's bodies, any body that's "feminized" so overly read for what we look like. From our weight to our hair, to whether we're made up or not, whether we put the time, whether we put the concern enough into our facial hair. Whether we've shaved, whether we've done our waxing, it's ridiculous. That speaks to particularly, how I experience my blackness, my fatness, and my womanness in this body, in spaces where I'm not supposed to be or where I'm so congratulated for being. If I get told one more time how articulate I am, I may box someone like literally.

> **Faith**[3]: Given I'm also trans, I experience dysphoria. A lot of my story of eating stuff, initially I had to deal with just the weight whatever, but I find I experience a lot of

[3] Faith identifies as non-binary and two-spirit and requested that I note that they were assigned female at birth.

internal transphobia because I'm fat. I feel like, "Oh I don't like pass well enough or I'll never be perceived as the gender I am because I'm fat."

Engaging in health performativity is not consequence free and can actually be harmful to both people who are taking up the good fatty archetypes and then, consequently, the bad fatty who is created in opposition to these archetypes (Bias, 2014). The creation of the biocitizen (a form of citizenship that the good fatty is striving for) excludes those who are not striving for or cannot achieve forms of good citizenship associated with the moral messaging of good health, creating the bad fatty. The 'bad fatties' are demonstrating they are indulgent, are lacking in self-discipline and restraint, and as such are violating the social contract and disregarding the potential negative impact their fat bodies can have on society.

The impacts of diet culture: 'Secret dieting' - "It just means that you throw food away and you purge and you exercise a lot"

The body ideals to which women are subject are unattainable. Susie Orbach (1990) argues in *Fat is a Feminist Issue* that this makes a woman's body not her own as she must continually attempt to conform and change her body to meet beauty standards. Hartley (2001) notes that women learn at a very young age, around ages 5 and 6, that their bodies are inherently flawed and that these flaws indicate that the female body must be changed constantly in order to meet unattainable beauty goals associated with femininity. Hartley (2001) describes this as a 'tyranny of slenderness'. In the opening quote for this chapter, Xia shares how the first time she started dieting and came to know her body as flawed was in kindergarten. This situation was the result of bullying by other kindergarten students, which demonstrates how not only does Xia see

her body as flawed, but other children around her (kindergarteners in Canada tend to be between 4 and 6 years old) have already been exposed to and internalized fatphobic messaging around appropriate body size. Similarly, many participants reported experiences of bullying as a child that pushed them toward extreme dieting.

> **Ariel**: Kids were mean. [The bullying] continued all through elementary school into high school. Grade 9, I was sick of it. I joined Weight Watchers, but got into it hard. I was carb counting. I cut out carbs. I was eating literally lettuce and salsa for a year. I dropped 120 pounds within six months.

> **Hannah**: I was very bullied when I was a kid and I felt really awful about my body. I felt like it was my fault and my body was disgusting and all those things.

> **Xia**: My name is Xia. As you can imagine as a kid that brought a lot of stuff in itself. Then you had that I'm the biggest kid in the class, then you add in that Shamu the whale is really popular when I am about 12 years old, and it all comes together to be this toxic cocktail. My entire high school experience, my entire university experience, my entire first major job out of university experience were all tinted by this idea that I'm so unhappy but once I achieve thinness I will be happy so I need to put all my energy into that.

Even when bullying experiences were not mentioned, participants shared how they began to diet at a very young age. Sabrina, for example, indicated that she started dieting at 11 years

old, Rachel started dieting when she was eight, and Xia started dieting in kindergarten.

> **Madison**: I kind of obsessed about food. It was like, 'Well, I'm hungry. Well, I'll have a glass of water'. I'll see how long I can go with that food and I thought about food all the goddamn time so I was fucking hungry. I lost weight and people kept saying, 'That looks so good. You're so positive.' I lost weight. It was kind of miserable.

Despite active and emerging push back against biomedical understandings of weight, health, weight loss, and individual responsibility, there still exists prominent and dominant messaging that being fat is unhealthy and can kill you, being thin is better for your health, and that getting thin will solve all the supposed problems associated with being fat (Campos, 2004). This is what Campos (2004) calls the obesity myth. The dominant discourses of fatness are problematic as the science in which they are built on, according to Gard and Wright (2005), is flawed. In their book *The Obesity Epidemic: Science, Morality, and Ideology*, Gard and Wright (2005) examine the way in which scientific research is used dubiously to push forward a specific health agenda. Obesity science, according to Gard and Wright (2005), is trapped in its primary interest of understanding body weight through a biological etiology, ignoring other factors. As LeBesco (2009), among others, have noted, weight is a far more complex social construct than biological etiology.

One of the major consequences of the obesity myth is that it has led to a simplified lay understanding of body size as resulting from 'energy in, energy out' or, more commonly, 'calories in, calories out'. The core principles of science on obesity are that being overweight is caused by too much food with too little exercise, which is bad for one's health. The scientific

literature on obesity views the body as analogous to a machine, functioning mechanistically, focusing on energy in and energy out. This assumption fails at accounting for variables outside of food intake and physical activity and ignores social determinants of health such as socioeconomic status, race, culture, the environment, or the government. When racial, ethnic or socioeconomic factors associated with weight are documented, they are often left out or misinterpreted by scientists as indicating that people in these groupings have insufficient understandings of health (Gard & Wright, 2005). As Campos (2004) highlights and Gard and Wright (2005) address, many studies have found the link between body weight and physical activity to be either inconsistent or unsubstantiated.

Anecdotally, I cannot count the number of times growing up and into adulthood my mother would say to me "Kelsey, it's as simple as calories in and calories out, you are eating too much and not exercising enough". The phrase 'calories in and calories out' is etched on my brain – a phrase that I internalized as representing my individual failure, my lack of self-control, and my laziness. These feelings were not uncommon to my participants either. Danielle, for example, shared how she felt about fatness as a young person: "In general, from such a young age, you're told like, 'It's your fault, you're eating too much, you're not exercising enough'". Internalizing a mechanical understanding of body size as simplified through the 'energy in, energy out' philosophy resulted in extreme calorie counting and excessive or dangerous amounts of exercise, and ultimately for some participants a diagnosable eating disorder.

Many participants shared with me the ways in which they engaged in calorie counting, the successes and failures of such a strategy, and the impact calorie counting had on their physical and mental health. Below are four stories from participants about their experiences of calorie counting specifically.

Karen: I went on this calorie counting bullshit, where I was eating anywhere from 1000 to 1200 calories a day, and exercising like a madwoman, for about six months until my body just gave up on me, and I lost all this weight and I hated myself more than I had ever hated myself. I think it was because of the dieting. That fucks with your brain. To me, it didn't matter that I lost 100 pounds, didn't matter that I was getting compliments, and I sometimes felt sexier, but at the same time felt like I had another 100 pounds to lose. Even then, if that had ever happened, I am certain that at that lowest weight ever, I would still have hated myself more than ever because of what you have to do to get there. I say my body gave up because it really did give up. I became so weak, I wasn't eating enough to maintain my energy. Whatever I was eating, I was working away to exercise, not even counting the fact that you need energy to get through your day generally. It was like, "Get rid of all the calories through exercising", and then you have a major deficit. It was so messed up, the weight. Once my body gave up, I started gaining the weight back.

Olivia: I would severely limit my caloric intake to maybe probably a 1,000 to 1,200 calories per day. I would have no junk food ever. No alcohol, no sugar. I would even boil chicken and steam vegetables and oatmeal. Things that would make you feel full but not really taste anything. I just didn't have any joy in eating or when I'd go out, I was paranoid like, "What can I order from here?" I'd have to be that person that would be like, "Can I get this but with not this? No oil." I did that a few times. It works, but then I would have a depressive episode. Going back to normal would just make me start gaining weight again.

Sabrina: The worst time of my life for body issues was when I tried the Dr Bernstein Clinic, which is a horrific abomination and it's not healthy. They tell you to eat a 900 calorie per day diet and you get injected once a week with vitamins you're losing out because you're taking so much of your diet out. They tell you that you're probably going to lose hair and that the only thing that matters is that you lose weight. They weigh you publicly. It's the whole thing. It's disgusting. I did that to myself, I spent probably $4,000 on it. The sad thing was that my aunts helped to pay for that because they thought that would make me happy. Maybe that was actually the beginning of the turning point for me because I was like this isn't health-- They're telling me to eat flavoured jello to make myself feel full all day so that I can basically just eat one meal, is not healthy. Just so that I can look this particular way.

Rachel: It was really from when I was in middle school until I was at the end of my undergrad and then I did one last stab at Weight Watchers in 2016 when Oprah got involved with it. I went into Weight Watchers again at that point and I spent one year on Weight Watchers. Then 2017, I was done, so I haven't dieted since January 2017. I [also] did Herbalife. I did Jenny Craig. I didn't follow through, but I started with Dr. Bernstein. I wasn't able to afford it at the time when I realized what it cost. I did a lot of juice cleanse diets, so just absolute crash diets. I did a cabbage soup diet, I did a water fast, I did a lot of juice cleanses. I would lose 20 pounds and then I would just stop losing weight. I would be dieting and I would extraordinarily limit my calories. I would do a juice cleanse, and even though I was taking in 900 to 1,000 calories a day, and it was just

> simply on juice plus water and maybe coffee with nothing added to it, I would just stop losing weight.

What these experiences demonstrate is an internalization of the responsibilizing discourse around appropriate body size and just how damaging that internalization can be. For many, it resulted in further disdain for their body; their relationship with their bodies did not improve contrary to frequent messaging that it would. In stories like Karen's, it is clear that extreme dieting, even when weight loss occurred, could result in hatred for their bodies and dissatisfaction with themselves. Zoe, who underwent bariatric surgery a few years before we spoke, shared how losing weight did not improve her relationship with her body.

> **Zoe**: I've never been happy with my body, but I've never been unhappy with it, I guess. About four years ago I was like, "I'm too fat now" and I went for weight loss surgery. That was an experience. I don't like or dislike my body anymore or less since that, which was an interesting transition with me because I thought I'd be like, "This is great." But I was like, "It's still a body, it's still doing what it needs to do."

Zoe also had experiences with extreme dieting prior to bariatric weight loss surgery.

> **Zoe:** I did Doctor Brown and that was for a pretty long time. [You] eliminate a whole slew of foods and slowly re-introduce them. For a while you would like - they tried to teach portion control and stuff too and be like, "Your meat should be your palm, and this-" whatever. Then they would be like, "You can have two strawberries." I was like, "For

what, to top my water?" Nothing I took long-term to be like, "This is what I'm going to implement in my life." It was, "This made me lose weight fairly quickly. This looks nicer on me, but then I'm going to eat my food and gain it all back." Then weight loss surgery was a long time of restrictive eating.

Kelsey: After you were dieting, you'd put the weight back on.

Zoe: Yes, every time. Plus, more from what I lost.

For others, the undertaking of extreme dieting, calorie restriction, and extreme exercise had negative implications on their overall mental health and well-being. Many participants reported that they had developed an eating disorder that often went undiagnosed due to the fact that they were simultaneously fat. For example, Rachel describes her experience with Weight Watchers and calorie counting and how that led to an eating disorder.

Rachel: When I was dieting, I was obsessed, obsessed with food. I was obsessed with counting calories or whatever the diet was. I did Weight Watchers for a long time. I had a horrible relationship with food where I was scared of it. I couldn't eat anything without weighing it or measuring it. I was overly restrictive. I actually had an eating disorder, but I was still overweight. I was losing weight to a point where I would've been considered a little bit overweight, not obese, but in the overweight category. I was actually anorexic or bulimic at times. I was struggling with eating disorders while I was dieting, and that goes back. I started dieting when I was eight. I've been on a diet since I was eight. When I was a teenager. I was struggling with eating disorders, but it didn't seem like I had an eating disorder. I was eating 500 calories a day at one point.

Rachel also described for me something she called 'secret dieting' - "it just means that you throw food away and you purge and you exercise a lot".

Throughout my interviews, it was clear that for many women, disordered eating and extreme exercise were celebrated, praised, and encouraged by those around them. I asked Rachel if anyone had diagnosed her eating disorder, and her response was "No". Because actually it was considered a good thing that I was losing weight". Ariel also explained how her weight loss was celebrated, until she became so sick, she needed to be admitted into inpatient care.

> **Ariel:** Yes, it was crazy. I had family members saying that I looked great and not realizing that I was chewing food and spitting it out in a cup. I developed an eating disorder. When I did tell them, because I was getting sunken-in cheeks, I was missing periods, I was very, very ill, I ended up going to the eating disorder clinic and going through that program.

As demonstrated by the passages above, dieting is not without consequence. The central idea of the obesity myth (Campos 2004) is that weight loss will solve the problems associated with being fat, and that losing weight will increase quality of life and health for fat people (Campos, 2004). Yet, the negative health implications of the diet industry and diet drugs outweigh the potential benefits, especially when, for the most part, diet and exercise are ineffective and weight is typically regained (Campos, 2004; Lyons, 2009). Pat Lyons (2009), in highlighting the harms of the diet industry, argues that the negative influences of the diet industry do not outweigh the potential benefits. Weight loss treatment cannot be understood as

harmless, even if it fails. Zoe, for example, was still considered 'obese' by BMI standards following her bariatric surgery. Chronic dieting and yoyo weight loss and weight gain have been linked to a plethora of medical problems. Both Lyons (2009) and Campos (2004) suggest that the effects of dieting and frequent weight loss and gain are more harmful and problematic then fatness itself.

Ultimately, this was reflected in the experiences of the women in my research. Extreme dieting, calorie restriction, disordered eating, and excessive exercise were detrimental to the physical and mental health of the women I spoke to. For most of them, they had gained back any weight lost and many had put on more weight. The idea that these folks would live better lives if they were not fat was at the forefront of their weight loss journeys; yet they did not experience positive changes to their lives, and in fact for many the negative impacts of drastic weight loss far outweighed any potential benefit. Despite this, representations of fat people losing weight and feeling better about themselves because of this weight loss remain prevalent in the lives of my participants; these representations often came from the media.

Fatness and the media: "[The media] makes me feel like there's something inherently wrong with me"

Another key theme that emerged around participants' relationships with their bodies was the impact the media plays in fostering negative feelings around body size. Specifically, when referring to media, the participants often spoke of weight loss commercials and advertisements, the presence of fat (or formerly fat) celebrities in the media, and the role of social media in their lives. The prevalence of negative portrayals of fatness and the barrage of weight loss advertisements reinforces body dissatisfaction and the individual responsibility of women to

change their bodies to meet societal goals.

As Hesse-Biber (2008) notes in *The Cult of Thinness*, the media is a tool of capitalism that sells culturally desirable bodies to women. However, the culturally desirable body is naturally unattainable, and the representations of such bodies in the media are digitally altered. The industry perpetuates an ideal of physical perfection that is physically impossible. The benefactors of such impossibility, according to Hesse-Biber (2008), are cosmetic companies, fitness companies, and the weight loss industry. Health concerns mask profit motives and companies benefit from confusion experienced by women aiming for an impossible body type. While the weight loss industry wins, in that they make a profit from fears of becoming or remaining fat, fat folks themselves lose in that they internalize these messages and feel individual responsibility to change themselves.

When asked how tv commercials and social media advertisements around the 'obesity epidemic' or weight loss made them feel, Faith shared how "it makes me feel like real shit about my body and just in general. Yes. It makes me feel like there's something inherently wrong with me". This bodily dissatisfaction as a result of fat phobia in the media came up frequently in my discussion with participants.

> **Brenda**: That's why ads just killed me. They made me hate myself, because every other ad is about weight loss. The obesity epidemic, it hurts me, and it drives me nuts. Especially when it's about kids. I'm like, "Why are we so fat? We're fatter than we've ever been". It especially makes me uncomfortable as it relates to the stereotypical American [participant is American born], and just the assumptions that go with that, that you eat Cheetos or high fructose corn syrup, or whatever, all the time. I'm like, "I don't eat those

things. I eat pretty healthy, and I'm still fat". It's like, "Yes." It just makes me really uncomfortable. Is this really what we're most worried about? It is. There's a lot of research that shows kids, women's greatest fears to be fat. People would rather lose a limb than be fat.

Lisa: It is hurtful at times. Not at times. Majority of it, it's hurtful because that's something you end up taking in those feelings and then you self-harm. I don't want to take away from someone who actually self-harms but self-harms because you start these dieting practices, which aren't really healthy. You end up starving yourself.

Wendy: It makes me really mad that I think it also, maybe on a deeper and maybe less conscious level, evokes feelings of shame because I think, "Well, that is my body. Is this what people think when they look at me?" I can't control the way that people are going to read my body, so as much as I think inside, I have this narrative of me as the amazing bad fatty. Other people looking at me are like, "There's that fat bitch. She needs to go to Weight Watchers or go to the gym." I think it brings up really uncomfortable feelings for me that I often try to negotiate through letting that first response of anger take over because it's just too exhausting to deal with the feelings of, A, disappointment and, B, shame.

In addition to affecting the way fat folks feel about their own bodies, these forms of media representation also influence the undertaking of commercialized methods of weight loss. Rachel shared the way weight loss commercials, and fat celebrities associated with weight loss

brands, ‘inspired’ her weight loss journeys. Her experience is also rooted in the responsibilization discourse discussed earlier in the chapter; when she was unable to achieve the weight loss being advertised by these companies, she understood this as her own individual failure and not a larger systemic problem with the diet and weight loss industry.

> **Rachel**: When I was trying to lose weight, I was overly inspired. I wanted whatever it was they were doing. If it was something you could throw money at, then I was game. I was influenced to do a lot of diets because of the media. Oprah's what got me on the Weight Watchers because I love Oprah. When she started backing up Weight Watchers, I bought Weight Watchers. I was one of those ones. I just wanted to do whatever I thought was working. But what's interesting is, I never realized that they weren't working for me. I always thought that it was just the one I was doing or that I was doing it wrong. I had someone tell me all diets work, it's just you're doing it wrong. Or, you're the problem but the diet works. I was like, "Okay, it's just me that's the problem but it's not the diet that's the problem." Now, when I see ads or things that, I think it's really sad because it's such a money machine. When I look back at life when I had so much less money when I was a student and I couldn't afford me doing all these things but was socially cycled in. Now that I would be able to afford it more, I couldn't spend it to save my life because I shouldn't believe in it. It's upsetting now. I'm realizing, looking back at how much money I spent on diets and understanding that that was an industry that I was paying into.

The obsession with diet products and companies, reflected in the profits seen by the diet industry, rest on fatphobia – the intense anxiety of becoming or remaining fat. Oliver (2005)

argues that the source of fat hate is fear and that “the ideology that underscores [fat prejudice] is an ethos of individualism and self-reliance” (p. 73). This ethos was reiterated throughout my discussions with participants, like in the examples listed above. Hesse-Biber (2008) highlights how the regulation of weight has become a tool of capitalism in contemporary times, arguably capitalizing on this fear of fatness. Health concerns mask profit motives for the weight loss and diet industry, who are often funding the research that promotes these health concerns. As Hesse-Biber (2008) notes, this adds up to huge profits for these companies.

In extending the discussion past the economics of the diet industry, she notes that it has changed the way in which people eat. Eating is no longer a natural process; instead, it has become a process whereby people rely on corporate products and messaging to regulate their diet and intake (Hesse-Biber, 2008) and we can see this in Rachel’s story about undertaking commercialized diets, and the stories of other participants like Ariel, Karen, and Sabrina, shared earlier in this chapter.

