

Anti-obesity public health vs. fat
acceptance: impacts on ‘fat’ as a
marginalized identity

by

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AUTHOR'S DECLARATION

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

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Abstract

I will argue that anti-obesity public health (AOPH), with a focus on Canadian AOPH, performs three functions with respect to the fat acceptance movements (FAMs). These are as follows. Firstly, AOPH *distracts* by derailing FAMs' advocacy for fat justice towards matters of health and the weight-science surrounding fatness. Secondly, AOPH *covers up* and creates new fat stigmatizing attitudes through the use of linguistic strategies such as medicalized language and devices called figleaves, which resonate with the public precisely because they enact deeply entrenched cultural themes of healthism. Lastly, AOPH attempts to *eradicate* fatness and thus fat-positive identities, which effectively aims to eliminate a valuable marginalized perspective, and epistemically disadvantages society as a result. Chapter 1 examines the content of the Canadian AOPH's latest (2011) *Obesity in Canada* report, which contains a skew in favour of a dominant and problematic discourse on 'fat' as interchangeable with 'unhealthy' and therefore objectionable, representing a pervasive mode of shaping FAMs' discourse that facilitates the derailment towards talk of health, weight science, and economic burden. Chapter 2 focuses on linguistic devices called anti-fat figleaves, which are statements or symbols that work to obscure fat stigmatizing speech acts, behaviours, or actions. These linguistic devices, in conjunction with a healthist cultural backdrop that elevates health to a supervalue and stigmatizes illness, work to reinforce anti-fat attitudes and fat discrimination, as disseminated by AOPH. Chapter 3 examines how the first two functions of AOPH, to distract fat justice and cover up fat stigma, shape and work to eradicate fat identity, using a model of marginalized identity formation to demonstrate this disruption and eradication of fat identity. I conclude that while there is a promising increase in focus on the harms of fat stigma and acknowledgement of fat autonomy in medicine, much more work needs to be done to do away with a weight-centred healthcare paradigm that reinforces fat discrimination through over-emphasis on obesity prevention and eradication.

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Table of Contents

AUTHOR'S DECLARATION.....	ii
Abstract	iii
Acknowledgements	iv
Chapter 1 Weight science: the current state of the debate	1
1.1 The first function of Canadian anti-obesity public health – distraction and derailment	1
1.2 Why is this important now? Anti-fatness in 2020.....	4
2.1 Government of Canada’s position on obesity – risk factors	6
2.1.1 Correlates & confounds – PHYSICAL ACTIVITY	7
2.1.2 Correlates & confounds – SEDENTARY BEHAVIOURS	9
2.1.3 Correlates & confounds – DIET.....	10
2.1.4 Correlates & confounds – SOCIOECONOMIC STATUS (SES).....	11
2.1.5 Correlates & confounds – CONCLUSION OF RISK FACTORS.....	13
2.2 Government of Canada’s position on obesity – The science	14
2.2.1 Health impacts of obesity – MORBIDITY	14
2.2.2 Health impacts of obesity – MORTALITY	16
2.2.3 Health impacts of obesity – ECONOMIC BURDEN	16
3.1 Canada’s anti-obesity public health (AOPH).....	17
3.1.1 Three levels of intervention.....	17
3.1.2 The role of public health	19
3.1.3 The harms of Canada’s <i>OIC</i> report and AOPH.....	19
4.1 Derailment of FAMs by AOPH	21
4.1.1 Look AHEAD as a paradigm example of the struggle in interpreting primary data.	22
4.1.2 Chapter 1 conclusion.....	25
Chapter 2 AOPH, healthism, and figleaves to cover up anti-fatness	26
1.1 The second function of Canadian anti-obesity public health – covering up and shifting norms	26
1.2 Weight stigma: contextualizing anti-fat AOPH	27
2.1 Healthism and the medicalization of fat.....	29
2.1.1 Medicalization.....	30
2.1.2 Blame and the potential-sick role.....	31
3.1 AOPH and healthism now	33

3.1.1 AOPH as compatible with healthism.....	33
3.1.2 AOPH as incompatible with healthism.....	38
4.1 Language and the “covering up” function of AOPH.....	39
4.1.1 Healthism and language.....	39
4.2 Linguistic phenomena in AOPH: language of healthism, medicalization, and figleaves.....	41
4.2.1 Saul’s definition of figleaves	42
4.2.2 Anti-fat figleaves defined	43
4.3 Two tiers of anti-fat figleaves.....	45
4.3.1 Tier 1 anti-fat figleaves – informal speech acts.....	46
4.3.2 Tier 2 anti-fat figleaves – concern trolling and doctor-patient dynamics.....	48
5.1 Shifting the norms of permissibility of anti-fatness.....	50
5.1.1 How anti-fat figleaves shift norms.....	50
5.2 Chapter 2 conclusion	52
Chapter 3 AOPH as an eradicating force and the effects on fat identity	53
1.1 The third function of Canadian anti-obesity public health – shaping and eradicating fat identity.....	53
1.2 Important terms.....	54
2.1 Fat as an identity (not just a quality).....	54
2.1.1 Components of stigmatized identities.....	55
2.1.2 Fat identity management behaviours	56
2.2 Fat as a marginalized identity – stages of development	58
2.2.1 Conformity.....	59
2.2.2 Dissonance	60
2.2.3 Resistance and immersion	61
2.2.4 Introspection & Integrative awareness	62
2.2.5 Moving through the R/CID stages	63
3.1 Disability and fatness.....	65
3.1.1 Accessibility	66
3.1.2 Pity	66
3.1.3 The stare.....	67
3.1.4 Cure.....	67
3.1.5 Fatness as disability	68

4.1 The fat perspective – importance of diversity	69
4.1.1 Healthy epistemic communities	70
4.1.2 Diversity development work	72
4.1.3 Situational and epistemic diversity	73
Conclusion.....	76
Bibliography.....	79

Chapter 1

Weight science: the current state of the debate

1.1 The first function of Canadian anti-obesity public health – distraction and derailment

Anti-fat attitudes, fat stigma, and the structural and institutionalized oppression fat people face as a result is a major barrier to fat justice, towards which contemporary fat acceptance movements (FAMs) aim. FAMs have taken many forms, such as the organizations National Association to Advance Fat Acceptance (NAAFA), the Association for Size Diversity and Health (ASDAH), and the Fat Underground.¹ FAMs have also taken the form of smaller groups or individual everyday activism, such as “online and in-person performance, fundraising, public speaking, education... and social media” blogs and platforms that “resist thinness culture while building fat-friendly communities”.² This social media presence of fat activism in particular has been coined ‘the Fatosphere’. While remaining rooted in FAMs’ historical goals to dispel the idea that fat is pathological,³ the Fatosphere is also a key player in uniting fat individuals to advance the formation of “group identification, shared narratives, and critical dialogue”.⁴ As suggested by the terms “fat acceptance”, FAMs prioritize fighting for justice and the dismantling of anti-fat discrimination for people who are fat. That is, FAMs are concerned with people who fall into the ‘overweight’ or above categories of body-mass index (BMI). ‘Overweight’ refers to BMIs between 25-30, whereas ‘obese’ refers to the range of 30-35 (Class 1 obesity), 35-40 (Class 2 obesity), or 40 and above (Class 3 obesity).⁵

The very idea of BMI categories that classify some bodies as *over* and others as *under* some normal, acceptable weight is indicative of the very anti-fat bias in place and assumption that being in the higher BMI categories are at odds with wellbeing. Fat liberation, then, takes as a main opponent the healthist idea that fat is a medical disorder of the body or mind, where healthism refers to a contemporary health movement that views “an increasing number of activities and domains of life in

¹ Striley, Katie Margavio, and Sophia Hutchens. "Liberation from thinness culture: Motivations for joining fat acceptance movements." *Fat Studies* (2020): 2.

² Striley & Hutchens, “Joining fat acceptance movements,” 3.

³ Striley & Hutchens, “Joining fat acceptance movements,” 2.

⁴ Striley & Hutchens, “Joining fat acceptance movements,” 3.

⁵ Centers for Disease Control and Prevention. Defining Adult Overweight and Obesity. <https://www.cdc.gov/obesity/adult/defining.html>. Visited June 4, 2020.

terms of the impact they have on health” as well as “the promotion of health to a ‘super-value.’”⁶ Through using causal-based links between fatness and illness that could be better viewed as correlation-based, and as a result of the over-valuation of health at the expense of other avenues of wellbeing, healthism opposes FAMs’ commitment to accepting and protecting fat bodies when it concludes that fatness should be targeted as a problem to be fixed. This “problem” is popularly referred to as the ‘war on obesity’ and manifests as a pervasive societal goal, taken on by institutions such as public health, to change bodies that are *over* an acceptable weight into bodies that fall within a BMI-determined *normal* range, or prevent bodies from becoming *over* weight in the first place.

While anti-fat attitudes are not new, they are persistent and on the rise. An example of this is the 2020 COVID-19 pandemic and the medical community’s push to link coronavirus symptom severity and bodyweight in people under 60 years old.⁷ In discussions surrounding fat stigma and liberation,⁸ the common objection relating to health and wellness provides a divergence that pulls the conversation away from the harm imposed by stigma and anti-fat discrimination and towards harms linked to high BMI. Conversations once centred on the oppression of fat people become a debate surrounding whether or not the “obesity epidemic” is a legitimate concern or whether the science conclusively show that fatness is harmful. This latter debate is fraught with conflicting empirical and qualitative data, as well as a stalemate regarding the value-ladenness of body size and health. Oftentimes, the fat activist responds in one of two ways: 1) to engage directly with the objection and use fat exceptionalism to counteract such arguments, or 2) to assert that the potential harms of fatness should not play a role in demanding liberation from fat stigma.

Strategy 1) is tempting, but does little to dismantle fat stigma. The fat exceptionalism response works like this: ‘fat liberation does NOT have to come at the expense of health, because lots of fat people are engaged in the same kinds of healthy behaviours as thin people!’ There might even be reference to individuals in fat bodies that run marathons or achieve other traditional markers of physical fitness. Blogger Kate Harding has coined a term for this kind of response as the “good fatty/bad fatty dichotomy”, explaining this response to FAM objectors: “it is easier to sell the idea of a fat individual who is focused on healthy behaviors than one who is not”, despite the fat liberation

⁶ Brown, Rebecca CH. "Resisting moralisation in health promotion." *Ethical Theory and Moral Practice* 21, no. 4 (2018): 999.

⁷ Harrison, Christy. “Covid-19 Does Not Discriminate by Body Weight.” *Wired*, April 17, 2020. Accessed May 7, 2020. <https://www.wired.com/story/covid-19-does-not-discriminate-by-body-weight/>.

⁸ Note that I will be using the terms ‘fat liberation’, ‘fat acceptance’, ‘fat justice’ and ‘fat acceptance movements’ interchangeably.

movements' consensus that fat stigma is unacceptable aside from healthy or unhealthy behaviours.⁹ Strategy 2), in contrast, is a better one, but one that is unsatisfying for the health objector. As a result, fat activists might find themselves stuck in a cycle of fat exceptionalist strategies, as well as arguing for or against the science suggesting that fat is either bad or neutral. Either way, this stalls FAM's progress.

Public health plays a central role in the aforementioned derailment of fat liberation from health objectors. Canadian public health is an institution that stands firmly on the side of recognizing fat (or more specifically the categories of obesity and overweight) as a problem and has taken on the task of addressing it for society's own good. As a result, public health research and campaigns, specifically anti-obesity public health (AOPH) are contributing to this derailment away from FAMs' objectives of fat justice and towards the haggling over evidence given by the medical community and public health experts on the harms of fat. Thus, in order to move forward, it seems FAMs must deal with objectors' health-related concerns about fat liberation, either by dismissing or engaging with those concerns and the empirical evidence propping them up. As such, my argument will focus on critical engagement with AOPH, and specifically Canada's AOPH organizations and initiatives.

Ultimately, I will argue that three functions of AOPH in particular interact with and build upon one another to shape and undermine fat liberation and fat identity. This chapter concerns its first function: to *distract* conversations away from stigma and social harm and towards talk of health and medicine, which is skewed in favour of anti-fat attitudes due to equivocation between causality and correlation as well as bias stemming from historical anti-fat convention in weight science. Chapter 2 aims to show how healthism, the medicalization of fat bodies, and the language that comes with these phenomena work to *cover up* fat stigma, reinforcing it as well as creating new anti-fat attitudes. Chapter 3 examines how AOPH, in its attempt to *eradicate* fatness, shapes and damages fat-positive (or fat-acceptance) identity formation.

As previously mentioned, Chapter 1 aims to address key pieces of empirical data utilized by Canadian AOPH that play a large role in providing fodder for the current debate on the permissibility of fatness. In section 2 of this chapter, I will examine Canadian government's position on obesity through their most recent report, the "Obesity in Canada: A Joint Report From The Public Health Agency Of Canada And The Canadian Institute For Health Information," (*OIC* report) released in 2011, showing that some main claims in the *OIC* report, namely of morbidity and mortality risk as

⁹ McMichael, Lonie. *Acceptable Prejudice?: Fat, Rhetoric and Social Justice*. Nashville TN: Pearlsong Press, 2013.

well as economic burden associated with obesity, have been refuted in the literature and call into question the strength of the claims in the *OIC*. In section 3, I will examine some of the concrete recommendations from the *OIC* report and put them into context of the harm they cause fat people. Lastly, in section 4 of this chapter, I examine a concrete example of a weight science study, the Look AHEAD study, in order to show that interpreting empirical data in weight science is complex and should be done critically, especially when such data is used to advance and justify public health interventions on fatness.

1.2 Why is this important now? Anti-fatness in 2020.

Revisiting the debate on the permissibility of fatness and its health-related implications is particularly important now due to the revitalization of the “war on obesity” and soon to be public health policies and calls-to-action that result from the current COVID-19 pandemic. The pandemic is highlighting a kind of harm reduction strategy that promises to result in more manageable COVID-19 symptoms through pre-emptive weight loss.¹⁰ While research at this point in time is sparse in unpacking the relationship between body weight and COVID-19 susceptibility and symptomology, researchers have been quick to propose the correlation. The main studies championing BMI correlation in COVID-19 cases are a CDC report issued in early April¹¹ and a French study published in *Obesity* journal in April,¹² both of which cite obesity as a significant risk factor. However, it is worth pointing out that important confounding factors are consistently overlooked by both studies, as pointed out by fat activist and registered dietician Christy Harrison.¹³ Among these factors are socioeconomic status and ethnicity, two factors known to result in poorer health status for a variety of associated reasons either independent of, or at least in addition to, body size.¹⁴ This is not to say that there may ultimately be a statistically significant correlative or causal story linking high BMI to COVID-19 symptom severity, but rather that it is much too early to propose the leap based on the current sparse evidence pool.

¹⁰ Sattar, Naveed, Iain B. McInnes, and John JV McMurray. "Obesity a risk factor for severe COVID-19 infection: multiple potential mechanisms." *Circulation* (2020).

¹¹ Garg, Shikha. "Hospitalization rates and characteristics of patients hospitalized with laboratory-confirmed coronavirus disease 2019—COVID-NET, 14 States, March 1–30, 2020." *MMWR. Morbidity and mortality weekly report* 69 (2020). Taken from: <https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6915e3-H.pdf>

¹² Simonnet, Arthur, Mikael Chetboun, Julien Poissy, Violeta Raverdy, Jerome Noulette, Alain Duhamel, Julien Labreuche et al. "High prevalence of obesity in severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) requiring invasive mechanical ventilation." *Obesity* 28, no. 7 (2020): 1195-1199.

¹³ Harrison, Christy. "Covid-19 Does Not Discriminate by Body Weight."

¹⁴ Adler, Nancy E., Thomas Boyce, Margaret A. Chesney, Sheldon Cohen, Susan Folkman, Robert L. Kahn, and S. Leonard Syme. "Socioeconomic status and health: the challenge of the gradient." *American psychologist* 49, no. 1 (1994): 15-24.

The UK is following suit with these leaps between BMI and COVID-19 risk. UK Prime Minister Boris Johnson, after suffering from severe COVID-19 symptoms himself, has publicly reported his belief that his bodyweight classification of “obese” is to blame for the severity of his symptoms, and that the illness is “all right for you thinnies”, re-invoking the old causal linkage story between bodyweight and the exacerbation of non-weight-related illness, in this case severity of COVID-19 symptoms.¹⁵ This attitude is not unusual, especially considering the UK’s historical commitment to both conventional and unconventional approaches to improving public health. For example, in 2010 the UK implemented a tactic called “nudging” to encourage individuals to make healthier choices regarding smoking, alcohol consumption, diet and weight.¹⁶ Nudging tactics, which aim to structure the environment in which one makes a health-related choice such that it enables the individual to choose in line with their own (presupposed) health-related values, have since been utilized world-wide. Johnson’s declaration causally linking fatness to severe illness also comes on the heels of Cancer Research UK’s stigmatizing 2019 anti-obesity campaign, “Obesity causes cancer too.” The campaign uses analogy to smoking in order to communicate the claim that obesity and overweight are at fault for increasing one’s chances of developing around 13 kinds of cancer.¹⁷ The imagery and rhetoric utilized by the campaign was criticized to have actively encouraged the association between disease and fat bodies. In 2018, the organization began to lay the foundation for such framing, passing out cigarette packs filled with potato chips rather than cigarettes.¹⁸ Much of the West, including Canada and the US, echo these same sentiments and poses a significant concern: anti-fat attitudes and the over-emphasis of the correlation between fatness and poor health will widen the barriers to care that fat bodies already face. This fear is not unfounded; early on in the pandemic, a Washington state neurologist in COVID-19 hotspot tweeted: “Seattle has 12 machines, which is less than what’s needed. So a central committee there is deciding: You can’t go on [ECMO machine] if you’re [over]

¹⁵ Colson, Thomas. “Boris Johnson believes he was hospitalised with the coronavirus because he is significantly overweight.” *BusinessInsider*, May 15, 2020. Accessed May 20, 2020. <https://www.businessinsider.com/report-boris-johnson-thinks-obesity-was-behind-covid-hospitalisation-2020-5>.

¹⁶ Behavioural Insights Team. “Applying behavioural insight to health.” *London: Cabinet Office* (2010), 28.

¹⁷ Cancer Research UK. “Obesity, weight and cancer.” Taken from: <https://www.cancerresearchuk.org/about-cancer/causes-of-cancer/obesity-weight-and-cancer>

¹⁸ McGonagle, Emmet. “Cancer Research faces ‘fat-shaming’ backlash over obesity campaign.” Campaign, July 9, 2019. Accessed May 20, 2020. <https://www.campaignlive.co.uk/article/cancer-research-faces-fat-shaming-backlash-obesity-campaign/1590441>

40 years old, if you have another organ system failing, or...incredibly...if your [body mass index] is [over] 25.¹⁹ Turns out these are all major poor prognostic signs.”²⁰

2.1 Government of Canada’s position on obesity – risk factors

Before I can effectively argue that AOPH serves the first function, it is useful to understand what kind of anti-obesity public health initiatives and campaigns are being undertaken, and what science forms their backbone. For the sake of simplicity, I will focus in on outlining the major initiatives and strategies adopted by Canada and by the Canadian government, although similar moves are being made elsewhere in the West, such as the US and UK.

Over the past few decades, the government of Canada has committed itself to finding ways to prevent and manage the rising prevalence of obesity and overweight. Public health branches of the Canadian government have taken on this task, developing strategies that target obesity at individual, community, and public policy levels in order to influence behaviours and environmental factors that may contribute to achieving a higher body weight.²¹ The most recent official report on obesity in Canada was released in 2011. The Canadian government released the *Obesity in Canada: A Joint Report From the Public Health Agency of Canada and the Canadian Institute for Health Information (OIC report)* in which statistics on obesity and its correlates are stated and speculated upon. Interestingly, all statistics are framed and interpreted through one specific lens: that the correlates are risk factors for obesity (in other words, that the risk factors may in some way *cause* obesity) and are thus potential loci of justifiable intervention.²² The report conflates body size to health status, equivocating between the two and even considering the BMI range “obese” as *itself* a health status. I will discuss the problem with this in the following subsection.

The conflation of BMI category and health status partially obscures the purpose of the *OIC* report and reflects some old frustrations faced by fat activists: is the goal to improve the health of Canadian

¹⁹ Note that a BMI of <25 is the BMI category of “normal weight”.

²⁰ Ward, Madeline. “Are Coronavirus Triage Protocols Sacrificing Fat People? Should They?” *IJFAB Blog*, May 25, 2020. Accessed June 1, 2020. <http://www.ijfab.org/blog/2020/05/are-coronavirus-triage-protocols-sacrificing-fat-people-should-they/>

²¹ Government of Canada. “Obesity in Canada – Opportunities for intervention.” June 23, 2011. Taken from: <https://www.canada.ca/en/public-health/services/health-promotion/healthy-living/obesity-canada/opportunities-intervention.html>

²² Public Health Agency of Canada, “Obesity in Canada: A JOINT REPORT FROM THE PUBLIC HEALTH AGENCY OF CANADA AND THE CANADIAN INSTITUTE FOR HEALTH INFORMATION.” 2011. Accessed May 20, 2020. pp 17. Taken from: <https://www.canada.ca/content/dam/phac-aspc/migration/phac-aspc/hp-ps/hl-mvs/oic-oac/assets/pdf/oic-oac-eng.pdf>

citizens, or to shrink their bodies? In order to claim that health necessitates weight loss in fat people to a normal BMI, it must be made evident that high BMI can be reasonably causally linked to poor health. Failure to do this renders the report a mere how-to guide for weight loss, as tracking the correlates of obesity without investigating confounding factors amounts to just that. This results in a cycle of confirmation: it presupposes the causal link between overweight/obesity and poor health, investigates factors that correlate with higher BMI, conclude they are risk factors for high BMI and thus a threat to health, and prematurely conclude we must minimize the correlates in order to eradicate obesity in order to improve health.

In this section, I will first outline the foundation of what the government of Canada considers the most prominent correlates or risk factors for obesity and overweight, examining each correlate using data that calls into question the assertions made about each correlate. These are: 1) Physical Activity, 2) Sedentary Behaviours and Screen Time, 3) Diet, 4) Socioeconomic Status (SES), and 5) Community Level Factors.²³ These factors are important in determining what is at the core of the government motivation to implement individual, community, and public policy-level interventions on fat people.

2.1.1 Correlates & confounds – PHYSICAL ACTIVITY

The *OIC* authors report that there is an “epidemic of ‘lack of cardio-respiratory fitness’”.²⁴ It is at first difficult to understand how this fact corresponds to obesity – plenty of normal-to-underweight individuals are included in this statistic as lacking in cardio-respiratory fitness as well. *OIC* ties in obesity with the follow up statement that “still emerging” evidence exists that might demonstrate a relationship between physical activity and “health outcomes such as obesity”.²⁵ Here is a clear example containing two instances of conflation of health and high BMI. Firstly, it conflates health and BMI by placing the general population’s issue of cardiorespiratory unfitness in the Risk Factor section for obesity (with the potential implication that overweight or obese people cannot or do not exercise enough and comprise the entirety of this statistic). Secondly, it conflates the two by categorizing obesity, which is based in BMI, as a health status in and of itself in its statement “health outcomes *such as obesity*” (my emphasis). The usage of BMI to examine individual health status is

²³ Public Health Agency of Canada, “OIC Report,” 17-27.

