Questioning the Culture of Fatphobia: A Commentary on the Systemic Marginalisation of Fat Bodies

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The COVID-19 pandemic has significantly changed all of our lives. When COVID began, I was a first-year undergraduate student of philosophy and now, I have a semester left before I graduate. There was one incident that really stood out to me during the pandemic. In 2021, I had my first visit to the doctor in a couple of years; I left the hospital as a patient diagnosed with PCOS.

Polycystic Ovary Syndrome, or PCOS, is best described as a "condition" characterised by excess androgen production and ovulatory dysfunction, affecting around 5-20% of people with ovaries of reproductive age worldwide. What I think is significant here is that I had to face a straight-sized gynaecologist to discuss my treatment. The physician weighed me, asked for my height and proceeded to do simple maths and calculated my BMI or Body Mass Index which, I found out, classified me as "overweight" and leaning towards "obesity". It is interesting how I went there with the expectation that I would learn more about PCOS and how I can live with it or help my body deal with it better but the resultant conversation with my gynaecologist was less about any of those things and more about how I, a fat person, could lose weight. They suggested the usual methods of weight-loss: dieting and exercise.

Now I am not claiming this to be objectively bad advice; exercise releases endorphins, prepares one for the day, helps to cope with stress and prevents cardiovascular problems. However, when exercise is promoted as merely a tool for weight-loss, then that becomes a problematic and prejudiced view. They did not ask me what I ate or what my daily eating habits were, instead assuming (in an unmistakably patronising way) that I had unhealthy eating habits. “But isn't losing weight healthier for you?" This is a question that I will try to answer and on which I will express my opinion in due course. For now, my point is that this is not what I expected a physician, a person of "normal" weight, a trained expert on the human body, to do.

The question I want to put forward here, and consequently at least try to answer, is: Was my gynaecologist's attitude to me justified? Is anti-fat bias and weight-based stigma justified? This essay addresses fatness, the history of body standards, the prevalent anti-fat bias in today's world and why it is that we discriminate against fat people. It also explores the consequences of anti-fat bias on both fat as well as non-fat people, and what the alternative ways of framing fatness are that might encourage equality and empathy.

A good place to start thinking about anti-fat attitudes would be fatness itself. It is argued that fatness is a social construction. While scholars outside of Fat Studies (along with the biomedical

community, the press, and most people) use the BMI to designate who is fat and who is not, people involved in the discipline of Fat Studies generally agree that ‘fat’ is a fluid subject position relative to social norms, relating to shared experience. Fatness can therefore be understood as a common characteristic which people who face a specific form of structural discrimination and oppression have in common (Cooper 2010). This article uses the word 'fat' to refer to fat people as a value-neutral and non-derogatory term, which is also an act of reclaiming the word itself from the harmful and taunting contexts in which it has previously been used.

Ideals of body shape and size have probably been around as long as modern humans have (Etcoff 2000). These ideals can often be associated with cultural values but also with environmental realities and economic orders. Generally speaking, fat bodies were (and are) appreciated where food is hard to come by and thin ones are admired in places where food is abundant.

Before the 1880s, a layer of fat signified that one could afford food and that they stood a better chance of warding off infectious diseases. In the 1880s and 1920s, however, people began hinting that fat was a health risk. This shift has been attributed to the economic prosperity in America, when people who were not necessarily elite could now afford to be fat, eliminating the possibility of fatness as a status symbol. This was substantiated by the European contention that being thin was a sign of moral and intellectual superiority as well as the newly-emerging medical sciences which quantified fatness by being able to measure calories and calculate ideal weights (Fraser 2009).

An example from outside the USA shows that anti-fat bias is not always the default. Among a tribe of Nigerian Arabs studied by anthropologist Rebecca Popenoe in the early 1990s, fatness was considered the female beauty ideal and young girls used to be “fattened up” for marriage (Popenoe 2005). However, modern Western ideals of slenderness have swept across the globe. In the 2001 Miss World beauty contest, Nigeria, after performing poorly for years, entered a tall, svelte young woman named Agbani Darego whose skinny appearance appealed to few in Nigeria itself, who won (Popenoe 2005; “Miss World Past Contestants,” n.d.). Since this incident, many young women were quick to adapt to Western-inspired ideals, more or less universalising American beauty standards.