Weight loss ads do not only affect the fat individual, but also the network of peers and family around them. Ajooni highlights how, whenever a weight loss ad was on the TV, a family member would comment on her weight and suggest undertaking that diet program.

> **Ajooni:** I can totally remember the amount of times like Hydroxycut, all these weight loss type commercials would come on and then if my grandma's sitting next to me, it would be like, so, "Hey, do you ever try that?" There was this whole cycle there, a commercial would come on and someone would make a comment directed at me and then back and forth every time. Not so much as now, but-- Because I've been much stricter with them. I've gone from defensive to "I'm sorry, that's your opinion, keep it to

yourself."

Ajooni followed this story with a discussion of the way her ethnic culture plays a role in the stigmatization she experiences as a fat, Indian woman. She also shares how, as a South Asian woman, she interacts with targeted advertising around eliminating fatness in South Asian communities by encouraging bariatric surgery.

> **Ajooni**: Indians have their own channel and their own little boxes of devices and within South Asian television shows and channels, half the time it's like, "come to India to get bariatric surgery done". I kid you not. There's so much stigmatization on fatness, and then you see that within South Asian channels as well now, which is sad. I think it's sad because it makes it-- There are people who've considered it, I've known people who've gone back to India just to get it done because it's a cheaper option.

For the women who I spoke to who identify as racialized, the influence of race and ethnicity could not be separated from their relationships with their fat bodies. They shared how they feel seeing representation in the media and how the representation of fat, racialized bodies (particularly of celebrities) influenced their relationship with their fat racialized bodies.

> **Lisa**: That's reflected in the media and then I guess the other thing with media is again with-- Even with fat people and fat celebrities, you look at them and especially with people of colour and obviously there's a lot of different aspects and pressures going on because they are people of colour, but the bariatric surgeries that have been going around.

The pressure that they're feeling to lose weight despite the fact that they were media role models for fat people.

Ajooni: Myself, I've never seen an actual plus size woman of color on television unless they're in black-based films, black family-based films and even then they're described and totally demonstrated and characterized in a different way. When the majority of the time it's white, thin women. I know with me that's one reason why I've struggled with body image issues because there was no representation in terms of myself.

Cheryl: This idea that black women are culturally immune to weight loss, to eating disorders, to fat preoccupation, it's all a lie. It's all a lie because we are living under the same sun. It's racist to think otherwise, quite frankly.

Kelsey: Is this a big line of thinking? This isn't one I'm familiar with.

Cheryl: Oh my God. Yes, it is a big line of thinking. There's a lot of research on women of colour and there's this resilience theory and they're "culturally immune" and well the more they know about their blackness, the less they care about fitting into Eurocentric body ideals, it's outdated if you ask me. It's outdated because it's just not real.

Gard and Wright (2005) examine the visibility of the 'war on obesity' in the media. They argue that obesity is constructed as an increasing global threat and a ticking time bomb for youth. News media employ imagery of overweight people, especially children, to underscore the constructed growing problem of the obesity epidemic (Gard & Wright, 2005). The media draw on the imagery of the 'couch potato', one that perpetuates fatness as occurring due to laziness,

excessive media consumption, and individual decision making (Boero & Thomas, 2016; Gard & Wright, 2005).

> **Cheryl**: The phrase 'Headless Fatty' it really sums it up, I think it is the utmost of disrespect. When you look on the news it will be any fucking topic and then you'll just see a fat person with no head. They're always in shorts or in a T-shirt, or they've got flip-flops on. It's like, what the fuck? That angers me, that really angers me. For me, it's always this hyper-visibility of our bodies as nothings, as these slobbering nothings that seem to just be either aimlessly walking in space or they always catch a picture of someone sitting at a picnic table or something or on a bench. That becomes the image for whatever story it is. Sometimes it's not even about food or weight, sometimes it's about the budget being over.
>
> **Kelsey**: A bloated person.
>
> **Cheryl**: It becomes the trope for anything to do with overdoing it or indulgence or anything, I hate it. The 'Headless Fatty' sums it up in terms of how I feel the media sees fat bodies. When they choose to see fat bodies, because as you know often times fat bodies are invisible.

The assumptions inferred by the media, whether news media, diet and weight loss commercials, or social media, further stigmatize fat folks and increase the oppression they face in society in general as they are seen to be violating social norms and not engaging in good biocitizenship.

Conclusion

Throughout this chapter, I have argued that the neoliberal ideology of individual responsibility, specifically in relation to body size, has resulted in fat women having negative relationships with their bodies and themselves. The adverse effects of responsibilizing discourses around weight loss and good citizenship (i.e., the biocitizen) include engaging in extreme dieting/weight loss practices, exposure to harmful portrayals of fat women in the media, and the pressure to conform to the stereotypes of the 'good fatty'.

In closing out this chapter, I want to share some of the ways the women I spoke to talk about their bodies and their relationship with their bodies. I had asked them how they describe their bodies and to share some of the words they used to describe them.

> **Danielle:** Some days, I'm like, "This body is mine, it does all these things that I love," sometimes I can even be like, "My stomach looks good today." And then some days I'm like, "Oh my god, I'm the worst. I'm super fat and gross, nobody will love me." That's my go-to bad day place.

> **Yasmin**: You know, Kelsey, when I think about it, I try not to describe my body because of the shame that I feel in my body, which makes me really sad.

> **Wendy**: I would say probably 70% of the time, [the term] fat makes me feel great. I love it. It's amazing to be able to claim that word for myself and to recognize that my body is fat and that's okay and how you should be-- like the culture and the environment should be accommodating of me and not the other way around. I think the fat activism in politics and

scholarship has been really helpful in reframing how I think about going throughout the world every day in a fat body. The other 30% of the time, it does feel shitty being read as a fat person because I think, again, you're sitting on one end of the subway seat and someone is on the other side and no one wants to sit in between you because you're a fat person. The 70% of me is saying, "This is amazing. I have more space. Don't sit here. I'm going to put my bag here." The other 30% of me is, "Oh, God, what do people think? I feel so awkward. I'm going to try to make myself smaller." That 30% of the time it just feels shitty and uncomfortable and I feel hyper-aware of myself.

Emma: I would say now I'm less confident naked now then I was before [I lost weight] when I had all that extra weight because my body is shaped differently. Things are fluffier and saggier. I can put clothes on and I feel like a million bucks. In different positions it is like, "Oh where did that come from?". I definitely feel different in my skin naked now since I've lost the weight. I'm trying to figure it out, because [people] really didn't give two shits before and now all of a sudden, they do, so it is just weird to think I am struggling with.

It is notable that even when achieving significant weight loss, Emma still was not happy in her body. Similarly, in the next chapter, we will see how Zoe, who has weight loss surgery, is still 'obese' even when meeting her weight loss goals (as per the bariatric clinic), but is left with saggy skin, an inability to qualify for surgery to reduce the skin, and a dissatisfaction with the result of her weight loss. This dissatisfaction is consistent with what Hartley (2001) calls the 'tyranny of slenderness'; as bodies constantly need to change to try to meet unattainable beauty goals, weight loss rarely results in an 'acceptable' body size.

Chapter 4: Fatphobia in health care: Experiences of anti-fat bias

Yasmin: With my previous doctor, I'd say, "I'm getting my blood sugar tested on the regular because I don't want the diabetes." I would talk about that, getting my blood sugar tested and then I would say, "You know, I'm looking at changing my diet and I need to start exercising." I would bring that up to her. She never said anything. I don't actually think she was concerned about my blood sugar at all.

Kelsey: Why do you think you would say these things to her?

Yasmin: For me, it's like, I want people to know that I know. I know what you're all thinking. I know what you're thinking, so I need you to know that I know. I'm aware that I'm not good enough. I'm aware that I don't meet the standard. I'm aware that I need to do this work. I'm aware that you probably think that I'm fat and lazy, just sit on the couch all the time and eat potato chips. I'm aware of these things and I want you to know that I'm aware of them so that they leave me alone. I think that is what it is.

Introduction

For fat women, visiting the doctor can result in a range of emotions, from frustration, anger, and dissatisfaction, to fear, anxiety, and feeling unsafe. Throughout my interviews, it was clear that for my participants, their experiences with health care professionals were rarely good, and in fact were often traumatic. A common experience for fat women in these spaces is that doctors will attribute any health concern they have to the size of their body (Brown & Ellis-Ordway, 2021; Ellis-Ordway, 2021; Gailey, 2014). The hyper visibility of the body convinces the doctor that the health concern is due to fatness; yet the hyper invisibility of people's lived

experience renders their knowledge about their own bodies and symptoms invisible (Gailey, 2014). Gailey (2014) notes that since most people believe that fatness is intrinsically tied to ill-health, this entrenchment does not disappear with physicians, resulting in the hyper(in)visibility of fat women in health care spaces.

The hyper(in)visibility of fat further enforces the oppression faced by fat women (Gailey, 2004; Prohaska & Gailey, 2019). Ellis-Ordway (2021b), drawing on Tylka (2014), explores the concept of a "weight normative" approach: an approach adopted by some health care professionals in which it is assumed that weight is both unhealthy and under the control of the individual. She notes that this "weight normative" approach has been disproven, as fat people struggle to lose weight despite their best attempts, and that this "failure of weight loss attempts, which happens as much as 95% of the time, results in shame, guilt, body dissatisfaction, and health care avoidance (Mensinger et al., 2018; Tylka et al., 2014)" (Ellis-Ordway, 2021b, p. 74). This approach harms fat folks through the assumption that being fat is harmful to their health, yet the reality is that weight cycling and yo-yo dieting are demonstrably harmful to health (Campos, 2004; Ellis-Ordway, 2021; Lyons, 2009; O'Reilly & Sixsmith, 2012).

In this chapter, I take up the question: With a focus on primary care physicians, how does the advice of medical professionals impact fat women's perceptions of their bodies and their health? Drawing on the experiences of my participants, I argue that anti-fat attitudes held by health care professionals, especially primary care physicians, result in weight-based discrimination for fat women in health care settings, further entrenching fatphobia in health care (Alberga et al., 2016; Amy et al., 2006; Balkhi et al., 2013; Brown & Ellis-Ordway 2021; Brown & Flint, 2013; Chrisler & Barney, 2017; Donoghue, 2014; Foster et al., 2013; Green & Brownstone, 2021; Hebl & Xu, 2001; Kasardo & McHugh, 2015; Miller et al., 2103; Puhl et al.,

2014; Schwartz et al., 2003). The stigma attached to being in a fat body, especially in health care spaces, results in fat women's internalization of shame about their very existence. This shame is demonstrated through feelings of moral failure (Lanipher & Cory, 2021) around an inability to lose weight, despite the insistence of their doctors and their own best efforts, the continued discussion of their weight and suggestions for weight loss by their doctors, and the physical environment of the doctors' offices (Shanouda, 2021) that limit the ability of the patient to fully participate in their own care. These experiences result in negative or non-existent relations with doctors and, ultimately, can result in denial of care (by the doctor) or avoidance of care (by the patient).

In this chapter, I share my participants' experiences with fatphobia, anti-fat bias, and discrimination in health care settings. Through the lens of disciplinary medicine, I explore my participants' experiences and lay out how biopedagogies of obesity help to understand the power relations between participants and their doctors. The hyper(in)visibility of their bodies in health care spaces resulted in participants feeling both dissected based on the size of their body while simultaneously their health concerns were ignored and overlooked. The hypervisibilty of their body also resulted in feelings of extreme shame and embarrassment. Many participants noted that these experiences would result in them taking precautions in advance of a doctor's appointment to try to minimize the impact of weight-based discrimination at the doctor's office.

Participants also spoke of the ways in which health care spaces are not equipped or set up to physically handle large bodies. This often resulted in anxiety and fear of attending health care appointments, as participants knew their fat bodies would not be accommodated. This lack of accommodation is a form of disciplinary medicine, in that by not accommodating the fat body it becomes clear that the fat body is not acceptable and needs to change.

Since the fat body is seen as unacceptable in health care spaces, my participants describe the ways their doctors encouraged them to change their bodies. Extreme dieting, especially when they were children, was a common suggestion by my participants' doctors. Additionally, many participants share how they were encouraged to undertake weight loss interventions like taking medication that encourages weight loss or undergoing bariatric surgery.

Ultimately, this chapter concludes by showing how fatphobic experiences in health care settings and anti-fat biases held by health care professionals negatively impacts the doctor-patient relationship. The result of this impact is that many fat folks experience inadequate care, are afraid of visiting their doctor, and may avoid care altogether.

Disciplinary Medicine

In this chapter, I root my analysis of my participants' health care experiences in the practice of disciplinary medicine and the medical gaze. Managing, surveilling, and regulating the constraints of appropriate body shape and weight act as normalizing mechanisms that manage and segregate people (Harwood, 2009). Such normalizing mechanisms occur pedagogically through complex and relational cultural practices that produce bioknowledge, through what is known as biopedagogies. Biopedagogies act as a control function with contemporary biopower and contribute to the regulation of the population and to individual discipline (Harwood, 2009). Specifically, according to Harwood (2009), biopedagogies of obesity are useful in analyzing the impact of relations of power in constructing the contemporary health subject.

Murray (2009) notes that it is through socialization that biopedagogies occur, as socialization perpetuates societal norms of aesthetics and puts forth meaning about the way

bodies are understood. Medical narrative, to Murray (2009), constructs weight as personal responsibility. She argues

> visible bodily markers (such as fat flesh) are read in ways that position subjects on either 'acceptable' or 'unacceptable' side of the normal/pathological binary equation that signify subjects as either adhering to the requirements of 'healthy' ethical living, or as engaging in 'unhealthy' behaviours that position one as a moral and aesthetic failure. (Murray, 2009, p.78)

Murray (2009) describes the fat body as a form of 'forced confession'. Drawing on research by Elizabeth Grosz, Murray (2009) argues that the practice of coding, giving meaning to, and reading bodies is problematic as the thin body is read as the healthy body. Those who are obese are seen as 'immoral' subjects, and by virtue of their visible fatness they are confessing to such immorality. This 'forced confession' is especially present in health care spaces and through the medical gaze.

The medical gaze, and in turn the doctor's gaze, is structured on the subjectivity of the doctor themselves, which is based on the doctor's perceptions (Murray, 2008). This means that perception of medical understandings are productive, and Murray (2008) argues that perception is a necessary function of power and knowledge. The clinical gaze is then informed by the perceptions of doctors. What Murray (2008) is arguing here is that the doctor is the subject who possesses the knowledge and power, informed by their perceptions, and this knowledge and power is reproduced onto their subjects (the patient). Since the perceptions of doctors are subjective, the dominant understanding of medicine as objective must be questioned (Murray, 2008). With respect to fatness, the fat body is always visible when it comes into contact with

doctors, and this visibility and the accompanying perception of the doctor is believed to correlate to knowledge about fatness (Murray, 2008). In the doctor's office, the fat body 'confesses', absent of any discussion. This confession often results in the pathologization of fat bodies, and as Murray (2008) highlights, the fat subject always performs a silent 'confession' – one of pathology, indulgence, disease – and this confession occurs before the doctor has even spoken to the fat patient. This confession, the look of the patient, influences the diagnostic and medical process (Jutel, 2009).

A shameful experience: "They told me that they needed eight people to hold me down, to roll me over. I felt like a freaking whale when they said that but I'm like, 'Whatever'"

Fatness, and therefore the fat body, are paradoxical (Gailey, 2014). The fat body is hyper visible, like other non-discursive appearance characteristics such as race, sex, ability, gender, and ethnicity, it cannot be hidden (Gailey, 2014). Non-discursive characteristics quickly communicate our situated identities to others, resulting in people making assumptions based on what they can see, not what they know. Fatness is worn on the body for all to see and to publicly dissect (Gailey, 2014; Murray, 2008), imparting 'common knowledge' of these bodies that are rooted in stereotypes and assumptions. Where the paradox exists is that fatness is also hyper invisible, meaning that fat people experience marginalization and erasure based on their body size (Gailey, 2014). The hyper invisibility of fatness can happen both explicitly in institutions (like the media and medicine) and implicitly in interpersonal networks (Gailey, 2014). Gailey (2014) refers to this paradox as the hyper(in)visibility of fat women – when fat women are both paid exceptional attention to, as they cannot physically hide based on the sheer size of their bodies, or exceptionally overlooked, where their needs and lives are dismissed. This

hyper(in)visibility, according to Gailey (2014), focuses on the extremes. It is not simply that fat bodies are either visible or not, it is that they are either hyper visible, dissected or made to be a spectacle, or hyper invisible, in that they are not just invisible, but erased.

Fat women straddle the line of being either hyper visible as well as experiencing invisibility and erasure. Below, Amelia shares a negative experience of attending a doctor's appointment.

> **Amelia**: I went into the office the morning of the appointment and the chairs were not just inaccessible. These are chairs that I hadn't seen in a really long time, the black leather with the metal arms that cover the whole side, and then wood. There is no way. There's absolutely no way. I walk into the office and I'm immediately like, "This is going to be awful." I walked up to the reception desk where the person would not look at me. They would not make eye contact with me and they said, "The doctor will be with you" or "We'll put you into the other room soon," and they told me to wait.
>
> I'm standing in the waiting room in a corner trying to make myself as small and invisible as possible, feeling all of the shame and the awfulness that had just happened from this interaction. I walk in, they pulled me into the exam room. I have never worried about the actual exam table at a doctor's office before because it's an exam table. When I think of an exam room, I picture a giant thing with all the cabinets and stuff underneath it that looks stable as shit. It's stable as anything. I walked into this room and there was this rickety old massage table with the tiniest little legs.
>
> ... I look for a chair and there's no chairs except for the same ones that had been in the waiting room, so now I'm standing in the exam room again. I still get so worked up about it.

> [it was] just completely unwelcoming. There was nothing in that office that even allowed for my existence let alone welcomed it. Then the doctor walks in and he says hi and he says grab a seat, and I'm like, "That's not going to happen." That table, there's no way. Then he's like, "What about a chair?", and I'm like, "That's not going to work either." He just looks at me and he turns back to his computer and starts pulling out my medical records while I'm standing. I'm like, "Sure," there didn't seem to be any other options

Exploring Amelia's experience while taking up Gailey's concept of hyper(in)visibility in health care discourses allows for an examination of the way in which fat women, when they visit their health care provider, are hyper visible. Their fatness is immutable, and the care they receive is often impacted by the visibility of their body size, evidenced in the apparent inability to accommodate larger sized bodies in Amelia's doctor's office. Yet they are also hyper invisible; their health care concerns are often minimized or neglected, with the recommendation that weight loss will improve their lives, the covert messaging behind creating a health care space where large bodies are not accommodated. In addition, this advice often comes regardless of whether the patient has asked for weight loss advice.