²⁴ Public Health Agency of Canada, “OIC Report,” 17.

²⁵ Public Health Agency of Canada, “OIC Report,” 17.

increasingly shown to be an outdated²⁶ and mostly uninformative,²⁷ and is therefore somewhat troubling to see in a report meant to act as the unbiased backbone upon which the government of Canada's public health implements anti-obesity strategies and interventions.²⁸

It is important to note that BMI is a description of the division of one's weight (in kg) by the square of their height.²⁹ Using this calculation to determine health status of an individual is troubling due to the BMI scale's documented inability to reliably predict important indicators of health, such as cardiometabolic health, on its own.³⁰ BMI is an outdated measurement of health status for numerous reasons, including the fact that it fails to account for body composition, which is a more reliable indicator of risk for health issues like metabolic syndrome³¹ and fails to be a reliable indicator of bodyfat at all.³² Further, the data shows overweight and obese individuals actually fare better than their normal weight counterparts surviving with cardiovascular disease,³³ and the BMI's statistical origins are relevant to populations as opposed to individuals, and specifically in "[p]rimarily... Anglo-Saxon populations, [calling into question] the generalizability and applicability of the BMI and its cut-off points to other populations".³⁴

Aside from *OIC*'s questionable usage of BMI as a health indicator, I argue further that fatness itself is less clearly linked to fitness and health than *OIC* asserts. While *OIC* is clear in its position that obesity intervention can be achieved through increase in physical activity in order to lose weight and thus improve health status, the data on this improvement in health due to weight loss is less clear. Consider the 'fit and fat' paradox in which there is documentation of fitness, regardless of fatness,

²⁶ Hall, Diane MB, and Tim J. Cole. "What use is the BMI?." *Archives of Disease in Childhood* 91, no. 4 (2006): 283-286.

²⁷ Tomiyama, A. Janet, Jeffrey M. Hunger, Jolene Nguyen-Cuu, and Christine Wells. "Misclassification of cardiometabolic health when using body mass index categories in NHANES 2005–2012." *International Journal of Obesity* 40, no. 5 (2016): 883-886.

²⁸ This is particularly important as critiques on the limits of BMI were already available at the time of the *OIC* report's publication in 2011.

²⁹ Centers for Disease Control and Prevention. "Defining Adult Overweight and Obesity." Taken from: <https://www.cdc.gov/obesity/adult/defining.html>. Visited June 4, 2020.

³⁰ Tomiyama, A. Janet, Jeffrey M. Hunger, Jolene Nguyen-Cuu, and Christine Wells. "Misclassification of cardiometabolic health when using body mass index categories in NHANES 2005–2012." *International Journal of Obesity* 40, no. 5 (2016): 883-886.

³¹ Kwon, Hyuktae, Donghee Kim, and Joo Sung Kim. "Body fat distribution and the risk of incident metabolic syndrome: a longitudinal cohort study." *Scientific Reports* 7, no. 1 (2017): 1-8.

³² Nuttall, Frank Q. "Body mass index: obesity, BMI, and health: a critical review." *Nutrition today* 50, no. 3 (2015): 117.

³³ Lavie, Carl J., Paul A. McAuley, Timothy S. Church, Richard V. Milani, and Steven N. Blair. "Obesity and cardiovascular diseases: implications regarding fitness, fatness, and severity in the obesity paradox." *Journal of the American College of Cardiology* 63, no. 14 (2014): 1345-1354.

³⁴ Eknoyan, Garabed. "Adolphe Quetelet (1796–1874)—the average man and indices of obesity." (2008): 47-51.

being correlated with decreased risk of mortality.³⁵ Similarly, there is documentation of the ‘healthy obesity’ paradox demonstrating populations of obese people with no health risks or comorbidities associated with obesity at more than a chance rate.³⁶ Both of these cases are considered paradoxes in that they demonstrate the fault in the assumption that fatness and low mortality or morbidity risk are mutually exclusive. This supports the idea of a non-weight-centred approach to health rather than *OIC*’s weight-focused approach. A non-weight-centred approach encourages a variety of physical activity with a focus on joyful movement, which has been shown to improve key health markers despite unchanged BMI.^{37,38} This data also demonstrates the problematic nature of *OIC* in identifying weight loss as a necessary step to improve cardio-respiratory fitness in fat people.

2.1.2 Correlates & confounds – SEDENTARY BEHAVIOURS

Next, consider Sedentary Behaviours and Screen Time. The *OIC* authors take note in this section that in adolescents, physical activity levels did not differ between obese and non-obese adolescents, but that obese individuals had on average more screen time than their non-obese counterparts. Their implication in offering these findings are unclear; are the authors suggesting that increased screen time correlates to a decrease in physical activity? The authors do not state this, instead finishing the section with a disclaimer that “[s]creen time for both adults and children is influenced by a number of demographic and socioeconomic factors, including age, sex, education, household income and urban vs. rural residency.”³⁹ Despite the fact that screen time is strongly correlated with demographic and SES factors, these statistics on sedentary behaviour and obesity are again being presented with a lean towards a certain interpretation. As written, it appears that sedentary behaviour, such as screen time, is being presented as another locus of obesity prevention, in that lowering levels of screen time could be used as a strategy for lowering levels of obesity. However, as stated earlier in the section, screen time is also highly associated with other, potentially confounding factors on which they do not follow up. It is further curious that the authors focus on screen time to encompass all sedentary behaviour related to obesity.

³⁵ Mansfield, Louise, and Emma Rich. "Public health pedagogy, border crossings and physical activity at every size." *Critical Public Health* 23, no. 3 (2013): 363.

³⁶ Mansfield, "Public health pedagogy," 363.

³⁷ Bacon, Linda, and Lucy Aphramor. "Weight science: evaluating the evidence for a paradigm shift." *Nutrition journal* 10, no. 1 (2011): 2.

³⁸ Bacon, Linda, N. L. Keim, M. D. Van Loan, Monique Derricote, Barbara Gale, Alexandra Kazaks, and J. S. Stern. "Evaluating a ‘non-diet’ wellness intervention for improvement of metabolic fitness, psychological well-being and eating and activity behaviors." *International journal of obesity* 26, no. 6 (2002): 854-865.

³⁹ Public Health Agency of Canada, “OIC Report,” 18.

The *OIC* authors also fail to show that sedentary behaviours such as screen time directly correlate with the increased risk of illness or poor health, instead focusing on the correlation between sedentary behaviours and weight. Like the previous section and physical activity, a change in weight need not accompany a change in sedentary behaviours, nor an increase in physical activity. Moreover, it is unclear that these sedentary behaviours meaningfully influence health status beyond body weight.

2.1.3 Correlates & confounds – DIET

Thirdly, consider the diet section. This section focuses on the types of foods eaten or not eaten, and their association to overweight and obesity. The authors cite the inverse relationship between fruit and vegetable consumption and obesity as well as the positive association between specific foods and obesity, such as “salad oils, wheat flour, soft drinks, shortening, rice, chicken and cheese”.⁴⁰ They also mention food insecurity, or in other words food scarcity, and its correlation with obesity. Food scarcity refers to having a lack of regular access to sufficient nutrition for socioeconomic or other circumstances.⁴¹ The authors note the correlation in literature between food scarcity and obesity, but quickly conclude that the data is sometimes conflicting. Thus, the purpose of this section in *OIC* is clear: that diet is another locus of intervention, even naming the specific foods to restrict or eliminate from one’s diet if obesity is to be prevented or managed.

In addressing this section, it is interesting to note that the authors spend no time discussing diet and its effects on health status, instead only discussing diet and its effects on body size. This does little to address or clarify that shrinking body size improves health. It is thus unclear whether this section of *OIC* is framing diet, referring to what foods one chooses to consume on a day-to-day basis, as one that aims to improve health or simply shrink one’s body size. Furthermore, there is good reason to doubt the recommendation to intervene with restrictive or eliminative dietary strategies, or in other words intentionally consuming less calories, or disqualifying certain foods from those that one might otherwise include in their day-to-day consumption. Restrictive and eliminative dietary strategies have been shown to correlate with “food and body preoccupation, repeated cycles of weight loss and regain, distraction from other personal health goals and wider health determinants, reduced self-

⁴⁰ Public Health Agency of Canada, “OIC Report,” 18.

⁴¹ Government of Canada, “Household food insecurity in Canada: Overview.” February 18, 2020. Taken from: <https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/health-nutrition-surveys/canadian-community-health-survey-cchs/household-food-insecurity-canada-overview.html>

esteem, eating disorders, other health decrement, and weight stigmatization and discrimination” according to researchers Lindo Bacon & Lucy Aphramor.⁴²

A number of journal articles are noteworthy in supporting findings by Bacon & Aphramor (2011) and challenge this section of *OIC*. The first noteworthy study examines vegetarian adolescents and adults, finding that while vegetarians show superior nutrient, vegetable and fruit intake and a lowered risk of overweight and obesity, the vegetarian group also shows significantly increased risk for out of control binge-eating and disordered weight-control behaviours.⁴³ My purpose in addressing this examination of vegetarian and vegan diets is not to suggest that veganism and vegetarianism are causes of disordered eating, but that even in adopting a paradigmatically healthy diet rich in *OIC*-recommended foods (such as fruits and vegetables), stringent rules surrounding what can and cannot be consumed appear to be associated with increased risk of developing disordered eating behaviours. This association can be applied to fat people targeted by *OIC*, which recommends they refrain from certain foods and stick to others. This study supports the idea presented by Bacon & Aphramor (2011) that dietary restriction of this kind is associated with increased risk of eating disorders as well as food and body preoccupation.

Another noteworthy study to support these findings is the 1996 literature review done by J. Polivy, *Psychological Consequences of Food Restriction*, in which it was found that dieting, or the intentional restriction of caloric intake or eliminating certain foods or food types from one’s day-to-day consumption, is highly associated with both negative physical and psychological consequences. These include binge eating once the restricted food is once more available to the dieter as well as an increase in emotional responsiveness, emotional dysphoria, and distractedness/troubles focusing.⁴⁴ Most interestingly, Polivy specifically recommends avoiding specific food restrictions or eliminations in one’s day-to-day food consumption, directly conflicting the advice of *OIC* authors.

2.1.4 Correlates & confounds – SOCIOECONOMIC STATUS (SES)

The next section outlines the correlate of SES with obesity. *OIC* takes note of studies that suggest an inverse relationship between obesity and income, but attribute this relationship to education, as higher

⁴² Bacon & Aphramor, “Weight science,” 1. (Formerly Linda Bacon at the time of publication.)

⁴³ Robinson-O’Brien, Ramona, Cheryl L. Perry, Melanie M. Wall, Mary Story, and Dianne Neumark-Sztainer. “Adolescent and young adult vegetarianism: better dietary intake and weight outcomes but increased risk of disordered eating behaviors.” *Journal of the American Dietetic Association* 109, no. 4 (2009): 648-655.

⁴⁴ Polivy, Janet. “Psychological consequences of food restriction.” *Journal of the American Dietetic Association* 96, no. 6 (1996): 589-592.

education tends to yield higher income. Similarly, *OIC* authors note that there is an association between job prestige and normal BMI range, which disappears when education is factored in for men, but that persists in women even when education is factored in. Here, the authors frame higher education as having some influence, then, on body size. This invites the reader to speculate about why this might be: perhaps individuals with higher education have a generally higher aptitude for controlling body size than their less educated counterparts. Another equally strong interpretation that the authors neglect is that perhaps the measured correlation between job prestige, education and obesity is actually a measurement of thin and SES privilege, which has been documented elsewhere. Bacon, O'Reilly & Aphramor in their 2016 chapter of *The Fat Pedagogy Reader: Challenging Weight-Based Oppression Through Critical Education* provide a radically alternative interpretation of the inverse correlation between education and obesity:

In education, for example, research indicates that teachers believe that fat students are less likely to succeed at work, more untidy, more emotional..., and more likely to suffer from family problems. Illustrating this, the U.S. National Education Association (2010) reports that “[f]or fat students, the school experience is one of ongoing prejudice, unnoticed discrimination, and almost constant harassment. From nursery school through college, fat students experience ostracism, discouragement, and sometimes violence. ... They are deprived of places on honor rolls, sports teams, and cheerleading squads and are denied letters of recommendation” (para. 7).⁴⁵

That weight-based discrimination can account for the statistically significant association between high paying jobs, higher education and BMI below the obese and overweight categories is clinically and empirically relevant, but fails to be considered in *OIC*. Aside from citing that obesity is sometimes the source of psychological distress, the authors do not suggest that these discriminatory factors can also lead to negative *physical* health outcomes, when this phenomenon is actually well-documented.^{46,47} Instead, the authors focus on classifying the link to social and employment discrimination as psychological harms incurred by overweight and obese people.

Rekha Nath does a comprehensive job in *The Injustice of Fat Stigma* (2019) in outlining the complexities of fat stigma, high BMI, and the health of fat people. One notable section in her article is the 2015 longitudinal study done by Sutin et al. that shows fat people who have perceived to have

⁴⁵ Cameron, Erin, and Constance Russell, eds. *The fat pedagogy reader: Challenging weight-based oppression through critical education*. (Bern, Switzerland: Peter Lang, 2016): pp 42.

⁴⁶ Bacon & Aphramor, “Weight science,” 1-13.

⁴⁷ Nath, Rekha. "The injustice of fat stigma." *Bioethics* 33, no. 5 (2019).

experienced weight-based discrimination have lower life expectancies. Another large study cited by Nath is one that suggests the experience of any stigma, which can include things like fat stigma, classism, racism and sexism, is not only psychologically distressing, but physiologically distressing, and that this kind of stress is a major contributor to negative physical health effects often attributed to obesity itself.⁴⁸ This includes increased risk of developing type 2 diabetes, hypertension, and heart disease.⁴⁹

2.1.5 Correlates & confounds – CONCLUSION OF RISK FACTORS

The last risk factor considered in the report are community-level factors. These include risks of obesity that stem from access to fresh produce and availability of exercise facilities.⁵⁰ Because this factor reiterates much of the content of the other risk factors, I will not spend time examining its informative function. The authors end this section with a disclaimer in reference to a UK study that examined community factors in physical activity:

“[I]n practice, given the paucity of community- based evaluations, policy-makers often rely on cause-effect relationships to be assumed to some degree” and that their analysis “merely applied a population perspective to such interpretation.” Nevertheless, they underscored that their results, which assume a cause-effect relation, should be interpreted with caution. Similar discretion should be used in considering the findings presented above.”⁵¹

If this is the case, Canadians should expect that recommendations to decrease body size from public health professionals would be offered with many disclaimers and implemented with extreme caution. This is not reflected in the report’s recommendations, nor Canada’s informal but pervasive declaration of a war on obesity. Instead, the authors conclude the section with reductive takeaways that include the following: certain population health measures that utilize unfounded causal assumptions be used to set priorities for obesity prevention and management, that more research is needed to assess the causes and direct and indirect determinants of obesity, there is an inverse relationship between income and obesity for women but no relationship for men, that hundreds of thousand of obese is avoidable if the population increased physical activity, and that a limitation of this kind of report is that certain factors cannot be taken properly into consideration such as access to

⁴⁸ Himmelstein, Mary S., Angela C. Incollingo Belsky, and A. Janet Tomiyama. "The weight of stigma: cortisol reactivity to manipulated weight stigma." *Obesity* 23, no. 2 (2015): 368-374.

⁴⁹ Nath, Rekha. "The injustice of fat stigma." *Bioethics* 33, no. 5 (2019): 580.

⁵⁰ Public Health Agency of Canada, "OIC Report," 21.

⁵¹ Public Health Agency of Canada, "OIC Report," 25.

healthy foods, consumption of traditional diets, marketing of foods and beverages to the population, and portion size.⁵²

2.2 Government of Canada's position on obesity – The science

Now, I will move onto the final relevant section of the report, which examines the mortality and morbidity risks associated with obesity. While this section of *OIC* should contextualize and justify the focus on eliminating obesity through conclusive evidence of its causal relationship to poor health, I argue that it fails to do so. I will provide some reasons to doubt the conclusiveness of the information offered here.

2.2.1 Health impacts of obesity – MORBIDITY

According to *OIC* authors, the major illnesses associated with obesity are type 2 diabetes, asthma, gallbladder disease, osteoarthritis, chronic back pain, some types of cancer, and cardiovascular disease.⁵³ They quickly move on to speak about the prevalence of obesity in Canadians and further risks to becoming obese (such as being an obese child). The authors then address the “psychological concerns (e.g., low self-esteem)” that fat people face, again making sure to keep this separate from the “physical health problems” fat people face.⁵⁴ As mentioned in the previous subsection, it is unclear why, with so much data available at the time of publication about the negative physical and mental health outcomes associated with being part of a stigmatized group, that the authors frame stigma as a psychological issue separate from physical health. One possible explanation is that they have vested interest to frame obesity as a fundamentally physical ailment, the treatment for which can also alleviate a more secondary, psychological kind of distress. This stands in contrast to framing the problem with obesity as at least a partially socially constructed issue, the solution to which should be efforts to destigmatize large body size rather than eradicate larger body size. However, this latter framing is distinctly at odds with the Canadian government's historical investment in obesity “treatment”.

Despite their emphasis of weight stigma as a strictly psychological harm distinct from physiology, the authors note that “negative attitudes and stereotypes about those who are obese have been linked to social and employment discrimination”, citing:

⁵² Public Health Agency of Canada, “OIC Report,” 26.

⁵³ Public Health Agency of Canada, “OIC Report,” 27.

⁵⁴ Public Health Agency of Canada, “OIC Report,” 27.

[o]ne systematic review [that] reported perceptions of weight bias and negative stereotypes about obese people in a number of sectors: at work, in health care settings, in schools and in the media. An analysis of the 2002/03 CCHS results found that, compared with men and women of normal weight, obese men and women were more likely to report high job strain and low co-worker support.⁵⁵

However, they do not extend this observation into discussion about the negative health outcomes for being subjected to such discriminatory treatment.

In addition to the failure of *OIC* to consider stigma to be a confounding factor influencing increased morbidity linked to fatness, the authors fail to account for the well-documented negative health consequences of engaging in intentional weight loss as a fat person. One such variable is the phenomenon of weight cycling, which describes periods of intentional weight loss and the regaining of that weight within 2-5 years. Weight cycling has been associated with inflammation leading to other obesity-correlated diseases, hypertension, insulin resistance, and a disorder called dyslipidemia characterized by an abnormally high blood-lipid content.⁵⁶ Bacon and Aphramor note that the negative health effects of weight cycling can just as well explain the increase in morbidity and mortality outlined by well-cited sources for obesity research, such as the National Health and Nutrition Examination Survey (NHANES).⁵⁷

Bacon & Aphramor also note that one of the strongest associated diseases with obesity, type 2 diabetes, was seen to be strongly associated with low SES even when factors such as physical activity levels and BMI were taken into account. In fact, the evidence on this suggests that “insulin resistance is a product of an underlying metabolic disturbance that predisposes the individual to increased fat storage due to compensatory insulin secretion”, and that it is equally likely that “obesity may be an early symptom of diabetes as opposed to its primary underlying cause.”⁵⁸ Another associated condition, hypertension, is also addressed; Bacon & Aphramor note key studies that show obese people with hypertension outlive thin people with hypertension, and the correlation between hypertension and obesity might not be pathological at all, but “a requirement for pumping blood through their larger bodies.”⁵⁹

⁵⁵ Public Health Agency of Canada, “OIC Report,” 27.

⁵⁶ Bacon & Aphramor, “Weight science,” 4.

⁵⁷ Bacon & Aphramor, “Weight science,” 4.

⁵⁸ Bacon & Aphramor, “Weight science,” 4.

⁵⁹ Bacon & Aphramor, “Weight science,” 4.

2.2.2 Health impacts of obesity – MORTALITY

Secondly, *OIC* authors consider the mortality effects associated with obesity. The authors admit that while the outer margins of the weight spectrum, i.e. both underweight and obesity class II & III, are associated with mortality risk, people in the overweight category show a decreased risk of mortality *compared to people in the normal range of BMI*. In fact, the report relays findings that being in the obese I category does not significantly affect mortality any more than being in the normal BMI category. They also acknowledge that “calculating the exact number of deaths in a population that are attributable to obesity is difficult”, stating that there are “methodological challenges of isolating the contribution of excess body weight from that of related risk factors, co-morbidities and confounding variables.”⁶⁰ This is an extremely important addition to the section, revealing a significant margin of error in estimating obesity and overweight as sources of major health risks, and the corresponding assertion that weight loss should be the focus of anti-obesity public health initiatives. It is difficult, if not impossible, to determine that someone’s ailments are the result of an obese BMI, or simply due to some other factor that happens to have a correlation to larger body size such as low SES and/or barriers to regular medical care.

Moreover, there is much evidence that stands directly contrary to *OIC*’s assertion that obesity is associated with an increased mortality risk at all. In a National 19-year old study, Lantz et al. (2005) determined that “[c]ompared to those in the "normal" weight category, neither overweight nor obesity was significantly associated with the risk of mortality.”⁶¹ In fact, that very same study determined for individuals over 55 years old, overweight and obese individuals showed a measurable decrease in mortality risk.⁶² Thus, *OIC* once more fails justify its focus on eliminating obesity as it is unable to conclusively offer evidence of a causal relationship between overweight and obesity to poor health, or in this case, to increased mortality risk.

2.2.3 Health impacts of obesity – ECONOMIC BURDEN

Given this contrary evidence and the lack of certainty with which *OIC* asserts an increased mortality and morbidity risk with obesity, it is curious that the authors move on to estimate the direct economic burden of obesity as upwards \$4.6 billion in 2008. If disease and mortality associated with obesity is

⁶⁰ Public Health Agency of Canada, “OIC Report,” 28.

⁶¹ Lantz, Paula M., Ezra Golberstein, James S. House, and Jeffrey Morenoff. "Socioeconomic and behavioral risk factors for mortality in a national 19-year prospective study of US adults." *Social Science & Medicine* 70, no. 10 (2010): 1558-1566.

⁶² Bacon & Aphramor, “Weight science,” 2.

actually caused by something else like stigma or low SES, and obesity is only correlated with stigma or low SES, it would be a mistake to then conclude that obesity is to blame for the money spent on treatment and management of those diseases and mortality resulting from those diseases rather than the complex web of factors actually responsible for the risk of disease and mortality (such as low SES). While I am not suggesting that the diseases associated with obesity are unaffected by adiposity, it is uncertain that obesity itself is to blame for costly medical treatment of those diseases, and that these costs and conditions would be less prevalent if obesity were less prevalent.

Moreover, it has been suggested that the argument positing obesity itself as posing significant economic burden on society is poorly founded. Conceptually, the economic burden argument itself is self-defeating. Research has been shown that since economic burden arguments cite increased mortality and early death for obese individuals, this early exit from the medical system should offset the supposed extra costs that obese individuals cause.⁶³ Furthermore, as I discussed in previous sections, we have good reasons to doubt claims that obesity itself is linked to mortality, or that the costly illnesses associated with obesity are necessarily caused by obesity. Lastly, other researchers have also debunked the economic burden claim against obesity on other grounds, such as the argument that “BMI profiling may actually result in higher costs and sicker people.”⁶⁴ This, along with the admission from the *OIC* authors that “[a] better understanding of the contribution of obesity to morbidity and mortality could help to develop more accurate economic costs”⁶⁵ provides sufficient reason to question the extent of obesity as an economic burden as asserted by *OIC*.

