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Dichotomies of Cure and Care in the Medicalization of Fat Bodies

Though Fat bodies have not been absent from historical knowledges collected and known around the globe, the West's preoccupation with declaring Fatness as a looming moral and medical danger drives multidisciplinary discourses centering Fat people as the epicentre of the "Fatpocalypse" (Pausé 135), undesirable proprietors of excess body mass who threaten the (enforced) collective agreement on embodiments and categorizations of "health". These body knowledges, whose basis for so-called-empirical truths are born from cultural western notions and regulatory striving, are continually held to a higher regard than the (Fat) bodies and inhabitants of these bodies who navigate the clinical setting. Fatphobia, an imperfect term that encapsulates the fat hatred, "weight bias, weight discrimination, and weight stigma" (Kost et al. 03) experienced by larger bodies particularly from healthcare practitioners, is woven so tightly into the clinical gaze that it can easily be disguised by authoritative medical knowledges, an excuse that permits and excuses malpractice of Fat individuals. As a result, care and cure become fractured, a dichotomous arrangement that shifts responsibility of health solely onto the Fat patient.

For the context of this essay, body knowledges represent the "tacit bodily knowledges" (Murray 362) that are not representative of objectively looking *at* a body and then processing that visual information in a blank slate way, but of seeing that body through preconceived

notions and ideals already perpetuated by culture and society (Alcoff in Murray 362). These knowledges do not have to remain presently, consciously, at the forefront of thought to take space in social action, but often enough the conscious knowledge is embraced by actors who cling to imposed status quo and weaponize it for societal regulation. Body knowledges used as authority in clinical settings are used to both assess and bar Fat patients from using what Carolin Kost et al. call "Cultural Health Capital" (CHC), a "toolkit" comprised of what the authors outline as "medical knowledge based on normative scientific rationale, communication and interaction competency, a proactive and instrumental stance towards health and body, self-discipline, a future-oriented perspective, and an ability to communicate social privilege and resources" (Kost et al. 04).

Like body knowledges, CHC is inherently tacit, shaped by conditions of class, race, gender, and ability. Marginalized peoples are equipped with lower communicable levels of CHC through systemic barriers, and any level of CHC they may or may not have becomes recognizable to clinicians based on visual cues and dismissed through tacit knowledges possessed by clinicians towards outliers (Kost et al. 04). For Fat people, and notably Fat people of colour (regardless of class), CHC is disarmed or rejected through clinical fatphobia as weight stigma perpetuates the belief that Fat patients could not simply possess tools such as "a future-oriented perspective", nor "a proactive and instrumental stance towards health and body" (Kost et al. 04). This pushes against clinical stances on objective care and underscores the ways that tacit knowledges seep into the standard of care given to patients of a larger size.

The Body Mass Index (BMI) was originally designed by a statistician named Adolphe Quetelet in the 1800s who altered equations to be able to display Dutch body mass under a

normalized curve (Anderson 197). This scale was not about size representation, but rather a mathematical puzzle that would allow Quetelet to (inaccurately) portray bodies in a standardized way. Today, this body mass index is used to categorize people as either healthy (under the curve) underweight, overweight, or obese. The BMI has not only become a weapon of the medical industrial complex, but of government, insurance companies, and their representatives. Use of the BMI is endorsed by The National Institutes of Health and even the World Health Organization for measurements of population and individual classifications of body mass, despite being misrepresentative of body mass cross-culturally and taking no account of differences in fat and or muscle weight, nor allowing for differences in body distributions across the sexes (Anderson 200). Michelle Obama's (2010) obesity campaign focusing on "overweight" children is one example of governmental involvement and deployment of the BMI to publicly tackle the "obesity crisis" (Pausé 135) without addressing systemic barriers that may lead to weight gain (such as poverty), not to mention the power imbalances of CHC and the classification of the obesity "epidemic" itself, riddled in fear-based language that heightens fatphobia.

Clinicians under this social reality become state sanctioned soldiers on the frontlines of the battle of obesity, stationed within the clinic walls (Kost et al. 08). Their fatphobia is sanctioned by incidences like in 2006, when the U.S.A. Surgeon General at the time Richard Carmona publicly declared obesity "the internal terror" (Morgan 191). He further stated that obese peoples were "domestic bioterrorists" (Morgan 191), turning body mass classification into a moral panic calling on American citizens to see this "issue" as not just medically and emotionally laden, but a matter of political nationalism. This creates polarization between bad and good citizens where

the good "literally watch their own weight, count their calories, and calculate their own BMI" (Morgan 197). Clinicians thus are morally justified (and deemed responsible) for maintaining and delivering fatphobic care to the Fat terrorists diminishing the country's resources and reputation.

The belief that fatness exists solely as an unwillingness or inability to practice self-control can be seen in the strong language that calls Fat peoples "bioterrorists", in need of authoritative care and paternalistic lecturing from health care practitioners. When a patient of "normal" size seeks health advice from their physician, they can utilize their possessed (or perceived) level of CHC, currency that affords them respect and involvement in the planning of their care, which dissolves power imbalances (to a limit) and allows for the further development of the patient's CHC, to which physicians are also co-developers of (Kost et al. 04). State sanctioned clinical fatphobia denies agency to larger bodied patients, not only dismissing and preventing them from using their cultural health capital in the moment to mitigate fatphobic harm and assert their bodily truths, but by simultaneously disempowering them from the ability to grow their CHC toolkits for future appointments and encounters. If Fat peoples (and other marginalized groups) are without the abilities listed as critical components of the CHC toolkit, it is only because they are denied the opportunity to possess, practice, and grow these resources.