Receiving unsolicited weight loss advice, an experience which many of my participants share, is a form of disciplinary medicine. Disciplinary medicine, according to Murray (2009), relies on morality to enforce control and regulation over people's understandings of their personal responsibility for their weight. Murray (2009) draws on Foucault's theory of confession and posits that the implication for fat bodies is that an obese subject is already known as problematic as their body serves as a silent confession. This silent confession confirms societal

understandings of the fat body as a diseased and as pathological, regardless of truth behind this claim (Murray, 2008; Murray, 2009)

Disciplinary medicine relies on people to self-surveil, so people must believe that it is their responsibility and their choice to improve their bodies using available knowledge (Murray, 2008). This self-surveillance is built on medical narratives that encourages people to monitor themselves in order to comply with 'good' health, and these narratives are built on 'expert' medical knowledge (Murray, 2008). Internalizing this 'expert' medical knowledge results in the internalization of the 'clinical gaze', where people believe they are doing what is best for themselves based on the perspective of medical knowledge. Disciplinary medicine relies on the illusion of personal choice; people need to believe that they have chosen to engage in behavioural change of their own volition, that it is their moral duty to change (Murray, 2008). When they do not succeed at behavioural change, they are considered to be moral failures (Lanipher & Cory, 2021; Murray, 2008). Their failure is their own individual responsibility.

This feeling of failure was either explicitly expressed or underlined many of the experiences that my participants shared with me. For example, I asked Danielle how visiting the doctor made her feel; this following experience occurred at a doctor's appointment where she received unsolicited weight loss advice.

> **Danielle:** Yes, it made me feel like I was wrong. Like my body was wrong and that it was my fault that I couldn't be right, which was thin, so I had a lot of blame. I was holding a lot of blame.

In this experience, Danielle describes the feelings of shame and blame that she felt. This example is similar to Amelia's where her body was hyper(in)visible; her fat body was on display for her doctor to comment on, yet her health care concerns were neglected and ignored in favour of weight loss discussions.

Knowing that their doctors would focus on their weight over their health concerns, many of my participants shared how they would lie to their doctor in order to bypass or conclude weight loss discussions, in effort to get to the actual reason for their visit. For example, Wendy went to see her doctor about snoring, concerned about potential sleep apnea. When her doctor focused only on her weight opposed to any further exploration, Wendy lied and told her doctor she was engaging in "healthy" behaviours, like exercise and diet.

> **Wendy:** [Recently I told my doctor] I was snoring really loudly. I wanted to check out what was going on because I thought it was maybe affecting my sleep, or I just think it wasn't something that was comfortable for me anymore. She was like, "Okay. Well, first, I would suggest that you try to lose weight. How often do you exercise? What's your general diet?" I just lied about it; So it was like, "Yes, I exercise three times a week. I eat really healthy," just to get her to move on. Then she's like, "Okay, well, I would suggest losing weight." She's like, "I can also refer you to a sleep clinic." I was like, "Okay, there we go. Maybe that should have been the first option." That was really frustrating because I felt my concern wasn't heard. It was totally attributed to my weight and-- like she's a general family practitioner. Is she qualified to be doing that? Also, knowing the research behind advising weight loss, that just seems super ethically irresponsible.

Other participants discussed lying to their doctors when they didn't want to disappoint or let them down. In reference to seeing a doctor for weight loss, Danielle shared what it was like when you oscillated between weight loss and weight gain while being monitored by a doctor.

> **Danielle:** You felt really good if you lost weight, like, man, people were so nice to you. If you didn't or if you gained, especially if you gained, obviously, they were just so disappointed in you.
>
> **Kelsey:** How could you tell they were disappointed?
>
> **Danielle:** Just the looks on their faces and just their general, like, "Well, try better next time," and, "Maybe you shouldn't have eaten this and this and this," and looking at your little fucking chart thing. Oh god, MyFitnessPal. That would be like, you'd use that as your-- first they had it on paper, but then when MyFitnessPal started and then you'd use that-- the amount of times I lied, too. I would lie to high heaven about everything I ate, and they'd still be like, "You're just not doing good enough." Whatever.

Danielle's experience with weight loss also draws on a contemporary example of self-surveillance around health: the rise of wearable technologies and health tracking applications. These technologies are contributing to a rise in biopower (Ward et al., 2018). Wearable health technologies, like the Apple Watch or the FitBit, reinforce notions of healthism by using 'expert' knowledge (built into the software) and modern science to monitor and regulate individual health (Ward et al., 2018). Individuals, in their understanding of their health as individual responsibility, self-monitor by using wearable technology, and thereby further normalize the role

of self-surveillance in the upkeep of health (Ward et al., 2018), while focusing on health targets set out by the technologies.

Gailey (2014), referring to Foucault's notion of the panopticon, notes that people engage in these self-disciplining behaviours because they are worried that someone could be watching, and therefore judging, them. And in the instances shared by some participants, like Wendy, people were watching and holding her accountable to the information she entered into the health tracking application MyFitnessPal. Wearable technologies and health tracking applications further self-disciplining behaviours. Often, users are able to sync their data with other users or friends in order to compare / hold themselves accountable to health goals. Even if another person is not watching, the technology is.

Preparing for the visit: "There's part of me that the anxiety brain just takes over and the shame and the fear and the panic, I get really panicked. There's the other part of me that's like, "Oh, fuck the fuck off." Like, "Just go to hell," and so it's an interesting experience"

The stigma associated with being in a fat body and accessing health care services is felt even prior to showing up at the doctor's office. For fat folks, regardless of race, gender, or education level, Brown and Ellis-Ordway (2021) note that doctors "often are unhelpful (at best) or cruel (at worst)" (p. 1). Brown and Ellis-Ordway (2021) highlight research by many scholars who find that over 50% of doctors describe their fat patients as "ugly, lazy, noncompliant, weak-willed, dishonest, and unintelligent" (p. 1) (see, for example, Campbell et al., 2000; Ferrante et al., 2009; Fogelman et al., 2002; Foster et al., 2003; Hebl & Xu, 2001; Huizinga et al., 2009; Price et al., 1987; Puhl & Heuer, 2009). Greene and Brownstone (2021) argue that "weight stigma does not originate in the fat body, but rather is built and reified in relational encounters

between bodies", noting that "although providers may aspire to a disinterested clinical gaze, they are not immune to visceral aesthetic responses when engaging with fat individuals under their care" (p. 126). Feelings of disgust held by health practitioners, even if involuntary, are not benign; these feelings are central to the ways in which weight stigma is enacted against fat patients (Greene & Brownstone, 2021). These feelings are not unknown to fat folks; instead, these understandings by doctors influence fat people from accessing care altogether (Brown & Ellis-Ordway, 2021; Greene & Brownstone, 2021).

My participants shared with me how visiting the doctor, in and of itself, is an emotional experience. I asked my participants how they feel before going to the doctor's office, and many expressed feelings of anxiety, shame, and hypervigilance. In answering this question, many participants told me that they do prep before going to the doctor. For example, Wendy plays out with her partner how the appointment may go.

> **Wendy**: I'll oftentimes talk with my partner. It'd be like, "Okay, if she says this, how do I respond to that? If she says that, what are some things I could say?" Or reading blogs about other people's advice about it so I found that to be helpful, but even just having to take the time and resources to do this research, I think it is so ridiculous in the first place too.

Amelia discussed how she engages in self-care prior to going to the doctor, including taking anti-anxiety medication to calm her anxiety prior to the appointment.

> **Amelia:** Self-care practices are essential for me before I walk into a doctor's office. Breathing exercises often while I'm at the doctor's office are essential for me to actually be able to stay and then repair work afterwards. I meditate frequently. I have to medicate myself [with anti-anxiety medication] to be able to go get the refill.

Another approach taken prior to appointments was to prepare as if they were going to a business meeting. For example, Kristina said "I prepare like I'm going to the lawyer. I think of my primary argument, and I think of my backup evidence". Here, she is preparing the arguments she will use with her doctor should weight loss be discussed or suggested. Cheryl also shares the preparation she does prior to going to the doctor; here she talks about the ways she tries to make herself look pulled together and professional, in order to gain the doctor's respect.

> **Cheryl:** Oh, God, I'm full of anxiety. I make sure my face is good, I make sure my hair is good, I make sure I have a great little outfit on. Sometimes I've even gone to the office with a briefcase or some sort of a bag apparatus so it just kind of looks like I'm coming from somewhere. I know it sounds ridiculous. Especially if it's a doctor I only see once in a while like my specialist or definitely hands down if it's a first-time visit. Oh, my God. If it's a first-time visit, hell, I'll even bring a business card just in case. I come prepared. I come to a professional meeting. Imagine that anxiety.

Elsewhere in my interview with Cheryl, she discusses how she experiences her Blackness and her fatness together, how she does not exist in just one of those identities. The way she prepares herself for health care appointments comes from the intersection of being fat and Black,

and the way those identities marginalize her in health care spaces. Shaw (2006) notes that "fatness and blackness have come to share a remarkably similar and complex relationship with the female body: both characteristics require degrees of erasure in order to render women viable entities by Western aesthetic standards" (p. 1). Similarly, Brown and Ellis-Ordway (2021) highlight how "for those with multiple marginalized identities, the harm they experience at the hands of medical professionals can be even worse; they face the stigma of not only their race, their gender, their income levels, their (dis)ability, and/or their queerness, but also their weight (Cox, 2020; Ellis-Ordway, 2019; Farrell, 2011; Greenhalgh, 2015; Hebl et al., 2003; Lind, 2020; Oliver, 2006a; Rinaldi et al., 2020; Robinson, 2020; Strings, 2019)" (p. 1). Through her preparation in order to appear professional, Cheryl tries to combat that erasure of her fat Black body. Brown and Ellis-Ordway (2021) remind us that people with multiple marginalized identities experience greater harm from health care professionals, and that the stigma of their race, gender, and weight (and other possible marginalized identities: in Cheryl's case she is also a queer woman) result in experiences of greater harm.

It is evident from Cheryl's example of her pre-visit preparation, as well as the experience shared from other participants, that fat folks engage in mental and physical preparation before visiting health care professionals in an attempt to minimize the harm that they may experience.

Physical space: "If I have to go into a medical setting, I go in with the assumption that my body is not going to be accommodated."

The anxiety that happens for many fat folks who are trying to access health care services is often coupled with a fear that their body size will limit their access to care on the basis that medical equipment in a doctor's office is too small, or ill equipped to handle fat bodies. This is

evident in Amelia's visit to the doctor's office, outlined above, where upon arrival it was clear the office was not outfitted with equipment that supports her body size. Amelia's experience is not unique; for example, in his work, Shanouda (2021) shares experiences of his doctor's concerns that his body size may be too large to get an MRI, or how his blood pressure is not taken at the doctor's office because they don't have cuffs large enough. He describes his experience trying to find an MRI machine in Toronto that would accommodate his size. His doctor did not know what hospitals would have one. Shanouda called the two Level 1 trauma centres in Toronto to see the capacity of their MRI machine and they have a maximum weight of 550 pounds (Shanouda, 2021). He called 15 hospitals in Toronto, the union of radiologists, Telehealth Ontario (which provides free advice from a registered nurse), and searched Google. None of these resources were able to identify a fat-accessible MRI machine.

For many of my participants, this fear is ever present when visiting the doctor or a health care professional. Below are some of the thoughts my participants shared regarding their fear of being too fat for the doctor's office.

> **Karen:** I've heard horror stories. If I have to go into a medical setting, I go in with the assumption that my body is not going to be accommodated, that it's going to take an extra gown, or that if they don't have a bigger cuff, I just have to go without getting my blood pressure taken, or if I ever do need an MRI, I'm going to have to settle for some other scanning device like a CAT scan or whatever, that doesn't give you as good of a picture of what's going on … It's almost like I anticipate substandard service, and I'm almost accepting of it because as long as I don't feel dehumanized by the way they're speaking to me or something, fine.

Megan: There's a lot of anxiety I experienced with the tests that I needed to get, I've never been in an MRI before. I barely fit in an MRI. I went to the hospital and they were great and they had two MRI machines and they're like, "We're going to wait for the other one," [laughs] and it was like, okay, we'll do that. The scrubs don't fit, the bottoms don't fit that they provide because they only go up to a large that stretches about this big and it's like … I'm definitely a larger fat person, but I'm not a super large fat person and if I have trouble worrying about the MRI and barely fitting in the MRI, what is somebody not getting? What test are they not getting because of it? I had to have a lumbar puncture, and I had to have it done not how they normally do it. Normally, they would just have you bend over and do it. I had to have it done by an X-ray technician, it was a team because they couldn't access my spine well enough because I'm fat. It's a huge ordeal every step of the way because our entire healthcare system doesn't seem to be designed to handle this very large segment of our population.

Imogen: There are mandatory things that they do, if the assistant brings you in, she takes your blood pressure, and she asks why you're there. I go probably once every other week, I'm there quite a bit. They have just stopped even trying to take my blood pressure, they don't have a big enough cuff. They don't know how to do it.

Ariel: I never sit on the exam table, because it is old and rickety and it's not-- I worked in healthcare, it's not a bariatric table which is a pretty fucking terrible name to call a table for the bigger people. No, I never sit on my doctor's table, no, there's no way. First of all, it's too

high off the ground and I'm not stepping on that plastic stool from the dollar store, because I'm going to fall and break my fucking hand. No, I always just sit on the chair. The chairs have the arms, so you are squished out of it. I'm pretty busty and have pretty wide shoulders. Yes, so I sit very uncomfortably and hate every minute of it.

The concerns shared by my participants above, and outlined in Shanouda's work, are concerns I relate to as a fat woman myself. I am terrified of needing an MRI. The only time my blood pressure has been taken in recent years was when I was pregnant with my son and attending a high-risk pregnancy clinic specifically for "obese" women. Any other time, my blood pressure is skipped over. Shanouda's (2021) experience searching for a fat accessible MRI machine sticks out to me because I have a vivid memory as a teenager of hearing about a fat friend of the family who was having an emergency health situation. She was a very large woman, and they did not have an adequate scale to weigh her. She was transported to a nearby zoo to use their scale to weigh her because they couldn't weigh her on the conventional equipment available. As I was writing this, I could not remember if this was something I imagined or if it had happened, so I Facetimed my mother to confirm. This was not the overactive imagination of a scared fat child; instead, it was an actual traumatic experience for a family friend that imprinted on my young self. I internalized her trauma; I have never forgotten this and have always feared that one day that could be me.

Doctor's offices, medical equipment, and other health related materials are not made with the fat patient in mind. As Shanouda (2021) notes, "scales, blood pressure cuffs, examination gowns, pelvic examination instruments, MRI and CT scanners, rollators, wheelchairs, hospital beds, even chairs (in waiting rooms and doctors' offices) inform fat patients of their

unacceptability as (fat) people" (p. 30). All of these serve as reminders to fat patients that their bodies are unacceptable, and that health care is not a safe space for them. The inability of health care equipment to accommodate fat patients is understood from a neoliberal ideology; it is not the job of the equipment to fit the fat body, but it is the job of the fat patient to reduce their size to an 'acceptable' standard where they are then seen as worthy of accessing care. As skelton (2022) describes in their zine *Lies Fatphobia Taught Me,* "fatphobia tells me that if I hurt, or if something is wrong with my body, it's probably my fault because I am fat. Fatphobia says I'm too big for the machine, too big for the chair. It ignores that someone decided to make it too small" (p. 211).

The disciplinary effect of BMI: "When I see people like, "You need a BMI of this." [I think] if I was that I would be malnourished to get down there."

The development and use of the BMI scale is an example of controversy contributing to the moral panic around obesity and one way in which biopower is exerted. According to Halse (2009) "BMI norm has progressively colonized the policies, practices, and procedures for measuring and documenting weight" (p. 46). The BMI scale is now the standard for understanding the weight of individuals and the weight of populations (Campos, 2004; Halse, 2009; Gard & Wright, 2005). Halse (2009) argues that the use of BMI as a standard is problematic as it uses language of scientific positivism to portray the BMI scale as objective, when, as demonstrated in Gard and Wright (2005), the BMI scale fails to account for any variation in bodies (such as ethnic origins or body composition) outside of height and weight, and as Flegal et al (2005; 2013) found, does not accurately demonstrate risk.

In understanding why BMI is still used, when arbitrary and contested, it is useful to draw on Halse's (2009) discussion of virtue discourse. According to Halse (2009), virtue discourses are "sets of values, beliefs, practices, and behaviours that establish regimes of truth and shape subjects and subjectivists by articulating and constructing particular behaviours and qualities as worthy, desirable, and necessary virtues" (p. 47). Even though the BMI scale is arbitrary and contested, its use has become normative in discussing weight and bodies, and therefore is a virtue discourse. Normative BMI as a virtue discourse is moralistic, and stresses society's ideals of a culture of thinness. Halse (2009) argues that "through the operation of biopower – the regulation of subjects by the state – the virtue discourse of a normative BMI constructs subjects who have material investment in maintaining the discourse" (p. 49). By this, she means that by constructing BMI as a normative measure for understanding weight and its supposed relationship to a myriad of problems, people are invested in supporting the discourse of BMI by regulating and policing themselves. Having a low BMI would demonstrate self-discipline and restraint, whereas having a high BMI is seen as failure.

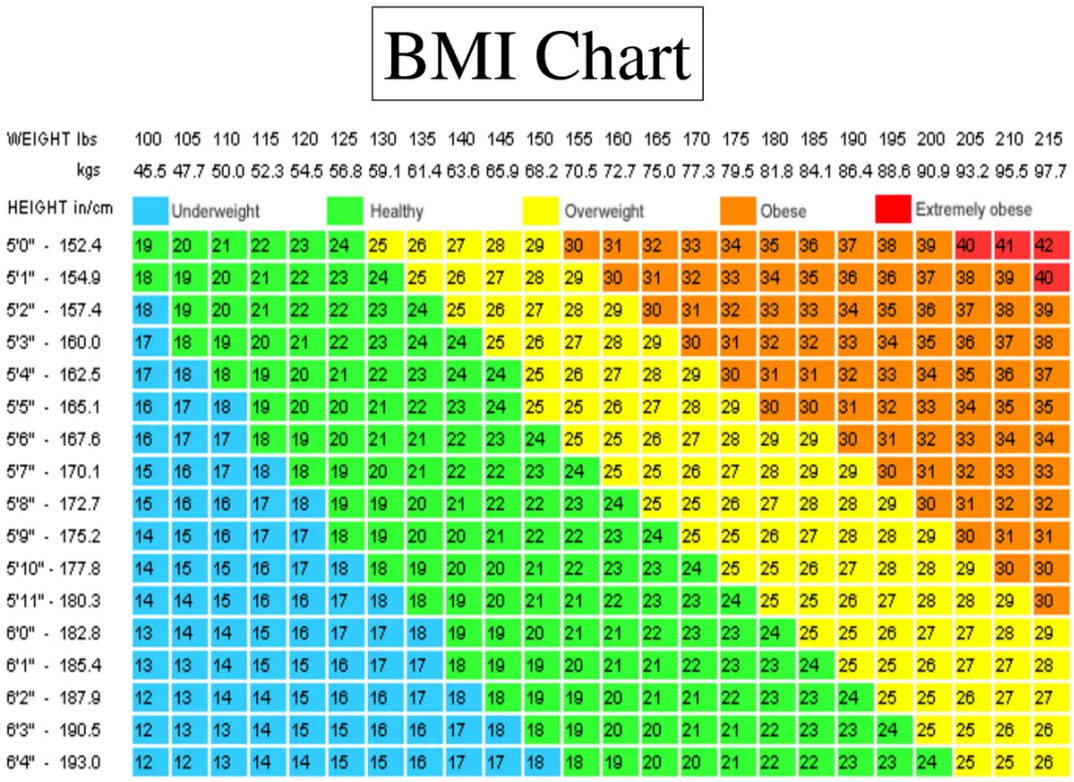
This preoccupation on weight, fatness, and BMI impacts what is seen as citizenship. In her work on biocitizenship, Halse (2009) describes a new species of human, the biocitizen. The biocitizen is a product of a global moral panic around the obesity epidemic. This biocitizen is governed by biopedagogies and biopower (Halse, 2009; Harwood, 2009). Biocitizenship, she argues, has emerged as a way to categorize people and society. The biopedagogies of obesity are crucial in analyzing the impact of the relations of power on how the contemporary health subject is formed (Harwood, 2009). In such constructions, normalizing mechanisms that dictate appropriate body shape, and weight act to manage and segregate people. The control function of

biopedagogies in contemporary biopower is their contribution to the regulation of the population and the discipline of the individual (Harwood, 2009).