3.1 Canada’s anti-obesity public health (AOPH)

Having outlined the backbone of the Canadian government’s attitudes towards obesity in its most recent report from 2011, I will discuss the specific types of anti-obesity public health strategies that Canada endorses through the *OIC*.

3.1.1 Three levels of intervention

According to *OIC*, the Canadian government borrows from the World Health Organization’s six essential underlying ideas for any anti-obesity public health initiatives. These include persistency and long duration of interventions, slow and steady transition strategies (through stages of obesity

⁶³ Nath, “Fat stigma,” 587.

⁶⁴ Bacon & Aphramor, “Weight science,” 6.

⁶⁵ Public Health Agency of Canada, “OIC Report,” 27.

awareness, change motivation, experimentation, adoption and maintenance of anti-obesity-related changes), education about behaviours and attitudes relating to obesity, advocacy from different societal institutions, “fostering shared responsibility for change among consumers, communities, industry and governments”, and anti-obesity legislation.⁶⁶

The first level of anti-obesity public health intervention espoused by the report are ones targeting individuals. These include therapy, a restrictive diet, and regular/increased physical activity, and bariatric surgery and prescription medication.⁶⁷ The second level targets the community, including educational interventions made in workplaces and schools, or through social marketing campaigns. Some examples cited by *OIC* of both Canadian and non-Canadian initiatives are Canada’s “ParticipACTION” campaign targeting physical activity, the “5 to 10 a Day” targeting fruit and vegetable consumption, England’s “Fighting Fat, Fighting Fit” campaign, which was a large, catch-all campaign aimed to increase awareness of the need for obesity prevention as well as promote other health-promoting behaviours, Australia’s “Measure Up” campaign targeting education about healthy weight, and the US’s “VERB” campaign targeting adolescent and youth physical exercise, as well as “Fruits & Veggies More Matters.”⁶⁸ At this level of community-based intervention, *OIC* encourages the following strategies to fight obesity via healthy eating and physical activity: the use of signage to encourage stair use, imposing longer or more intensive physical education in schools, worksite programs for counselling, education, incentives for dietary or exercise change, the manipulation of choice architecture in grocery stores to encourage choosing healthy foods, workplaces and schools changing what kinds of food and beverages are available, and nutrition reminders and training for medical and health care professionals.

In this community level section, the authors end with some weaknesses in the current evidence base for obesity intervention, including “a focus on obesity in isolation, rather than as part of an integrated chronic disease prevention approach.”⁶⁹ The use of this disease terminology, despite the fact that the government of Canada has yet to classify obesity as a chronic disease, is particularly noteworthy. Inclusion of this language in the report may betray a certain bias for the pre-existing attitudes towards obesity. It is possible that this is an attempt to focus on the diseases associated with obesity rather than obesity as a disease itself, and thus transition to a less pathologizing treatment of fatness.

⁶⁶ Public Health Agency of Canada, “OIC Report,” 30.

⁶⁷ Public Health Agency of Canada, “OIC Report,” 30-31.

⁶⁸ Public Health Agency of Canada, “OIC Report,” 31.

⁶⁹ Public Health Agency of Canada, “OIC Report,” 32.

However, the tone and pattern of *OIC* in describing high BMI as itself a state of poor health as well as its focus on reducing adiposity of bodies as necessary for improved health suggests otherwise.

Lastly, *OIC* authors discuss the third level of intervention for obesity: public policy. They suggest that given the socioeconomic and geographical limitations of these types of interventions that the following be focused on or implemented: subsidy programs to support healthy eating, urban planning and transportation planning to promote active commuting and recreational physical activity, regulations relating to the marketing of calorie-dense, non-nutrient-dense foods, financial incentives to promote increased physical exercise, and financial disincentives such as a tax on “unhealthy”.⁷⁰

3.1.2 The role of public health

While there are different and sometimes competing ideas of the function and ethics of public health, most converge around the idea that public health is meant to reduce harm and promote flourishing of its population.⁷¹ Specifically, public health has four distinct characteristics: that it focuses on the whole community rather than individuals, that it focuses on collective good, that there is a prioritization of prevention, that it usually has an association with the government, and that it is intrinsically evidence-based and/or outcome-driven.⁷² The justification for implementing public health policies also fall into some main categories, where any combination of the following may be used to justify policy or intervention at a public health level. They are that the public health intervention must increase overall good (which is typically insufficient justification on its own), that it deals with the problem of collective action and efficiency well (where noncompliance is small and does not undermine the intervention), that it is fair in its distribution of unfairness and burden (in that the burdens incurred are more or less equivalent for everyone), that it satisfies the Millian harm principle (in that some liberties may be taken from individuals in order to prevent harm to the general public), and/or that it is for the population’s own good (in that it is some form of paternalistic).⁷³

3.1.3 The harms of Canada’s *OIC* report and AOPH

The general role and justification process involved in public health is important philosophical background in evaluating Canada’s AOPH initiatives at all three levels of intervention recommended

⁷⁰ Public Health Agency of Canada, “*OIC* Report,” 33.

⁷¹ Faden, Ruth; Shebaya, Sirine, “Public Health Ethics”, *The Stanford Encyclopedia of Philosophy (Winter 2016 Edition)*, Edward N. Zalta (ed.), URL = <<https://plato.stanford.edu/archives/win2016/entries/publichealth-ethics/>>, Section 2.

⁷² Faden & Sirine, “Public Health Ethics,” Section 1.

⁷³ Faden & Sirine, “Public Health Ethics,” Section 2.1-2.6.

by the *OIC* report. Most importantly, the presence of harm to the fat population is relevant when considering implementing the AOPH recommendations contained in the *OIC*. Because its recommendations have roots in anti-fat bias and ignore⁷⁴ conflicting scientific accounts of the actual relationship between obesity, its confounds, and morbidity and mortality, *OIC* poses a particular difficulty for justification of the recommendations it makes to address obesity in Canada.⁷⁵ In particular, consider the recommendation to impose caloric restriction for the management of obesity⁷⁶ despite ample data that eliminative and/or restrictive dieting leads to significantly increased risk of both physical and psychological damage and disorder, especially in children and adolescents.^{77,78,79,80} Furthermore, the report's reference to fat people as "patients"⁸¹ living in bodies that default as diseased⁸² by virtue of their size alone is troubling, especially in juxtaposition to evidence that body size does not inform health status on its own,^{83,84,85} and that there is good evidence (confirmed by researchers and the very authors of the *OIC* report) that many confounds exist that might obfuscate the relationship between obesity and its "risk factors."⁸⁶ Moreover, weight-focused interventions that target individuals in larger bodies are difficult to justify in that they act to further burden a population already documented to suffer from incapacitating fat stigma. Recall that such stigma has been measured to mentally, economically, and physically disadvantage and marginalize fat people.^{87,88} Through imposing further intervention into the lives of this marginalized group and uncritically recommending weight loss to individuals above the normal BMI range, the government of Canada is, intentionally or not, perpetuating and amplifying harm and burden incurred by fat people.

⁷⁴ Refer to Bacon & Aphramor's "Weight science: evaluating the evidence for a paradigm shift", which pools such conflicting research preceeding the 2011 *OIC* report.

⁷⁵ Faden & Sirine, "Public Health Ethics," Section 3.

⁷⁶ Public Health Agency of Canada, "OIC Report," 30.

⁷⁷ McFarlane, Traci, Janet Polivy, and Randi E. McCabe. "Help, not harm: Psychological foundation for a nondieting approach toward health." *Journal of Social Issues* 55, no. 2 (1999): 261-276.

⁷⁸ Bacon & Aphramor, "Weight science," 6.

⁷⁹ Robinson-O'Brien, Ramona, Cheryl L. Perry, Melanie M. Wall, Mary Story, and Dianne Neumark-Sztainer. "Adolescent and young adult vegetarianism: better dietary intake and weight outcomes but increased risk of disordered eating behaviors." *Journal of the American Dietetic Association* 109, no. 4 (2009): 648-655.

⁸⁰ Polivy, "Psychological consequences of food restriction," 589-592.

⁸¹ Public Health Agency of Canada, "OIC Report," 30.

⁸² Public Health Agency of Canada, "OIC Report," 32.

⁸³ Mansfield, "Public health pedagogy," 363.

⁸⁴ Nath, "Fat stigma," 577-590.

⁸⁵ Bacon & Aphramor, "Weight science," 6.

⁸⁶ Public Health Agency of Canada, "OIC Report," 28.

⁸⁷ Nath, "Fat stigma," 580.

⁸⁸ Bacon & Aphramor, "Weight science," 5.

What is the function, then, of AOPH in Canada? At the time of the report's release in 2011, there was already evidence that fat is not conclusively deadly. There was also evidence emerging that outline the unsustainability of weight loss^{89,90,91} and corresponding dangers of cycles of loss and regain in fat people,^{92,93} and the resulting long-lasting metabolic adaptations that promote weight regain that keep fat people who wish to lose weight stuck in a vicious cycle.^{94,95} It is a wonder that AOPH policies recommended by *OIC* are justifiable by the standards outlined in Section 3.1.2 of this chapter.

Even despite the harms of anti-obesity public health strategies and the misrepresentation of the science underlying them, anti-fat attitudes persist in the general public and the medical industry, rooting themselves as a pillar in the current Canadian, and perhaps more generally Western, sociocultural climate. The government of Canada's stance on the current state of the country's 'obesity problem' and how to move forward reinforce pre-existing anti-fat attitudes and provide the general public with a seemingly reputable and immutable objection to derail fat liberation: "But what about health?"

4.1 Derailment of FAMs by AOPH

The harm done by AOPH, as demonstrated by Canada's stance on obesity from *OIC*, undermines its own goals to reduce harm and promote flourishing in the population. As it stands, and at the time of the *OIC* report in 2011, there is surprisingly little scientific literature taking issue with the presupposition that fat is deadly. There is a tendency to accept this dominant interpretation of weight science data from scientists, and especially as utilized by government organizations meant to promote

⁸⁹ Miller, Wayne C. "How effective are traditional dietary and exercise interventions for weight loss?." *Medicine & Science in Sports & Exercise* 31, no. 8 (1999): 1129-1134.

⁹⁰ Tomiyama, A. Janet, and Traci Mann. "Focusing on weight is not the answer to America's obesity epidemic." *American Psychologist* 63, no. 3 (2008): 203.

⁹¹ Mann, Traci, A. Janet Tomiyama, Erika Westling, Ann-Marie Lew, Barbra Samuels, and Jason Chatman. "Medicare's search for effective obesity treatments: diets are not the answer." *American Psychologist* 62, no. 3 (2007): 220-233.

⁹² Montani, J-P., Yves Schutz, and Abdul G. Dulloo. "Dieting and weight cycling as risk factors for cardiometabolic diseases: who is really at risk?." *Obesity Reviews* 16 (2015): 7-18.

⁹³ Strohacker, Kelley, Katie C. Carpenter, and Brian K. Mcfarlin. "Consequences of weight cycling: an increase in disease risk?." *International journal of exercise science* 2, no. 3 (2009): 191-201.

⁹⁴ Klok, M. D., S. Jakobsdottir, and M. L. Drent. "The role of leptin and ghrelin in the regulation of food intake and body weight in humans: a review." *Obesity Reviews* 8, no. 1 (2007): 21-34.

⁹⁵ Wadden, Thomas A., Robert V. Considine, Gary D. Foster, Drew A. Anderson, David B. Sarwer, and José S. Caro. "Short-and long-term changes in serum leptin in dieting obese women: effects of caloric restriction and weight loss." *The Journal of Clinical Endocrinology & Metabolism* 83, no. 1 (1998): 214-218.

public wellbeing, and build upon it instead of questioning the initial interpretation itself. This cultivates an environment in which public health's commitment to waging a war on obesity is performing a function that far outreaches that of the specific campaigns espoused by government public health to decrease the average body weight in Canada. Rather, it provides reputable fodder for objectors to FAMs, the objectors to which derail conversations away from the harm fat stigma and towards arguments about conflicting scientific accounts, sometimes including contrasting interpretations of the same primary data. This supports the idea that derailing conversations away from fat liberation and stigma, and rerouting towards conversations about health, is both a difficult and persistent obstacle for FAMs as well as an empirically weak move from objectors as the data fails to show conclusively that fat is unhealthy and therefore objectionable, or that fat liberation comes at the expense of health.

4.1.1 Look AHEAD as a paradigm example of the struggle in interpreting primary data.

Scientific findings meant to provide support for the idea that fat is harmful and therefore objectionable are often misrepresented, or at the very least, difficult to interpret. This trend is noted by Bacon & Aphramor: the kind of dieting and weight loss behaviours recommended by public health policy and practice consistently misrepresent the weight science evidence. Many other researchers have pinpointed this problem, noting that “bias and convention interfere with robust scientific reasoning such that obesity research seems to ‘enjoy special immunity from accepted standards in clinical practice and publishing ethics.’”⁹⁶

Some might be unconvinced that the research on obesity suffers from such pitfalls and perhaps even accuse the evidence I have cited in opposition of *OIC* of similar methodological problems. While it is likely true that both sides of the debate have their own unique sets of problems, it is also true in general that the science can be difficult and confusing to interpret, leading to multiple and often conflicting interpretations about the same data. Take, for example, the frequently cited 2001 Look AHEAD study. The National Institutes of Health implemented the Look AHEAD trial in order to better understand long term intentional weight loss and its effect on “cardiovascular morbidity and mortality in overweight individuals with type 2 diabetes.”⁹⁷ The objective of the study, then, was to decrease the risk of cardiovascular events through intensive lifestyle intervention involving group and

⁹⁶ Bacon & Aphramor, “Weight science,” 2.

⁹⁷ Look AHEAD Research Group. “The Look AHEAD study: a description of the lifestyle intervention and the evidence supporting it.” *Obesity* 14, no. 5 (2006): 737.

individual therapy and education sessions, prescription of weight loss medication, and the exchange of two meals and one snack per day to a liquid or bar meal replacement, dietary restriction of approximate 1200-1800 calories depending on starting weight, and intervals of increasing physical exercise.⁹⁸

In the subsequent years after the trial's launch, both anti-obesity scholars and their skeptics have cited Look AHEAD with opposing takeaways. While anti-obesity researchers cite the success of the study in its apparent demonstration of the effectiveness of intentional weight loss in reducing cardiovascular morbidity and mortality in participants,⁹⁹ institutions such as the American College of Cardiology (ACC) have reviewed and documented its failure to do the very same. Specifically, American College of Cardiology doctor Anthony Bavry summarized the study as a failure in a 2016 review,¹⁰⁰ noting the study's failure to show that lifestyle intervention (with the goal of intentional weight loss) actually reduced incidence of cardiovascular events for participants, the main intention of the study¹⁰¹. In fact, the Look AHEAD study was reported to fail by this standard at multiple points along the study's duration, including at the 1-year and 4-year marks¹⁰². Look AHEAD's desired result, to show reduced cardiovascular events in the test versus control group, were simply not achieved. This led to Look AHEAD's early abandonment years before the intended 10-year duration.¹⁰³ It is noteworthy that Bavry mentions the study's achievement of significant participant weight loss, and that this weight loss could be indicative of a decrease in cardiovascular risk, but that this effect was diminished over the course of years 1-4 of the study and beyond.¹⁰⁴

Despite these facts, scholars have persisted in their conflicting accounts of the trial. Montesi et al., in another 2016 publication, cite the same 1-year and 8-year statistics of bodyweight percentage lost and other health markers as the ACC review, but declared the study a success on the grounds of the study showing that "well-conducted lifestyle modification programs can product clinically

⁹⁸ Look AHEAD Research Group. "The Look AHEAD study: a description of the lifestyle intervention and the evidence supporting it." *Obesity* 14, no. 5 (2006): 737-742.

⁹⁹ Thomas, J. Graham, Dale S. Bond, Suzanne Phelan, James O. Hill, and Rena R. Wing. "Weight-loss maintenance for 10 years in the National Weight Control Registry." *American Journal of Preventive Medicine* 46, no. 1 (2014): 17.

¹⁰⁰ Bavry, Anthony A. "Action for Health in Diabetes – Look AHEAD." *American College of Cardiology*. October 4, 2016. Taken from: <https://www.acc.org/latest-in-cardiology/clinical-trials/2013/10/01/15/55/look-ahead>

¹⁰¹ Bavry, "Look AHEAD."

¹⁰² Bavry, "Look AHEAD."

¹⁰³ Salvia, Meg G. "The look AHEAD trial: translating lessons learned into clinical practice and further study." *Diabetes Spectrum* 30, no. 3 (2017): 166-170.

¹⁰⁴ Bavry, "Look AHEAD."

meaningful long-term weight loss”.¹⁰⁵ Montesi et al., however, note that Look AHEAD was not able to fully solve the weight regain issue seen with most instances of weight loss, presumably referring to the same attenuation of benefits of weight loss over years 1-4 that Bavy references. While both reviews cite the very same statistics, the former concludes that the study failed while the latter concludes that the study was successful in one aspect dismissed by the first. The Look AHEAD study is being measured as a success using different variables only indirectly intended by the study’s design (to show that long term weight loss is possible). It is thus somewhat unproblematic that Montesi et al. conclude the study a success given their focus on weight loss and not the study’s primary objective (to reduce risk of cardiovascular mortality and morbidity in obese people with type 2 diabetes). However, this declaration of success undoubtedly obfuscates the takeaway from the study for readers.

The Montesi et al. review is also in contrast to third review published in 2015 by Soleymani et al. This article also suggests the study’s success, citing the same health markers and bodyweight statistics as Bavy and Montesi et al., but without Montesi et al.’s caveat that weight regain was not mitigated by Look AHEAD. Rather, Soleymani et al. conclude the success of both the study’s interventions to decrease the risks associated with type 2 diabetes in participants, as well as long term weight loss.¹⁰⁶ They neglect to mention that the control group actually showed a larger, but still extremely minimal improvement in cardiovascular health markers, than the test group, which led to the study’s early abandonment.¹⁰⁷ Recall that this conclusion is at odds with that offered by Bavy’s 2016 ACC review on Look AHEAD, in which he states, “Among overweight/obese patients with type 2 diabetes, intensive lifestyle intervention failed to reduce the incidence of adverse cardiovascular events. As a result, the trial was terminated early due to futility.”¹⁰⁸

The lesson behind this study’s mixed public interpretation, as well as the mixed interpretation of the scientific community is generalizable to weight science in general and the anti-fat bias that leads to the reinforcement and perpetuation of anti-fat bias and findings in weight science. That is, empirical studies in weight science often yield data that can be interpreted in a multitude of ways by even the experts, including ways which appear to conflict. This is important to note in debates challenging FAMs that default to questioning the healthiness of fatness; conclusions made by

¹⁰⁵ Montesi, Luca, Marwan El Ghoch, Lucia Brodosi, Simona Calugi, Giulio Marchesini, and Riccardo Dalle Grave. "Long-term weight loss maintenance for obesity: a multidisciplinary approach." *Diabetes, metabolic syndrome and obesity: targets and therapy* 9 (2016): 39.

¹⁰⁶ Soleymani, Taraneh, Sunil Daniel, and W. Timothy Garvey. "Weight maintenance: challenges, tools and strategies for primary care physicians." *Obesity Reviews* 17, no. 1 (2016): 84.

¹⁰⁷ Bavy, "Look AHEAD."

¹⁰⁸ Bavy, "Look AHEAD."

scientists regarding empirical study findings are ultimately interpretations of data, which can be imperfect, difficult to make, or influenced by pre-existing anti-fat bias and convention in the weight science field.

4.1.2 Chapter 1 conclusion

From sections 1 and 2 of this chapter, it is clear that the evidence-based backbone for the public health recommendations from the *Obesity in Canada (OIC) Joint Report From the Public Health Agency of Canada and The Canadian Institute for Health Information* are less than certain. *OIC* authors, and thus the larger context of the Canadian government's position on obesity and overweight, lack consideration of the potential harms that arise from misrepresenting the causation/correlation relationship between obesity, mortality, and morbidity. The content of the *OIC* is skewed in favour of a dominant and problematic discourse on fat as interchangeable with unhealthy and therefore objectionable, and thinness as the standard for, or necessary for, health. Canada's AOPH as evidenced by the government supported *OIC* report, represents a pervasive mode of shaping the discourse on fat acceptance movements, helping to facilitate a derailment towards talk of health, weight science, and economic burden. Public health has the potential to act as an extremely damaging, highly pervasive and erosive force on fat identity as it perpetuates marginalization and stands directly at odds with the fat liberation movement.

Chapter 2

AOPH, healthism, and figleaves to cover up anti-fatness

1.1 The second function of Canadian anti-obesity public health – covering up and shifting norms

From chapter 1, public health is influential and meant to reduce harm, but anti-obesity public health increases harm and facilitates the derailment of FAM's conversations away from advocacy for fat individuals and towards arguments about health. I showed that this is an empirically weak move, as the relationship between health and body weight is complex, full of confounds, and non-linear. Canada's treatment of obesity, as evidenced by the *Obesity in Canada (OIC) Joint Report From the Public Health Agency of Canada and The Canadian Institute for Health Information* and the Canadian government's endorsement of its content, can, I argue, generalize up to include anti-fat attitudes pervasive in much of the West and is therefore provides a valuable case study.

In chapter 2, I will argue that Canada's anti-obesity public health not only derails conversations about fat liberation, but facilitates a shift in pre-existing norms of equality such that anti-fat discrimination becomes more socially acceptable. AOPH does this not only by centring conversations about fatness on issues of health (from chapter 1), but relies on certain linguistic strategies such as the use of disease and medicalized language that impact the way we see fat bodies, their social status, and our beliefs about fat bodies outside of the medical industry. I argue that this language resonates with the public precisely because it enacts deeply entrenched cultural themes of healthism. This use of language can also help explain why both the professional medical and public spheres retain the belief that fat is unhealthy, immoral, and a public health crisis despite scientific and ethical literature suggesting otherwise. We already know that anti-obesity public health is at odds with its function to reduce harm and encourage flourishing for fat people facing weight stigma,¹⁰⁹ but despite the conflicting evidence suggesting that fat is deadly, and despite well-documented evidence that *stigma* is deadly, AOPH persists. I believe it does so because it serves a certain function within an institutionally oppressive system that disadvantages fat people.

First, I will show that anti-fat attitudes as well as fat discrimination are prevalent and even increasing in frequency. Next, I will describe what I assert is enabling this increase using work by

¹⁰⁹ Pausé, Cat. "Borderline: the ethics of fat stigma in public health." *The Journal of Law, Medicine & Ethics* 45, no. 4 (2017): 510-517.

Robert Crawford's ideology of healthism and the medicalized language underlying it. It is this ideology that embeds anti-fat attitudes as intuitive against the current, shared healthist cultural backdrop in Canada. Then, I will show how the components of Crawford's healthism align with Canada's AOPH using the *OIC* report in order to show how AOPH's strong healthist foundations and medicalized, disease language to describe fat bodies drive the perpetuation of anti-fat attitudes and discrimination as well as create new anti-fat attitudes through a linguistic and/or symbolic tactic called figleaves. Jennifer Saul defines figleaves as linguistic devices employed to cover up what would otherwise be overtly or covertly prejudiced speech or action, and involves the use of certain words, phrases, symbols, or actions to do so.¹¹⁰ Disease language can be thought of as language that attributes diseased qualities to a physical trait, such as term "epidemic" to the word "fat". Lastly, I will show how the use of these anti-fat figleaves work to shift norms of permissibility of expression of anti-fat attitudes or discriminatory behaviour.