While fatness is about personal identity, embodiment and agency, it is also a social construction reasserted through social institutions such as education, industry, healthcare, government and the media.

The medicalization of weight led to the usage of terms such as "overweight" and "obese", which convey clinical and moral judgment that a person is over the "correct" weight. "Obesity" was officially established as an "epidemic" in 1994 by the World Health Organisation (WHO). WHO statistics report that levels of "obesity" have tripled since 1975 (Wanniarachchi et al. 2020). "Obesity" has thus become a large, sustained focus in the last 30 years. Considering all of this, it is not surprising that there are anti-fat attitudes both within healthcare and outside it. A 1982 study

of over 400 physicians who identified patient characteristics that aroused feelings of discomfort, reluctance, or dislike, suggested that one-third of the sample listed obesity as one of these conditions, making it the fourth most common characteristic, ranked behind drug addiction, alcoholism and mental illnesses (Klein et al. 1982). Negative attitudes and reluctance in physicians may lead obese individuals to hesitate in seeking healthcare.

Most bodies we see in the media are slim or "normal-sized". Fat bodies are relatively invisible in popular culture, appearing in rather specific contexts such as in comedy, reality television and very rarely in drama. In news, documentaries and reality television, fatness is typically depicted as a health problem to which certain companies might offer a remedy. It is presented as a problem to be solved. Fatness is always numbers and statistics, not people. Comedy is maybe the only genre where fat people not only have made notable appearances but also have been successful (Kyrola 2021). Think back to Oliver Hardy from Laurel and Hardy or Newman in Seinfeld all the way to Rebel Wilson and Melissa McCarthy today. But the problem here is that fat people as comic relief is, in itself, a very problematic thing. They are usually there for other characters to make fun of them or to behave in a lazy, weird, unacceptable fashion often involving lots of food.

In the circle of education, the social exclusion and bullying of fat elementary and secondary students by peers and by teachers has been observed. Teachers perceive fat students as less able academically, physically and socially (J. Fikkan and Rothblum 2005). In the post-secondary level, fat people are less likely to be admitted in the first place but even if they are, they are likely to face discrimination in assessment, peer exclusion and harassment leading to a decrease in the likelihood of graduating (J. Fikkan and Rothblum 2005).

In many different parts of the world, fat people face severe hindrances in their professional life. Overweight employees are often assumed to be lacking self-discipline, be lazy, less competent, less conscientious, sloppy, disagreeable, and emotionally unstable. Reservations such as these result in unfair hiring practises, lower wages, denial of promotions and job termination even when fat candidates/employees are better qualified than their colleagues (Leibenstein 2021).

It is also important to note that fat women experience significantly more prejudice and discrimination than thinner women and men of any weight do in several domains, such as employment, education, romantic relationships, healthcare and media (J. L. Fikkan and Rothblum 2012). It is fair, having briefly touched upon instances on anti-fat bias, to assert that fat people do, in fact, face discrimination.

But why do fat people face discrimination? What is the justification for anti-fat bias?

Let us start with "obesity", the understanding of fatness as a medical problem. What "obesity" does is actually view fatness through a medical frame, thus problematizing fatness. Abigail Saguy in her *What's Wrong with Fat?* refers to frames like these as problem frames, which are basically

different ways of establishing why fatness is a problem (2013). Other popular problem frames include an immorality frame and a public health crisis frame.

When fatness is viewed through the medical frame, it is argued that excess weight or fat is a medical problem and that excess weight must be lost through medical means. This view is commonly adopted by medical journals and healthcare professionals while interacting with fatness. A public health crisis frame claims that increasing weights of the general population is a public health crisis, and that BMI ought to be reduced at the population level. This is where we can situate the World Health Organization's declaration of the obesity epidemic. However, this justification has been adopted by the media, commercial weight-loss companies and people in general. An immorality frame assumes that fat is evidence of sloth and gluttony, both moral problems, which must be countered by exercising restraint. The 1995 movie *Seven* comes to mind, in which the instance of gluttony is represented by a fat person who overeats.