BMI and height-to-weight ratios were on the minds of almost all my participants; for the most part, the BMI scale was used as a tool by their doctors to shame them into weight-loss. In my own experience, I remember being a young teenager, maybe 13 years old, and visiting my doctor about a non-weight related issue. She proceeded to pull out the BMI chart, an experience many of my participants have also had, and plotted out my height and weight on the chart. I was about 5 feet tall and 200lbs. Figure 4.1 below is near identical to the BMI chart I was shown as a child (and, in conversation with many participants, the same one they were shown). Plotting my 13-year-old body on this chart placed me the furthest to the right on the chart, under the category of "extremely obese". I vividly remember my doctor pointing to the green 'healthy' section of this chart and telling me that I should strive to reach the goal of having a BMI in that range, which at my height would be a maximum weight of 125lbs. Not only did this feel impossible and overwhelming, but she followed this up with a reminder that if I continued at the rate I was going, I would be "off the charts" unhealthy, literally as my BMI would be so high that it was unimaginable to the creators of this chart and would fall outside its bounds; truly a 'body out of bounds' (Braziel, 2001).

Figure 4.1

Body Mass Index Chart



Note: From Business Insider, 2018

The BMI chart loomed large for many of my participants[4]. Gina and Paula shared with me an experience similar to my own.

[4] I asked a colleague of mine to review this chapter for me as I worked through my dissertation; she left the following note which, to me, speaks to the widespread reach of this specific chart: "this ridiculous chart. I remember doing an exercise in high school where we all did the chart together, which now that I think of it, what a great opportunity for bullying, what were they even thinking (that we would be bullied into compliance with the norms)" (personal communication, 2022).

Gina: There was the one time that they told me I was overweight, and they pulled up the BMI chart and told me to lose weight and gave some advice, which I remember feeling a lot of shame about that … I gained a lot of weight, but I hadn't noticed. It wasn't until then, that I really realized that something was "wrong".

Paula: Okay, so I mean it's hard because you can Google this chart and it's been based on what, like your height, which is not reasonable for a lot of the times. But I would say-- I don't know, because I think it was a long time ago. I am five foot eight and I think I'm supposed to be 135, 140 pounds, so something like that. I wouldn't even consider if I was 160 being overweight, but because I am over 200, I am overweight at that point. So it was just something that I've given myself.

According to Harwood (2009), drawing on Foucault, biopower is where the sovereign powers are inflicted on lives to conserve or protect life through power. One key example here is the practice of regulating health and health policy (Harwood, 2009). Biopedagogies, then, serve two functions: they draw attention to the ways in which the biopolitical sphere has pedagogical power and offer a way to interrogate the hidden pedagogical practices of biopower (Harwood, 2009). The biocitizen learns to be good and productive through moralizing messages of health (LaMarre, Rice & Jankowski, 2017). The biopedagogies of anti-obesity discourses are built on neoliberal assumptions of health (LaMarre et al., 2017). Neoliberalism not only shapes the social and economic structure of Western society but impacts the personal lives and embodiment of people living under neoliberalism (Harjunen, 2021). Drawing on Ventura (2012), Harjunen (2021) explains how the values and norms in society today are shaped by neoliberalism, and the

everyday lives of people become organized and regulated through this system. Ventura (2012) calls this organization “neoliberal culture”, and Harjunen (2021) examines the fat body in the context of this “neoliberal culture”. As Harjunen (2021) describes:

> neoliberal culture has its normative or “preferred” body, the norms of which are based on self-control, productivity, and individual morals. In order to become a successful neoliberal subject, ability to perform this ideal or preferred body is crucial. Achieving the preferred body requires self-monitoring or self-disciplinary behaviour and apparent failing in self-governing is interpreted as a social and moral failing that results in social sanctions. (pp. 68-69)

The biopedagogies of anti-obesity discourse, and the subsequent neoliberal assumptions of health, were evident throughout my research. Many participants expressed their frustration with their own internalized, neoliberal understandings of their body and their health, in combination with disappointment when they felt that they were doing all they could to lose weight, while that weight loss never seemed to be enough for their doctor. For example, Ariel shares her experience with weight loss, Weight Watchers, and her doctor’s disappointment.

> **Ariel:** When I started Weight Watchers, I weighed 234 pounds. I was 16, so over that six months then I lost 120lbs, so that would be, 150-- I weighed about 152lbs. I'm 5'8", 152 pounds. I remember going to my doctor and my doctor saying, "You're still considered overweight." I was thin. Like we're talking bones were popping out. I was wearing a size-five pant. Like little, little, little, and I remember coming out of that doctor's office and being like, "I knew I was still fat. You guys are all telling me that, no, I'm slim, I'm slim,

> I'm slim." I'm like, "No, I knew it. Did you hear what she said?" I remember, so a week after that, I went hard at the gym, I wasn't eating. I cut down to 137 pounds. I couldn't maintain it, but that was the smallest I'd ever been. Looking at the BMI online, I was still considered slightly overweight, you should lose 10 pounds. I see pictures of myself now, I look at that young girl and be like, "You're so broken. Like just the sunken and just my hair was falling out, just the fucked up things, but no, no, no, you're still too overweight. You still need to keep going."

BMI is also being used by health care professionals to deny gender affirming surgeries for transgender and gender non-conforming people (Brown & Ellis-Ordway, 2021) based on the argument that transgender people with higher BMIs pose too great a risk to negative health outcomes from the surgery. This denial of access to life changing (and, perhaps lifesaving) surgery is not based in evidence of negative health outcomes for those who do have surgery (Rothenberg et al., 2019). This was particularly pertinent to my participant Faith, who shared with me their struggle to obtain gender-affirming surgery.

> **Faith:** I had a really fatphobic experience with a surgeon for gender-affirming surgery. Basically, they eventually approved me for surgery … I waited a year and then in my pre-op [appointment] two weeks before the surgery, they calculated my BMI and then I was denied surgery. It was already a two-year wait for surgery.

In their work on fat trans bodies, Marshall (2022) similarly shares their experience with BMI and surgery – both gender-affirming surgery and knee surgery – noting the contrast

between the two. When they needed knee surgery, their BMI was not seen as a risk factor for determining their suitability for surgery, yet when they tried to seek gender-affirming surgery, Marshall (2022) describes how BMI was used as a tool to shame them and deem them not fit (or deserving, as Marshall describes it) of gender-affirming surgery. In trying to access gender-affirming surgery, Marshall (2022) describes their experience with the plastic surgeon:

> the next stage of the visit to the plastic surgeon was the dreaded fat talk. Friends of mine who had been here had forewarned me about it and I had steeled myself for this. From the moment the cisgender-male surgeon walked into the examining room with his inhumanly high and full cheekbones, I was no longer a patient. I was an 'obese' patient that became an object of an anti-fat examination (p. 507).

This use of BMI to deny folks access to surgery is similar to the use of BMI to deny access to IVF treatment for people trying to get pregnant. In my personal experience, as a woman trying to get pregnant using fertility services, I was immediately told that there is a BMI cut off for IVF treatment and I would only be allowed to try non-surgical interventions for getting pregnant, such as an intrauterine insemination (IUI). Even then, I had to fight, advocate for myself, and switch fertility clinics (see Ioannoni, forthcoming, for a detailed look at my experience) to be allowed to try and get pregnant at a fertility clinic.

Diet culture: "[The doctor] had this lovely story about his wife, about how she essentially starved herself and that's how she was able to lose weight and keep it off."

Concerns around body size and the regulation of people's weight start very early in life. For myself and many of my participants, the surveillance of our bodies is common throughout our adulthood; however this surveillance started in childhood.

Childhood

The surveillance of body size starts at an incredibly young age. Specifically, childhood obesity is seen as a major societal problem, and is similarly discussed in the discourse of 'epidemic' (Wright, 2009). Children are seen as an 'at-risk' population, and as such they are in need of intervention to prevent or correct their 'obesity' problem (Harwood, 2009) and one of the primary sites of this intervention is the family (Harrison, 2012). As Harrison (2012) finds, actions taken to reduce childhood obesity often rely on the regulation and monitoring of children's bodies.

Parental focus on the bodies of their children is not a new phenomenon, Quirke (2016) notes that experts have been advising parents to focus on their children's bodies and how they, as parents, care for their child's body. However, prior to the 1940s, the body size of their children was not of primary concern; it was assumed that children would outgrow their "baby fat" (Quirke, 2016). Around the 1970s, childhood obesity came to be seen as a global social problem, although it had not yet been categorized as an epidemic (Quirke, 2016). Fat children and youth were seen to be the result of children being sedentary, not exercising, and eating too much fast food (Mitchinson, 2013). While children were bearing the responsibility of not meeting acceptable body standards and being characterized as "out of control" (Mitchinson, 2013), parents, especially mothers, were also heavily scrutinized and blamed for the weight of their child (Friedman, 2015; Ioannoni, 2017; Quirke, 2016). Parents, mothers especially, are strongly encouraged to be in control of the overall health of their children and their family (Fierheller, 2022; Ioannoni, 2017; Maher et al., 2010) and heavily blamed when their children do not conform to the normalized, accepted body type (Boero, 2009; Campos, 2004; Friedman, 2015; Ioannoni, 2017; Quirke, 2016).

Throughout my interviews, participants often discussed their health care experiences in two categories: childhood, and adulthood (though the line of where childhood ends and adulthood begins was not clear or consistent among participants). When discussing childhood health care experiences, the overarching commonality was the role that parents played, especially mothers, in participants' experiences with their doctors. For example, Jane shared with me her experience as a child and the advice her doctor gave her mother in order to prevent Jane from overeating.

> **Jane**: She would tell my mom and not tell me, and give my mom stuff for me to eat and not tell me. Making my mom in control of this, so that it's not my responsibility, it's my mom's responsibility. She was old school.
>
> **Kelsey:** Did you do these diets as a kid?
>
> **Jane:** I didn't have a choice. My mom was the one who was giving me food, right? [laughs] I was never allowed [food] because my mom didn't allow me. My brothers were allowed to go and grab snacks or whatever and mine would be arranged. She used to give them dessert after I went to bed, but I blatantly knew what was going on because this was the doctor's recommendation. She put bells on the food room, so when you opened it she could hear … It was horrible. I felt so bad about myself growing up.

When I was talking with Jane, all I could think about was how humiliating of an experience this must have been for her. Her doctor recommended that her mother put bells, or some other form of noise maker, on the fridge, cabinets, and pantry so that she would be audibly notified if Jane tried to get something to eat, in order to stop her. This noise would also notify

everyone else in the house that Jane was trying to access food. I could also relate to Jane's experience: my eating and access to food as a child was also hyper regulated by my mother. While there were no bells in my household, there was severe anxiety over whether or not I could reach for a snack without getting caught or shamed. A childhood friend said to me recently that she always found it so weird that we had to ask for a snack in my house growing up, and that 'no' was a possible, and likely, answer to that request.

Parents are not seen only to be responsible for food intake, but for other interventions as well. Quirke (2016) finds that the messaging around the parental role in weight loss for fat children has not changed in the past 30 years; the messaging parents receive on how to 'help' their fat children is to "get them to eat more healthy food, get more exercise; eat less junk food, and be less sedentary" (p. 146). Many of my participants discussed the role their parents played in their forced attempts at weight loss as children and the involvement of their parents in their health care appointments. As children and youth, their parents, often their mothers, attended doctor's appointments with them. As Jane mentioned above, this resulted in her doctor focusing on her mother and making her mother responsible for Jane's health and weight. This was a common theme among other participants as well. For example, Brielle describes her mother's presence at her doctor's appointment and how Brielle herself did not need to bring up her weight: either her mother or the doctor would do it for her, in conversation with each other.

> **Brielle:** Until I moved out, my parents would always be with me to doctor appointments or whatever and they would always bring it up or my doctor would bring it up. I never needed to bring up my weight because other people would always bring it up for me.

Similarly, Tanya discusses how her general practitioner, in conversation with her mother, decided that Tanya needed to see a nutritionist, who ultimately put her on a restrictive food plan.

> **Tanya:** I had put on a bunch of weight from the prednisone [prescribed for a health problem]. This was the GP that I really liked. So, he was like, "Okay, I know a really good nutritionist, like you're going to go for personal nutrition counseling". I remember for my family it was out-of-pocket and kind of far away, but he was like, "She's really good," and my mom was like, "I had heard of her before,". Then she put me on a food plan and it was like nothing. There was no food on it. Super restrictive. Her one thing was, if you do this all week you get to go out and have one treat or something, right? So, for a while I just followed it. That was what I did. I would go with my mom, because I was still in high school at that time. I remember being like, this is totally unmaintainable. I'm not eating. I'm in 12th grade and I'm not eating any food.

The impact of the family on weight loss is explicitly tied to interactions with health care professionals for fat people, especially those who were fat as children. Harrison (2012) argues that "the discourse of the childhood obesity epidemic is making children the target of regulatory practices that are generally ineffective, sometimes physically harmful, and often quite painful or extremely humiliating" (p. 337). Harrison (2012) notes that this intervention often takes place in the family; I would further this understanding by arguing that intervention often takes place in the family at the instruction of health care professionals. I found consistently throughout my interviews that parents, especially mothers, were hyper focused on their children's weight and that this focus and concern was rooted in discussions with their child's doctor and that the advice

from the doctor was almost always harmful and humiliating. As Rashatwar (2021) shares “diet culture created a family-wide surveillance that criminalized my fat child body. Even my younger siblings were deputized into the food police and asked to report to my parents what I would eat after school” (p. 213).

Weight loss suggestions

Weight loss advice from doctors certainly does not stop once childhood ends. One of the major changes though is that parents are no longer involved in the doctors’ visits; rather, the suggestions for weight loss from the doctor goes directly to the patient, and those suggestions can range from practical to completely harmful, as many of my participants have outlined for me. This advice included diet suggestion, medication recommendations, and referrals for weight loss (bariatric) surgery.

To start, Rachel and Danielle shared with me interactions they have had with their doctors on weight loss, and the subsequent diet recommendations that were made.

> **Rachel:** I had a doctor tell me that the starvation diet works and he told me, "You have to lose weight." I was smaller than I am right now. It's shocking, but I had a doctor who was like, "Yes, it works." Whatever you got to do … He had this lovely story about his wife to back it up, about how she essentially starved herself and that’s how she was able to lose weight and keep it off. That was supposed to inspire me, but it was horrific at the time because of all people now a doctor has told me to eat five or seven calories a day. Then you think, “I should be doing that.”

Danielle: Probably my early 20s, I went to this place called the Wharton Clinic. Have you heard of them? It's a bariatric clinic. I don't actually know if they still exist because I went to my doctor and I'm like, "I want to lose weight and feel better about myself," and they're like, "Okay, go to this place". I went there, I think, for three or four years and they gave you a meal plan and they tracked your weight and they did one of the ECGs or whatever and they do fucking pinch tests. Oh my god, it was the worst experience every time.

You did weight counseling, they put you in a room with this thin white lady, and she would counsel you on what you were doing wrong because you needed to stay within your 1500 calories and food diaries and all this nonsense. It was horrible. The doctor would come in. One particular moment, I remember there was the doctor coming in being like, "Don't you want to lose weight? What are you doing? You're clearly not dedicated to this," basically. He left and I burst into tears. I'm like, "Fuck you, I'm doing as much as I can." Then, the guilt about, "Well, I did have that extra cookie that other day," and all that nonsense. Eventually I stopped going there just because it just made me feel horrible about myself.

There are two very clear forms of harm happening, as demonstrated in the above experiences. First, both Rachel and Danielle share the harmful approaches to weight loss that were encouraged by their doctors. Focusing on a weight centered approach to health, as O'Reilly and Sixsmith (2012) argue, leads to more harm for fat people, as this perspective on 'obesity' can lead to weight cycling. Weight cycling, the repeated loss and regain of weight through dieting,

has been found to be associated with negative health outcomes (Campos, 2004; Lyons, 2009; O'Reilly & Sixsmith, 2012). In her work on the harm of the diet industry, Pat Lyons (2009) also argues that the negative influences of the diet industry do not outweigh the potential benefits. Weight loss treatment, she argues, cannot be understood as harmless, even if it fails. Chronic dieting, yoyo weight loss and weight gain have been linked to a plethora of medical problems. The effects of dieting and frequent weight loss and gain are more harmful and problematic than fatness itself (Campos, 2004; Lyons, 2009; O'Reilly & Sixsmith, 2012), and there is no currently known way to safely, effectively, and permanently lose weight (Berg, 2017).

Many fat people have spent some, or perhaps most, of their lives battling with disordered eating in efforts to lose weight, and these battles are often based on the advice or recommendation of their doctors (Ellis-Ordway, 2021). In drawing back to my own experiences as a fat child who had a thin sister with a severe eating disorder, I spent so long engaging in disordered eating habits (like calorie counting, severe reduction of food intake, excessive exercise, and journaling about my food intake). These were behaviours that were encouraged for me but seen as problematic and in need of changing for my thin sister. In my sister's case, these behaviours were recognized as a pattern of disordered eating, and yet my doctors, paediatrician, nutritionist (and a handful of other doctors I was encouraged to see) all prescribed these behaviours to me in order to promote weight loss. As Ellis-Ordway (2021) notes, these disordered eating behaviours are encouraged "in the pursuit of weight loss" despite the harm that these behaviours can cause (p. 13). As such, disordered eating for fat folks comes to be seen as the norm and as "following the doctor's orders" (Ellis-Ordway, 2021).

The second form of harm demonstrated here relates back to the discussion earlier in this chapter on stigma and shame, and the effects of disciplinary medicine. Both Rachel and Danielle

share that despite the harmful approaches to weight loss that they are being suggested, they leave the appointments with a feeling that maybe they are not working hard enough, or full of guilt around their dietary practices. These feelings can be understood through Murray's (2008) framing of the clinical gaze, as the perception of the doctor is a form of power exercised onto the fat patient.

Weight loss interventions: Medication and bariatric surgery

In his work *The Obesity Myth,* Campos (2004) highlights the question of whether quality of life and health would be better for fat people if they lost weight. Asking this question, he argues, ignores the aspects of health and weight, such as socioeconomic status, that contribute to good health. According to Campos (2004), most epidemiological research fails to control for factors that contribute to health outside of weight. Overall, the negative health implications of the diet industry and diet drugs outweigh the potential benefits, especially when, for the most part, diet and exercise are ineffective, and weight is typically regained. Interestingly, in her 2012 book *Killer Fat*, Boero (2012) argues that most people who are trying to lose weight are not doing so due to the spectre of 'ill health', but in efforts to fit into what society sees as 'normal'. In their work *Surviving and Thriving While Fat*, Rashatwar (2021) shares their experience of attempting weight loss due to the shame and stigma they felt around failing to control their body size. Rashatwar notes that "when I was first pressured to have weight loss surgery (WLS) in 2009, the only thing I worried about was my immense shame at the thought of my friends or family finding out I had failed so horribly at being able to control by body size, that doctors had to cut my healthy guts open. Shame dictated my life. It was woven into the fabric of my everyday life." (p. 214).

