

“WARMTH, SYMPATHY, AND UNDERSTANDING MAY OUTWEIGH THE SURGEON'S KNIFE OR THE CHEMIST'S DRUG”... UNLESS THEY'RE FAT. AN ANALYSIS OF FAT PATIENTS' EXPERIENCES WITH HEALTH CARE PROVIDERS

by

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DEDICATION

This thesis is dedicated to Shelby Waugh, who left us far too soon.

I love and miss you, my dear friend.

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This project would not have been possible without the assistance and support of so many people. And one fat cat.

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ABSTRACT

“WARMTH, SYMPATHY, AND UNDERSTANDING MAY OUTWEIGH THE SURGEON'S KNIFE OR THE CHEMIST'S DRUG"... UNLESS THEY'RE FAT. AN ANALYSIS OF FAT PATIENTS' EXPERIENCES WITH HEALTH CARE PROVIDERS

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Dominant medical discourse of fatness primarily focuses on weight and weight loss as a means to achieve health, rather than focusing on overall wellbeing and implementing healthy behaviors without weight loss as a central pillar. The United States has seen a 66% increase in weight stigma since 1995 (Puhl, Andreyeva, & Brownell, 2008). Unfortunately, the prevalence of weight stigmas amongst health care providers occurs at the same rate as the general public (Pantenburg et al., 2012). Fat women are especially prone to weight shaming by doctors. Doctors shame patients, refuse to treat them for the symptoms presented, and generally view the patients as not worthy of their time. The pervasive negative attitudes in the biomedical community has perhaps an unintended consequence: it actually motivates the fat person to avoid interacting with health professionals *at any cost*.

Though there are a plethora of studies confirming weight biases amongst medical providers, there is very little research exploring fat women's experiences with health care providers and the consequences of medical fat phobia. This is an intersectional feminist study examining how the medicalization of fatness and fat phobia intersect in the treatment of fat patients, and how it impacts the care fat women receive. Semi-structured interviews were conducted with women who have been classified by a medical professional as overweight or obese. These women experienced malpractice, fat shaming, and physical anti-fat messages when seeking health care. This study highlights the critical need to change the way health care providers view, treat, and understand fat patients.

CHAPTER ONE

Amanda was suffering from ulcerative colitis and asked her gastroenterologist for a celiac blood test. He refused to administer the test even though he was the one to diagnose her with ulcerative colitis. Frustrated, Amanda wanted to know why. The doctor believed that she couldn't have celiac disease because Amanda was fat, and the 'typical' celiac patient is underweight. Instead, she was given an expensive prescription medication that nearly killed her. Amanda's doctor hadn't warned her of any side effects and she experienced a rare, but life-threatening reaction. Amanda spent two weeks on a ventilator in the ICU.

Amanda's doctor refused to take responsibility, citing the medication he prescribed couldn't have caused her reaction. It had. She later tried to sue the doctor, but was told by her attorney that because she lived, she wouldn't win in court.

Amanda's story is, unfortunately, not uncommon.

Problem Statement

Weight is not something that can be hidden. Doctors immediately know when someone is fat. Kushner (2014) demonstrated visible fatness biased health care provider's

impressions of the person and their ability to follow medical advice. It is faster, cheaper, and easier to treat something you can see than try and find something you can't. This is especially true when considering medical care.

Weight is considered a master status, meaning it overshadows all other characteristics and heavily influences medical diagnoses (Drury & Louis, 2002). Packer (1990) found fat women are often treated with a lack of respect by their doctors who then attribute health problems to weight before any physical examination or testing. This can sometimes lead to very serious conditions being overlooked or ignored by medical providers, exacerbating them and putting the patients at unnecessary risks.

I argue that rather than classifying fatness as an inherently diseased state, we must accept body size diversity and treat fat patients holistically. In doing so, we can learn how to better serve fat patients (and all patients experiencing prejudice and intolerance of any kind). This will likely increase the number of fat patients seeking health care, and improve the overall quality of care.

Critical obesity research is considered the singular authority on fatness and what it means to be fat. Critical obesity studies typically recognize the stigmas associated with fatness while still operating under the medicalized obesity umbrella. Organizations like the University of Connecticut (UConn) Rudd Center for Food Policy and Obesity recognize the high levels of weight stigmas faced by fat people in the United States. They produce materials to promote size acceptance and a reduction of medical weight bias.

However, their primary focus remains “promoting solutions to childhood obesity” (Rudd Center for Food Policy and Obesity, 2017).