1.2 Weight stigma: contextualizing anti-fat AOPH

Weight-based discrimination, as well as anti-fat attitudes, is measurably increasing. One study shows this by examining perceived anti-fat discrimination through surveying a representative sample of individuals in the United States¹¹¹ from 1995-1996, and then again from 2004-2006 using the same sample of individuals. The objective of the study was to measure the change in self-perceived discrimination based on body weight over a ten year period. The results found that in all age groups, weight-based discrimination increased by 66% in 2004-2006 as compared to 1995-1996.¹¹² The study also found that this prevalence of weight-based discrimination is comparable to the prevalence of race and age-based discrimination.¹¹³ The authors note that this is especially troubling in light of the absence of social protections of fat people as compared to social protections on the basis of age and race at the time of publication.¹¹⁴

Another longitudinal study showed similar results. Charlesworth et al. examined implicit and explicit attitudes towards six different demographic factors, including sexuality, race, skin tone, age,

¹¹⁰ Saul, Jennifer M. "Racial figleaves, the shifting boundaries of the permissible, and the rise of Donald Trump." *Philosophical Topics* 45, no. 2 (2017): 98.

¹¹¹ Recall that while my case study regarding AOPH and anti-fat discrimination is rooted in Canada, I acknowledge that cultural similarities in the treatment of fat in the West allow for generalizations of findings to be made from the US to Canada, or the West in general.

¹¹² Andreyeva, Tatiana, Rebecca M. Puhl, and Kelly D. Brownell. "Changes in perceived weight discrimination among Americans, 1995–1996 through 2004–2006." *Obesity* 16, no. 5 (2008): 1132.

¹¹³ Andreyeva et al., "Changes in perceived weight discrimination," 1132-1133.

¹¹⁴ Andreyeva et al., "Changes in perceived weight discrimination," 1133.

disability, and weight.¹¹⁵ This study used a subset of data from Harvard's Project Implicit demonstration, the subset totalling 10 years and 4 million tests. These tests included both implicit association tests, as well as surveys of explicit attitudes towards the six aforementioned factors. For race, sexuality, age, and to a lesser extent skin tone and disability, explicit attitudes shifted towards neutrality (away from discriminatory).¹¹⁶ Body weight stood out as the slowest to change explicit attitudes towards neutrality, and further differed from the other five factors in implicit attitudes, which were shown to shift *away* from neutrality (and towards more discriminatory). The authors speculate that such a trend might be due to:

factors such as an increasing focus on health and the obesity epidemic, the increasing numbers of overweight individuals in the United States, and the perceived controllability of the stigma. Furthermore, we note that... body-weight attitudes involve a perceived but measurable decline of the body and may therefore be seen to have an objective basis.¹¹⁷

Both of these studies' findings are important. In particular, Charlesworth & Banaji have shown that while explicit attitudes towards body weight have shifted towards neutrality, implicit attitudes have not. Firstly, if this finding is as significant as the study asserts, it might suggest that because discriminatory attitudes towards fat people have increased, the social climate has evolved to make it less acceptable *express* explicitly discriminatory attitudes towards body size, but not less acceptable to *hold* them. Secondly, the speculation on the part of the authors as to why an increase in negative implicit attitudes occurred is quite telling. They posit that such attitudes might be based in non-subjective fact¹¹⁸ rather than stemming from (weight-related) bias. They cite "health", the "obesity epidemic," and "controllability of... stigma" as non-subjective reasons for the trend.

This speculation is concerning. Recall from chapter 1 that the relationship between health and body weight is complex and that body size alone cannot determine health status. Furthermore, it has been suggested by weight science scholars that even in the scientific community there is an historical anti-fat bias resulting in unethical conventions and standards that perpetuate and misrepresent weight science with a skew toward anti-fatness.¹¹⁹ Charlesworth & Banaji's intention in invoking health as an explanation for increased negative attitudes about fat is unambiguously skewed towards anti-fat

¹¹⁵ Charlesworth, Tessa ES, and Mahzarin R. Banaji. "Patterns of implicit and explicit attitudes: I. Long-term change and stability from 2007 to 2016." *Psychological Science* 30, no. 2 (2019): 175.

¹¹⁶ Charlesworth & Banaji, "Patterns of attitude change," 182,186,188.

¹¹⁷ Charlesworth & Banaji, "Patterns of attitude change," 190.

¹¹⁸ Charlesworth & Banaji, "Patterns of attitude change," 190.

¹¹⁹ Bacon, Linda, and Lucy Aphramor. "Weight science: evaluating the evidence for a paradigm shift." *Nutrition Journal* 10, no. 1 (2011): 2.

bias, as is suggested by their statement that fatness is associated with a “measurable decline of the body,”¹²⁰ referencing the over-simplified link between fatness and poor health, and worse, leaving room for the justification anti-fat attitudes and possible downstream discrimination towards fat people.

Charlesworth & Banaji’s study shows some evidence of anti-fatness, reiterating old narratives of individual responsibility, health, and the use of disease language to do so as evidenced by the quote on page 28. Their observation that part of the reason for this shift away from weight-neutrality and towards weight bias is rooted in the increasing association between weight and health, and the increase in health valuation in the US (and thus generalizable to Canada or the West) is, I assert correct. As such, in the next section, I will use work done by Robert Crawford (1980) to further unpack these phenomena in light of weight stigma and the ways in which weight stigmatizing language goes unnoticed or normalized. Public health is a major disseminator of these ideas which contributes to the increase in discriminatory attitudes despite explicit claims that obesity-related policies should avoid downstream stigmatization and discrimination.

2.1 Healthism and the medicalization of fat

Healthism and its perpetuation through the language of medicalization work together to reinforce and obscure harms done to fat people. Robert Crawford is among the first to write about modern/contemporary healthism; major themes of his conceptualization can be seen in current attitudes about health and wellness, especially underlying public health and specifically anti-obesity public health. In his 1980 article *Healthism and the medicalization of every day life*, Crawford defines (contemporary) healthism as the elevation of health to a super-value. Healthism sees personal health leading to a holistic state of wellbeing as the most important achievement for which one can strive.¹²¹ Crawford also asserts that in this “preoccupation with personal health as a primary... focus for the definition and achievement of well-being... primarily through the modification of life styles,”¹²² healthism contains conflicting tenets and conclusions often overlooked by the healthist. His main concern is that the (at the time) emerging liberal advocacy for health and wellbeing focuses too narrowly on external factors that contribute to poor health and fails to account for the individual experience, and that while healthism attempts to fill this gap, it fails as it neglects to recognize the

¹²⁰ Charlesworth & Banaji, “Patterns of attitude change,” 190.

¹²¹ Crawford, Robert. "Healthism and the medicalization of everyday life." *International Journal of Health Services* 10, no. 3 (1980): 368.

¹²² Crawford, “Healthism,” 368.

individual experience as socially embedded,¹²³ instead leading to the re-enacting of harmful dominant social scripts.¹²⁴ As a result, a healthist approach depoliticizes the concept of health and health-promotion because it promises that complete health and wellbeing is in the hands of the individual, and that they can achieve it if they try hard enough.¹²⁵ This is a damaging promise because health is complex and multifaceted, often out of the hands of the individual, and often influenced by one's sociocultural climate.

2.1.1 Medicalization

A major component of healthism and the elevation of health to a super value is the collapsing of aspects of life that were previously thought to be unconnected to management by the medical system into the medical system's domain. Crawford posits that the two forms of medicalization interact to reinforce one another. These are 1) certain social phenomena that were once under the expertise of, for example, religion are now linked to medicine. This first form is problematic mostly because medical experts are weighing in on things that exist out of their area of expertise. The second form of medicalization is 2) the framing of socially unacceptable/undesirable behaviour as rooted in sickness or illness, such as drug addiction and sexual dysfunction.¹²⁶ In combination then, medicalization 1) extends medical expertise into non-medical areas of life, and then when deviant behaviours arise in non-medical areas of life, 2) such deviances call for medical intervention as they have been framed as medical problems that healthcare professionals then take on using a medical perspective.¹²⁷ The diagnosis and treatment, often occurring between patient and doctor, disregards the social dimension of the problem the individual faces, and therefore, in Crawford's words, depoliticizes their issue. This depoliticization obscures the cause of the problem and reduces the patient to a deficient body, which the doctor and patient are attempting to fix.¹²⁸ Here, Crawford notes that a holistic approach to health is one possible avenue out of such a depoliticized, "isolating medical experience", but that holism still contains the residues and problems of healthism. That is, it still situates the body as the locus of illness, where "illness is a message from within...; both cause and cure can be found there"¹²⁹ and

¹²³ Crawford, "Healthism," 384.

¹²⁴ Crawford, "Healthism," 367.

¹²⁵ Crawford, "Healthism," 368.

¹²⁶ Crawford, "Healthism," 370.

¹²⁷ Crawford, "Healthism," 370.

¹²⁸ Crawford, "Healthism," 373.

¹²⁹ Crawford, "Healthism," 375.

encourages the individual to make changes in different spheres of their life to fix their ailment rather than addressing the social dimensions and inequities that might be at fault.¹³⁰

At its core then, healthism is an ideology that promises wellbeing in exchange for the “self-restructuring of attitudes, emotions, and behaviors”.¹³¹ Crawford asserts that this aspect of healthism undermines its own main goal (which is to liberate the individual to control their own health and wellbeing) through encouraging eradication of certain “unhealthy” behaviours, attitudes, and conditions without addressing the structural, external causes of these behaviours, attitudes, and conditions.¹³² In disregarding this important aspect of the behaviours, the individual is sabotaged in their efforts to free themselves from stress and illness and unsure where to attribute their failure. With too much emphasis on individual responsibility when it comes to health and wellbeing, healthism risks tricking people into thinking their individual action is enough to achieve their health ideals,¹³³ obscuring sociocultural harms that negatively impact wellbeing but that ought to be advocated against,¹³⁴ and invoking blame to individuals when they fail to take their health into their own hands and achieve their health and wellbeing ideals.¹³⁵

2.1.2 Blame and the potential-sick role

Not only is the concern that individuals will appear blameworthy for becoming ill, but that individuals will become morally scrutinized for not actively preventing “illness” (including unacceptable social behaviour medicalized using disease or sickness rhetoric) by healthism’s standards. Crawford describes this as the healthist’s “*potential-sick role*”, marked by a focus on disease and illness prevention.¹³⁶ Not only is the failure to take preventative measures reflected poorly on the individual, but it is condemned as socially irresponsible. Such condemnation is often justified in terms of economic strain; failure to engage in health promoting behaviours meant to prevent sickness is interpreted to translate directly into rising taxes and insurance premiums in a Western healthist culture.¹³⁷ Engaging in risky behaviours such as smoking or even less obviously risky behaviours such as untreated chronic stress become undesirable social behaviours framed as medical

¹³⁰ Crawford, “Healthism,” 374.

¹³¹ Crawford, “Healthism,” 375.

¹³² Crawford, “Healthism,” 375.

¹³³ Crawford, “Healthism,” 377.

¹³⁴ Crawford, “Healthism,” 378.

¹³⁵ Crawford, “Healthism,” 378.

¹³⁶ Crawford, “Healthism,” 379.

¹³⁷ Crawford, “Healthism,” 380.

issues to which healthcare professionals are called in to medicate or treat. Failure of the individual to seek out the care of some professional to treat their aberrant, health-risk behaviour (or to self-medicate in a healthism-approved manner) is seen as the violation of a moral duty posited by the potential-sick role.¹³⁸

Crawford notes the emergence of healthism in the West, its self-perpetuating nature and the problems that might arise from uncritical adoption of healthism. Through the process of extending medicine into previously non-medical spheres, and the increasing application of medical expertise into previously non-medical spheres, along with general acceptance that individuals have a moral duty to prevent sickness through health promoting behaviours mutually reinforce one another until, as Crawford predicts, “more and more experiences are collapsed into health experience, more and more values into health values.” At the time of the paper’s publication in 1980, Crawford notes that the concept of “health” begins to encompass more than just absence of illness, but a variety of positive qualities associated with the preventative-sick role such as happiness, purpose, self-esteem, satisfaction, creativity, optimism, celebration of life, and work-life balance. In other words, health as a pan-value becomes an impossibly large amalgamation of qualities that together comprise complete and total mind, body, and soul wellness.¹³⁹ As a result, Crawford predicts the dichotomization of health and disease, where everything good is encompassed by health, and anything outside of that category as deviant. As a result, the individual is left to attempt endless compensation for the unavoidable aspects of life that have been medicalized as deviant or risky. This is an impossible task even without the added fact that healthism depoliticizes health and ignores important sociocultural, relational aspects of health that are outside of the control of the individual. The individual must compensate both for “deviant” behaviour of their own, as well as “deviance” imposed onto them, but that go unrecognized as external and outside of the individual’s control.¹⁴⁰ Our anxiety is both soothed and renewed by our endless pursuit of health, or complete and total wellbeing.

The idea of deviance (or socially undesirable behaviour medicalized as risky to our health and wellbeing) is central in Crawford’s paper and has applications to current day discourse on fat acceptance movements (FAMs). According to Crawford, social undesirable behaviours are largely comprised of coping behaviours. The kinds of coping behaviours Crawford focuses on are ones that have what we see as obvious health risks, such as smoking and drinking. Here he creates a nuanced

¹³⁸ Crawford, “Healthism,” 380.

¹³⁹ Crawford, “Healthism,” 381.

¹⁴⁰ Crawford, “Healthism,” 382.

understanding of such behaviours. That is, the need for individual coping behaviours comes largely out of one's position in society. Specifically, coping behaviours deemed unhealthy by healthism are likely to arise due to external factors, or one's social embeddedness. These external factors are precisely what healthism minimizes and ignores as influential to one's wellbeing, health, or ability to prioritize health.¹⁴¹

Thus, Crawford's healthism provides a reasonable explanation for the persistence of anti-fat sentiments in the public and medical spheres despite the inconclusive nature of scientific evidence linking fatness to pathology. It also helps to explain the common intuition to perceive fatness as objectionable on the basis that it is unhealthy or deviant. Healthism also provides a backdrop upon which the associated language techniques that medicalize fatness, pathologize fatness, and obscure anti-fat attitudes through words, phrases or symbols can function.

3.1 AOPH and healthism now

Anti-obesity public health works within a healthist framework. It echoes Crawford's description of healthism in six ways. To demonstrate this, I will provide examples from The Canadian government's *Obesity in Canada: A Joint Report From the Public Health Agency of Canada and the Canadian Institute for Health Information (OIC)*, which I take to be paradigmatic of AOPH in Canada, and representative of anti-fat public health in the West more generally. Lastly, in this section I will briefly discuss ways in which AOPH as demonstrated by the *OIC* appears to differ from Crawford's healthism, but ultimately aligns with it.

3.1.1 AOPH as compatible with healthism

AOPH as demonstrated by OIC agrees with Crawford's healthism in the following ways:

1) AOPH prioritizes "health".

AOPH's prioritization of 'health', while somewhat ill-defined by public health, seems at first unproblematic. After all, it is AOPH and more generally public health (PH)'s job is to improve the health and wellbeing of its citizens. This means that AOPH must, among other things, value harm reduction and the promotion of wellbeing. What aligns this fact with the problematic ideology of healthism is its non-specificity, as well as its simultaneous conflation of certain, ever-expanding markers of health with wellbeing itself. What aspects of life should AOPH or PH in general be

¹⁴¹ Crawford, "Healthism," 385.

responsible for? AOPH itself encompasses a massive variety of traits that conflate health and wellbeing, listed by Crawford, who rightly observes that,

[h]ealth, or its supreme – “super health” – subsumes a panopoly of values: “a sense of happiness and purpose,” “a high level of self-esteem,” “work satisfaction,” “ability to engage in creative expression,” “capacity to function effectively under stress,” “having confidence in the future,” “a commitment to living in the world,” [or] the ability “to celebrate one’s life”.¹⁴²

AOPH, using *OIC* as a representative case study, wants to tackle any avenue of behaviour or quality in a fat person’s life that can be reasonably causally linked to their state of obesity. Recall that this included factors such as screen time¹⁴³ or self esteem,¹⁴⁴ and individual or family therapy,¹⁴⁵ whose connections to obesity and health were stated unclearly. Chasing an ever-expanding list of health behaviours is problematic, if not impossible. *OIC*’s targeting of weight, food and exercise as health-relevant behaviours to socioeconomic status, job prestige, stigma, and screen time, citing nothing more than correlation to justify their inclusion are demonstrative of the similarities of AOPH’s trouble with collapsing too many factors in health status, and specifically health status as it relates to obesity and the greater context of healthism’s collapsing of too many factors into the category of health.

2) AOPH adopts the mentality of the potential-sick role.¹⁴⁶

AOPH adopts the mentality of the potential-sick role unambiguously in its emphasis on obesity *prevention*, targeting children and their behaviours as well as specific dietary components common to fat adults such as chicken and rice, presumably to help people prevent fatness and thus prevent illness. This extends the responsibility of individuals to prevent weight gain to avoid even the chance of weight-correlated illness, a main theme in Crawford’s healthism. Recall that Crawford finds this problematic because of the corresponding emphasis on individual responsibility in this prevention role and the stigma associated with not only acquiring illness, but failing to properly demonstrate they are doing all they can to minimize risk. As Crawford notes, the potential-sick role “mandates a moral duty: the obligation to correct unhealthy habits”.¹⁴⁷

¹⁴² Crawford, “Healthism,” 380.

¹⁴³ Public Health Agency of Canada, “Obesity in Canada: A JOINT REPORT FROM THE PUBLIC HEALTH AGENCY OF CANADA AND THE CANADIAN INSTITUTE FOR HEALTH INFORMATION.” 2011. Accessed May 20, 2020. pp 18.

¹⁴⁴ Public Health Agency of Canada, “OIC Report,” 27.

¹⁴⁵ Public Health Agency of Canada, “OIC Report,” 30.

¹⁴⁶ Crawford, “Healthism,” 380.

¹⁴⁷ Crawford, “Healthism,” 380.

AOPH not only targets already-fat people who are healthy to avoid becoming ill, but removes itself one step further by attempting to prevent people from becoming fat, so they can prevent people from potential illness associated with some fat people. *OIC* demonstrates this tendency through their primary targeting of obesity rather than the conditions for which obesity is a symptom. This is a problem as high BMI and certain obesity-related illnesses have a complex relationship. For example, recall that in the case of developing type 2 diabetes, there is evidence that weight gain is an early warning symptom of diabetes onset rather than a cause.¹⁴⁸ This examples demonstrates *OIC*'s adoption a potential sick-role prevention strategy in their focus on obesity prevention rather than prevention of illnesses associated with obesity, and that this is a mistake from a health-promotion standpoint.

3) AOPH underemphasizes key external factors.¹⁴⁹

AOPH underemphasizes some key external factors that influence health, especially those related to negative social treatment fatness. The *OIC* report emphasizes factors that contribute to the *individuals'* statuses as fat, such as SES, access to fresh food, and exercise. It does not, however, look at factors external to the individual that contribute to their declining health due to the way fat is socially constructed. The holism approach that AOPH takes in *OIC* is one that looks at risk factors for becoming fat, specific to the individual, and attempts to guide the individual to minimize them rather than take into account the social embeddedness of a fat individual and the ways in which their environment damages them. In other words, they spend inadequate time talking about the confounds between obesity and unhealthiness, and skim over issues that arise due to weight stigma, bias, discrimination. AOPH prescribes weight loss to improve health, and they focus on the external social factors that might cause obesity, but nothing else informs the health status of the fat person.

4) AOPH overemphasizes individual responsibility.

Similar to 3), AOPH constructs the pursuit of health through a focus on individual intervention on their thoughts, behaviours and emotions. Not only does AOPH minimize key external factors like the social construction and treatment of fatness, but it simultaneously over-inflates individual responsibility to prevent oneself from being fat. By individualizing health (through telling fat people that they have an individual responsibility to lose weight and keep it off), the reasons why this might be hard or impossible, or genetic reasons why this is hard or impossible, will be disregarded. As a

¹⁴⁸ Campos, Paul, Abigail Saguy, Paul Ernsberger, Eric Oliver, and Glenn Gaesser. "The epidemiology of overweight and obesity: public health crisis or moral panic?." *International Journal of Epidemiology* 35, no. 1 (2006): 57.

¹⁴⁹ Crawford "Healthism," 375.

result, fat individuals are left to internalize individual responsibility, blame, shame, and stigma associated with their inability to lose weight and keep it off through *OIC*'s recommendations. Recall that examples of these factors dismissed or downplayed by AOPH as demonstrated by the *OIC* report are the physical effects of experiencing stigma (instead blamed on adiposity rather than the associated stigma), socioeconomic status and barriers to access to food, metabolic adaptations that encourage weight-regain in the event of weight loss, and the cardiovascular risks involved in weight-cycling.

5) AOPH problematizes coping.¹⁵⁰

The *OIC* report spends little time addressing or considering that coping through eating is a healthier coping mechanism than something like, for example, alcohol consumption, and that both eating or alcohol consumption can be better coping mechanisms than the absence of any coping mechanism. This demonstrates the importance of a harm reduction approach that anti-obesity public health and the *OIC* report deal with inadequately despite harm reduction's importance to the philosophy of public health. Instead, AOPH demonizes certain coping behaviours without reference to the socially embedded reasons for that coping or mention of alternatives.

This is suggested by *OIC*'s recommendations to, for example, access therapy to help control weight-related behaviours. While *OIC*'s suggestion to seek therapy to control weight-related behaviours do not explicitly refer to overeating leading to weight gain, I think it is reasonable to assume that such behaviours are included in their recommendation. A commonly cited cause of overeating, although not one explicitly mentioned by the *OIC* report, is 'emotional eating', which refers to food consumption for the purposes of emotional coping, soothing or comfort. However, using food to cope is not necessarily causally linked to high BMI, nor is it necessarily linked to harm. For instance, 'emotional eating' is not actually shown to translate to over-consumption of food or increased weight in self-proclaimed emotional eaters.¹⁵¹ Furthermore, it has been shown that people who are particularly preoccupied with food and/or diet tend to retrospectively attribute a label of 'emotional eating' to periodic episodes of what individuals consider abnormal eating behaviours for themselves, whether they've engaged in consumption of foods they would not normally eat, or consumption of foods that they have otherwise eliminated from their diets.¹⁵² Instead, the idea of

¹⁵⁰ Crawford, "Healthism," 370.

¹⁵¹ Bongers, Peggy, and Anita Jansen. "Emotional eating is not what you think it is and emotional eating scales do not measure what you think they measure." *Frontiers in Psychology* 7 (2016): 1-11.