What is evident from this discussion is that there is a focus in health care on weight loss, without recognizing the socioeconomic conditions that impact 'good health', the lived experiences of the people in which measures to achieve 'good health' are being prescribed, and a failure to recognize or understand the reasons why people may be engaging in weight loss behaviour; it is not enough to treat the fat body as simply one in need of weight loss. This lack of understanding came up throughout my interviews when participants shared their experiences of being prescribed weight loss medications (or, alternatively, not being prescribed medication for conditions unassociated with weight loss) and being recommended for bariatric surgeries. These weight loss interventions were often unwelcome or had negative consequences on the patients.

The first weight loss intervention method that was commonly shared by my participants was being prescribed medication to promote weight loss. Many of my participants told me about their experiences with weight loss medication, as recommended by their doctors. These medications came with many unfortunate side effects. For example, Penny told me about her experience with Fen-Phen, an anti-obesity drug that was taken off the market in 1997 due to its link to heart valve problems (Hitti, 2008). Penny explained "there was a diet pill that they were putting people on, Fen-Phen, that the doctor put me on it to make me lose weight and all it was doing was stressing out my heart". Cheryl, Jane, and Amelia also share a similar experience of being put on weight loss medication and the side effects that emerged from that experience.

> **Cheryl:** Xenical was a blue pill. He put me on that. I had just finished college, that means I was 17, 18 years old, just starting my undergrad, so this might have been like maybe 98 or 99, something like that … He said, "You have to try and do something to get some of the weight down."… I was put on that drug, I think I was on it for about six months and

> I'll tell you, I shrunk … I think I'm going to look up Xenical and see what some of the outcomes were because God only knows. Xenical was a magic drug, that separated the fat from the food, so your poop would be oily and running.
>
> **Jane:** She tried to put me on Saxenda or something, a new weight loss injectable. I have anxiety and depression. Three people in the study killed themselves. She didn't put those two together. It's $30,000 a year. When I went to go actually investigate, I'm like, "I can't pay that." … It's an injectable that's supposed to suppress your appetite. I'm like, "But I don't feel like I eat that much."
>
> **Amelia**: There was a medication that stopped your body from absorbing fat. That had really wonderful side effects [laughs]. I had done that for a while on the advice of a doctor … when I was at the worst of my disordered eating.

As Amelia tells us, she was at the worst of her disordered eating at that time. Many would assume this is binge eating, a stereotypical assumption for fat folks; however, many of the women in this study shared with me that their experiences with disordered eating were specifically in relation to trying to lose weight. Despite engaging in disordered eating practices in attempts to lose weight (often encouraged by doctors, as we saw earlier with Rachel and Danielle), Amelia's doctor encouraged further intervention by way of medication that would help with weight loss. Amelia also mentioned that, when she asked her doctor for advice on her health, she was sent to a weight loss clinic instead.

> **Amelia:** I sought out the advice of my family doctor who sent me to a weight loss clinic that was run by nurses. I did not talk about disordered eating but was like, "I'm interested in looking at health stuff." And they send to me to a weight loss clinic.

Ursula also described an experience where she was encouraged to take medication that would promote or result in weight loss; however, in this case the medication was to help deal with her depression.

> **Ursula:** I was a little depressed after my breakup. I was with someone for five years. It didn't work out. I was a little depressed. I put on a bit of weight, and then I was feeling very self-conscious about my weight, and there was this medication that my doctor had on and off been trying to push me on. At first, I didn't want to do it because one of the symptoms of the medication is a risk of increase in urinary tract infections and all that. Another benefit of taking the medication that he was always trying to sell me on is, "You'll lose about 20 pounds, you'll pee it out."

Here, her doctor is trying to motivate her to take a medication she is unsure she wants to take, for issues related to her mental health, by promoting the potential side effect of weight loss. Her doctor is using the appeal of weight loss to encourage her to take a medication she is unsure of.

The push to take a medication to cure the fat body is one I am all too familiar with myself. As a teenager, I can remember two different times I was put on medication with the purpose of promoting weight loss. The first drug I was put on by my doctor was a drug called Meridia, an appetite suppressant that was meant to curb food cravings (Hoffman, 2000). The

drug was advertised as being effective in helping obese patients lose 5% of their body weight, though studies found it only had a minimal effect on metabolism and that patients regained weight once they stopped the drug (Hoffman, 2000). My memory of taking this diet pill was that I did not achieve any noticeable weight loss, and that I felt miserable the entire time I was on it. I continued to feel like I was failing at controlling my body, when even medication could not help me. In 2010, not long after I stopped taking Meridia, it was pulled from the market (like the long line of diet pills before it) for the negative health effects it could have on patients taking the drug, such as an increase in heart attacks or strokes in patients with a history of heart problems (Perrone, 2010).

The second medication I remember being prescribed for the explicit intention of weight loss was Metformin, a drug used to help control high blood pressure in patients with type 2 diabetes (WebMD, n.d.). I am not and have never been diabetic, yet I was put on this medication because an off-label use, according to my doctor, was weight loss. I remember going to the pharmacy to fill this prescription and the pharmacist asking me to fill out some paperwork to register with the pharmacy as diabetic (to receive support and guidance), and when I told her I was not diabetic, she was very confused as to why I was being prescribed this medication. I do not remember how long I took this medication; like Meridia, it was not effective in helping me lose weight, but it did make me feel horrible all the time. I remember how unwell I felt on this drug, which was the reason I ultimately stopped taking it.

The final note about medication that I heard from a few participants was how their health care professionals, often in psychiatric spaces, would discourage a particular medication that would help with their psychiatric condition when one of the side effects was potential weight

gain. Olivia shared her experience with her psychiatrist and finding a medication that would work for her mental health condition.

> **Olivia:** At the time, I was so new to seeing mental health professionals, and I was trying to get my meds worked out because what I was taking wasn't working. The doctor had switched me to new meds. She's like, "These ones won't cause you to gain weight." It didn't start setting in until she kept mentioning it every session. I was like, "This is not something I brought to you as an issue, so I'm not sure why you keep bringing it up." She was like, "If I write you a letter, OHIP will pay for gastric bypass." I was like, "I don't want gastric bypass."

Here, despite her insistence that she was not seeing the psychiatrist for weight related advice, Olivia's doctor was insistent on pushing weight loss measures and was taking potential weight gain into account without consulting Olivia first to determine if that was a concern for her, before suggesting an appropriate medication to help with her mental health concerns.

The second weight loss intervention that was commonly raised by my participants was bariatric surgery. Many of my participants shared their experiences of being encouraged to seek bariatric surgery, being recommended to bariatric clinics, strongly considering bariatric surgery, and one of my participants had had bariatric surgery. As we saw above with Olivia, having weight loss surgery recommended without having asked about it is a common experience for fat folks in health care settings.

Yasmin: On the intake session, without even asking me, he just gave me information on things I can get in touch with about losing weight. I was just like, "I didn't even say I think I might want to lose some weight. How—" Just, without even asking. He's like, "You could do a gastric bypass." I was like, "Whoa, whoa, whoa." In my head, I'm thinking, "What?" I had a friend of mine who did that. I don't want to do that.

Ariel: My family doctor referred me to the Bernstein Clinic and that was like a big no-no for me. I also went to another weight loss clinic that was geared towards, if you lost I think it was 15% of your body weight, then you could do gastric bypass or the lap band. This is all the stuff that my doctor promoted. I was in my early 20s, still very young, immature and my parents were supportive of this. I remember going in saying, "This is not for me. 20 years old and looking at getting gastric bypass. This is not being healthy."

Ursula: My doctor's saying, "Hey, go do this gastric banding." Without even realizing I'm goddamn poor and I have no financial stability or security, and you're telling me, "Go take a $15,000 loan."? I can barely afford rent, or food, or anything else and you're telling me, "Take a $15,000 loan to get a surgery."?

Almost all my participants who shared their discussions with their doctors on weight loss surgery indicated to me that this suggestion was unsolicited; it was assumed that they would want to take such drastic measures to change their fat body. Many of my participants told me that they knew of friends or family members who have had weight loss surgery and that their experiences in their bodies, post-surgery, were not positive. Knowing someone who had weight loss surgery and

was either still fat, or suffering negative side effects of the surgery, was often noted by participants as a reason they were not interested in bariatric surgery. Others discussed the financial burden of surgeries that may not be covered by OHIP, or the appointments and expectations for weight loss leading up to the surgery.

Finally, Zoe, my only participant who disclosed having had bariatric surgery, told me that she is still expected to be fat post-surgery. She explained the different weight loss goals associated with time-based milestones post-surgery (three years, five years, ten years, etc.). At the time of our interview, Zoe was 5 years out from her surgery and was meeting her weight loss goals; however, despite having bariatric surgery and meeting her goals, she was still categorized as 'obese' by the BMI standards, with the expectation that she will stay in that category in the future. She shared with me one of the side effects of weight loss surgery that many folks do not consider: excess skin.

> **Zoe:** [asking the doctor if the excess skin will go away] they're like, "Only a certain percentage," and some people are very hopeful that it somehow retracts. I was like, "No, I have a lot of skin." I still have a lot of skin. [laughs] It's not going anywhere. It's a conversation that they do have with you to be like, "Just a heads up. It's very common that you're still going to be unhappy." It's true.

To deal with excess skin, the skin that remains once weight loss happens, fat folks need to get plastic surgery. Unlike weight loss surgery, plastic surgery to remove excess skin is not covered by OHIP as it is considered cosmetic, and therefore it is an out-of-pocket expense for folks who have had bariatric surgery. On top of that, as mentioned earlier in reference to Faith,

for gender affirming surgery and trying to get surgery in a clinic setting, you must meet certain BMI thresholds to qualify. This is something Zoe has explored, and she shared with me that she has been denied surgery for skin removal, she said "I'm still too fat for cosmetic surgery". This was followed, from both of us, by a laugh of disbelief. I asked Zoe if, retrospectively, she would choose to do this surgery again and she told me "absolutely not", nor would she recommend it to anyone.

Harmful doctor-patient relationships: "You have to negotiate between 'Do I want to be told that I'm fat and lousy and pathetic' or 'do I want to sit at home and be sick for a while longer'"

Throughout this chapter, I have shared my participants' experiences with their health care providers, which are often rooted in fatphobic and stigmatizing understandings of the fat body. In addition to the consequences of visiting health care providers who hold anti-fat bias, fat folks are further harmed in that these experiences often lead to fraught relationships with their health care providers, where they do not feel comfortable having open and honest conversations about health, and ultimately, to avoiding health care services all together.

Ellis-Ordway (2021b) argues that "the terms weight stigma, weight bias, and anti-fat bias all refer to the social rejection and/or devaluation based on having a body size that does not conform to social norms or expectations (Tomiyama et al., 2018). Weight stigma can be explicit and conscious or implicit and outside of awareness" (p. 72). As discussed in Chapter 1 when contextualizing fatphobia in health care, health care practitioners are not necessarily deliberately discriminating against fat folks and they don't set out to harm fat patients; however their implicit negative attitudes impact the relationship they have with their patients (Ellis-Ordway, 2021b;

Foster et al., 2003; Hebl & Xu, 2001). Greene and Brownstone (2021) argue that when health care providers do not acknowledge and deal with the "disgust" they have for fat bodies, this disgust will seep into health care settings and manifest itself through judgment, rejection, and bias towards fat patients. When patients do not trust their health care provider and have experienced discrimination and sizeism in the health care setting, they are reluctant to return to their health care provider, and this reluctance results in long term health consequences such as incomplete follow-ups, delays in cancer or other important health screenings, and an absence of care (Chrisler & Barney, 2017; Kascardo & McHugh, 2015; Phelan et al., 2015; Schwartz et al., 2003).

I asked my participants about their relationships with their doctors. As shown in the accounts below, the majority of my participants shared with me that a focus on their fat bodies and constant suggestions of weight loss negatively impacted their relationship with their doctor. Natalie, Wendy, Demi, Faith, and Olivia share how they view their doctor and the ways their relationship is strained by the anti-fat bias they experience.

> **Natalie**: My relationship with my male family doctor was extremely strained. I just couldn't stand to be around him. I would legitimately cry every time I had to go to him because I thought he was so mean to me and I couldn't handle it and I was genuinely rolling the dice on whether I would get anything from him so I really hated seeing him. I really began to resent him … my appointments were, like, in and out in five minutes because that's all he had to say. I just couldn't deal with him. It was very strained.

Wendy: It makes it really fraught, and it negatively impacts it in a very significant way because, again, it makes the doctor's office feel unsafe. It makes the doctor feel like a not safe person. It makes the doctor feel untrustworthy. It makes me doubt the care that I'm receiving and it makes me doubt my doctor's knowledge. It also just makes me feel shitty and, on a basic level, you don't want to interact with people who aren't going to make you feel good, so why would I go visit a doctor who is just going to shame me and not listen to me and not see me as an actual person, that just see me as this fat body that needs to be fixed? … I would say, overwhelmingly, my experiences with health care professionals have been negative.

Demi: If I could never go to the doctor in my life, I would probably do that. I have a friend who is a midwife now. She's going to submit pap tests for me, let me do my own paps and submit them for me. I like that a lot better than having somebody's arm inside of me than potentially giving me a lecture on my body size. I don't like doctors, I don't trust doctors.

Faith: It definitely negatively impacted my relationship with my doctor because I felt like my concerns weren't being taken seriously.

Olivia: It makes you lose trust in the doctors. It makes you feel like you're getting second rate service because you're fat. In the back of my mind even though I know it's not true it starts to reinforce that idea that maybe it is true. I'm like, "I worked really hard not to feel that way and you're just pushing it into me and it's really frustrating."

Similarly, Amelia shared a sentiment that seemed to be accepted across most of my participants as well: a desire to get out of the doctor's office as fast as possible. She said "when I'm done with the doctor. You cannot get me out of that office fast enough. I feel l need to shower right away". Many of the women I spoke to talked about a need to engage in self-care strategies following their doctor's appointment as a way to mitigate the harm they experienced. Others, like Paula, spoke of the lasting negative effect of an appointment on their day, or even their week, ranging from feelings of annoyance and moodiness to significant depressive episodes.

> **Paula:** I feel really crappy for a solid two weeks. It takes a long time for me to recover from that. It actually affects me into my relationship too, because then I'm like, "Well, okay. If they're talking to me about my weight right now, that means that everybody else is looking at me like this." It's not just from a healthcare—It must be because I look a certain way. I always feel like really—My self-confidence just plummets immediately. Then I don't want to go back. I prolong going back for follow-ups, because it makes me feel like shit. I don't want to go back and feel like shit. I am in control of the way I feel. If I'm going back to you and you make me feel not good, then I'm not coming back. Sometimes I wait forever until I absolutely have to go to book an appointment. You know?

The ultimate consequence of experiencing discriminatory treatment from health care professionals is that fat folks often will forgo health care all together, like Paula shares above, sometimes avoiding it at all costs. Chrisler and Barney (2017) describe how discriminatory

treatment, or sizeism, is a health hazard in and of itself. As demonstrated throughout this chapter, patients who are seen to be too fat are often subjected to feelings of shame from their health care providers, which can result in doctors providing them with health damaging recommendations to deal with their weight (Chrisler & Barney, 2107). These recommendations result in negative physical and mental health effects (Chrisler & Barney, 2017). Teachman and Brownell (2001) argue that anti-fat bias in health care professionals is not directed at obesity as a condition, but at obese people themselves, further entrenching the argument that Chrisler and Barney (2017) make that sizeism itself is a health hazard.

In general, it was common among my participants to avoid the doctor unless absolutely necessary. Megan, Jane, and Natalie share how they actively avoid going to the doctors.

> **Megan:** It makes me want to go less frequently, which, I know that I need to go to the doctor. I know I have to go the doctor. I need to take care of my health, despite whatever hang ups I personally have about it, whatever things I've internalized and all that, but it's really hard. It's hard to do that when it's not a safe and welcoming environment. I would like to switch family doctors because of it. It felt like my biggest fear is—There's certainly anxiety around, what if the next one's worse? Or just as that?

> **Jane:** Going in was dreadful because the first thing she did is throw you on the scale. Really? Let's get naked or in your underwear. The fact that she was so small, she was probably five feet, probably smaller than five feet and skinny, made it so much worse. I dreaded going. It would have to be so bad for me to go and I got strep a lot as a kid, so I

would just not tell my mom and go to school. I think I blocked a lot of it out to be honest. She was the type of person that I'd go in for strep, "And you need to lose weight and you're getting big and this, that and the other." Yes, the worst, traumatizing.

Natalie: Even though I'm smaller now, I think I would still avoid—I'm still only seeing doctors for specific issues that are, like, one thing I need fixed. A lot of those times, the things that I—There are times when I sort of assume they're going to say, "This is weight-related," so I should probably get started doing some stretches at home or something, or this is potentially weight-related, so I'd like to wait a week and see if it goes away, because I would kind of like to have that off. I feel beaten down because of it.

Similarly, Kristin, Gina, and Yasmin root their avoidance of health care in the discriminatory treatment they receive.

Kristin: We regularly ignore health things because we don't want to know or because it's an inconvenience but it's just another factor on top of that is I don't want my doctor to just ignore something very serious because well, it's just your weight. Why even bother? Why waste my time? Why would I waste my time just to be told that it's because you're fat.

Gina: I feel that as a fat woman, I'm getting slower care than everyone else has access to.

> **Yasmin:** Think I tend to avoid going. I don't know if I avoid because of how I anticipate that they're going to treat me or if it's because I anticipate that I'm not of value to them. Also, I'm very much of the mind that if something's wrong, it'll get better. [laughs] So I don't go anyway. Yes. I think if it's really bad, then I'll go. I don't particularly like it. Yes. I feel maybe like a burden a little bit on the healthcare system

Common in these experiences are feelings of wasting the doctor's time, receiving differential care rooted in sizeism, and feeling like their fat body is a burden on the health care system.

Even more troubling though were the stories from my participants who put off care in potentially (and in some cases, ultimately) dangerous, life threatening situations. Demi talks about experiencing chest pains where she was concerned, she could be having a heart related episode, yet her fear of the doctor almost prevented her from getting it checked out.

> **Demi**: I'd rather be in pain than deal with someone's projection about my body, which is a terrible thing. I had an episode that I thought was heart-related and it was really scary to go and get checked it out. It wasn't, it was indigestion. It's scary and extra scary because you're like, "What's this person going to do? What are they going to say?"

For Megan, her chronic illness went undiagnosed for years due to her expectations of her doctor's response to her symptoms. It was not until she saw a health care specialist for a different, unrelated issue that her chronic illness was spotted and she was recommended for specialist treatment.