As Fat patients are believed to be unable to manage their weight and therefore "health", clinicians are not required to entertain any non-emergent health concerns until body weight has been reduced to an agreeable metric determined by the clinician. The late Fat activist and Scholar Cat Pausé collected numerous accounts of occasions such as this through interviews with folks all over the Fat spectrum, underpinning these interactions as not just fatphobic, but instances of

malpractice and abuse. One participant named Judith had a clinician say to her that "Every fat woman wants to believe it's because of her thyroid and it never, ever is" (Pausé 135) when she requested a thyroid panel, which eventually did show significantly reduced functionality when finally run 10 years later. Another participant named Susan shared that as she was greeted by a pulmonologist at her scheduled appointment, instead of just saying "hello" the words "I knew your problem before I even saw you, all I needed was to see that you weighed over 300 lbs to know why you are short of breath" (Pausé 137) were spoken as they entered the room. Participant Lauren shared her clinician's disregard towards her dietary and exercise habits, stating "When I talk about my diet no one believes me, because I am morbidly obese and everything I eat must be fast food. If I talk about enjoying long walks, I must be lying because I'm morbidly obese and therefore can't be exercising" (Pausè 138).

Ellen Maud Bennett, just one of the many Fat women whose lives were lost to sanctioned malpractice, has a story that echoes the experiences of Judith, Susan, and Lauren. Though she died in 2018 *from* untreated cancer that became inoperable, the *reason* she died was because of her size. She had been dismissed over the course of several years and told that her health issues were because she was Fat, and to check-in with her provider once she had lost a lot of weight. When she did finally receive a cancer diagnosis as her condition became an "emergency", she died several days later (Kost et al. 02). It is evident that the Hippocratic Oath undertaken by physicians does not apply to the standard of care provided to Fat patients (Pausé 139).

Clinicians' unwillingness to see health circumstances of Fat individuals as anything other than fatness, becomes a lazy overarching diagnosis designed to limit the interactions between patient and provider and reiterate that their physical condition is a choice which they are responsible for

remedying. This notion of choice stigmatizes and shames Fat folks into avoiding healthcare settings that disregard their health needs and blame them for any bodily woes they may experience, even though weight gain is an indicator symptom for a plethora of health conditions. However, there are additional ways in which the clinical environment perpetuates the biases encapsulated by fatphobia to police access and use of clinical spaces. Medical gowns that are one size only, chairs with armrests that constrict and injure wide hips, scales that are limited to 400 or less pounds, and exam tables and arm cuffs that accommodate "normal" bodies only (Pausé 137) are just some of the physical barriers people of size face when navigating healthcare. Instead of clinical settings using technologies and equipment available within the industry, it is up to the (Fat) patient to lose weight despite their untreated medical issues (unrelated to fatness) and to come back when they are worthy of care. In the meantime, they must rely on industrial spaces to be weighed or invest in expensive home monitoring devices. As highlighted by Pausé's participant Sarah, "No patient should have to go to a junkyard in order to find out a basic vital health statistic" (Pausé 139).

Running parallel to avoidance of care, is the problematic approach of cure and erasure of the Fat body. As explored in governmental obesity eradication campaigns such as the "Let's Move" initiative, that same agenda is sustained by clinicians as the sole focus of treatment for the Fat patient (Anderson 204). Viewed as unable to achieve this on their own, extreme diets, weight loss medications and even weight loss surgeries that remove 90% of healthy stomach tissue to reduce eating capacity are prescribed as "cure" to the transgressional individual (Morgan 193). All three of these weight loss methods pose significant health and safety risks for patients, however the agenda of "fixing" Fat folks is held to a higher importance than the people whose

lives are now at risk through bio-technical stomach alterations, restrictive diets that can lead to disordered eating patterns, and GLP-1 type medications that take away appetite and can have permanent consequences on organ health for those who do not need them.

A concerning result of fatphobia and of the weight loss pressures forced onto Fat folks across societal spheres, is the willingness and acceptance to utilize Fat eradication prescriptions and methods due to profound exhaustion from navigating weight bias. This acculturated and internalized fatphobia prevents holistic embodiment of the Fat self, an unfortunate success of the size agenda. Eli Clare writes in "Impacts of Cure" that "cure promises wholeness even as the world pokes and prods, reverberating beneath our skin, a broken world giving rise to broken selves" (Clare 158). Fat hatred perpetuates the notion that once a person is no longer Fat, they will be fully embodied, embraced by society, and assume their civic duty to the status quo. What the promise of cure does not reveal up front, is that even if the weight is lost, the stomach has been reduced to a 2oz capacity, and metrics fall under a normal curve, Fat hatred will still tell the "cured" that they only got there through cheating, through interventions they were too lazy to achieve on their own, and they will continue to be judged by clinicians reviewing their charts at appointments (Morgan 209).

Unlike the standard of care afforded to people of "normal" size and those whose thinness affords them continual usage and development of CHC, collaborative health treatment, and health planning, Fat peoples are berated, abused, and denied equitable health care based on the notion that they are both responsible for and the driver of their own health issues. It is this dangerous (sanctioned) notion that repeatedly bullies Fat patients into precarious health liminality, with the only lifeboat being offered posing additional health and safety dangers for

their bodies. Fat people are deserving of the same standard of care provided to those who fall within preferred classifications of the BMI, and of empowered embodiment regardless of size. To draw on Eli Clare once again, “The ideology of cure would have us believe that whole and broken are opposites and that the latter has no value” (Clare 159). Fat people should not have to die from conditions separate from their thinner counterparts. Fat people are whole.

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