¹⁵² Adriaanse, Marieke A., Sosja Prinsen, Jessie C. de Witt Huberts, Denise TD de Ridder, and Catharine Evers. "I ate too much so I must have been sad': Emotions as a confabulated reason for overeating." *Appetite* 103 (2016): 318-323.

emotional eating in conjunction with other coping mechanisms has been shown to be an important locus of cultural, tradition, connection and wellbeing.¹⁵³¹⁵⁴

6) AOPH medicalizes fat bodies and lives.¹⁵⁵

This can be seen in the instances of AOPH, and specifically the *OIC* report, of referring to fat bodies and some aspects of fat people's lives as medical problems that need fixing through medical or therapeutic intervention. Recall from chapter 1 that an example of the *OIC* referring to fat bodies as a medical problem came in the form of describing one's status as obese to be a health status itself (rather than a statistical description of height and weight)¹⁵⁶. Also recall from chapter 1 that fat people's lives, and in particular the decisions they make, are framed as in need of medical or therapeutic intervention in the *OIC* report through discussion of their decision to engage in screen time activities¹⁵⁷ as well as choosing specific foods such as rice¹⁵⁸ as behavioural links to obesity and therefore illness.

It's important to note that addressing fatness as a medical issue of disease might be an attempt to provide a more objective and less moralized view of fatness that aims to focus on the body rather than the fat person's character. For example, in the addiction debate, pushing for a disease model of addiction in which addiction is seen as a brain disease and the person with the addiction as a victim of disease was meant to put to rest the choice model of addiction in which those addicted to drugs were seen as having chosen their addiction and continuously choose to stay stuck in it. Some might argue, then, that a disease model of fat might attempt to destigmatize fatness and take personal choice or responsibility out of it. However, the disease model of fatness undermines any destigmatization in other ways, such as robbing the fat person of agency (implying that they are a victim of their "disease"), as well as being medically inaccurate (because the disease model of drug addiction has been shown to fall short in providing sufficient evidence to conclude it is indeed a brain disease. It also fails in the context of obesity because we have shown that obesity does not necessarily imply illness).

¹⁵³ Satter, Ellyn. "Emotional eating." *Ellyn Satter Institute* (2019). Taken from: <https://www.ellynsatterinstitute.org/family-meals-focus/46-emotional-eating/>

¹⁵⁴ The sources in footnotes 151-153 were published in 2016-2019, which was after the 2011 *OIC* report. I am not suggesting that the *OIC* report should have taken the content or ideas within these sources into account, but rather that the *OIC*, as it currently stands, discounts important coping mechanisms and that this aligns with the healthist ideal.

¹⁵⁵ Crawford, "Healthism," 370.

¹⁵⁶ Public Health Agency of Canada, "OIC Report," 17.

¹⁵⁷ Public Health Agency of Canada, "OIC Report," 18.

¹⁵⁸ Public Health Agency of Canada, "OIC Report," 18.

7) AOPH frames health as liberation.

Framing health as liberation, or weight loss as freedom, without the social embeddedness dimension in 3), that AOPH underemphasizes key external factors such as weight stigma, risks keeping people stuck in a cycle that ends up damaging health more than promoting it. For example, framing weight loss as a panacea for health keeps people locked into a cycle of yo-yo dieting that we know from research is highly associated with all of the comorbid conditions blamed on obesity rather than weight cycling. However, this framing of health and weight keep people chasing weight loss after cycles of common if not inevitable weight regain.¹⁵⁹

3.1.2 AOPH as incompatible with healthism

It is also important to acknowledge the ways in which AOPH *differs* from healthist ideology, at least at first glance.

Firstly, AOPH as demonstrated through *OIC* overtly acknowledges that weight stigma is harmful and should not be utilized in public health initiatives.¹⁶⁰ This appears to go against healthism's reliance on blame to promote health. Evidence of this acknowledgement also reveals itself in *OIC*'s account of the renaming of some anti-obesity health initiatives in the recent past ("Fighting fat, fighting fit" to "Change4Life"¹⁶¹) on the basis that the former name has the potential to be too narrow and/or stigmatizing. Another possible locus of disagreement between AOPH and healthism is demonstrated by *OIC*'s recommendation to attend to the external, social embeddedness dimension of health, acknowledging things like socioeconomic status and other marginalized identities as having a bearing on health and body size.¹⁶²

These two loci of possible disagreement between AOPH and healthism end up ultimately compatible. For example, while AOPH and in particular the *OIC* report condemn the use of fat stigma to improve health, they simultaneously employ it in their efforts using certain linguist strategies to do so. Such linguistic strategies will be addressed below. Moreover, *OIC*'s, and AOPH's more generally, attempt to consider social and environmental factors involved in obesity to prevent it rather than prevent obesity-related illnesses or stigma still place the onus on the individual to either modify their own environment through behaviour change or therapeutic intervention in order to manage and

¹⁵⁹ Nath, Rekha. "The injustice of fat stigma." *Bioethics* 33, no. 5 (2019): 583.

¹⁶⁰ Public Health Agency of Canada, "OIC Report," 30.

¹⁶¹ Public Health Agency of Canada, "OIC Report," 31.

¹⁶² Public Health Agency of Canada, "OIC Report," 18.

change their bodyweight.¹⁶³ This strategy also fails to distinguish itself from healthism in that it focuses primarily on weight of the individual, dismissing the social and environment factors that harm that individual. In other words, AOPH seems primarily interested in helping modify environmental factors with the goal of decreasing the number of *fat people*, rather than protect fat people that already exist from harm.

4.1 Language and the “covering up” function of AOPH

Now that healthism as a powerful credibility-affording backdrop for AOPH and anti-fat medicine has been laid out and contextualized with contemporary AOPH, I will move on to show that the conversational move to invoke health in conversations about fat liberation is not just a distraction as was suggested in Chapter 1, but acts additionally as oppressive in nature; a driver for the perpetuation of fat stigma. Defaulting to medically based disease language and invoking health and medicine in conversations about fat liberation and its core tenet of body acceptance obscures this oppressive nature, and can take many forms that are all functionally similar to the linguistic figleaf (although all forms rely on the perpetuation of a medicalized, disease model of fat). I argue that two levels of figleaf occur within public health with origins in medicine and disseminated on a large scale by AOPH statements, reports and initiatives, and work together to obscure overtly fatphobic behaviour, hide and preserve anti-fat attitudes, normalize/create new anti-fat attitudes, and give permission to anti-fat behaviours and speech. The use of these figleaves are effective exactly because they exist against a healthist backdrop that has elevated health to as a super-value, resulting in the downstream conflation of body size with health status as moral signifiers. As a result, I will further conclude that not only does AOPH contribute to the derailment of fat liberation to matters of health based in factually questionable science, but AOPH’s roots in healthism result in language and behaviour that hides its anti-fat nature and ends up creating new, stronger anti-fat attitudes and gives permission to discriminate based on weight.

4.1.1 Healthism and language

Should the fact that one chooses to live inside of an “unhealthy” body mean that they deserve the prejudice they experience? Should it mean that they are obligated to change the body that they’re in? These questions are main concerns for FAMs, which is positioned against public health, the medical industry, and the larger picture healthist backdrop against which both operate. While fat liberation

¹⁶³ Public Health Agency of Canada, “OIC Report,” 30.

and public health do not necessarily need to be in conflict, the conflation of body size to health status exhibited by the medical industry and disseminated on a large scale by AOPH have made them so; accepting one's (fat) body is interpreted through an AOPH lens as advocating for avoidable unhealthiness and burden to society. As a result, the language associated with the pathologizing of fatness originating in the medical industry and its role in maintaining the link between fatness and unhealthiness, and between fatness and stigma. I have alluded to this vocabulary's origin in a Western healthism-fueled medical industry and as adopted by public health efforts to combat obesity/overweight. This kind of vocabulary embeds body size in health status, specifically the comorbid conditions associated with people in larger bodies discussed in chapter 1 such as cardiovascular disease. It does this in the following way.

Public health, generally, relies on a social consensus that health is important. Crawford's description of healthism from the previous section paints a picture of how this came to be and how it is self-perpetuating. AOPH in particular relies on this same healthist foundation, but focuses on the correlation between larger body size and illness, or the risk of potential illness. While its focus is on health, AOPH, as evidenced by the *OIC*, does little to address the achievement of health outside of healthism-approved behaviours conducive to shrinking bodies. This shifts the focus of AOPH from health to body size, and in doing so dilutes its own focus on health. Rather, AOPH takes aim at *all* fat bodies, including healthy fat bodies, in order to decrease both illness and potential illness, regardless of the health status of those contained in the upper BMI ranges.

This dilution of AOPH to focus on weight loss is culturally acceptable because of a super-valuation of health, social privileging of thinness, and largescale trust that body size and health are indeed inextricably linked (despite good evidence that this relationship is fraught with confounds, exceptions, and resulting harm). The reason it's easy to accept AOPH's shifted focus from health to body size is because of the socially ingrained anti-fat attitude which has been in place well before the emergence of data showing correlation between body size and health status. While we might recognize that fatphobia is inappropriate (see chapter 2, section 1's studies on implicit and explicit fat bias), we also have a deep and intuitive relationship with the values espoused by healthism, making this acceptance of "fat is objectionable" a more palatable one that does not require an individual to self-identify as fatphobic, but rather can maintain their status as someone who simply values health and wellbeing. Healthism successfully obscures the anti-fat attitudes underlying the desire to shrink our bodies because, as aptly pointed out by Crawford, the "[s]olution to the problem of disease is directed toward breaking the most immediate causal link. Thus, medical perception pushes causal

understanding toward the immediate and local, and solution toward the elimination of symptoms and the restoration of normal signs.”¹⁶⁴ This conveniently allows people to retain their belief that “fat is objectionable because fat is unhealthy” even in light of evidence that shows the relationship between fat and unhealthiness is a flawed heuristic at best.

4.2 Linguistic phenomena in AOPH: language of healthism, medicalization, and figleaves

I have suggested that a healthist backdrop and the increasing medicalization of fat bodies contributes to the retention of belief that fat is objectionable despite evidence to the contrary. I then moved on to suggest that within this healthist framework and medicalization, which is perpetuated by AOPH, comes a certain vocabulary that reinforces fat stigma and encourages the construction of new anti-fat attitudes and permissibility of fatphobic behaviour. This includes new vocabulary, norms, and symbolic associations between certain language and moral character, which is a trademark of healthist ideology. Although I will not spend much time unpacking these examples further, these linguistic phenomena can be seen in the shift of the moral model of fat to the disease model, and with it disease language use in non-medical circumstances to describe fat bodies. This includes use of BMI terminology to refer to bodies (where obese and overweight are seen as health risks in themselves), the conflation of health status and body size, as well as epidemiology language such as the “obesity epidemic” or “obesity pandemic”. An example of this pathologizing language is the use of addiction-language to describe food behaviour. This is particularly problematic when food consumption becomes medicalized by virtue of a person’s weight alone. In such cases, or even in cases of non-fat bodies engaging in food preoccupation or cycles of bingeing (as seen in individuals with binge-eating disorder), the language of food addiction and the rise in a 12-step addiction approach to combat undesirable food consumption and control body size¹⁶⁵ is a clear example of the ways in which the language of healthism perpetuates fat stigma. Lastly, the linguistic phenomenon of the figleaf is utilized by AOPH as part of its function to further healthism, medicalization and resulting fat stigma, which will be defined in the next section.

¹⁶⁴ Crawford, “Healthism,” 371.

¹⁶⁵ Overeaters anonymous, “Working the Program.” Taken from: <https://oa.org/working-the-program/>

4.2.1 Saul's definition of figleaves

The linguistic phenomenon that I will spend the rest of this chapter unpacking is that of the linguistic figleaf. Figleaves are a linguistic device coined and developed by Jennifer Saul (2017) within the context of anti-black racism in the United States. Figleaves describe a phenomenon in which overtly or covertly prejudiced speech or action is covered up using certain words, phrases, symbols, or actions. These figleaves are meant to appear inconsistent with the prejudiced speech or action in order to prevent some audience, or the speaker themselves, from making the inference that the speaker is prejudiced, or that their prejudiced statement coming before or after the figleaf was not in fact prejudicial. At the very least, figleaves aim to portray the speaker as neutral or unprejudiced towards some group despite some incriminating evidence that the speaker is prejudiced based on their behaviour or actions.¹⁶⁶

Supporting elements of figleaves that make them successful are the concepts of the Norm of Racial Equality (NRE) and racial resentment.¹⁶⁷ Saul defines the norm of racial equality as approximately the self-identification of oneself as non-racist, or the imperative, "Don't be racist."¹⁶⁸ This norm does not preclude the individual from holding racist beliefs or attitudes, however, so long as the individual does not judge their beliefs to be racist. This allows the individual who claims to adhere to the norm of racial equality to hold either covertly or overtly racist beliefs, but fails to acknowledge them as racist, and thus maintains a self-image of non-racism.

Next, Saul pulls from psychological research to define racial resentment as agreement with statements such as "Irish, Italian, Jewish and many other minorities overcame prejudice and worked their way up. Blacks should do the same without any special favours".¹⁶⁹ Racial resentment is important because it facilitates the audience's acceptance of a given figleaf. Given that most Americans are shown to hold racially resentful attitudes¹⁷⁰ while also subscribing to the Norm of Racial Equality, this poses a scenario of cognitive dissonance in most people off of which figleaves can capitalize. In instances where a speaker utters or performs a racist action and utilizes a figleaf accordingly, the audience looks internally to decide whether or not the statement or action was racist.¹⁷¹ In many cases, the audience *wants* to judge the statement or action to be non-racist because

¹⁶⁶ Saul, "Fingleaves," 98.

¹⁶⁷ Saul, "Fingleaves," 99.

¹⁶⁸ Saul, "Fingleaves," 100.

¹⁶⁹ Saul, "Fingleaves," 99.

¹⁷⁰ Saul, "Fingleaves," 99.

¹⁷¹ Saul, "Fingleaves," 102.

of their adherence to the Norm of Racial Equality. They accept the figleaf as good reason to make the judgment “non-racist”, a process that is smoothed by pre-existing racially resentful attitudes.¹⁷²

However, figleaves go a step further than to cover up racism and soothe an audience into comfortably ruling questionable behaviour, and their own status as non-racist.¹⁷³ Saul draws on work by Rae Langton & Mary Kate McGowan to suggest that over time, the use of figleaves coupled with racist action or speech can begin to shift social perceptions of what counts as racist such that even blatantly damaging racist statements will become acceptable.¹⁷⁴ This will result in the normalization of not only racist speech but behaviour, and can include things like structurally racist policy in a public context or individually racist actions in a private context.

Whereas Saul uses figleaves to analyze the era of Trump in the context of the United States, I will examine figleaves in relation to anti-fat bias in the medical and public health industry in Canada.¹⁷⁵ In doing so, I will show how figleaves account, in part, for our uncritical commitment to AOPH’s sometimes overt anti-fatness. I argue that figleaves can explain the shifting of anti-fat attitudes away from neutrality and towards discriminatory that researchers such as Charlesworth & Banaji (2019) and others (Andreyeva et al., 2008) have measured.

4.2.2 Anti-fat figleaves defined

Figleaves discussed by Saul include two types: synchronic and diachronic. Synchronic figleaves take place at the same time as the racist action or speech. Diachronic figleaves happen either before or after the prejudiced statement, action or behaviour, either short term or long term in distance. Before I offer examples of anti-fat figleaves, I must first show how the concepts of racial resentment and the Norm of Racial Equality might translate into what I will refer to as weight-based resentment and a Norm of Weight-Neutrality.

Consider in more depth the underpinnings of the Norm of Racial Equality. Another term that communicates the norm of equality underlying Saul’s norm of racial equality is egalitarianism, defined as the idea that “[p]eople should be treated as equals, should treat one another as equals, should relate as equals, or enjoy an equality of social status of some sort. Egalitarian doctrines tend to

¹⁷² Saul, “Figleaves,” 102.

¹⁷³ Saul, “Figleaves,” 103.

¹⁷⁴ Saul, “Figleaves,” 101.

¹⁷⁵ Note that while my focus is about Canadian AOPH, cultural similarities between treatment of fatness in Canada, the US, and much of the West allows for application of a Canadian-focused examination to other AOPH in the West.

rest on a background idea that all human persons are equal in fundamental worth or moral status.”¹⁷⁶ According to Charles Gallagher (2015), race-neutral¹⁷⁷ egalitarianism “is the tendency to claim that racial equality is now the norm [in the West], while simultaneously ignoring or discounting the real and ongoing ways in which institutional racism continues to disadvantage racial minorities.”¹⁷⁸ As a result, white people are able to reconstruct narratives of race-based inequalities as narratives of inequality explained by other, non-racial factors.¹⁷⁹ The focus of the narrative might shift from socially external, institutional factors to internal, individualized factors such as work ethic, character, or attitude.

We can see how this concept can generalize to other norms of acceptance, such as self-identification as non-sexist and the upholding of the imperative, “Don’t be sexist.” Such a norm might compel an individual to take up the position that gender should not be a cause of someone’s unfair treatment, but simultaneously preserve sexist beliefs in that individual who fails to acknowledge those beliefs as sexist, but rather attributable to some non-gendered factors. Similarly, we can have a Weight-Neutral Norm of Equality where we generally accept the assertion that one should not be discriminated against on the basis of body size alone. Others have observed such a norm, but describe it as “the [simultaneous] social undesirability of fat but also the [social] inappropriateness of open prejudice against fat.”¹⁸⁰ This observation is compatible with research that shows the decrease of explicit anti-fat attitudes, albeit a slow one, but the increase in implicit anti-fat attitudes.¹⁸¹ Thus the Norm of Weight-Neutral Equality can be thought of as adjacent to the concept of the Norm of Racial Equality and might take the form of “Don’t discriminate based on weight alone.”

This observation of the undesirability of fat and simultaneous social inappropriateness of open prejudice against fat bodies also alludes to the second important aspect of figleaves: racial resentment. The weight bias equivalent is easy enough to unpack, especially as measures of both explicit and implicit bias and discriminatory attitudes towards fat people have been documented.¹⁸² Scholars such

¹⁷⁶ Arneson, Richard, "Egalitarianism", *The Stanford Encyclopedia of Philosophy* (Summer 2013 Edition), Edward N. Zalta (ed.), URL = <<https://plato.stanford.edu/archives/sum2013/entries/egalitarianism/>>.

¹⁷⁷ Note that the use of “blind” as part of “color-blind” is an ableist usage of blindness as it pertains to race-neutrality. As a result, I have substituted “color-blind” for “race-neutral”.

¹⁷⁸ Gallagher, Charles. "Color-blind egalitarianism," in *Theories of Race and Ethnicity*, ed. Karim Murji and John Solomos (Cambridge, U.K: Cambridge University Press, 2015), 40.

¹⁷⁹ Gallagher, “Color-blind egalitarianism,” 42.

¹⁸⁰ Brewis, Alexandra A., Amber Wutich, Ashlan Falletta-Cowden, and Isa Rodriguez-Soto. "Body norms and fat stigma in global perspective." *Current Anthropology* 52, no. 2 (2011): 269-276.

¹⁸¹ Charlesworth & Banaji, “Patterns of attitude change.”

¹⁸² Charlesworth & Banaji, “Patterns of attitude change.”

as Cat Pausé have noted that fat is seen as dangerous with regards to societal economic burden as well as highly blameworthy for this burden.¹⁸³ In reference to a healthist backdrop that presumes thinness to be a symbol of health, as well as accepts that health is the responsibility of the individual if they simply try hard enough, these resentful attitudes towards fat people make sense. It is precisely due to this blame framework that weight-based resentment works as analogous to racial resentment. While thin, “normal” people behave to remain thin, fat people are failing in this regard, and this failure is seen to be due to an issue with the individual’s work ethic, discipline, or self-control.¹⁸⁴ Thus, there is good reason to believe that fat resentment is at work and functions similarly in kind to racial resentment in Saul’s figleaves. Rather than the statement, “Irish, Italian, Jewish and many other minorities overcame prejudice and worked their way up. Blacks should do the same without any special favours”,¹⁸⁵ fat resentment might come in the form of “Thin people are such because of their hard work, discipline, and self-control. Fat people should take their health into their own control rather than burden our healthcare system and use up its resources.” Fat resentment is important because it also facilitates an audience’s acceptance of an anti-fat figleaf, which I will provide examples of in the next section. Given evidence of the widespread existence of anti-fat, resentful attitudes¹⁸⁶ while also generally prescribing to the Norm of Weight-Neutral Equality, this poses a similar instance of cognitive dissonance as in Saul’s race-based figleaves. In instances where a speaker or institution implements or utters something fatphobic and utilizes an anti-fat figleaf accordingly, the audience looks internally to decide whether or not the statement or action was actually fatphobic, or perhaps justified, or neutral.¹⁸⁷ As for race, in many cases the audience *wants* to judge the statement or action to be non-discriminatory because of their adherence to the Norm of Weight-Neutral Equality. They accept the figleaf as good reason to make the judgment “non-fatphobic”, a process that is smoothed by pre-existing fat-resentful attitudes.¹⁸⁸

4.3 Two tiers of anti-fat figleaves

Now that I have shown how racial figleaves can apply to anti-fat discrimination, I will move on to explain the two tiers of anti-fat figleaves disseminated by AOPH. While there are many different

¹⁸³ Pausé, Cat. "Borderline: the ethics of fat stigma in public health." *The Journal of Law, Medicine & Ethics* 45, no. 4 (2017): 510-517.

¹⁸⁴ Pausé, "Borderline: the ethics of fat stigma in public health," 510-511.

¹⁸⁵ Saul, "Fikleaves," 99.

¹⁸⁶ Pausé, "Borderline: the ethics of fat stigma in public health," 511.

¹⁸⁷ Saul, "Fikleaves," 102.

¹⁸⁸ Saul, "Fikleaves," 102.

types of figleaves as described by Saul, I am referring to two different levels that figleaves can function at generally in the context of anti-fatness. One tier draws directly from healthism's emphasis on the importance of health and the importance of individual action to achieve it. This level of figleaf relies on the occurrence of a concrete speech act, and is specific to most instances where the health status of a fat body is invoked where health was not primarily relevant. The second tier of figleaf occurs in a broader range of situations where speech acts are not necessary, but centers itself on the idea of *concern*; specifically, concern for the health of fat individuals. I will now proceed to discuss both tiers of figleaf, providing examples to illustrate each type.

4.3.1 Tier 1 anti-fat figleaves – informal speech acts

The first tier of anti-fat figleaf are formed as speech acts, which can occur both at the time of the weight-stigmatizing statement or at a time separate from the speech act. This level of anti-fat figleaf functions regardless of the utterer and works by condemning fatness through condemning health. Take the dialogue surrounding the 2019 Nike model implementation as an example of this level of figleaf. In 2019, Nike London released a plus-sized mannequin, adorned in activewear, among the smaller mannequins in one of its flagship stores. The response to this move was mixed. People like journalist Tanya Gold reacted with contempt, stating that “[o]bese mannequins are selling women a dangerous lie”, that the mannequin is “immense, gargantuan, vast. She heaves with fat,” and “cannot run”, but rather “[s]he is, more likely, prediabetic and on her way to a hip replacement.”¹⁸⁹ Gold goes on to condemn the Nike brand altogether, wondering, “What terrible cynicism is this on the part of Nike?”¹⁹⁰

The fat Nike mannequin example is illuminating for many reasons. In this example, the Nike model itself is not the figleaf, but rather it is Gold's statements about the model that function as anti-fat figleaves. While Gold's statements have been criticized as fatphobic, her position has also been well-defended. This supports the idea that individuals opposing the model's implementation are utilizing anti-fat figleaves to cover up their objections, similar to the ones contained within Gold's that are at least partially affective at obscuring anti-fat bias towards the fat mannequin. For example, Twitter erupted with responses to the Nike mannequin, including tweets like, “@Nike Mannequin normalising obesity. Not a good move, but seems the U.K. loves to be in denial of fat”, and a non-

¹⁸⁹ Gold, Tanya. “Obese mannequins are selling women a dangerous lie.” *The Telegraph*. (2019). Taken from <https://www.telegraph.co.uk/women/life/obese-mannequins-selling-women-dangerous-lie/>. July 3, 2020.