All of these frames must be seen in the context of the very real tendency to blame fat individuals for their bodies. While there are discourses where sociocultural and biological factors are blamed for fatness, discussions of "obesity" in the U.S. are largely dominated by emphasising personal responsibility. Bad individual choices are to blame for "obesity". Sloth and gluttony are portrayed as the cause of the medical and public health crisis of "obesity". Given the disproportionate influence of the US on global cultural standards, especially with the advent of mass media and social media, this tendency of assuming individual responsibility is now practically global. The neoliberalist, consumerist culture of the U.S. has manifested itself in many forms across the world, including attitudes towards fatness (Harjunen 2021). The concept of personal responsibility, thus, fosters anti-fat attitudes and discourse, as weight loss simply becomes a matter of "calories in, calories out," in which case it stands to reason that fatness can only occur as a result of people's freely chosen actions (Royce 2016). This also ignores the social mechanisms that perpetuate inequality for people of different sizes such as discrimination, the medicalization of fatness, and the moral panic surrounding the so-called obesity crisis.

With these frames in mind, let us now analyse these “so-called” justifications of anti-fat bias in detail, questioning whether or not they do, in fact, justify the discrimination faced by fat people.

Underlying the medical frame of fatness is a biased assumption that weight-loss can be maintained and that being thin or fat is a personal choice. However, statistics prove otherwise. Studies note that weight-loss attempts by Americans have risen in tandem with, interestingly, an increase in "obesity" among adults in the United States (Glenn 2009). Moreover, although success in weight loss maintenance seems to have improved, most people regain a significant amount of the weight they lost after 4-5 years (Anderson et al. 2001).

A similar assumption that the medical frame makes is that diets work. However, a review of 21 Randomised Control Trials reveals that weight-loss by dieting had no clear association with health

outcomes (Tomiyama, Ahlstrom, and Mann 2013). In fact, dieting may actually have a direct relation with one's chances of gaining weight (Spear 2006).

In the context of preadolescents and adolescents, the following have been theorised as reasons for why dieting leads to gaining weight (Spear 2006; Field et al. 2003). First, dieting may result in an increase in metabolic efficiency, requiring dieters fewer and fewer calories to maintain weight. When dieters return to their previous eating habits (because restrictive diets are not continued for an extended period of time), dieters tend to put on most or all of the weight they lost. Secondly, dieting may lead to a cycle of caloric restriction followed by binge eating. Restrictive dieting could lead to binge eating as satiety and hunger cues weaken and restricted foods become increasingly attractive.

But "isn't it unhealthy to be fat?" It is noted that "obese" (not "overweight") people are, on average, more likely to die of cardiovascular disease than those people of "normal weight" (those with a BMI between 18.5 and 25). However, it is equally important to note that people who are "underweight" (those with a BMI below 18.5) or of "normal weight" are, on average, more likely than those with a BMI between 25 and 35 to die of chronic respiratory disease, acute respiratory and infectious disease, or infections (Saguy 2013). Considering these observations in equal weight, it only seems natural to question the assumption that the heavier one is, the unhealthier they are.

Studies labelling BMI as a standard to determine healthy and unhealthy weights and connecting obesity with health concerns like hypertension, diabetes and cardiovascular disorders, make it clear that approximately 9% of what accounts for a health outcome is related to BMI. Conversely, the outcome of whether someone has health problems or not, 91% of the time, has no relation with their BMI (Burgard 2009).

Fat is fat unrelated to health, but even if there were a connection between fatness and health, the anti-fat attitudes in medical and social circles not only proves useless in helping people reduce weight but also often *lead to* "obesity" as well as other health issues. "Obese" patients are, as findings suggest, at risk both of developing adverse medical conditions and negative interactions with their physicians. Negative interactions with physicians could negatively affect the quality of care provided to "obese" patients. This increases the patients' risk of developing health complications, which further reinforces the original negative attitudes, making it a self-perpetuating cycle (Brownell et al. 2005).