> **Megan:** I recently was diagnosed with a chronic illness, I have swelling around my brain. It's in the scale of chronic illnesses. I get a lot of headaches in my life. It's not the end of the world. If I bend over, sometimes things go dark, but I've had it for years … I ignored a lot of my symptoms for years because it was just this internal dialogue of "Well, it's just because fat. You need to be fitter or you need to work on being more active or something along those lines," and that's why you kind of feel shit sometimes. It ended up that I went to just a general eye exam and there you go like, "Your eyes are really swollen" and sent me to a specialist who sent me to the hospital and several thousand tests later, it's like, "This is what you have".

Finally, Karen experienced a life-threatening blood clot in her leg. She continued to ignore the symptoms she was having for days until it was unbearable. She then went to the emergency room for care.

> **Karen**: I thought it was maybe just nerves because I had been given my first teaching assignment, and it was starting the week after. I was like, "I got to go prepare." I was walking from work to the subway, and I just had this pounding that stopped me in my tracks. I was like, "That's weird. Maybe it's just anxiety." I brushed it off, and then for about a week, every single day got harder and harder to breathe to the point that I couldn't even, by the time the Monday rolled around, when I finally went to the ER, I couldn't have walked from my bedroom to the bathroom in the small condo without feeling like I had run a marathon. It was intense. I kept trying to brush it off … Thinking, every year when it comes around that time, the anniversary of the time I was in the

> hospital, I think more and more about it. I'm like, I could have died because I thought I would be told I'm just fat, so go away. I postponed getting care. That's horrible.

In unpacking Karen's experience, I draw on her own analysis of the situation, as she herself demonstrates a critical understanding of the impact of fatphobia.

> **Karen:** This is fat phobia coming through. Medical fat phobia coming through because I was concerned that if I went to the ER for a breathing problem, they're just going to tell me, "You're fat. Go lose weight, it'll fix itself." I could have died. This is a thing that kills people, and I put it off for a week before going to the ER. It got to the point that I could barely walk across the street without feeling like I was going to collapse.

Conclusion

Throughout this chapter, I have argued that the anti-fat attitudes held by health care professionals, especially primary care physicians or family doctors, result in weight-based discrimination for fat women in health care settings. This discrimination further entrenches fatphobia in health care spaces. The experiences of my participants demonstrate how consequential fatphobic discrimination, weight-bias, and anti-fat attitudes are for fat patients. The consequences of fatphobic discrimination are immense and deeply felt.

I opened this chapter with a discussion of disciplinary medicine and an explanation of the ways in which disciplinary medicine and the medical gaze influence the managing, surveilling, and regulating of the fat body. Throughout this chapter, the experiences of my participants

demonstrate the ways in which the fat body performs 'silent confession' (Murray, 2008) and the impacts of the hyper(in)visibility (Gailey, 2014) of the fat body in health care spaces.

The stigma attached to being in a fat body is unmistakable in health care settings, and it results in fat women's internalization of shame around their very existence. Throughout the experiences shared within this chapter, shame is demonstrated through feelings of moral failure around an inability to lose weight, despite the insistence of their doctors and their own best efforts, the continued discussion of their weight and suggestions for weight loss by their doctors, and the physical environment of the doctors' offices that limit the ability of the patient to fully participate in their own care. When healthcare professionals make assumptions about their patients on the basis of body size, this can cause harm to the patient themselves (Ellis-Ordway, 2021). These are subtle (or, sometimes not so subtle) indications to fat patients that their bodies are unacceptable or flawed, or not worthy of care, a feeling expressed by many of my participants.

The understanding that having a high body weight will cause fat folks to develop medical diseases comes from correlational data that often ignores other factors that contribute to body size, such as social determinants of health or the impact of weight stigma on access to health care (Bacon & Aphramor, 2011; Brown & Ellis-Ordway, 2021). Experiences of weight stigma, as my participants shared with me, can result in negative or non-existent relationships with doctors and, ultimately, may result in denial of care (by the doctor) or avoidance of care (by the patient). Avoiding care, or being denied care, can ultimately have devastating or life-threatening consequences.

In 2018, Canadians were made aware of the passing of Ellen Maud Bennet, 64, when her obituary went viral online. Bennet was diagnosed with inoperable cancer and died only a few

days after receiving this diagnosis (CBC, 2018). Her obituary highlights the discriminatory treatment she received from her doctors, resulting in her cancer being caught at such a late stage. Her obituary reads:

> A final message Ellen wanted to share was about the fat shaming she endured from the medical profession. Over the past few years of feeling unwell she sought out medical intervention and no one offered any support or suggestions beyond weight loss. Ellen's dying wish was that women of size make her death matter by advocating strongly for their health and not accepting that fat is the only relevant health issue. (Times Colonist, 2018).

Feeling unwell yet being told by doctors to lose weight in order to feel better is an experience far too common to fat women, and the consequences of such fatphobic care can be deadly. Despite this, as outlined in the next chapter, doctors continue to embrace a pathological view of fatness and implore their fat patients to engage in discourses of weight loss.

Chapter 5: A Critical Analysis of the 2020 Obesity Canada Guidelines

Xia: I feel that in Canada because it's socialized, there's this idea that fat people are a burden on the healthcare system. I do think part of me feeling [like] a good citizen is not using the socialized healthcare that we're so proud of and patriotic about because I got it in my head that I'm going to cost the whatever healthcare system millions of dollars when I'm older, so I need to save the money now. Even when I broke my toe, I taped it up, I never went and got an X-ray … I definitely think there was a part of it that was, "I didn't want to have to go to a doctor for a foot issue as a fat person." I also don't want to be a sad-- I don't want to add the statistic of, "Fat people need our care all the time. Look, all she did was break her toe and she cost us X, Y, and Z amount of money," where that would have been the amount of money for anybody in that situation. I definitely think I purposely-- Part of me being a good Canadian citizen and intersectionality with being a good fat woman means I don't use our healthcare system

Introduction

In 2020, Obesity Canada, a registered Canadian charity with a focus on 'improving' the lives of 'obese' people, released an updated version of the *Canadian Adult Obesity Clinical Practice Guidelines* (CPGs), a follow up to the *2006 Canadian Clinical Practice Guidelines on the Management and Prevention of Obesity in Adults and Children*, both of which were published in conjunction with the Canadian Medical Association Journal (CMAJ). According to Obesity Canada, this guide was "developed by Obesity Canada and the Canadian Association of Bariatric Physicians and Surgeons … [and] were authored by more than 60 Canadian health care professionals, researchers and individuals living with obesity" (Obesity Canada). Together, these

entities put forward 80 'key recommendations' for practitioners dealing with "people living with obesity". These recommendations were published as a guideline in the CMAJ, while the other 19 chapters are housed on the Obesity Canada website (obesitycanada.ca/guidelines).

In this chapter, I ask the question: How does the categorization of obesity as a disease by Obesity Canada, in the Canadian Adult Obesity Clinical Practice Guidelines, further entrench fatphobia in health care practice? To answer this, I critically analyze the recommendations put forward in the CPG guidelines for health care professionals, and I ground this analysis in the experiences of my research participants. While there are 20 total chapters put out by Obesity Canada, I focus on the first chapter, *Obesity in Adults: A Clinical Practical Guideline,* which is a summary guide designed for widespread distribution, and its key recommendations for health care providers. Drawing on fat studies literatures, a Health At Every Size (HAES) perspective, and data from my interview participants, I argue that the categorization of obesity as a disease in this guideline encourages health care practitioners to pathologize their fat patients, and to inform their treatment through the lens of weight loss and weight management. Based on my participants' experiences, I would argue that this practice is harmful to fat folks. Further, I contend that the recommendations for practitioners on how to interact with obese patients perpetuate fatphobia and maintain weight-based discrimination that occurs in health care settings. The guidelines acknowledge bias against obese patients; however, they do little to improve on this inequity.

Diagnosis: Diseased!

The Obesity Canada guidelines open by explicitly defining 'obesity' as a disease. In the very first sentence and the first 'key point' of the guideline, obesity is described as "a complex

chronic disease in which abnormal or excess body fat (adiposity) impairs health, increases the risk of long-term medical complications and reduces lifespan" (Wharton[5] et al., 2020, p. E875). Categorizing obesity as disease at the onset of the document establishes the lens in which subsequent discussions of weight will be framed and the recommendations for practitioners that follow. This lens pathologizes fat people and positions them as a major public health issue in need of solutions or cures.

Throughout the guide, fat patients are described as "people living with obesity", a 'people first' perspective embodied by Obesity Canada (an approach meant to differentiate the person themselves from the 'disease' they are afflicted with). There have been calls by some scholars to use 'people first' language with respect to obesity, arguing that 'people first' language would result in a decrease in anti-fat bias and stigma against fat patients (Dietz, Ravussin, and Ryan, 2015; Kyle and Puhl, 2014). Kyle and Puhl (2014) argue that "By addressing the disease separately from the person—and doing it consistently—we can pursue this disease while fully respecting the people affected" (p. 1). However, adopting a 'people first' approach to describe fat patients has the opposite effect; this approach further entangles fatness and disease. Meadows and Daníelsdóttir (2016) note that person first language is "mired in the medicalization of body state" (p. 2) and instead of resulting in fat people being treated with more respect (one of the intentions behind person-first language), using the term "people living with obesity" further entrenches anti-fat attitudes among health care providers.

The act of designating obesity as disease highlights the power of science and medicine to act as a form of social control, whereby medicine as an institution formalizes a specific

[5] Dr. Sean Wharton is the medical director of the Wharton Clinic, an OHIP covered "weight and diabetes management" clinic that several of my participants have experience attending (like Danielle, who shared her experience with this clinic in a previous chapter).

classification of people as problematic (Jutel, 2009). The categorization of obesity as a disease relies on the process of medicalization, whereby something that is not inherently medical comes to be viewed through a medical lens (Boero, 2012; Paradis, 2016). This process of medicalization influences the way in which body size comes to bear disease status (Boero, 2012; Meadows and Daníelsdóttir, 2016, Murray, 2008; Paradis, 2016). Jutel (2009) argues that the power to classify a condition or person as disease is fluid.

In classifying obesity as a disease, the Obesity Canada guidelines feed on anxieties around the 'obesity epidemic'. They highlight the increase in the prevalence of obesity globally and in Canada, and position this increase as a "major public health issue that increases health care costs and negatively affects physical and psychological health" (Wharten et al., 2020, p. E875). The impact of designating a specific body size as 'disease' has manifested itself in the rhetoric of the 'obesity epidemic'. Boero (2012) describes the 'obesity epidemic' as a type of post-modern epidemic, as obesity is not contagious. Instead, as noted previously, obesity gains disease status through the process of medicalization (Boero, 2012; Murray, 2008; Paradis, 2016). The term 'epidemic' functions to scare people into acting responsibly, drawing on and employing medical discourses to do so (Murray, 2008).

The idea that health care providers see fat folks as a drain on the health-care system was not lost on my participants. Many of my interview participants expressed fear or anxiety over how their health care provider would view and treat them at an appointment. Several participants shared how they felt in anticipation of seeing their doctor. For example, Demi shared:

> **Demi:** It's just nerve-racking. I wonder if everybody has that feeling. Just to me even just when you ask the question, in the pit of my stomach, I feel this like queasiness. It always

feels like I'm going in on the defensive. I'm always like, "What's going to happen? Like, what are you going to say to me? What am I going to be dealing with? What am I going to have to steal myself for? It's just embarrassing for some reason. Not for some reason. It's clear what the reasons are.

When talking to my participants about the obesity 'epidemic', many brought up the problematic way doctors interpret this 'epidemic' and how it influences their practice. Participants expressed feeling frustrated with the reliance on the 'obesity epidemic' narrative by their health-care professionals and questioned the practical impact of dealing with body size through this lens. Classifying obesity as a disease and referring to fat folks as 'people living with obesity' through the guideline embodies the critiques and concerns that fat folks have with the health-care system.

Danielle expressed her frustration with the way in which the 'obesity epidemic' dominates health care:

Danielle: I think this "obesity epidemic" that has really infiltrated the medical system. It's still normalized in the medical system that people don't even question it. Doctors don't question it. I'm like, "What the hell are they doing in medical schools that they're not questioning this?" They must be aware of pharmaceutical companies funding studies, come on. They're smart people there in medical school. I just wish the doctors thought more critically about the information that they're being fed, that there was more of instruction on bedside manner and that kind of thing, treating your patients like people.

Similarly, Megan talked to me about the moralistic component of 'war on obesity':

> **Megan:** The moralistic aspect of it always drives me nuts. Well, one, this treatment that like I'm some sort of burden on society and the healthcare system to begin with, when I can certainly point to other groups that are going to be worse that we don't criticize. Obviously, because you're entitled to healthcare, no matter what you choose to do.

Other research participants found the use of 'epidemic' to describe increases in body size problematic. Victoria reasoned that body size changes over time, and that does not constitute an epidemic:

> **Victoria:** I don't want to say it's an epidemic because an epidemic is a pretty severe word to use. Yes, I think more people are larger than they ever were in history, but I don't think it's an epidemic. I just think that they're spinning things in a different way to make it sound worse than it is. I also feel we change over time. If people are larger, then change to make things better for them instead of just thinking of it the same way it always was. Change can be good.

Victoria's perspective is consistent with many fat studies and critical obesity scholars. As explored in Chapter 1, scholars like Gard and Wright (2005), Klein (2001), LeBesco (2004), and Oliver (2005) have all highlighted how at particular historical junctures different threads of thinking about weight converge to produce new understandings of the value of weight. Obesity science, according to Gard and Wright (2005), is then trapped in its primary interest of

understanding body weight through the medical lens: one that represents a large body as a diseased body.

Ultimately, describing increase in body size as disease highlights how the power and impact of medicalization of body size on people in fat bodies is immense. This framework for viewing the fat body itself can deter fat folks from accessing care, and yet the Obesity Canada guidelines fully embrace, and seemingly encourage, this perspective.

Treatment? Constant Intervention and Surveillance

The automatic assumption that fat people live unhealthy lives and need to be saved or cured is a common theme that emerged in my interview data. For example, in the passage below, Ariel recalls a recent experience with her health-care provider and the frustration it led to.

> **Ariel:** I don't feel that my weight defines how healthy or unhealthy I am, but I definitely feel that when I go to the doctors, I definitely feel like what I think I'm healthy, they throw in my face, "Yes, you're not that healthy. You're probably going to die at 50." That was a very recent conversation. That is with all blood work coming back that I'm like, "I'm good. I'm within normal ranges of everything." They're like, "Yes, but the stress that you're putting on your body by having the fat, you are probably going to die at 50." I'm like, "Oh, well, better live my life in the next 18 years real good then.

Instead of trusting the results that came back from her bloodwork, indicating no health concerns, Ariel's doctor relies instead on fatphobic tropes of early mortality and stresses that her health is at risk by virtue of her fatness (Brown & Ellis-Ordway, 2021). The Obesity Canada guidelines,

with their focus on obesity as chronic disease, similarly reject the idea that fat people can lead healthy lives and instead focus on ways in which health-care providers should be intervening in the lives of fat folks to treat and cure their fatness. Obesity Canada outlines a five-step process that they say should "guide a health care provider in the care of people living with obesity" (Wharten et al., 2020, p. E878). Taken directly from their guide for practitioners, the five-step process they outline is as follows:

1. Recognition of obesity as a chronic disease by health care providers, who should ask the patient permission to offer advice and help treat this disease in an unbiased manner.
2. Assessment of an individual living with obesity, using appropriate measurements, and identifying the root causes, complications and barriers to obesity treatment.
3. Discussion of the core treatment options (medical nutrition therapy and physical activity) and adjunctive therapies that may be required, including psychological, pharmacologic and surgical interventions.
4. Agreement with the person living with obesity regarding goals of therapy, focusing mainly on the value that the person derives from health-based interventions.
5. Engagement by health care providers with the person with obesity in continued follow-up and reassessments, and encouragement of advocacy to improve care for this chronic disease. (Wharten et al., 2020, p. E878)

The process outlined above embodies the biomedical understanding of fatness as disease. It asserts that the first thing a health care provider needs to do in dealing with a fat patient is to recognize their body as diseased and in need of treatment. However, basing an appointment with a fat patient around the idea of weight loss is often unproductive and is certainly not a novel

suggestion. Many of the participants in my research project expressed how, in visiting their doctor, they receive weight loss advice despite being there for a different reason, and often the primary reason for their visit is neglected or not addressed at all. These appointments were often described to me as a waste of time. As Kristin told me:

> **Kristin:** We regularly ignore health things because we don't want to know or because it's an inconvenience but it's just another factor on top of that is I don't want my doctor to just ignore something very serious because well, it's just your weight. Why even bother? Why waste my time? Why would I waste my time just to be told that it's because you're fat.

Many research participants in my study often encountered this very discussion with their health care providers, repeatedly. Not only is a focus on weight loss preventing folks from receiving the care they originally went to the doctor for, but it is also creating harm. As Brenda explains:

> **Brenda:** It's always baffled me that the first rule is to do no harm in the doctor's oath and when you do that to people--- They see it as being for your own good, but it totally is not. Any fat person who's being honest will tell you that, "No, it is not to my benefit for you to tell me what society and the media tells me a hundred times a day, which is that I'm too fat, I need to lose weight. I know that and it's not like--" That's the thing. They're always like, "Have you ever tried to lose weight? Have you ever thought of weight loss?" Are you fucking kidding? Of course I've tried and of course, I've thought about it. How can you not? Five-year-old children who are skinny, think about it. Everyone thinks about it. "Could I be thinner?"

The anxiety, fear, and harm caused by a focus on weight and weight loss was shared by many of my participants. Wendy describes a similar feeling of anxiety when visiting the doctor:

> **Wendy:** I feel anxiety. It's not a good feeling. I don't enjoy going. Not even just because- - I don't know that anybody particularly enjoys going to the doctor, but I dread it, because I know that I'm going to have to be prepared or potentially brace myself for some comments said about my fatness or my body. I know that my body's perceived in a certain way. I'm worried that, at some point, what's actually going on with me? Is it going to be recognized? Like you read all of these stories about women who have had like 50-pound tumours and their doctors don't recognize that, they're like, "Eat salad," and then they die. I'm like, "Oh, my god. Is that going to happen to me one day? I don't know." I feel I just don't trust or get the healthcare system at this point. My interactions with my own doctors have not really been any more confidence-inspiring. It feels really anxiety [inducing] and unpleasant, and I need to mentally prepare myself before.

The medicalization of fatness has resulted in fat bodies being conceptualized as 'obese', diseased, and in need of intervention. The five-step process of Obesity Canada outlined above neglects aspects of a fat person's health that are not weight-based. The guide suggests practitioners focus on core treatment options for obesity like nutrition therapy, and additional therapeutic interventions like bariatric surgery. The focus on 'initial intervention and continued assessment' in order to improve this 'chronic disease' assumes that fat folks live a specific, unhealthy lifestyle that needs intervention. Fat people already internalize understandings of their bodies as over-indulgent, as representing lack of self-control, and as evidence of individual

failure. These messages, as Gard and Wright (2005) argue, are difficult to resist. There exists an assumption that body size is indicative of individual nature, and this assumption further contributes to the pathologization of weight (Gard & Wright, 2005; Jutel, 2009). These assumptions are embodied in the five-step process outlined by Obesity Canada guidelines.