¹⁹⁰ Gold, Tanya. “Obese mannequins are selling women a dangerous lie.” *The Telegraph*. (2019). Taken from <https://www.telegraph.co.uk/women/life/obese-mannequins-selling-women-dangerous-lie/>. July 3, 2020.

sarcastic tweet that reads “Great motivator to get people to buy workout gear. “Buy our stuff and workout or you’ll be unhealthy and overweight like this mannequin.” Great job Nike!”, and “I dislike the normalization of our unhealthy society”.¹⁹¹ These statements, while not figleaves themselves, demonstrate a willingness to accept people’s own fatphobic positions, as well as individuals like Gold’s, because they consider their belief that “fat is objectionable because fat is unhealthy” to be factual rather than stigmatizing.

Gold’s article, mixes fatphobic language with references to health as justification, sometimes within the same sentence. This use of health-concern coupled with fatphobic language is a paradigm example of a synchronic anti-fat figleaf. Synchronic figleaves, according to Saul, are statements that are “provided at roughly the same time as the utterance for which it is a figleaf.”¹⁹² As a result, those reading the stigmatizing language in her article are prompted to self-monitor themselves for the presence of intolerance (towards fat bodies), and need to look no further than her ‘Health Mention’ figleaves to assure themselves that while the article is heavy-handed, it is ultimately objecting to Nike promoting unhealthiness, not promoting hatred and discrimination of fat bodies just on the basis of their aesthetic.

Another more subtle figleaf contributing to Gold’s anti-fat figleaves is her position as a fat woman herself. This figleaf takes some effort on the part of her audience to investigate, but the result is something akin to what Saul refers to as a Friendship type of synchronic figleaf. A Friendship figleaf is roughly the “assertion of a fondness for the group attacked”.¹⁹³ This can happen through claiming to have a good relationship with the group, or in this case if Gold spoke about her good relationship with fat people in her life. Instead, I want to offer the possibility that Gold’s very identity as fat can achieve this same effect, whether it is intentional or not. The inference can be made that if a fat journalist is condemning Nike for promoting obesity, then their condemnation must be a fair assessment since it is unintuitive to imagine that someone would harm themselves in this manner. This works even despite the usage of stigmatizing language that might signal a highly subjective, biased, and self-loathing attitude in Gold’s work.¹⁹⁴

¹⁹¹ Polianskaya, Alina. “Weighty Issue: Nike slammed for ‘normalising obesity’ with plus-size mannequins in their London store.” *The Sun*. (2019). Taken from: <https://www.thesun.co.uk/fabulous/9261213/nike-sparks-debate-after-introducing-plus-size-mannequins-to-london-store-as-some-say-theyre-normalising-obesity/>. July 3, 2020.

¹⁹² Saul, “Fikleaves,” 103

¹⁹³ Saul, “Fikleaves,” 104.

¹⁹⁴ Note that Tanya Gold has a history of writing articles where she is grappling with yo-yo dieting and has been actively at war with her body, swinging between fat acceptance and fat critical since at least 2008.

Synchronic figleaves of these types are particularly obvious in cases where non-medical professionals use the health-based arguments against fat that are promoted and disseminated by public health and the medical industry. As we saw in Chapter 1, the *OIC* report uses language that directly conflates body size and health (such as using obesity as a descriptor for health status) and recommends restrictive diets despite evidence that such diets backfire, are correlated to bingeing and weight regain,¹⁹⁵ and cause psychological damage even in the case that weight loss is a byproduct of the restriction. These recommendations pave the way for the impression that weight loss is 1) positive, and 2) achievable with the right individual behavioural change. This borrows directly from healthist ideology, inadvertently reinforcing the idea that people exist in fat bodies because of a flaw in self-control or discipline. AOPH thus maps out a successful, convincing, and derailing objection to fat that does not have to rely on subjectivity or aesthetic objections.

4.3.2 Tier 2 anti-fat figleaves – concern trolling and doctor-patient dynamics

The second level of anti-fat figleaves that occur are characterized by the idea that there is a benevolence or concern underlying anti-fat policies, speech, or behaviour. While these can be either synchronic or diachronic figleaves that take the form of concrete speech acts as well, they differ from the previous section in that they begin in the medical sphere between doctor and patient where doctors' credibility is bolstered by their expertise.

An examples of this level of anti-fat figleaf can be seen in the oft-cited experience by fat people who are weighed and given diet or weight-loss advice regardless of their purpose for their doctor visit. In this situation, the doctor's recommendation for weight-loss is the weight-stigmatizing act, while the nature of the relationship between patient and doctor acts as the figleaf that obscures the stigmatizing nature of this behaviour. Take Kai Hibbard, former Biggest Loser competitor as an example. It took cycling through multiple doctors to get to the bottom of her symptoms of swollen, painful joints and persistent fever, as she states in a conversation with Registered Dietician Christy Harrison, before one investigated further than her bodyweight. Finally, Hibbard was diagnosed with rheumatoid arthritis.¹⁹⁶ Despite this autoimmune disease's weak correlations to body size,¹⁹⁷ her

¹⁹⁵ Polivy, Janet, and C. Peter Herman. "Dieting and bingeing: A causal analysis." *American psychologist* 40, no. 2 (1985): 193.

¹⁹⁶ Harrison, Christy, host. "Healing from Weight Stigma and Diet Culture with Kai Hibbard, 'Biggest Loser' Contestant Turned Anti-Diet Activist." *Food Psych* #133 (podcast). December 4, 2017. <https://christyharrison.com/foodpsych/5/tag/kai+hibbard>.

¹⁹⁷ Stavropoulos-Kalinoglou, Antonios, et al. "Obesity in rheumatoid arthritis." *Rheumatology* 50, no. 3 (2010): 456.

weight alone was repeatedly targeted before her eventual diagnosis, followed by recommendations to lose weight in order to decrease her then unexplained symptomology.¹⁹⁸ Through the medical system's tunnel-vision focus on her BMI, and the fact that her BMI fell into the obese category, her care suffered and she spent years with untreated, undiagnosed, and advancing rheumatoid arthritis that could have been treated and slowed. This experience is, unfortunately, not uncommon especially in reference to fat women navigating healthcare.¹⁹⁹

This behaviour is discriminatory, but goes unnoticed. While doctors certainly do have expertise and are appropriately afforded credibility regarding matters of medical intervention, it is the over-inflation of this credibility that has the potential to cause harm, especially when the doctor is acting in accordance with weight-stigmatizing medical convention. The principle of beneficence associated with one's status as a doctor,²⁰⁰ as well as a societal tendency to elevate their medical authority to an over-inflated, all-encompassing authority, acts as a figleaf and conceals weight-stigmatizing behaviours from doctor to patient. A doctor need not use an utterance or overt statement to figleaf their discriminatory focus on weight at the expense of the patient's other health conditions, or stigmatizing behaviour of weighing patients and linking their symptoms on weight.²⁰¹ Rather, I assert that the clinical setting and dynamic between concerned doctor and in-need patient acts to obscure the weight stigmatizing attitudes held by the doctor.

Public health approaches the wellbeing of people with a similar kind of benevolence that has the potential to figleaf weight-stigmatizing attitudes and policies. The concept of "concern-trolling" takes this concern and benevolence related to health and uses it in order to oppress. Concern-trolling describes a phenomenon in which the role of the speaker as an ally or at least weight-neutral is preserved despite simultaneously expressing a subtle, or even unintentional moral distaste for the relevant group to which they claim to be neutral about, or an advocate for.²⁰² This moral distaste is disguised as concern, and in the case of fatphobic concern-trolling, concern for the individual's health based on their fatness. This concern takes different forms depending on the social position of the concern-troll. Where it's implicit and rarely overtly stated in the doctor-patient dynamic, and implicit

¹⁹⁸ It's important to note that rheumatoid arthritis cannot be managed through weight loss.

¹⁹⁹ Lee, Jennifer A., and Cat J. Pausé. "Stigma in practice: barriers to health for fat women." *Frontiers in Psychology* 7, no. 2063 (2016): 1-15.

²⁰⁰ The principle of beneficence refers to the moral obligation of a doctor to act in accordance with the benefit of their patient. This definition is taken from Beauchamp, Tom, "The Principle of Beneficence in Applied Ethics", *The Stanford Encyclopedia of Philosophy* (Spring 2019 Edition), Edward N. Zalta (ed.), URL = <<https://plato.stanford.edu/archives/spr2019/entries/principle-beneficence/>>.

²⁰¹ Note that this can be either intentional or unintentional, and most likely the latter.

²⁰² Holi, Ella. "Health concerns and moral distaste- 'Concern trolling' as a moralizing rhetoric." (2019).

in AOPH's claims that fat is an issue of health and wellbeing due to the core philosophy of public health as trustworthy and for the benefit of its people, it is markedly more overtly stated in non-medical, public spheres in order to amplify the implicit concern from medicine and AOPH.²⁰³ In the public sphere, a more explicit statement needs to be made in order to communicate this concern and might come in the form of figleaves such as "I'm just concerned about their health"²⁰⁴ and "it's okay to be fat so long as you're healthy!"

This second level of figleaf differs from the first because it does not rely on overt statements in order to figleaf, and it has a significantly larger focus on benevolence, often from doctors, rather than blame, as is found in Gold's Nike mannequin article.

5.1 Shifting the norms of permissibility of anti-fatness

One of Saul's main concerns with the racial figleaf is its ability to shift norms of permissibility. In the case of anti-fat figleaves, the concern is that repeated use and normalization of anti-fat figleaves results in more and more discriminatory behaviours, speech, and policy. With data confirming that fat stigma is increasing,²⁰⁵ this is a real concern. Next, I will consider how this might take place regarding discrimination against fat people.

5.1.1 How anti-fat figleaves shift norms

The shifting of norms might be taking place as follows. If we agree as a society that health is at least very important if not the most important thing, as posited by Crawford's healthism, and we accept medical professionals and public health's advocacy of weight loss in fat people as necessary for their health, then it is highly likely that social constructions of fatness will be centred around aberration and morally blameworthiness. The two tiers of anti-fat figleaves I discussed in the previous section reinforces this through both overt statements linking fat to health as well as the perceived benevolence of medicine and AOPH. It thus becomes an easier and easier task to justify the rise in disdain and pathologizing fat bodies as well as the person inhabiting a fat body for "choosing" it.

²⁰³ Holi, Ella. "Health concerns and moral distaste-'Concern trolling' as a moralizing rhetoric." (2019).

²⁰⁴ Fabello, Melissa A. "11 Reasons your Phony 'Concern' for Fat People's Health Has Got to Stop." *Everyday Feminism*. (2016). Taken from: <https://everydayfeminism.com/2016/01/concern-trolling-is-bullshit/> July 5, 2020.

²⁰⁵ Pausé, Cat. "Borderline: the ethics of fat stigma in public health." *The Journal of Law, Medicine & Ethics* 45, no. 4 (2017): 510-517.

This shift in finding anti-fat discriminatory behaviour permissible is not a theoretical worry. The normalization of both informal and formal, academic and scientific writing using “war on obesity” vocabulary is suggestive of this escalation that I argue is largely due to the amplification of an anti-fat, healthist medical industry by public health. I will demonstrate in the next chapter why I suggest declaration of a war on obesity might translate to the declaration of war on fat people themselves. Already subjected to systemic discrimination, healthism-espousing, medicalizing AOPH and its ability to figleaf anti-fat sentiment leads to the encouragement of fat people to declare a war on their own body and identity. This is both discriminatory *and* socially acceptable. It is both socially incentivized with punishments for gaining weight and rewards for losing it. That declaring a war on a marginalized group of people is acceptable is thanks to, at least in part, the linguistic phenomenon of figleaves which have offered a way to shift what speech or actions count as discriminatory. In addition, they provide a sympathetic, apologetic justification even for speech that *does* count as discriminatory.

For speech that fails to be figleafed and *must* be interpreted as fatphobic, there is still an opportunity for the speech to be interpreted sympathetically or even as justifiable thanks to the stickiness of the health-invoking figleaf. While accepting the premise that we should not discriminate solely based on body size, and in the presence of irrefutable evidence that someone is advocating for it, one still has an out that allows them to agree with the biased speaker and at the same time preserve the Norm of Weight-Neutral Equality in themselves. They do this by interpreting anti-fat discrimination, especially in reference to particular fat people, as attributable to non-weight-based factors such as character, self-control, or work ethic. In the process, the individual can enact and perpetuate anti-fat attitudes and behaviours even while accepting that fat people should not be discriminated against on the basis of their body size alone. This allows for at least partial agreement with the overtly discriminatory statement or behaviour that has failed to be figleafed.

This phenomenon is useful in describing what Saul takes to be a large part of the problem of social inequity: individuals who believe in the fair and equal treatment despite race (or other identity attributes such as disability or body size) but continue to hold and enact racist (or ableist, or fatphobic) behaviours and actions, supporting the oppressive structure disadvantaging on the basis of race (or ability, or body size) but failing to recognize race (ability, body size) as the actual locus of discrimination. This effect is seen in matters of fat and body size too; the individual who is fat is thought to have chosen to be or continue to be this way and is blameworthy for their condition. Arguably, the disadvantages fat people face are seen to be due to a body of negative character traits of

which larger body size is just one symptom. This is distinct from matters of race-neutral norms of racial equality who do not (presumably) point to race to be a symptom of bad character, but rather the reverse (that poor character may be a symptom of their racial ethnicity for biologically essentialist reasons or otherwise). Thus, we can take the two views everyone should be treated fairly despite their ethnicity or weight, but still hold that fat people, at least in some ways, deserve the difficulties they face. And in this way, increases in the permissibility of fat discrimination are advanced, with anti-obesity public health paving the way.

5.2 Chapter 2 conclusion

I have shown in this chapter that a deeply ingrained healthism underlying the medical industry is amplified by public health and specifically AOPH using strong linguistic strategies that ease the acceptability of their anti-fat bias and content. AOPH thus provides an avenue through which the discrimination against fat people is advanced, creating new anti-fat attitudes and resulting in the increasing permissibility for anti-fat actions and nationwide policy to be implemented, encompassed by the spirit of the phrase “The war on obesity”. While it is not only healthism that poses a problem for fat justice, healthism’s interaction with other factors such as the bolstered credibility and social standing of doctors, that solidify AOPH’s position on fatness as a major barrier to FAMS in its ability to cover up and create new anti-fat attitudes and avenues of discrimination. Medicalization of fat bodies and its connection a healthist backdrop is helpful in demonstrating why it is simultaneously unproblematic to care about health and wellbeing, while still disagreeing with the excessive medicalization of bodies that end up creating a hierarchy of what’s important in every day life (pathologically prioritizing a certain idea of health, for example).

Chapter 3

AOPH as an eradicating force and the effects on fat identity

1.1 The third function of Canadian anti-obesity public health – shaping and eradicating fat identity

This last chapter examines how Canadian anti-obesity public health, through its *distraction* (from Chapter 1) and its *covering up* of anti-fat attitudes/policy through amplification of fig leaves (from Chapter 2), works to *eradicate* fat identity. Recall that in chapter 1, I used a case study of the latest *Obesity In Canada* report in order to show that AOPH in Canada over-emphasizes the detrimental effects of fatness, which I take as representative of the general attitude towards fatness. The *OIC* and AOPH more generally often draws upon data that ignores confounds and prioritizes a focus on body size over mental and physical health status. In chapter 2, I continued to critique AOPH using the *OIC* report as a case study. I argued that the West's healthist backdrop cultivates an environment in which confirmation of evidence that fat is unhealthy and therefore objectionable is more readily accepted by both the public and the medical industry than evidence on the contrary. I argued that language plays an important role in this confirmation; namely that the use of medicalized, disease language and speech acts to refer to fat bodies is figleafed by a Western healthist backdrop where the public justifies anti-fat attitudes and language through invoking health (the first tier of anti-fat figleaf) and the medical industry perpetuates anti-fatness through the very nature of the doctor-patient benevolence dynamic (the second tier of anti-fat figleaf). AOPH interacts with this healthist backdrop, disease language and anti-fat figleaves to disseminate their information, as evidenced by the *Obesity in Canada* report and anti-fat public health initiatives contained within it.

In this final chapter, I aim to show how this theme of distraction and covering up of anti-fatness, amplified by AOPH, works towards the goal of eradication of fat people. Specifically, I will show how AOPH's goal of eradication not only detrimentally shapes, but disrupts full formation of a coherent, fat-accepting group identity, ultimately positioning fat people against themselves such that the war on obesity becomes a war on fat people themselves. In the next section, I will explain what I mean by 'fat identity'. In section 2, I will exposit a particular case of one author's experience in forming a fat (-positive) identity in order to suggest that fat can be seen as more than an apolitical body trait, but a cohesive group identity. In the remainder of section 2, I will show how a formal account of marginalized identity formation can be applied in the case of fat identity, unpacking each

stage and the ability for a fat individual to move through each stages. I will show how each stage of identity development maps onto the stages of fat identity formation and the ways in which AOPH might disrupt or keep people rooted in particular stages. In section 3, I show how AOPH's treatment of fatness as a thing to remedy is analogous to historical treatment of disability as something to 'cure'. In doing so, I suggest that there is something particularly objectionable about AOPH's treatment of fatness as it targets fat as a marginalized group identity. Lastly, in section 4, I argue that the eradication of fatness through AOPH's efforts is epistemically disadvantageous to society using an analysis of what makes for an epistemically healthy community.

1.2 Important terms

By 'fat identity', I'm referring to 1) one's recognition of their fatness as a quality that contributes significantly to one's sense of self and identification with other fat people, and 2) that this recognition and identification as rooted in acceptance or positivity. This is an important piece of nuance surrounding the terms "fat identity". It could be argued that fat identity consists of the simultaneous state of acknowledgement that one is fat and that this contributes significantly to one's sense of self, as well as attempting to shed this piece of their self that they internalize as unacceptable and objectionable. When I speak of AOPH as detrimental to fat identity development, I am suggesting that AOPH negatively effects development of fat-positive, or fat-acceptance identity development in which the fat person is free to occupy a larger body without trying to change or make up for it.

I will now move on to Cat Pausé's argument in which she establishes the idea of fat as an identity, as well as 'coming out' as fat in much the same way one can come out as gay, trans, or disabled.

2.1 Fat as an identity (not just a quality)

In Pausé's 2012 autoethnographical paper *Live to tell: Coming out as fat*, fat is presented as a marginalized identity. This is done through the telling of Pausé's own personal story, as per the autoethnographical method. Pausé frames fat as a marginalized identity that is distinct from that of literature cited in my previous chapters, in which fat is either considered by medical professionals a condition that poses health risk to the individual, or at the very least an undesirable aesthetic quality due to its association with certain negative character traits. In *Coming out as fat*, Pausé goes further to argue for the application of "coming out" as fat as an identity due to its similarity to other marginalized group identities such as LGBTQ+ identities. The concept of "coming out" in reference to LGBTQ+ identities and as applied by Pausé to fat as an identity, entails the process of "declaring

and embracing a[n] identity, which opens the opportunity to have [one's] body read in new ways, on [one's] own terms",²⁰⁶ embracing one's physicality "while throwing off the stigma attached by the dominant culture."²⁰⁷ Thus, coming out as fat is an attempt to reclaim one's body and identity while renouncing the stigma attached to having a larger body size.

Her paper demonstrates the need for a more comprehensive model of fat identity formation, outlining the problems with existing identity formation models through the telling of her own story and experience of fat.²⁰⁸ These include the failure of gay and lesbian, feminist, and ethnic identity models of group identity development to sufficiently address all the key aspects of, and variation involved with coming out as a marginalized or non-dominant identity. These models, according to Pausé are insufficient for those identities and are therefore also flawed accounts when applied to fat identity. Such current models portray coming out and identity formation as linear and often disregard context such as relationships and other aspects of social embeddedness in the process. Moreover, Pausé notes that these models fail to acknowledge stigma as a constant process of management, and that this management looks different depending on the different intersections of non-dominant identities in each individual.²⁰⁹ Next, I will address the reasons why fat can be considered an identity, including the markers of stigmatized identities as they apply to fatness as well as strategies with which Pausé references the stigma associated with fat identities tend to be managed by the fat individual.

2.1.1 Components of stigmatized identities

According to Pausé, fat can be framed as an identity, and particularly a stigmatized identity, because it has the four components of stigmatized identities more generally. These are "labelling differences, associating stereotypes, 'Us' vs. 'Them', and discrimination."²¹⁰

Briefly, these translate to fat identities as follows. Firstly, labelling differences comes with the sociocultural context in which thin bodies are the norm and fat bodies are visually divergent from this norm. Secondly, associating stereotypes can be demonstrated through social narratives connecting fat with traits such as "ugly, sloppy, lazy, asexual, socially unattractive, sexually inactive, undisciplined, dishonest, less productive, and... out of control".²¹¹ Pausé notes from her personal experience that

²⁰⁶ Pausé, Cat. "Live to tell: Coming out as fat." *Somatechnics* 2, no. 1 (2012): 45.

²⁰⁷ Pausé, "Coming out as fat," 44.

²⁰⁸ Pausé, "Coming out as fat," 53.

²⁰⁹ Pausé, "Coming out as fat," 53.

²¹⁰ Pausé, "Coming out as fat," 45.

²¹¹ Pausé, "Coming out as fat," 45.

friends have reassured her that she is not fat despite her self-identifying that way, but that what they really mean with this reassurance is that they do not associate her with those negative stereotypes.²¹² Thirdly, ‘Us vs. ‘Them’ is evident most basically from the unavoidable visibility of fatness and the distinct difference between a slender and a fat body. Lastly, fat people are discriminated against in that they are structurally disadvantaged. Pausé demonstrates this aspect through reference to the tendency for fat people to have lower income in comparison to their ‘normal’ weight counterparts, inferior access to housing and medical treatment, poorer well-being, barriers to and within education,²¹³ and her personal experience being denied a residency visa to New Zealand due to her health status as indicated by her body mass index.²¹⁴

Next, I will outline the next piece of evidence that establishes fat as an identity, and particularly a stigmatized identity through reference to stigmatized identity management strategies as applied to fat individuals.

2.1.2 Fat identity management behaviours

Another piece of evidence that fat is a stigmatized identity comes from data showing that fat people engage in identity management behaviours surrounding their status with a larger body size. It is certainly possible that identity management can be practiced without serious negative impacts to the individual doing the managing, as is the case for a variety of non-marginalized aspects of one’s identity (such as one’s identity as a dog owner, for example). The kind of identity management fat people must perform, on the other hand, is in fact burdensome in that fat is stigmatized. Managing this stigma means doing work to shield oneself from the consequences of this stigma. Borrowing from Goffman, Pausé cites three types of identity management behaviours in which fat people engage: covering, withdrawing, and passing.²¹⁵

‘Covering’ in fat identity management involves behaviours that attempt to mitigate the discomfort caused by society’s reaction to their stigmatized identity. Pausé uses examples of fat people who are (publicly or privately) on diets or exercise regimens in order to minimize judgment on their bodies through practicing weight-control behaviours and pursuit of weight loss to prove they’re attempting to

²¹² Pausé, “Coming out as fat,” 45.