It is also important to note that association is not the same as causation. Saguy mentions, using the example of higher rates of cervical cancer in "obese" women, how many studies associating "obesity" with a negative health outcome do not examine whether both "obesity" and the negative health outcome may actually be due to a third unmeasured variable (2013). The causal mechanism for higher rates of cervical cancer in "obese" women appears to be mainly social, not physiological. Medical bias and discrimination based on weight make fat women more likely than thinner women to avoid doctor's visits, resulting in infrequent Pap smears. Some studies even offer proof of

doctors refusing to perform Pap smears on fat women (Amy et al. 2006). With this in light, it is misleading to say that obesity causes higher rates of cervical cancer, since weight-based stigma is a barrier to health care access leading to later detection and greater risk of cervical cancer among "obese" women.

Having pointed out some of the contradictions that lie within the medical frame and, consequently, the public health crisis frame of fatness, it seems appropriate to recognize a frame that addresses these contradictions and offers a different approach. This is the Health at Every Size (HAES) approach. Lindo Bacon, the author of *Health at Every Size*, captures the motivation behind the HAES approach when they say: "Fat isn't the problem. Dieting is the problem. A society that rejects anyone whose body shape or size does not match an impossible ideal is the problem. A medical establishment that equates 'thin' with 'healthy' is the problem (Bacon 2008)." HAES is a fivefold approach, which incorporates weight inclusivity, health enhancement, eating for well-being, respectful care and life-enhancing movement (Burgard 2009; "The Health at Every Size® (HAES®) Approach" n.d.).

There are studies that prove that the HAES approach works better than the traditional dieting approach. A 2006 study conducted by researchers in the U.S. Department of Agriculture observed the physical activities and health of 78 "obese" women in two groups, one following conventional dieting methods (which included weight monitoring, controlled eating and brisk exercise) and the other following the Health at Every Size Approach (which included self-esteem building, following natural hunger and satiety cues, making health meal choices and engaging in enjoyable physical activities) (Wood 2006). Although the conventional dieters lost a good amount of weight in a 6-month period, they gained back this lost weight in a period of two years and had no significant change in their cholesterol or blood pressure levels which are indicators of cardiovascular health. On the other hand, the Health at Every Size group, although they did not lose weight, lowered their levels of cholesterol and blood pressure significantly. This is good proof that (1) one can become healthier without having to lose weight, and (2) losing weight does not guarantee one's better health. Taking all of the above-mentioned points in consideration, a solid case against the medical frame of fatness is thus made.

The immorality frame portrays fatness as a result of gluttony and sloth. This is where a lot of fat stereotypes unknowingly originate: fat people are gluttonous and sloth, lower in intelligence, slovenly, greedy, and without self-control (Williams 2017). In fact, the immorality frame, in certain ways, underpins the medical and public health crises. However, none of these are necessarily true. These stereotypes rationalise anti-fat attitudes and normalise fatphobia in society even today.

These rationalisations (that is, according to Williams, putative justifications that do not withstand scrutiny) accompany every form of unjust prejudice (Williams 2017). Racism is often rationalised by attributing innate deficiencies and character flaws, while sexism is considered inseparable from

derogatory stereotypes about women. Although ideas such as these are no longer acceptable in Western societies, rationalisations for weight-based stigma are normalised and encouraged.

None of these rationalisations or frames truly justify fatphobic attitudes adopted by society. Moreover, it is completely hypocritical to call fat people immoral and use that as justification to mistreat them. Discrimination itself could be considered immoral, and so could inequality and stereotyping. Treating people differently on the basis of body fat or body weight is a failure of equality; the inability to suitably accommodate body diversity is a failure of respect. What anti-fat bias essentially does is that it "fosters an unjust hierarchy based on disgust (Williams 2017)".

So, was my physician's attitude against me justified? After all the things I read and saw and felt, I do not think their anti-fat and weight-centric attitude was justified. Remember that this conversation is not just about whether or not fat is associated with health (which it is not), but that *even if it was*, it does not warrant discrimination. Every person deserves to be treated equally before law and in interpersonal relationships of any kind. Every child deserves their parents' love. Every patient deserves an unbiased consultation with a physician. Every candidate deserves a fair shot at an interview. Every shopper deserves equal opportunity to buy clothes that are their size. Every citizen deserves their basic needs and requirements to be met by public facilities. Fat people are no different. They are people. They deserve to be treated as people, nothing more and nothing less.

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