Obesity Canada could have chosen to embrace alternative approaches to health and body size such as social determinants of health approach, recognizing factors of health outside of a biomedical model, or a Health At Every Size (HAES) perspective, Lindo Bacon and Lucy Aphramor (2011) call for a reimagining of health by embracing a Health At Every Size (HAES) perspective. As discussed in Chapter 1, Bacon and Aphramor (2011) call for a perspective on health that focuses on intuitive eating and relies on internal body cues, instead of focusing on body size, diet, or weight loss. As Deb Burgard (2009) notes, this approach differs from conventional treatment "in its emphasis on self-acceptance and healthy day-to-day practices, regardless of whether a person's weight changes" (p. 42). In their 2016 study, Frederick, Saguy, and Gruys found that exposure to fat rights and a HAES perspective on health resulted in a decrease in the perceived risk of fatness, supporting the argument that a HAES perspective helps to combat weight stigma.

Acknowledging Bias: Does it work?

As previously stated, the guideline document is just one chapter in a series of 20 chapters. However, the guideline chapter contains a table of 80 key recommendations (E879) that are made as a result of the analysis in the subsequent 19 chapters, and this guideline was published in CMAJ for widespread dissemination in the Canadian health care community. These

recommendations focus primarily on assessment and intervention by health-care providers, and maintenance of treatment plans.

The recommendations set out in the guideline are solely from a biomedical perspective and neglect to incorporate other approaches to health, such as a Health At Every Size perspective (Bacon and Aphramor, 2011). As mentioned earlier, Obesity Canada did have a chapter discussing weight bias. In "Chapter 2: Reducing Weight Bias in Obesity Management, Practice, and Policy" (Kirk, Ramos Salas, Russel-Mayhew, 2020), the authors put forward 4 key recommendations that focus on how health-care providers need to recognize and assess their biases, avoid using judgmental words, and not make assumptions that an issue is related to weight. This is the only chapter and set of recommendations that focus on understanding the potential impact of the doctor on the care of fat patients.

Anti-fat biases held by health care providers, and more importantly, the discriminatory mistreatment of fat folks by their doctor due to perceptions about body size, is a significant issue in Canadian health care. As Yasmin shared with me:

> **Yasmin:** I think overall, the word that comes to mind is dismissed. I think in a way it's because if I'm not going to deal with the issue of my weight, then why are we actually helping you because until you'd address that issue, we can't help you because everything is attached to that issue. When I went to the hospital for pain, I was dismissed because of my weight. The intake with my doctor, I really had a sense of, 'Well, you need to deal with this issue'. I feel like the Canadian health system, that they don't really care [about you] if you're overweight, that they don't-- You become second tier, in a way. I feel like it's not-- I feel judged and blamed for it. Like, 'If you were to do this, then you would be valued and we

would make the effort to take care of you.' I think that's one of the reasons why I don't regularly go to the doctor even though something might be wrong, because I'm like, 'What's the point?'.

Fat Studies scholars critique the medical gaze and note how the subjectivity of doctors is based on their own perceptions. Since the perceptions of doctors are subjective, the dominant understanding of medicine as objective must be questioned (Murray, 2008). With respect to fatness, the fat body is always visible when it comes into contact with doctors, and this visibility and the accompanying perception of the doctor is believed to correlate to knowledge about fatness (Murray, 2008). Because fatness is hyper visible (Gailey, 2014; Murray, 2008) a fat patient is 'outed' prior to any discussion of the reason for the visit. This means that a doctor will view the patient through the lens of a 'person living with obesity', prior to any verbal interaction. This 'confession' of fatness results in the pathologization of fat bodies (Murray, 2008) and influences the diagnostic and medical process (Jutel, 2009), as explained in Chapter 4. The pathologization of fat bodies is not lost on the patients themselves. For example, Brenda describes her fear of visiting the doctor.

Brenda: It's multi-fold, but just as a fat person, just not being able to go-- look, having to worry about, "Is this doctor going to discriminate against me," because probably 85% of them do and have and will. Just the work of finding it out-- it's hard enough to find a doctor for a normal person but to have to research and ask friends and I still don't have a family doctor. I've been in Toronto for 17 years. It's really just a lack of confidence. It's

just the lack of any doctors giving a shit about what's wrong with you. They just see you as a fat case that needs to go lose weight.

"Health At Every Size, please"

During my interviews with fat women, I asked them what they thought doctors needed to do when working with fat patients. Overwhelmingly, participants wanted doctors to treat them with humanity and to recognize that fat does not necessarily mean unhealthy.

Kelsey: If you had a say or if you could advise or influence doctor training, what would you suggest as strategies for dealing with fat patients?

Madison: Oh my god. Health at Every Size, please [chuckles].

Kelsey: Do you want to explain what Health at Every Size is to you?

Madison: To me, Health at Every Size means you don't treat weight, you treat a person. There's lots of things that you can recommend to a patient that have nothing to do with weight. Who gives a shit about weight loss?

Many participants expressed how doctors would automatically assume that they have an unhealthy diet or do not engage in exercise or movement. Yet, for many participants, this assumption is not an accurate representation of their lifestyles. Danielle states that she wants doctors to "not to work from an assumption that fat is unhealthy and needs to be eradicated. I really would like doctors to have access to fair information and that is not influenced by pharmaceutical companies and diet industries, that kind of thing." Similarly, Hannah advocates:

> **Hannah: ..**.for doctors to look at the whole picture and to understand that there are other things that need to be worked on and also they know that this doesn't work, don't they? They're always like, "We know it's really hard. Weight loss is not really successful." They know it's not working but they're still suggesting it. What can we be suggesting instead?

The Obesity Canada guidelines do acknowledge the value of improving health and well-being. In the guide, they state that:

> ….. there is a recognition that obesity management should be about improved health and well-being, and not just weight loss. Because the existing literature is based mainly on weight-loss outcomes, several recommendations in this guideline are weight-loss centred. However, more research is needed to shift the focus of obesity management toward improving patient-centred health outcomes, rather than weight loss alone. (Wharton et al., 2020, p. E876)

What is frustrating about this assertion is that there has been a lot of research done and scholarship produced (see, for example, Bacon and Aphramor (2011), Burgard (2009), Campos (2004), Gard and Wright (2005), and Murray (2009) to name a few) on the ineffectiveness of a weight loss approach, both in terms of the negative impact this approach has on fat patients and alternatives to a weight loss approach, such as the HAES[6] approach. Many participants in my research brought up HAES, even directly referencing Lindo Bacon and their work on this issue.

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[6] While this dissertation is not explicitly calling for the adoption of HAES by health care practitioners, many participants shared their desire for a HAES approach to care when asked about changes they would like to see in health care. HAES is not a problem-free model (see Chapter 1 for some of the concerns around HAES and healthism), and there is significant pushback and tension in the fat studies community around HAES, accountability, and harm (see Mercedes, 2022; ASDAH, 2022; and NAAFA, 2022, among others, for more detail).

Gina describes how she uses HAES as a strategy in navigating weight-based discussions with new doctors:

> **Gina:** When I'm going to see new doctors, I usually pull up an article on how to deal with weight discrimination. There's a little note card with research-based evidence for Health at Every Size that I bring in case they give me a hard time. I can be like, 'Look at this research'.

Other participants, like Demi and Karen, explain how they try and incorporate a HAES perspective into their own understanding of their weight and health. Demi shares how, instead of rejecting dieting which has been harmful to her in the past, she is trying to take up a HAES approach.

> **Demi:** Now, I'm just trying to do an awareness type thing, but it's not a diet. I'm trying to move more intentionally and trying to think about food more intentionally and think about how I feel when I eat something and just being more mindful. This is kind of Lindo Bacon, right?

Karen, similarly, in taking up a HAES approach to understanding her body, talks about how, in rejecting traditional diet and exercise regimes, she is learning how to live in the reality of her fat body through knowing more about how fat bodies move through and navigate daily life.

Karen: I'm trying to move around a 400 pound body. Of course I'm going to breathe hard. I'm going to have legs that are very muscular because this is a big body to carry around everyday. I think that was one of the most revolutionary things a friend said to me once was, "Of course you're going to breathe hard. You're moving around a lot of weight. There's nothing to be feel ashamed about that." Then Lindo Bacon's book, Health at Every Size, talked about like-- Or I think it was an article that they wrote, Lindo Bacon and Lucy Aphramor, I think. They talk about how like, "Okay, maybe fat people have a higher blood pressure, but also maybe it just takes more to pump blood through a bigger body." We don't get that from the health-- Articles and stuff like that don't study that. They just say, "It's bad that your blood pressure is that high," or whatever.

Conclusion

Brenda: I feel like it's like the war on drugs. It's probably not going anywhere anytime soon, so let's learn how to deal with it. Let's learn how to deal with people where they are. It's ridiculous to say, "Go lose weight before we can do this surgery on you," because a lot of times, you don't have that option. I also think that we need size discrimination laws because this just is going to keep happening. It's not illegal. You can be like "No, you're fat, I'm not doing XYZ thing for you," and that's okay, but it's absolutely not okay.

In this chapter, I argued that the categorization of obesity as a disease in Obesity Canada's *Canadian Adult Obesity Clinical Practice Guidelines* (CPGs) is problematic, and that these guidelines may in fact encourage health-care practitioners to pathologize their fat patients. This practice is harmful to fat patients and further medicalizes their bodies. The guidelines set

out by Obesity Canada may acknowledge the existence of bias against patients categorized as obese, but they do little to improve on this inequity. They also do not engage with any critical scholarship that works to dismantle harmful assumptions on body size.

Ultimately, the Obesity Canada guidelines and their key recommendations fail the very group of people they are supposed to be helping. Instead of working to combat weight stigma and bias or to make health care more accessible for fat folks, the guidelines further pathologize fat patients as 'diseased' and categorize them as 'people living with obesity' that need intervention and treatment. This is not an uncommon public health strategy. Public health often portrays obesity as resulting from individual behavioural failures, yet also argues that obesity is an 'epidemic' (Boero, 2021). This represents what Boero (2012) calls the normative / pathological duality. Similarly, Murray (2009) argues that when 'obesity' is represented as disease and framed from a medical perspective, the 'cure' is for the individual to adopt 'health' behaviours and to change their lifestyle. This is the primary focus of the guidelines by Obesity Canada; they are most interested in instructing health-care practitioners on how to assess their patients as 'diseased' with obesity, and how to encourage intervention with the ultimate outcome of weight loss. While there is a nod to understanding weight bias and stigma, it is superficial. These guidelines fail to actually take up the issue of weight-based discrimination in any meaningful or productive way, and instead encourage continuing marginalization of people based on the size of their bodies.

Conclusion

Introduction

In this final chapter, I explore the implications of my dissertation and the contributions I make to fat studies scholarship as a fat sociologist. I begin with a summary of my research questions and my methodological process. I then highlight the key contributions of my dissertation to the field. I conclude this chapter with a few recommendations for the direction of future research.

Summary of my research process

In this dissertation, my primary goal was to explore the following question: How does fatness act as a barrier to accessing health care services for fat women in Canada? In approaching this question, I subsequently identified four research questions that would be the basis for my study. I asked:

1) How has fatness come to be socially constructed as a moral panic of an 'obesity epidemic', resulting in the medicalization of fatness?

2) How does the framing of fatness as an 'obesity epidemic' impact the relationship fat women have with their bodies and themselves?

3) With a focus on primary care physicians, how does the advice of medical professionals impact fat women's perceptions of their bodies and their health?

4) How does the categorization of obesity as a disease by Obesity Canada, in the 2020 Canadian Adult Obesity Clinical Practice Guidelines, further entrench fatphobia in health care practice?

These research questions formed the basis for my interview guide, which I used to interview 35 folks who either identified as women or indicated they were assigned female at birth, but now identify otherwise. To understand and contextualize the data from my participants' interviews, I worked at the intersections of fat studies, sociology of health, and a feminist perspective, both in theory and in practice. Using feminist standpoint epistemology, I aimed to understand and center the experiences of my participants in both the research process and the analysis. Additionally, recognizing that as a fat woman I cannot separate myself from the research I conduct, I utilized the methodological approach of auto/biography to include my own experiences into the research project, both in the interview setting and in the writing of this dissertation.

Discussion of findings and contributions to the field

In a country where universal health care is in theory accessible to all, many fat women experience barriers when attempting to access this care based on their weight and face anti-fat bias and discriminatory treatment by their doctors. In this section, I identify six key findings that come out of my dissertation and contribute to the field of fat studies from a sociological perspective.

1. The neoliberalization of body size and the rise of the 'biocitizen' (Halse, 2009) has resulted in fat women having antagonistic relationships with their bodies.

The social construction of fatness as an 'epidemic' has resulted in fat women having adverse, antagonistic relationships with their bodies. This antagonism stems from the widespread perpetuation of moral panic around an 'obesity epidemic'. The myth of the 'obesity epidemic', as

explored in Chapter 3, fosters stigma around fat bodies, whereby society sees fat bodies as a grotesque problem in need of solving. The stigma associated with obesity has resulted in fat people being seen as lazy, lacking willpower to control their bodies, and moral failures (Ellison, McPhail, & Mitchinson, 2016). Fat women internalize these understandings of their which results in negative relationships with oneself. Throughout my interviews, participants expressed the connection between their body size, their understanding of their individual behaviour, and the ways in which society views them through the lens of the obesity epidemic. Their feelings about their own bodies were bound up in feelings of a lack of self-control and self-restraint. As Bordo (2003) and Oliver (2005) argue (as noted in Chapter 1), being fat, or having excess body weight, is seen as personal inadequacy and failure. This presumed failure presents challenges to upward mobility, as those who are fat are seen as lazy, lacking discipline, and unwilling to conform to societal standards (Bordo, 2003).

The presumed decision to be fat and not lose weight (though, as presented throughout this dissertation, participants were in constant fluctuating relationships with dieting and weight loss efforts) impacts the ability of fat women to fully participate in society. Participants expressed concerns around romantic desirability, their ability to participate in daily aspects of life such as walking long distances or biking, participating in sports, making friends, or advancing in their career. The common denominator of concerns around body size, unrelated to health and health care, is that being fat prevents a full and enriched engagement in the social world due to the moral panic around the 'obesity epidemic' and the stigma that comes from being in a fat body. These antagonistic relationships are rooted in neoliberal understandings of individual failure to be thin and are influenced by the expectation to perform 'good health' and conform to the

stereotype of the 'good fatty', the uptake of extreme dieting and disordered eating practices, and exposure to harmful portrayals of fat women in the media

The neoliberal context in which fatness is understood demonstrates the responsibilization discourse that positions fat people themselves as problematic and connects to the rise of what Halse (2009) calls the 'biocitizen'. As discussed in Chapter 4, citizenship for the biocitizen connects the private lives of individuals and their bodily practices to their citizenship rights (Halse, 2009). Specifically, the good citizen is one that is active and healthy – code for a thin citizen. When people fail to control their weight, they are not good biocitizens. A fat citizen then is a bad citizen, one who is violating what is considered the good of society, by failing to take care of themselves and their weight (Halse, 2009). Weight comes to represent a social contract between citizens; thus, being fat violates this social contract and the fat, failed biocitizen is understood to be a burden on society

The neoliberal ideology of individual responsibility, specifically in relation to body size, has resulted in fat women having negative relationships with their bodies and themselves. The consequences of responsibilizing discourses around weight loss and good citizenship (i.e., the biocitizen) include engaging in extreme dieting/weight loss practices, exposure to harmful portrayals of fat women in the media, and the pressure to conform to the stereotypes of the 'good fatty', as evidenced by the rich data from my participants in Chapters 3 and 4. Here, they are engaging in health behaviours that they understand to be consistent not only with 'good health', but with good citizenship (Halse, 2009; Harwood, 2009).

2. Discourses of responsibilization and disciplinary medicine are engrained in the way health care is practiced in Canada, and this negatively impacts the relationships fat patients have with their health care providers.

In Chapter 4, I explored the ways in which medical knowledge is constructed and subsequently exercised on fat patients. As noted previously, Murray (2008) argues that medical knowledge is actively involved in the disciplinary process of making the fat body deviant, as medical knowledge contributes to the pathologization and the ascribing of the deviant label to fat bodies. The stigma associated with hypervisibility of fat bodies, then, acts as discipline: people are expected to abide by or conform to social norms to ensure the good of society. This pathologization of fat bodies contributes to the stigma experienced by fat women in their everyday lives, but especially in health care settings.

Disciplinary medicine feeds off the neoliberalization of body size (as discussed earlier in this chapter) as it relies on people self-surveilling and buying into the belief that it is their personal responsibility and choice to improve their bodies (Murray, 2008). Disciplinary medicine relies on the illusion of personal choice; people need to believe that they have chosen to engage in behavioural change of their own volition, that it is their moral duty to change (Murray, 2008). This self-surveillance is built on medical narratives, explored in Chapter 4, that encourage people to monitor themselves in order to comply with 'good' health. These narratives are built on 'expert' medical knowledge (Murray, 2008) from doctors or health care practitioners. Internalizing this 'expert' medical knowledge results in the internalization of the 'clinical gaze': where people believe medical knowledge is the only source of what is good for them. Throughout Chapter 4, my participants (and myself) shared experiences of receiving weight loss advice from their doctors, ranging from extreme dieting to starvation, and even surgical

intervention. One of the primary ways my participants experienced disciplinary medicine was through receiving unsolicited weight loss advice from their health care providers. Disciplinary medicine, according to Murray (2009), relies on morality to enforce control and regulation over people's understandings of their personal responsibility for their weight. In some instances, when participants could not or would not conform to the expectations of weight loss from their providers, they were denied care. For example, Faith experienced this in relation to gender-affirming surgery, while Zoe was denied skin removal surgery following dramatic weight loss through bariatric surgery.

3. The fat body is a space of hypervisibility that is constantly engaged in silent 'confession'.

Fat women are also in a constant state of 'forced confession': fat people are seen as 'immoral' subjects, who, by virtue of their visible fatness, are confessing to such immorality (Murray, 2008). This 'forced confession' is especially present in health care spaces and through the medical gaze. The fat patient always performs this silent 'confession' (Murray, 2008) – one of pathology, indulgence, disease – before the doctor has even spoken to the fat patient. Such confession influences the diagnostic and medical process, and the medical advice provided to the fat patient. This silent confession confirms societal understandings of the fat body as diseased and pathological, regardless of the truth of the person's lived reality.

Murray (2008) notes that the 'fat woman' is seen to be lazy, reluctant, or unwilling to change herself, a compulsive eater, hyper emotional, and a physical and moral failure. She furthers this argument by suggesting fat women are also seen as sexually unattractive, unintelligent, unhealthy, and dirty. They are treated with suspicion, and often face hatred and disgust from the general public (Murray, 2008), similar to the hyper visibility described by

Gailey (2014). The moral messaging around fat bodies, and the discriminatory and marginalizing experiences result in fat women being socialized to feel shame about their bodies, as well as a constant pressure to change their failing bodies (Murray, 2008).

4. The neoliberalization of the body and the impact of disciplinary medicine consequently result in the creation of the contemporary health subject

The medicalization and pathologization of fatness and the disciplinary effect of medicine contribute to the formation of the contemporary health subject (Harwood, 2009). As Jutel (2009) argues, a circular relationship exists between health and anxiety. As such, diagnosing citizens as 'overweight' reflects societal beliefs that a relationship exists between health and appearance (Jutel, 2009). At the same time, the power of medicine as an institution uses 'science' to validate the anxieties of the public and reinforces social control. Jutel (2009) argues that the reproduction of anxieties and the diagnostic process through the power of medicine contributes to the exploitation of overweight people as the medicalization of weight opens up commercial interests and industries that benefit from the classification of overweight as disease.