²¹³ Pausé, “Coming out as fat,” 46.

²¹⁴ Pausé, Cat. "Frozen: A fat tale of immigration." *Fat Studies* 8, no. 1 (2019): 45.

²¹⁵ Pausé, “Coming out as fat,” 46.

‘fix’ the ‘problem’.²¹⁶ Covering can also take the form of fat people accepting inferior societal treatment and regard, often due to internalized beliefs that they deserve their maltreatment on the basis of their body size or character related to their fatness.²¹⁷

Next, Pausé cites ‘withdrawal’ as a key identity management behaviour. This includes avoidance behaviour where fat people remove themselves from the aspects of society that harm them. This can look like cancelling or avoiding medical appointments, withdrawing from friends and family, or abstaining from physical activity or spiritual activities.²¹⁸

Lastly, fat people engage in ‘passing’ identity management behaviour. Passing occurs when, as the result of behaviour employed by the marginalized individual, the dominant crowd recognizes the stigmatized individual, who has successfully blended into the dominant crowd, as part of the dominant crowd. She uses the example of lighter-skinned Black people who can “pass” as white (through light-skinned Black people keeping silent about their ethnicity or even participating in skin lightening cosmetic strategies), gay and lesbian people who can pass for straight (by concealing their sexual orientation), or HIV positive people who can pass as HIV negative (by not revealing this part of their identity). Passing can occur with individuals with a fat identity, according to Pausé; this happens when fat people lose weight and shift from occupying a large body to a smaller body, average or thin body. While fat individuals might engage in covering behaviours such as weight-loss behaviorus to get to this smaller body size, passing occurs when a once fat person becomes integrated into thin culture and disengages from their association with their previously fat body. It is interesting to note, however, that Pausé emphasizes individuals who lose weight still maintain their stigmatized fat identity even after weight loss takes place. Despite the residue of internalized fat identity in these individuals, they are not interpreted by the dominant (non-fat) culture as fat, and their complicity in distancing themselves from their once-fat state can be interpreted as passing.²¹⁹

Thus, Pausé provides good evidence that fat is not only an identity, but a stigmatized identity with which fat people are forced to negotiate in order to move through the world unscrutinised, and as effortlessly as their thin counterparts. Her own experiences of identity formation and management support work done by authors on other stigmatized identities, as well as her assertion that coming out

²¹⁶ Of course, individuals who are not intentionally engaging in covering might perform this behaviour. Whether it’s intentional or not, a fat body that is attempting to lose weight and exhibits these behaviours is viewed more favourably by society who finds fat bodies objectionable.

²¹⁷ Pausé, “Coming out as fat,” 48.

²¹⁸ Pausé, “Coming out as fat,” 48.

²¹⁹ Pausé, “Coming out as fat,” 47.

is an important way in which fat people can reclaim and reshape their identity without adopting the stigma that comes with living in a larger body. Through her academic approach to fat activism, social media use,²²⁰ her reclaiming of the word fat via self-identification as such, adornment of a favourite necklace that reads “fat”,²²¹ and her request to be paired with a fat child in a volunteer mentorship program, Pausé demonstrates her own journey through not only adopting a fat identity, but reconstructing it as a fat-positive identity through coming out. She notes that her experience is just one of many possible journeys and that there is a need for a comprehensive fat identity development model that current literature lacks.

Having suggested that fat can be seen as an identity itself and not a medical or apolitical aesthetic trait through Pausé’s autoethnographical work as a fat person herself, I will next examine what I think is a promising model for the stages stigmatized identity formation as applied to fat identity. I will outline these stages and how I propose they relate to fat identity formation

2.2 Fat as a marginalized identity – stages of development

Carmen Salazar & Lyndon Abrams outline a model of marginalized identity formation with specific reference to racial as well as other socially marginalized identities such as sexuality and gender.²²² This model is referred to as the Racial and Cultural Identity model (R/CID model) and involves progression through 5 stages. These are ‘conformity’, ‘dissonance’, ‘resistance and immersion’, ‘introspection’, and ‘integrative awareness’. It is noteworthy before I begin to outline these stages of identity formation that the R/CID model is vulnerable to Pausé’s concerns about current popular identity formation models. Specifically, R/CID oversimplifies formation such that it portrays a linear progression through the stages and makes inadequate reference to social context and embeddedness, such as relationships and other social aspects of one’s embeddedness. However, this model, which originated from Sue & Sue’s 1999 work, is being presented by Salazar & Abrams with a special emphasis on the intersection of multiple identities, some of which are combinations of dominant group identities (such as whiteness) with marginalized identities (such as disability).²²³ The authors state that “racial or ethnic identity is not experienced the same by each group, nor is identity development in other cultural groups... the same as ethnic or racial identity,” but that the aim of the

²²⁰ Pausé, “Coming out as fat,” 49.

²²¹ Pausé, “Coming out as fat,” 51.

²²² Salazar, Carmen F., and Lyndon P. Abrams. "Conceptualizing identity development in members of marginalized groups." *Journal of Professional Counseling: Practice, Theory & Research* 33, no. 1 (2005): 51.

²²³ Salazar & Abrams, "Conceptualizing identity development," 49.

article is to focus on “common themes in the experiences, attitudes, and beliefs of members of marginalized groups.”²²⁴ I will thus utilize the structure of this model to outline what I believe is a potentially oversimplified, but useful, trajectory of fat identity formation to suggest the ways in which AOPH and its objective to eradicate fat identity take place along the way. In outlining the stages, I will briefly examine the stages of formation of just one axis of marginalization: fat identity.²²⁵

2.2.1 Conformity

To begin, the first stage of marginalized group identity formation is ‘conformity’. This entails firstly the internalization of the dominant group (be it whiteness, or straightness, for example) as superior or default, and secondly internalization of negative cultural narratives about one’s own marginalized group.²²⁶ While the negative consequences on the individual with the marginalized identity of this stage are evident, often accompanied by shame and distancing of oneself from the rest of the non-dominant group, the authors note that this stage can also be protective in environments in which being proudly part of one’s marginalized group is dangerous; through conformity and suppression of painful emotions associated with being stigmatized, Salazar & Abrams assert that members of a marginalized group can reduce their risk of targeting by the dominant group.

This stage of fat identity development is demonstrated by the many tendrils of diet culture, specifically in the West. Thinness as aesthetically and ethically superior are evident in multiple overlapping spheres of society. This is exemplified by cultural themes of striving for purity through restriction (of food through fad diets and cleanses) or Crawford’s analysis of contemporary healthism and a strong cultural aversion to the potential-sick role. A societal preference for thinness over fatness is present. Pausé writes about her experience in this conformity stage, often hallmarked by weight control behaviours shared by Goffman’s ‘covering’ stage of identity management, such as restrictive dieting and exercise for the purpose of weight loss. These behaviours are assimilatory in nature and all have in common the desire for the fat person to either shed their fatness or exist in a perpetual state of attempting to shed their fatness. This stage could also be characterized by neglect for their physical and mental wellbeing, such as avoiding medical appointments in which they might experience discrimination that could jostle them out of the conformity stage.

²²⁴ Salazar & Abrams, "Conceptualizing identity development," 49.

²²⁵ While it’s important to take into account the intersection of other marginalized identity in a single individual, this aspect is beyond the scope of this chapter.

²²⁶ Salazar & Abrams, "Conceptualizing identity development," 51.

2.2.2 Dissonance

The next stage is ‘dissonance’ in which, either gradually or suddenly through marked historical events, an individual is made aware of the injustice they or others like them face. An example of this is the killing of Trayvon Martin by police in 2012 that sparked national recognition of the Black Lives Matter movement. Salazar & Abrams assert that this dissonance can look like, “This is racism, this is sexism, this is homophobia. Why should I feel ashamed of who I am?”²²⁷ and can be accompanied by the physical or emotional distancing of oneself from the environment in which the conformity state was maintainable.

The dissonance stage with respect to fat identity is complex. Before I draw comparisons to fat dissonance, consider once more the conformity stage and how one might move on to dissonance. I assert that the conformity stage, and in particular the weight-management behaviours that accompany it, function to preoccupy the individual and keep them stuck in the conformity stage. Recall, for example, that dieting behaviours are shown to be significantly correlated with bingeing and a heightened preoccupation with food.²²⁸ Food preoccupation, food and body measuring, food and body monitoring behaviours, regimented exercise or meal plans to achieve a caloric deficit, and the mental and physical exhaustion that go into those weight-management behaviours are taxing.

If these measures seem over-exaggerated or extreme, take, for example, intentional weight loss through AOPH-recommended parameters. From the Canadian Government’s *Obesity in Canada* report, recommended measures include behaviours such as increased exercise, caloric deficit, and dedication to one-on-one therapy to treat obesity-related behaviours from a mental illness perspective. This might look like therapeutic intervention to treat obesity from a food addiction framework, binge-eating disorder framework, or simply therapeutic intervention to help individuals refine their willpower to prevent emotional eating, in which one uses food for emotional comfort.²²⁹ This is in addition to the potential exercise, restrictive diet and other forms of therapy or mental health support that an individual may already be implementing. Even these basic recommendations result in the consumption of a significant portion of one’s cognitive capacities. Disability scholar Anna Mollow

²²⁷ Salazar & Abrams, "Conceptualizing identity development," 52.

²²⁸ Polivy, J., & Herman, C. P. (1985). Dieting and bingeing: A causal analysis. *American Psychologist* 40, no. 2, 193–201.

²²⁹ Others have argued elsewhere for the recognition of emotionally-based eating as benign and unfairly linked to unhealthiness, such as registered therapist Judith Matz, registered dietician Christy Harrison, and activist Virgie Tovar.

(2015) writes her own experience of dieting and the suffering involved, which reflects the testimony of many others:

During my graduate school years, I wore a size zero and performed heterosexuality at full force. For me, heterosexuality was not conducive to Butlerian resignification; like dieting, it always hurt. Of course, sexuality and size are not exactly analogous: although some lesbian or gay people do [claim identities as] straight or bisexual and lead happy healthy lives, dieting is miserable for pretty much everyone.²³⁰

She goes on to write that she restricted her food to avoid gaining weight and becoming fat. She notes that the term “restriction” sounds clinical and objective, but that “[i]t’s not. Hunger is pain... To ask someone to diet – and, worse, to call a diet a “permanent lifestyle change” – is to ask this person to consent to a life of permanent pain.”²³¹ This testimony provides one of many examples of people’s experiences surrounding the pain, suffering and preoccupation with food and body image on individuals pursuing intentional weight loss. This is true of the extreme end of the dieting spectrum that approaches eating disorders, but is also true of the measures prescribed by AOPH, and specifically the *Obesity in Canada* report. With so much of one’s cognition and emotional capacity dedicated to the task of weight management, there is less left over to invest in questioning the initial assumption that weight is something that must be managed. Moreover, it’s unlikely people will be able to navigate thoughts of questioning the discrimination they face. Recall that this is because the conformity stage is hallmarked by internalization of the blame accompanied with one’s marginalized identity. This makes it difficult to recognize discriminatory treatment as unjust, let alone question one’s behaviour patterns that aim to remove oneself from line of fire, so to speak, through pursuit of intentional weight loss.

2.2.3 Resistance and immersion

Next, Salazar & Abrams posit the ‘resistance and immersion’ stage. Strong emotions arise in this stage as a reaction to the acknowledgement of discrimination against oneself and others like oneself.²³² While the authors do not state this directly, there is a sense that the individual experiencing this stage recognizes more clearly the group to which they belong that is the target of discrimination. Interestingly, a common emotion in this stage is that of shame. Salazar & Abrams explain that shame

²³⁰ Mollow, Anna. "Disability studies gets fat." *Hypatia* 30, no. 1 (2015): 210.

²³¹ Mollow, "Disability studies gets fat," 210.

²³² Salazar & Abrams, "Conceptualizing identity development," 52.

is associated not with being part of the marginalized group but a kind of remorse that for their previous state of conformity in which the individual internalized and accepted negative stereotypes and narratives about the dominant group's supremacy. Where one's stigmatized identity was disconnected from one's sense of self, this stage brings a sense of pride and openness about their identity. Oftentimes this stage includes the immersion of oneself into the culture targeted by discrimination.

This stage is embodied by the existence of fat liberation groups and demonstrations. An early example of this can be seen as follows²³³:

Like any good countercultural movement from the 1960s, [fat liberation's **National Association to Advance Fat Acceptance (NAAFA)**] started with a sit-in. Or, rather, a "fat-in." In 1967, 500 people came together in Central Park in New York City to protest bias against fat people. Together, this group ate, carried signs of protest, burned diet books and photos of model Twiggy, and were visibly, publicly, and loudly fat without being apologetic. And that same year, a man named Llewelyn "Lew" Louderback wrote an article for the Saturday Evening Post titled, "More People Should be FAT," in response to the discrimination his wife faced. This was one of the first public defenses of fatness in the mainstream.²³⁴

Not only do these groups and demonstrations embody the resistance aspect of this stage of identity formation, but the immersion aspect is also embodied through the shameless embrace of fatness and displays of solidarity evident behind the organized gather of groups of fat activists for such events.

2.2.4 Introspection & Integrative awareness

The fourth stage is 'introspection', in which the individual is focused inward on trying to reconcile their entire identity to accommodate their new embrace of a stigmatized identity. Specifically, the authors describe it as a struggle to reconcile "values of my group [that] I wish to retain and [the] values from [the] majority culture I wish to embrace".²³⁵ One's sense of self is still somewhat in flux as one struggles to find a way to hold their stigmatized identity and the pain that it brings while still existing in a world that stigmatizes it, unwilling and/or unable to return to the conformity stage to do so. Lastly, Salazar & Abrams assert that individuals go through 'integrative awareness'. This stage is

²³³ Note that not all individuals who enter the 'resistance and immersion' stage do so through public demonstration and/or activism, but that this is one particularly obvious way for it to manifest.

²³⁴ Gerhardt, Linda. "The Rebellious History of the Fat Acceptance Movement." *Center for Discovery: Eating Disorder Treatment*. 2019. <https://centerfordiscovery.com/blog/fat-acceptance-movement/>.

²³⁵ Salazar & Abrams, "Conceptualizing identity development," 53.

the result of successfully finding a way to reconcile one's marginalized identity proudly while continuing to exist in the world and a whole, complete sense of self is secured.²³⁶ This stage is marked by a sort of critical consciousness that the authors note is draining and a possible cause of burnout, especially as it pertains to the individual's drive to work towards activist goals for social change.

These final two stages can apply to individuals who, in Pausé's words, 'come out' as fat, where self-identification with a fat identity is finally rooted in fat positivity or acceptance. These two stages of introspection and integrative awareness take place in the context of a society that believes fat is unhealthy, that unhealthy is unacceptable, and that it requires the individual to navigate through what parts of a healthist culture they wish to reject, such as the idea that weight loss is always good, and what parts they wish to retain, such as the idea that health and wellbeing is generally important. These two ideas (that rejecting that fat is objectionable because it's unhealthy and that health and wellbeing are generally important) need not be in tension, because one can be fat and healthy without focusing on weight. However, the current framing of the scientific debate, from chapter 1, positions them against one another.

2.2.5 Moving through the R/CID stages

From my discussion of conformity and dissonance stages, I will now discuss the problems that AOPH, as evidenced by the *OIC* report, poses to fat people moving through the stages of a fat identity formation. Specifically, the difficulty in moving from the conformity stage to the dissonance stage requires special attention in the formation of fat identity.

This is because AOPH's guidelines and recommendations for weight management are, I argue, conducive to keeping fat people rooted in the conformity stage: keeping them busy, body and food preoccupied, exhausted, and unable to notice or question the discrimination they face based on their fatness. As stated in 2.2.2, individuals who move on traverse the boundary from conformity to dissonance must do so with an immense social, as well as personal, disadvantage. Even then, once in the dissonance stage, fat people must maintain this dissonance through justification of their body size and health status to themselves and potentially others, including friends, family, acquaintances, colleagues, and healthcare professionals. They must choose to question the assumption that their body is wrong and do so amidst pervasive messages from medicine and public health that fat is deadly and weight loss is imperative. This poses an additional barrier to fat identity formation; thanks to this uphill battle through the first two stages of identity development, is potential return to the conformity

²³⁶ Salazar & Abrams, "Conceptualizing identity development," 53.

stage. This might occur as a result of failed attempts to continue to question the assumption that fat is objectionable on the basis that the weight science is imbued with convention that supports this conclusion as well as the institutionalized discrimination fat people face at work, school, or the doctor's or therapist's office. When faced with the backlash of accepting one's fat body and objecting to the pressure to change it (both from scientific sources as well as other societal avenues) it is conceivable that maintenance in the dissonance stage is impossible. Moreover, the stability that accompanies a return to the conformity stage might be preferable or even inevitable in light of this pressure.

While the purpose of this chapter is not to argue in favour of a particular model of fat identity formation, it is important to accommodate the possibility that progression through the stages are nonlinear, even containing regressions to earlier stages. In addition from blocking movement from conformity to dissonance, AOPH also risks imposing barriers to full identity formation across the remaining three stages for similar reasons. Just like for conformity and dissonance, it does this through conflation of body size and health status as well as the over-emphasis of a certain concept of health (for example thin) as morally superior. AOPH's function, through their goal to manage and ultimately eradicate fat bodies ends up threatening, slowing or diminishing formation of and identification with fat as a marginalized group identity.

Recall that like public health more generally, anti-obesity public health in Canada has objectives rooted in the promotion of health and wellbeing of its citizens. It is thus concerning that AOPH pushes the targeting of fat people not in order to help them manage the harm they incur, but to target them in order to make them not fat, or less fat, both on a personal, individual level as well as a public, structural level. This sentiment agrees with the "war on obesity" mindset endorsed by the very same scientists and researchers quoted by Canadian AOPH in the OIC report, making clear that their attempt to eradicate fatness is akin to an attempt to eradicate fat people. In a context where fat is closer to an identity than to a condition inflicted upon someone's body, to declare a war on obesity is closer to declaring a war on a person, or group of people.

To support my assertion that, because fat can be framed as a marginalized identity, the war on obesity taken on by AOPH is effectively a war on fat people, I will draw from disability scholar Anna Mollow on the similarities between historical outlooks on disability as something to treat or eradicate and current scientific discourse on fatness as something to treat and eradicate.

3.1 Disability and fatness

AOPH organizations and literature, such as the *OIC* report, is clear in its objective to prevent, reverse, or otherwise manage obesity. This is primarily a goal surrounding body size and how we can change or decrease it on average in the population. This objective survives in part due to the correlations between larger body size and incidence of certain illnesses such as cardiovascular disease. While confounds such as weight cycling and weight stigma can account for this correlation, the most immediate causal link, as interpreted and presented by the *OIC* report, is to body weight. Thus, AOPH's goal to decrease the population's body weight is to decrease this incidence of illness and improve public health. I have shown that AOPH causes harm in the process of this goal as it 1) oversimplifies and misrepresents the weight science as well as 2) increases discrimination against fat people through amplification and perpetuation of healthism, medicalization, and the language associated. These two functions of harm position AOPH against fat acceptance movements which, among other things, aims to advocate for and decrease discrimination against fat people.

In the first half of this chapter, I have shown that fat is a marginalized identity, the formation of which can follow a similar trajectory to other marginalized identities (through the stages of R/CID). I have also shown the ways in which AOPH's objectives impact, disrupt and confuse fat identity formation and that this is a problem that leaves fat people in a constant state of fighting or internalizing their oppression with no way to reclaim that identity. In the last section of this chapter, I will demonstrate why AOPH's objective to prevent, shrink and manage fat bodies makes not just individual fat people worse off, but society more generally. The war on obesity becomes a war on fat people both because it blocks identity-formation for an already marginalized group and because, in its attempt to eradicate fatness, it eliminates an important social perspective, leaving both fat studies and society epistemically disadvantaged.

Mollow's 2015 article centres on what she refers to as "setpoint epistemology" (SE). This is the hybrid between sitpoint (a variation of standpoint) epistemology and setpoint theory. Standpoint epistemology embodies the idea that "the perspectives of subordinated social groups have an epistemic advantage regarding politically contested topics related to their subordination, relative to the perspectives of the groups that dominate them."²³⁷ On the other hand, setpoint theory refers to an increasingly supported scientific concept of a genetically predetermined bodyweight range that each

²³⁷ Anderson, Elizabeth, "Feminist Epistemology and Philosophy of Science", *The Stanford Encyclopedia of Philosophy* (Spring 2020 Edition), Edward N. Zalta (ed.), URL = <https://plato.stanford.edu/archives/spr2020/entries/feminism-epistemology/>.

of us have, and that our bodies adjust to stay within.²³⁸ SE takes it that fatness can be seen as a form of disability, where disability is characterized by oppression imposed by sociopolitical dimensions rather than “individual defect”.²³⁹ In the article, Mollow outlines ways in which fatness, its associated stigma, and the social and medical forces attempting to “cure” them are structurally similar to historical and contemporary disability, ableism, and the idea of curing our population of disability.

3.1.1 Accessibility

Firstly, Mollow draws a comparison between fatness and disability in the arena of society’s inaccessible design to accommodate different kinds of bodies.²⁴⁰ Fat bodies, in particular, fail to be accommodated in many aspects of every day life. These include, for example, narrow aiseways, chairs, and doorways. She emphasizes that these are failures in social structures external to individuals who struggle to navigate them, not problems with individuals themselves. This is an important idea in disability studies which emphasizes the need for a more compassionate, universal design of public spaces and institutions in order to recognize that there is nothing ‘less than’ about disabled people, but rather that political, social and environmental aspects of life disadvantage them.

3.1.2 Pity

Secondly, Mollow notes the role of social narratives of pity that occur in both perceptions of disability and fatness. In relation to anti-obesity, she writes that the role of pity is subtle as it’s often “eclipsed by... shaming and blaming” fat people for their fatness.²⁴¹ Through public health-inspired strategies such as the infamous fat and soda taxes (extra fees tacked onto calorie-dense, nutrient sparse foods such as sodas and fast foods), this strategy paints fat people as victims who can’t help themselves and require outside intervention to treat or manage their weight. Mollow flags some leftist feminist communities as vulnerable to this ‘pity’ framing, evident from their critiques and expressions of “concern” for fat people, blaming capitalism or other social structures for the prevalence of fatness rather than the social structures that do harm to fat people.²⁴²

²³⁸ Mollow, "Disability studies gets fat," 199-200.

²³⁹ Mollow, "Disability studies gets fat," 201.

²⁴⁰ Mollow, "Disability studies gets fat," 201.

²⁴¹ Mollow, "Disability studies gets fat," 201

²⁴² Mollow, "Disability studies gets fat," 202.