Similarly, Hesse-Biber (2008) notes that the representation of the thin body, via the 'thin ideal', perpetuates an ideal physical perfection that is physically impossible. The reinforcement of the thin ideal also results in young girls living in fear of becoming fat (Bordo, 2003). The impossibility of physical perfection opens up commercial interests, as Jutel (2009) noted. The benefactors of the imperfect body are cosmetic companies, fitness companies, and the weight loss industry (Hesse-Biber, 2008), and, more broadly, the medical industrial complex. Health concerns mask profit motives and companies benefit from women aiming for an impossible body type.

Jutel (2009) argues that "condemnation of overweight hinges on the premise that it is a disease that puts individuals at risk and renders populations vulnerable" (p. 60). Being overweight, Jutel (2009) posits, has come to be considered a disease by both the medical community and lay people, which is evident in Chapter 5 through the Obesity Canada 2020 Guidelines. She highlights how the process of diagnosing and labeling are key to the way that medicine demonstrates social control as a diagnosis or label formalize a person or condition as problematic.

Drawing on what Graham (2005) calls 'lipoliteracy', Murray (2008) argues that in Western society, there is a well-developed and ready to deploy literacy around fat bodies. By this, she means that people draw on, consult, and reproduce common narratives around 'normality' and deviance, and are quick to read the fat body using these narratives. These 'lipoliterate' narratives are productive, in that they create and entrench the establishment of obesity as disease and collapse with other narratives of failure – such as moral failure or aesthetic failure (Murray, 2008). Murray (2008) stresses the need to challenge the power and authority of medicine and the ability of the medical voice to render some bodies as pathological and/or immoral. It was evident throughout Chapter 4 that the medical voices of health care practitioners further entrenched narratives of failure with my participants.

5. Fatphobia and anti-fat bias held by health care professionals results in fat women having negative relationships with their doctors and the health care system more broadly. These experiences of fatphobia and anti-fat bias contribute to overall avoidance of health care settings by fat patients.

In Chapter 4, I explore my participants' experiences with health care professionals and find that all of them have experienced fatphobia and anti-fat bias from their health care professionals, across their childhood and adulthood. These anti-fat attitudes held by health care professionals, especially primary care physicians, result in weight-based discrimination for fat women in health care settings, further entrenching fatphobia in health care, as discussed in Chapter 4 in the academic literature and in my participant's experience. The stigma attached to being in a fat body, especially in health care spaces, results in fat women's internalization of shame about their very existence and often results in an avoidance of health care spaces altogether.

When healthcare professionals make assumptions about their patients on the basis of body size, it can cause harm to the patient themselves (Ellis-Ordway, 2021). These are subtle (or, sometimes not so subtle) indications to fat patients that their bodies are unacceptable or flawed, and not worthy of care. My participants shared with me that these experiences of weight stigma resulted in negative or non-existent relationships with doctors and, ultimately, the denial of care (by the doctor) or avoidance of care (by the patient). Avoiding care, or being denied care, can ultimately have devastating or life-threatening consequences, which some of my participants shared in Chapter 4. Another fear shared by my participants was that when health care providers make assumptions about their patients based on their size, they can miss other key health problems the patient may be experiencing.

At the end of Chapter 4, I provided the recent example of Ellen Bennet, whose inoperable cancer was discovered too late and whose obituary was used to illustrate the impact of fat shaming by health care providers. Many of my participants expressed fear of having health care concerns ignored or undiscovered because their doctor makes incorrect assumptions about their

health based on their weight. This is something I experience as well. It is a looming fear that something will slip by, undiagnosed, due to doctor negligence rooted in anti-fat bias and fatphobia. As Joy Cox (2021) tells us:

> How can any fat person be assured that they will receive adequate care in facilities with health care workers who have been taught that their size is reflective of the feelings they have about themselves and that they lack willpower to achieve goals that will assist in making them healthy? How much trust should a fat person put into a doctor who repeatedly prescribes weight loss despite their office visit having nothing to do with their weight? (p. xiv).

As my participants expressed throughout my interviews, the fear of mistreatment from their health care practitioners leads to a breakdown of trust and an avoidance of accessing care.

6. ***Despite overwhelming evidence to the contrary, health care professionals are ignoring the research on anti-fat bias and are instead doubling down on obesity as disease. This is evidenced by the 2020 Obesity Canada's Canadian Adult Obesity Clinical Practice Guidelines that advise doctors to diagnose fat patients as having obesity as a chronic disease and confirmed by my research participant's experiences.***

In 2020, Obesity Canada released the *Canadian Adult Obesity Clinical Practice Guidelines*, as explored in Chapter 5. These guidelines encourage doctors to see their fat patients as 'people living with obesity' and to diagnose them with obesity as a chronic disease. They propose a series of steps to engage with fat patients about their weight and their health, which ignore aspects of fat people's health that are not associated with weight. The primary suggestion for doctors of fat patients is to focus on core treatment options for obesity like nutrition therapy,

as well as additional therapeutic interventions like bariatric surgery. The Obesity Canada guidelines make a series of presumptions about fat patients which illustrate the neoliberalization of body weight and the assumption that if patients work hard enough and follow the medical advice from their 'expert' doctors, they will lose weight and this weight loss will 'cure' their health problems.

The focus of these guidelines on the importance of 'initial intervention and continued assessment' to improve this 'chronic disease' assumes that fat folks live a specific, unhealthy lifestyle that requires intervention. Instead of exploring or embracing alternative approaches to health and body size, like the Health At Every Size model or an appreciation of the social determinants of health, Obesity Canada doubles down on fat bodies as pathological, a disease in need of a cure. They encourage doctors to continue to pathologize their patients. This practice is harmful to fat patients and further medicalizes their bodies.

As seen by my participants, fat people already internalize understandings of their bodies as over-indulgent, as representing lack of self-control, and as evidence of individual failure; they do not need Obesity Canada to encourage their doctors to further promote these messages through disciplinary medicine. These messages, as Gard and Wright (2005) argue, are difficult to resist due to the assumption that body size reveals (or confesses) their individual nature. This is exacerbated by the pathologization of weight. Further, these assumptions are embodied in the five-step process for dealing with 'people living with obesity', as outlined in the Obesity Canada guidelines. While the guidelines make a superficial nod to the existence of bias against 'patients living with obesity', they do little to improve on this inequity or to encourage doctors to re-frame their understanding of their fat patients. They also do not engage with any critical scholarship that works to dismantle harmful assumptions about body size.

This ultimately results in Obesity Canada creating and disseminating a guide for practitioners that suggests key recommendations which fail those they claim to help. They make little effort to combat weight stigma or anti-fat bias and make no attempts to improve access to health care for fat patients. Instead, the guidelines further pathologize fat patients as 'diseased' and categorize them as 'people living with obesity' that need intervention and treatment. This is on remarkably similar with public health strategy that portrays obesity as resulting from individual behavioural failures, as previously discussed, while arguing that that obesity is an 'epidemic' (Boero, 2021)

Directions for future research

As fat studies is an emergent and burgeoning field, there is extensive potential for important and transformative research to come. In this section, I highlight three areas of research to be taken up in fat studies scholarship: the intersections of race, weight, and access to health care; fatness and COVID-19; and issues of access to fertility treatments for fat women.

Intersections of race, weight, and access to health care

In this dissertation, I did my best to recruit women of diverse ethnic or racial backgrounds to participate in my research. Despite my best efforts, my participant sample was overwhelmingly white. My participants provided me rich data that elucidates key issues around access to health care for fat folks; however, this data does not speak more broadly to the intersection of race and fatness in accessing health care. While I aimed to understand fatness and health care through an intersectional feminist perspective, I could only work with the data I have and recognize that future work in this area is incredibly needed. As Amy Farrell (2021) reminds

us "Intersectional feminist theory … clarifies the ways that fatness as both an identity and as a category of discrimination and stigma must always be understood *in context* and *in relationship to* other forms of identity and oppression" (p. 49). There are many BIPOC scholars who do work on the relationship of fatness and race (see Adodo and Warsame, forthcoming; Andrew, 2018; Bahra, forthcoming; Harrison, 2021; Mxhalisa, 2021; Shaw, 2006; Strings, 2009; Strings, 2020, among others!). Future research connecting fatness, race, and access to health care in Canada would extend the impact of my findings further.

Fatness and the COVID-19 pandemic

As I completed my data collection in 2019 and I was pregnant and then on maternity leave in 2020, my data was not able to address the COVID-19 pandemic. The impacts of the pandemic are too vast to capture in words and are still developing as I finish this project; however, the fear around impact of COVID-19 on fat folks has been immense. In my own life, I was 8 months pregnant at the beginning of the pandemic and gave birth at the end of April 2020. It was absolutely terrifying. I already had immense anxiety around the labour and delivery process (in general, of course, but more specifically as a superfat woman giving birth) that when COVID-19 hit, my anxiety skyrocketed. Due to my son's stubbornness, I ended up needing to have a C-section, adding 'major surgery' to that existing pile of anxiety! Ultimately, everything worked out fine and, in contrast to the majority of my health care experiences in the past, I had such a pleasant experience with all the health care providers involved in my delivery (see Ioannoni, forthcoming for a discussion of fat positive pregnancy clinics).

Despite this personal positive experience, COVID-19 opened up new forms of the moral panic around obesity and further perpetuated fatphobia in health care. Early research on COVID-

19 continued the long-drawn-out argument that fatness is linked with severe disease outcomes, arguing that this is no different with COVID-19 (McPhail & Orsini, 2021). Fairly quickly, news articles started popping up about the ways in which obesity increases risks associated with COVID-19 (see, for example, "Obesity increases risk of COVID-19 death by 48%, study finds" in *The Guardian)*. Bessey and Brady (2021), in their analysis of Canadian media, looked at the media framing of the relationship between "obesity" and COVID-19. They found that the media reported on the potential connection between obesity and the severity of illness from COVID-19 as if it was a given, despite a lack of research at the time (Bessey & Brady, 2021). They argue that:

> media coverage of COVID-19 and "obesity" frames fatness in highly medicalized, moralized, and individualistic terms that reifies pre-existing biomedical, healthist, and neoliberal logics that construct health as a matter of moral obligation and personal control. "Obesity" was further framed as the result of health behaviours, and therefore a modifiable risk factor of COVID-19 illness (Bessey & Brady, 2021, p. 28).

The neoliberalization of body size and weight clearly remains prevalent through discourses of health when related to fatness and COVID-19.

In addition to the moral panic around fatness and COVID-19, the medical surveillance of fat bodies has not changed since the start of the pandemic; instead, it has increased. The Government of Canada considered obesity, constituted as having a BMI ≥ 30, to be an underlying medical condition that qualified Canadians for early access to vaccine distribution with other 'high risk' populations (Government of Canada, n.d.). Many of my fat friends and I (offline and in the fatosphere) took advantage of this to access our initial vaccinations! A common sentiment in my fat circles was that folks wanted to get the vaccine as soon as humanly

possible – for protection from COVID-19, but also for protection from (and out of fear of) the way our fat bodies would be treated in hospital if we were to get seriously ill with COVID-19. The primary fear here was not getting COVID-19, but how we would be treated if we ended up sick and in need of care.

Fat studies scholars and fat activist communities (like NAAFA) push back against persistent generalizations that assume fat people are negligent when it comes to their personal health and well-being (McPhail & Orsini, 2021). Instead, they push for the dismantling of obesity as a medical risk for severe health outcomes (like in the case of fatness and COVID-19), and as a disease in and of itself, as this thinking further perpetuates the stigma against fat bodies, entrenching the common stereotype that fat people are a drain on the health care system (a fear that many of my participants expressed) (McPhail & Orsini, 2021).

In Ontario, the #NoBodyIsDisposable Coalition created the "Know Your Rights Guide to Surviving COVID-19 Triage Protocols" toolkit for fat folks who face potential discrimination based on size when being triaged. This toolkit covers documents (such as Power of Attorney, advance directives, and wills or trusts) one should settle before needing to go to the hospital, ways to create connection with your health care providers, things to take with you to the hospital, strategies for advocacy, 'survival strategies' to use if you face discrimination, and sample letters to give to health care providers (Tidgwell & Shanouda, forthcoming).

While fat studies scholars and activists have taken up the call to arms to combat fatphobic and stigmatizing discourses connecting fatness and COVID-19, the need for further research remains, though I acknowledge that many scholars are likely conducting that research at the time of writing this dissertation.

Weight as a barrier to access for reproductive services

There are so many areas for future research that I have not discussed; nonetheless, the final direction I want to highlight is one that I am personally interested in investigating as a fat studies scholar, post graduate school: barriers to access to reproductive services. When I started my Ph.D., I was a single, early 20-something with dreams of completing my Ph.D. in rapid timing. Ending my Ph.D. (eight years later), I am in my early 30s, and am a solo mom to my amazing son Rowan, with dreams of making it to the end of each day and getting a decent night's sleep. What I couldn't have known at the start of my project was just how present anti-fat bias from health care providers would become for me.

I always knew I wanted to be a mom, regardless of whether I had a partner to journey into parenthood with me. After ending a long-term relationship in my late 20s, I decided instead to focus on making my dream of becoming a mother a reality. I started looking into fertility services for single women and decided to undertake an intrauterine insemination (IUI) in order to get pregnant using donor sperm. Making this decision was the easy part, carrying it out was incredibly difficult.

In Canada, the primary way to access donor sperm is to use a fertility clinic. Sperm is purchased from a sperm bank and is shipped directly to the clinic. My doctor referred me to a smaller fertility clinic just outside Toronto, on my request, as they had lower wait times and a (thin) colleague of mine had used this clinic for her pregnancy. Below is an excerpt from a forthcoming chapter in *The Mother Mortality Project* that I wrote about my experience trying to get pregnant and having to fight against my fertility doctor:

> It was quite clear from the start that we did not see eye to eye on this matter. First, from this appointment onwards, he prefaced almost every statement with "I am not discriminating

against you, but….". He also told me his job as a doctor is to "first do no harm" and that getting me pregnant could be harmful both to me and my potential future child.

He refused to help me get pregnant. I had my doctor refer me to another clinic, and after more time waiting, another consultation, another lecture on my body size, a consultation with a high-risk OBGYN, months of cycle monitoring, and one (only one!) IUI, I was finally pregnant.

Consequently, my passion for studying health care access barriers for fat women has significantly amplified in the years since I started my Ph.D. As I end this chapter of my life, I want to start another one, looking at access issues for reproductive services and specialized health care providers and services for fat and pregnant people. As mentioned in Chapter 4, Faith and Zoe shared how their BMI disqualified them from receiving care in a clinical setting that requires anesthesia (such as gender-affirming surgery or skin removal surgery). This is true for women who want to undergo in vitro fertilization (IVF), as egg retrieval is done under anesthetic. This was made very clear to me by my fertility doctor, who stressed that not only am I ineligible for IVF based on my BMI, and that he would only perform non-medicated IUIs (which means no medication to stimulate egg release) as this could result in a pregnancy of multiples (more than one fertilized embryo). This meant that if an unmedicated IUI, more colloquially known as the 'turkey baster method'[7], didn't work, I was out of luck. Even then, my fertility doctor (who at the time was part of a large fertility practice where there is a rotation of doctors available to do IUIs every day, even if your doctor is not scheduled when you ovulate) kept his schedule clear in the days leading up to my ovulation as he admitted to me that he could not ensure that all his colleagues would perform my IUI, based on my BMI. Despite his

[7] The difference being that the doctor uses a small catheter to insert the sperm timed with ovulation, in a clinical setting opposed to the comical tropes of the administering of sperm via turkey baster at home. Essentially though, the same process!

misgivings about getting pregnant at my size, I am incredibly grateful for this. That being said, my experience with reproductive services and my engagement with the literature around weight, pregnancy, and fatphobic discrimination propel me into doing further research in this area.

Final thoughts

This dissertation was both an academic undertaking and a labour of love. It was often frustrating, upsetting, and infuriating. Conducting this research, analyzing the data, and writing this dissertation brought up a lot of my own past trauma around my relationship with my body and experiences I have had with health care. Talking with my participants and writing up their stories re-opened wounds that I thought were long healed. It required me to work through and process a lot of my own medical trauma while simultaneously processing the traumatic experiences of my participants. This was not easy, but it was ultimately empowering.

I carry my participant's experiences alongside my own; they come with me to every doctor's appointment. They are with me every time a new health care practitioner asks me what I do, and I tell them "I'm a Ph.D. student studying weight-based discrimination in health care", and they are the unspoken "so don't fuck with me" that follows.

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Appendix A: Interview Recruitment Poster

DO YOU IDENTIFY AS FAT?

Have you been told you are 'OVERWEIGHT', 'OBESE', or 'FAT' by health care professionals?

I am looking for fat identified, female identified participants who are interested in taking part in an interview to discuss weight, fatness, and health care.

You are invited to share your experiences of interacting with the health care system, specifically with primary care doctors, with the researcher, who is also a fat-identified woman.

For more information, contact:
Kelsey Ioannoni, kelseyi@yorku.ca

This research has been approved by the Office of Research Ethics at York University

Appendix B: Focus Group Recruitment Poster

DO YOU IDENTIFY AS FAT?

Have you been told you are 'OVERWEIGHT', 'OBESE', or 'FAT' by health care professionals?

I am looking for fat identified, female identified participants who are interested in taking part in a focus group about weight and health care.

You are invited to share your experiences of interacting with the health care system, specifically with primary care doctors, with a small group of other fat identified women.

There are two focus groups available:

1) **Monday, November 20th from 2-4pm**
2) **Thursday, November 30th from 2-4pm**

The focus groups will be hosted at York University.

For more information, contact:
Kelsey Ioannoni, kelseyi@yorku.ca

***If you prefer to participate in an individual, one-on-one interview, please contact Kelsey Ioannoni at kelseyi@yorku.ca**

This research has been approved by the Office of Research Ethics at York University

Appendix C: Participant Demographic Survey

Please note: all answers are anonymous and not affiliated with your interview data. All questions are OPTIONAL; you are not obligated to answer any question you are uncomfortable with.

1) Please indicate your gender: _____

2) Please indicate your sexual orientation: _____

3) Please select the category that includes your age:

    a. 18 – 24 years old
    b. 25 – 34 years old
    c. 35 – 44 years old
    d. 45 – 54 years old
    e. 55 – 64 years old
    f. Over 65 years old

4) Please indicate your ethnic identification:

    a. Aboriginal (Inuit, Métis, North American Indian)
    b. Arab/West Asian (e.g., Armenian, Egyptian, Iranian, Lebanese, Moroccan)
    c. Black (e.g., African, Haitian, Jamaican, Somali)
    d. Chinese
    e. Filipino
    f. Japanese
    g. Korean
    h. Latin American
    i. South Asian
    j. South East Asian
    k. White (Caucasian)
    l. Other: _____

5) Based on the medicalized model of Body Mass Index (BMI), how would your body mass be described?

    a. 'Underweight'
    b. 'Normal'
    c. 'Overweight'
    d. 'Obese'
    e. Prefer not to answer