3.1.3 The stare

Thirdly, Mollow notes the similarity of ‘the stare’ in both issues of disability and fatness. This refers to the objectification and fixation on the physicality of the individual and the pathologizing of their physical traits (whether it’s how they move in the world or other physical traits they might have).²⁴³ “The stare” is effectively utilizes what Noortje van Amsterdam refers to as “dominant discourses on beauty and health [that] co-construct a body hierarchy which positions slender people as the norm (the unmarked position) and fat people as deviant or dissonant (the marked position).”²⁴⁴ One offshoot of this dimension of ‘the stare’ and stemming from the privilege of thin bodies is the “racialized [construction] of “the obesity epidemic”” where, for example, Black and Hispanic people are particularly seen to be at fault or risk of being obese.²⁴⁵ These populations are constructed as “objects of concern, [and] never as subjects with opinions of their own.”²⁴⁶ In the process, harmful social narratives of PoC as lazy or lacking willpower are reproduced, but packaged through health-related concerns of those same traits or behaviours (laziness and lack of willpower) linked to obesity.²⁴⁷ For this reason, the stare in grounding societal treatment of fatness and societal treatment of disability should be taken particularly seriously.

3.1.4 Cure

Fourthly, Mollow notes that like in issues of disability justice, weight-science researchers don’t know how to “cure” their fat subjects of their fatness. The evidence on the long term inefficacy of intentional weight loss is plentiful (see chapter 1 for a more comprehensive literature review). Mollow makes reference to this data, adding in empirical evidence that finds bodyweight to be a highly genetically linked trait rather than a purely behavioural or environmental trait. Despite the inconsistency belying the science that both shows the inefficacy of intentional weight loss but recommends it to every fat person, fat people continued to be reassured that they can achieve weight loss (and thus improved health) if they try hard enough. Mollow notes that this “try harder” attitude bears striking resemblance to a similar attitude in the historical treatment of disability, specifically overcoming polio through optimism and effort.²⁴⁸

²⁴³ Mollow, "Disability studies gets fat," 203.

²⁴⁴ Van Amsterdam, Noortje. "Big fat inequalities, thin privilege: An intersectional perspective on ‘body size’." *European Journal of Women's Studies* 20, no. 2 (2013): 158.

²⁴⁵ Mollow, "Disability studies gets fat," 203.

²⁴⁶ Mollow, "Disability studies gets fat," 203.

²⁴⁷ Mollow, "Disability studies gets fat," 203.

²⁴⁸ Mollow, "Disability studies gets fat," 204.

Not only are researchers unsure how to “cure” their fat patients of their fatness, but their short term recommendations are both harmful and ineffective, according to Mollow. In an attempt to reduce the suffering of fat people, institutions like AOPH only ever gesture at the problem at fat stigma, but unilaterally focus their efforts on how to create sustainable weight loss in the population. This focus on eradication of fat bodies rather than on fixing the social and environmental harms done to fat people by virtue of their fatness is stigmatizing. Mollow uses a quote from Marilyn Wann to drive her point home: “There is no nice, unstigmatizing way to wish that fat people did not eat or exist.”²⁴⁹ This parallel between fat and disability once again points to the war on obesity as a war on fat identities themselves.

3.1.5 Fatness as disability

The similarities between societal and medical handling of disability and fatness is striking. Its similarities are, as supported by Mollow, due to an underlying framework of healthism and medicalization of bodies. One of the aspects tying together disability and fatness is the deeply ingrained cultural narrative of individual agency, or complete control over one’s body, ability, and health. Fat and/or disabled peoples’ very existence challenges this fundamentally healthist idea. Recall that Crawford (1980) posits the idea that one has complete individual control through modification of their behaviours, thoughts and emotions as at the core of healthism, and that this is a strategy meant to ease our anxieties associated with the threat of potential sickness.²⁵⁰ Thus, when fat people exist and continue to exist despite endless pursuit of weight loss or a “cure”, this is extremely anxiety-inducing for a society with implicit, ingrained healthist ideals. This is especially true with respect to SE’s commitment to setpoint theory, which espouses that “neither how much one eats nor how much one weighs is subject to individual control” in the end.²⁵¹

I have shown that there are striking similarities between treatment of disability and treatment of fatness. While cultural narratives have shifted away from “curing” disabilities and it becomes less acceptable to aim to genetically modify individuals to eradicate disability, cultural narratives surrounding fatness have gone the other direction. Rather than acknowledging the possibility of fatness as an identity with a valuable perspective, and one that deserves social protections, a cultural healthist backdrop and the medicalization of fat bodies has resulted in the continued fight against

²⁴⁹ Mollow, "Disability studies gets fat," 205.

²⁵⁰ Crawford, Robert. "Healthism and the medicalization of everyday life." *International journal of health services* 10, no. 3 (1980): 382.

²⁵¹ Mollow, "Disability studies gets fat," 211.

obesity and the doubling down of efforts to shrink fat bodies or prevent them from becoming fat. Fat, like disability, is a core component of identity. This fact grounds talk of the war on obesity as necessarily implying eradication of fat bodies, which in turn frames the war on obesity a war on fat identities. In the next section, I will demonstrate how this war on fat identity results in the epistemic disadvantage of our communities and institutions, borrowing from Carla Fehr's work on the benefits of diversity in scientific communities.

4.1 The fat perspective – importance of diversity

To end this chapter, I will briefly discuss what I see as the most common objection to my assertion that AOPH's goal to eradicate fat bodies and thus fat identity and perspectives is harmful. That is, objectors may assert that regardless of the possible confounds between certain illnesses (such as cardiovascular disease) and fatness (such as weight cycling and weight stigma), decreasing the prevalence of fatness *could* improve overall population health and result in positive overall societal change. While our efforts to shrink fat bodies might be both psychologically and physically harmful and stigmatizing now, the objector might say, it could be a necessary evil before we find a conclusive solution to fatness such that no one needs to be fat, face stigma, or potential increases in health risk.

I think this line of reasoning is incorrect for many reasons, including those posited by authors discussed earlier in this chapter. Firstly, from Pausé's article, fat people have a unique and valuable perspective in society. In fact, from the R/CID model, fatness can be seen as a very real marginalized community with its own developmental process, experience, and culture. Mollow also contributes to addressing this objection in that the same could be argued for the eradication of disabilities, but has been shown extensively in disability studies literature that this is a violent, unjust, and ableist response to disabilities.²⁵² I argue in line with these authors, but with a special emphasis on the epistemic advantage of having diverse, marginalized perspectives as part of academia and society in general. To argue in favour of this emphasis, I will use Fehr's (2011) article, *What is in it for me? The benefits of Diversity in Scientific Communities*.

²⁵² Clare, Eli. "The Restoration of Health." In *Brilliant Imperfections: Grappling with Cure*. Durham, NC: Duke University Press, 2017.

4.1.1 Healthy epistemic communities

In this article, Fehr argues that “it is in researchers’ epistemic interest to take active steps to increase the diversity in their communities.”²⁵³ She addresses scientific communities, and in particular academic departments, asserting that it is in a scientific community’s best interest to increase their gender diversity, as knowledge production is improved as diversity increases. Taking as a basis that knowledge production is a social activity, Fehr shows that a certain approach to diversifying an epistemic community is necessary to maximize a department or community’s output. I will apply Fehr’s framework to other academic communities, as well as non-scientific, non-academic social institutions. Specifically, I will use Fehr’s position as it relates to the value of fat perspectives in academic and non-academic spaces, to demonstrate the epistemic advantages (of inclusion of fat people) afforded to scientific communities, the fat liberation community, and society more generally.

The epistemic benefits of fat perspectives is important to include in juxtaposition to AOPH’s aim to decrease the number of fat bodies and identities in society; not only does this benefit-focused perspective address the injustice surrounding eradication of fatness, but demonstrates the positive value fatness contributes and that we would lack if AOPH, with its current set of goals, is successful. Fehr begins by framing communities, as opposed to single individuals, as centres of knowledge production. It is therefore important that these communities contain many different types of individuals to avoid reproducing the same knowledge and perspective that one individual (or a socially homogenous group) might.²⁵⁴ She draws on Longino’s take on an epistemically healthy community, including the need for “every member of the community [to] be regarded as capable of contributing to its constructive and critical dialogue”.²⁵⁵ Her example of this importance is the contribution of feminist critiques on reproductive science in which feminist philosophers and scientists advanced our understanding of the fertilization process through uncovering unscientific assumptions of female passivity and male dominance that distorted our understanding of the fertilization process. Her point is that through developing a scientific community composed of different genders (as opposed to a homogenous group of white male scientists, for example), gendered assumptions have a better chance of being noticed and corrected. There are numerous

²⁵³ Fehr, Carla. "What is in it for me? The benefits of diversity in scientific communities." In *Feminist Epistemology and Philosophy of Science*, (2011): pp. 134.

²⁵⁴ Fehr, "What is in it for me?" 135.

²⁵⁵ Fehr, "What is in it for me?" 136.

examples of this trend of diversity and the uncovering of bias and advancement of a field as a result of this kind of diversity.²⁵⁶

Similarly, the addition of fat perspectives in bioethics, for example, can uncover certain healthist assumptions or problematic approaches to the treatment of fat people in a given discipline. Recall that Mollow notes the problematic nature of approaches to fat justice that overemphasize or attempt to altogether do away with the topic of health. Rather, Mollow's setpoint epistemology posits that discussions of health are actually *central* to issues surrounding fat justice and liberation. This is not to say that all health-centred approaches to critiquing fatphobia are advisable; Mollow notes that "the fat justice movement has historically extended beyond right-based discourse... [to] [challenge] a wide range of deeply embedded cultural beliefs and practices, many of which pertain directly to the issue of health."²⁵⁷ She goes on to observe that in eliminating health entirely from discussions of fat liberation, we risk ignoring an important dimension of fat discrimination, which is the health-related harm incurred through repeated attempts at weight loss and discrimination faced in the medical industry that disadvantages fat people. Thus, entirely doing away with health and science-related discussion obscures specific harms done to fat people, and which are essential parts of fat liberation discourse.²⁵⁸

We can see, then, why including fat perspective as part of an epistemic community would enrich it, especially considering the firsthand experiences of fat people who are discriminated against in healthcare settings. Thanks to scholars such as Pausé and firsthand stories included in Mollow's article such as Kirby (who lived with untreated asthma), and Benesch-Granberg (whose mother died from an untreated but treatable condition), the importance of including the topic of health in fat liberation discourse is pointed out to be essential, whereas it may have been overlooked by non-fat individuals who lack the perspective of fat individuals navigating the healthcare industry.²⁵⁹ It is precisely the difference in experience and background assumptions that fat people have that allows them to pinpoint these important mishandlings of the fat liberation movement. While this is just one aspect in which fat perspectives can advance the field (of fat studies), this is not the only arena in

²⁵⁶ Fehr, "What is in it for me?" 137.

²⁵⁷ Mollow, "Disability studies gets fat," 206.

²⁵⁸ While Mollow does not spend time on the alternative approach (which is to over-emphasize health), I will reiterate that the over-emphasis of health faces its own problems. That is, from chapter 1, rerouting conversations about fat liberation and justice to matters of squabbling about the science and medical status of fat people by virtue of their fatness (and not their health status by virtue of stigma and discrimination), is a derailment rather than constructive discourse. A balance must be struck to avoid the over- and under-emphasis of health in FAMs' dialogues.

²⁵⁹ Mollow, "Disability studies gets fat," 207.

which epistemic advancement takes place with fat perspectives. For example, fat perspective in healthcare or public health can help to identify anti-fat bias and harmful background assumptions that could improve public health policy.

4.1.2 Diversity development work

Fehr moves on to discuss that while the benefits of having diverse perspectives in academic departments correlates to an increase in a department's research and output, the specific kinds of improvements depend on the kind of diversity (gender or other), discipline, and department. Thus, it's difficult to promise that specific improvements will be made, but rather that diversity hiring is epistemically advantageous and that the specific advantages will reveal themselves after the fact. It is at this point that Fehr points out the ways in which a diversity focus can go wrong: departments may make token diversity hires, departments can 'free-ride' off of the valuable perspectives that diverse but informal intellectual communities who are connected to the department offer (thus avoiding increasing the department's formal number of diverse hires), and that hiring a diverse group will not necessarily translate to those members being free to express dissent in the department.²⁶⁰ In particular, I would like to focus on the latter part, especially as it relates to the idea of *diversity development work* in response to these pitfalls not only in the academic department context in which Fehr discusses it, but also in non-academic spheres and societal institutions including health and medicine.

Diversity development work is defined by Fehr as a way for epistemic communities to cultivate and protect dissenting perspectives through 1) training, hiring, retaining individuals with marginalized identities, 2) taking steps to reward epistemic diversity work, and 3) encouraging aspects of the department's dynamic that cultivate the production of dissenting views and perspectives.²⁶¹ It is through these diversity development techniques that the epistemic community is ethical as well as epistemically optimal in terms of product or research output. This is important because, as Fehr notes, some epistemic benefits are still possible even when the environment fails to cultivate and support dissenting views, as is the environment in STEM fields for women, but it simply isn't enough.²⁶² I will assert that the failure to cultivate an environment in which dissent is promoted is applicable to fat individuals in both academic and non-academic spaces.

²⁶⁰ Fehr, "What is in it for me?" 137.

²⁶¹ Fehr, "What is in it for me?" 145.

²⁶² Fehr, "What is in it for me?" 145.

4.1.3 Situational and epistemic diversity

In order to nurture environments that include diverse identities, and reward and encourage dissention, Fehr asserts that a department needs both situational and epistemic diversity. Where situational diversity refers to the inclusion of members in the community with different identities such as gender, sexuality, body size, or class, epistemic diversity refers to the difference in background assumptions with which each member approaches their research or work.²⁶³ While these two types of diversity interact, they are distinct.²⁶⁴ Fehr writes that certain cultural factors and constraints can be in place that disrupt situational diversity from resulting in epistemic diversity, such as a department's failure to cultivate an environment that properly promotes, encourages and rewards dissention among members of the epistemic community.²⁶⁵ Failure to do so creates a suboptimal environment, leaving a situationally diverse group of individuals, but an inability for those individuals to express, utilize, or even notice their unique sets of background assumptions.

One of Fehr's example of this type of failure comes from data that shows women's diminished credibility and judgment of quality of work in comparison to men's in the social sciences. For instance, studies have been performed that show a higher level of scrutiny on documents labelled with a traditional woman's name, and fewer criticisms on the very same document labelled with a traditional man's name. If this is the case, it can be inferred that the work of women is not only more highly scrutinized, but is less likely to receive uptake from their scientific community. This trend of undervaluing women's perspectives and work as compared to the kind of uptake that men in the discipline get is what drives the occurrence of situational diversity (where women are intentionally hired to promote diversity in the institution) without epistemic diversity (where women are not actually free to express dissenting opinions or recognize or challenge biased background assumptions of the dominant group). This is an example of situational diversity, i.e. the hiring of women and even achievement of gender parity in a department or institution without epistemic diversity, i.e. the diminished credibility and therefore epistemic contribution of the works by the diverse members of the department or institution despite reaching parity.

Consider now the applicability of this situational without epistemic diversity for fat people. While data is still emerging on public perception of fat people, their credibility and how people judge and value their work, I argue that this situational diversity without epistemic diversity is also applicable to

²⁶³ Fehr, "What is in it for me?" 146.

²⁶⁴ Fehr, "What is in it for me?" 147.

²⁶⁵ Fehr, "What is in it for me?" 148.

fat identities. Based on the information we have on the nature of fat stigma and social narratives surrounding fatness and stereotypes of laziness, asexuality, failures of willpower, gluttony and overindulgence (see chapter 1), a similar discredited social positioning of fat people to Fehr's case of women in STEM is applicable, whether it's in the public health and medical sphere or otherwise. This might also lead to both their situational and epistemic exclusion from both academic and non-academic institutions and spaces.²⁶⁶ As we saw from Pausé's and the R/CID model's account of stigmatized identity management and formation, a stigmatized identity is accompanied by hostile, exclusionary environments. This poses a problem for successful diversity development work regarding fat people in much of the same ways women in STEM face. If those with diverse, and especially minority, stigmatized identities have epistemically valuable things to offer, then the potential pitfalls associated with diversity development work applies to fat people in academia as well as non-academic spaces. The difference, however, is that fat people face an additional barrier. Specifically, their bodies are seen as fundamentally opposed to health and wellness with institutions such as AOPH uncritically advocating for their eradication, and thus the undervaluing of their perspective.

Recall that AOPH aims to both help reduce the current levels of fatness in the population as well as prevent fatness. If AOPH is successful in their goal to shrink currently fat bodies, Fehr's concern of situational diversity without epistemic diversity becomes especially relevant. Recall that Pausé asserts a fat-turned-thin person *still* has an internalized fat identity (through navigating the world as a fat person for a formative period of time). However, the fat-turned-thin person now *passes*, assimilating into the dominant culture of thin supremacy. As a result, their epistemically unique set of background assumptions, such as picking out biases like 'fat equals unhealthy', or that the medical industry's discrimination against fat people is more of a driver of illness than fatness itself, may be silenced, unwelcome, or simply irrelevant in that community. If the latter goal of AOPH is achieved, then this means fewer fat identities in general. This is a more straightforward case of eliminating a marginalized perspective altogether and mimics many concerns from disability scholars on the dangers of the scientific endeavour to eliminate disabilities.

If I have been convincing in my establishment of fat as an identity, and furthermore as a stigmatized identity with the hallmarks of stigmatized group identity formation, then fat people both

²⁶⁶ It's also noteworthy that the intersection of non-white, woman, and fat identities will interact and compound this effect.

have a unique perspective that communities can be epistemically advantaged by, as well as have barriers to the inclusion to such communities.

Conclusion

While much of this thesis has been focused on evidence of the function of AOPH from Canada's latest *OIC* report from 2011, the problems discussed persist in 2020. In a recent document published by the Canadian Medical Association Journal on August 4, 2020, guidelines for caring for obese patients, including 5 steps for clinicians to follow when 'treating' their obese patients, was released that re-enact the same problems of medicalization, stigmatization, and goals of eradication of fatness and fat identity. These guidelines are: 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, and 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.²⁶⁷

These five guidelines reproduce the same problems with the medical industry's handling of fat in the 2011 *OIC*'s report; in particular, they do so through perpetuating the usage of BMI to evaluate health status and a focus on body size reduction rather than the other factors negatively influencing health of the fat individual. Ultimately, these new guidelines, while attempting to present themselves as "nonbiased" interventions, contain themes of the conflation of body size and health status, the use of stigmatizing medicalized language, which is covered up by the doctor-patient concern and benevolence-based figleaf to obscure such stigma, and focus on eradicating fatness through encouraging the fat person to try to shed their fatness. This shedding of their fatness comes with disenfranchisement from their status as fat, rejecting what I have shown to be a core part of one's marginalized identity, and resulting in the undervaluing of fat as a marginalized identity that deserves social protections. *CMAJ*'s new guidelines highlight the importance of continued critical engagement

²⁶⁷ Wharton, Sean, David CW Lau, Michael Vallis, Arya M. Sharma, Laurent Biertho, Denise Campbell-Scherer, Kristi Adamo et al. "Obesity in adults: a clinical practice guideline." *CMAJ* 192, no. 31 (2020): E875-E891.

with the moralizing messages about fat bodies coming from the scientific community and medical industry, and as disseminated by PH and AOPH.

Anti-fat attitudes, fat stigma, and the structural and institutionalized oppression fat people face as a result is a major barrier to fat justice towards which contemporary fat acceptance movements (FAMs) aim. I have argued, using the Canadian Government's official *Obesity in Canada (OIC) Joint Report From the Public Health Agency of Canada and The Canadian Institute for Health Information*, that AOPH serves three functions which build upon one another to shape and undermine fat liberation and fat identity until public health's infamous 'war on obesity' effectively becomes a war on fat identity and fat bodies themselves.

In chapter 1, I showed that AOPH's first function is to *distract* conversations away from stigma and social harm and towards talk of health and medicine, which is skewed in favour of anti-fat attitudes due to assumed causal linkages between fatness and illness, as well as bias stemming from historical anti-fat convention in weight science as made evident from the *OIC* report. I showed that the content of the *OIC* is skewed in favour of a dominant and problematic discourse on fat as interchangeable with unhealthy and therefore objectionable, and thinness as the standard for, or necessary for, health. Canada's AOPH as evidenced by the government supported *OIC* report, represents a pervasive mode of shaping the discourse on fat acceptance movements, helping to facilitate a derailment towards talk of health, weight science, and economic burden.

AOPH damages fat identity and fat acceptance movements not only by centring conversations about fatness on issues of health, but through reliance on certain linguistic strategies unpacked in Chapter 2. These strategies include the use of disease and medicalized language as well as the linguistic phenomenon of figleaves to obscure weight stigmatizing speech acts and behaviour that end up shifting norms of permissibility towards creation of new anti-fat attitudes and avenues of discrimination. I asserted that these linguistic strategies work precisely because they help to enact deeply entrenched cultural themes of healthism. This use of language can also help explain why both the professional medical and public spheres retain the belief that fat is unhealthy, immoral, and a public health crisis despite scientific and ethical literature suggesting otherwise. I also showed in Chapter 2 that deeply ingrained healthist roots underlying the medical industry is amplified by public health, and specifically AOPH, using examples from Canadian AOPH in the latest (2011) *OIC* report. I concluded that AOPH thus provides an avenue through which the discrimination against fat people is advanced, creating new anti-fat attitudes and resulting in the increasing permissibility for anti-fat speech, behavior, and public policy.

In Chapter 3, I built upon ideas offered in Chapters 1 and 2 to show that public health has the potential to act as a pervasive and damaging force on fat identity as it perpetuates marginalization of people in fat bodies and stands directly at odds with FAMS. Through AOPH's functions to distract and cover up anti-fatness, the goal to eradicate fatness altogether follows. I concluded that this goal of eradication is not only unacceptable because of the resulting damage and disruption in fat peoples' ability to form a coherent, fat-accepting group identity but because such an eradication threatens a valuable epistemic point of view in society: the fat perspective. AOPH's functions to disrupt FAMS with talk of health and weight science, cover up and create new anti-fat discrimination using the language of healthism and medicalization, and to work towards eradication fat identity altogether positions fat people against themselves such that the war on obesity becomes a war on fat people themselves.

While the latest CMAJ guidelines contain the very problems I've discussed in these three chapters, they also contain some evidence of a growing awareness of the harmfulness of fat stigma. For example, in guidelines 1), CMAJ authors Wharton et al. specify that the patient should be "asked permission" before given advice on weight loss, and that this advice should attempt to be "unbiased".²⁶⁸ This shows an awareness of the individual's autonomy, and specifically to respect their wishes regarding whether or not their body size is focused on as a part of their treatment. This is a promising preliminary step in the medical industry's treatment of fatness; prioritizing fat people's choices paves the way for the opportunity for the medical industry to hear their voices, and in particular, fat individuals and activists who criticize treatment of fat people in the industry, as well as those who criticize the very need for a weight-centred healthcare paradigm at all. A combination of the acknowledgement of the effects AOPH has on fat identity that I have demonstrated through Chapters 1-3, the recognition that fat perspectives are valuable to society, as well as an increasing recognition from the medical industry that fat people should have control over their care and whether or not they would like their weight to be part of their care, are promising steps forward in the fight against fat stigma.

²⁶⁸ Wharton, Sean, David CW Lau, Michael Vallis, Arya M. Sharma, Laurent Biertho, Denise Campbell-Scherer, Kristi Adamo et al. "Obesity in adults: a clinical practice guideline." *CMAJ* 192, no. 31 (2020): E875-E891.

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