Anti-obesity strategies currently involve speculative and costly investment in disrupting energy balance, food taxation and marketing, coercive physical activity, genetic engineering, pharmacological and surgical interventions and sanctions against fat people, as well as public-private partnerships with the weight loss industry.

Rather than working to change the way fatness is understood, groups like the Rudd Center work to fuel the \$60 billion spent annually in the weight loss industry (LeTourneau, 2016). This is not unique to the Rudd Center. In fact, nearly all of the most prominent critical obesity researchers are funded by weight loss industries (Brown, 2015). One example of this can be seen in the work of George Bray, a prominent and respected obesity researcher from Louisiana State University. Bray coauthored an article that implored an increase in available obesity medications and insisted that drugs are an essential element of obesity treatment (Bray, 2013). This study was, in part, funded by Orexigen Therapeutics, Abbott Labs, Medifast, and Theracos; all companies who either have diet drugs on the market now or who have drugs under review by the FDA (Brown, 2015).

In addition, critical obesity researchers operate under the assumption that while fat patients do experience high levels of stigma, obesity and overweight are still dangerous, diseased states to be treated. This system is designed to maintain power by keeping fat embodiment within their purview (Cooper, 2016). James Hill, a prominent

obesity researcher, “equate[d] the fat acceptance movement with a 'cancer acceptance movement' that would say: ‘you've got cancer; just accept it and live with it” (Saguy, 2013). ‘Obesity’ is forced as the singular lens through which we are tasked with understanding a complex, multifaceted lived identity. These organizations, along with media frenzies, leave no space for any dissenting research to be heard.

There is an urgent need for more scholarship from a multitude of disciplines studying fatness in order to counter the medicalization of fatness. The field of Fat Studies is an up and coming discipline that does just that. Fat Studies scholars come from nearly every academic disciplines including history, literature, medicine, sociology, psychology, and feminist studies. This study operates within the interdisciplinary field of Fat Studies and challenges the notion that fatness is a diseased medical state.

Significance

Fatness is a spoiled identity and as such fat people are shamed for their bodies and unable to receive social acceptance (Goffman, 1963). People who are stigmatized will do anything possible to avoid situations where they face heavy shame (Drury & Louis, 2002).

The United States has seen a 66% increase in weight stigma since 1995 (Andreyeva, Puhl, & Brownell, 2008). The prevalence of weight stigmas amongst health care providers occurs at the same rate as the general public (Pantenburg et al., 2012). Doctors shame patients, refuse to treat them for the symptoms presented, and generally

view the patients as not worthy of their time (Pausé, 2016). The pervasive negative attitudes towards fat people actually result in the fat person avoiding interactions with health care professionals at any cost (Pausé, 2016).

Health care providers' anti fat attitudes are heavily documented and studies show fat patients are less willing to seek medical care if they think their health care provider holds a weight bias (Drury & Louis, 2002). Doctors report spending less time with fat patients and perceive fat patients as unhygienic, out of control, lazy, and depressed (Drury & Louis, 2002, Pantenburg et al., 2012, Brochu, 2012, Persky & Eccleston, 2010, to name a few). Fatness is stigmatized as a toxic and dangerous threat to our society, creating moral panic (Throsby, 2007).

In a study of medical students' attitudes towards fat patients, Pantenburg et al. (2012) found fat patients were the main target of derogatory humor in the hospital setting. Fatness is assumed to be a result of someone being out of control, letting themselves go, and not caring about their lives or health. We are literally taught every day that fat is bad, and we not only believe this, but embrace it, leading to a huge moral panic. (Pausé, 2016).

Purpose

This research will analyze fat peoples' experiences with medical professionals and by extension, seeks to understand how fat bodies are harmed by the medicalization of fat. By providing evidence of the detrimental effects of weight bias on health care, this study will encourage doctors to be aware of their own weight biases and to confront them. A

reduction in doctor's weight bias will lead to better treatment of fat patients and an increase in the level of care they receive. When fat patients know they will receive unbiased, patient-focused health care, they will be more willing and able to seek medical attention for both emergency and non-emergency care. This study will focus on the experiences of women, as weight stigmas are gendered. Women experience weight prejudice at higher rates than men (Wooley, Wooley, Dyrenforth, 1979).

There are several objectives within this study. This study aims to understand how fat patients navigate the health care system. This includes facilities that do not accommodate their weight such as scales, examination tables, and chairs. It also will investigate how fat patient's experiences with health care professionals have impacted them medically. Specifically, have these women been refused diagnostic tests, have symptoms been ignored, and have they had to see more than one doctor for treatment. Third, an investigation into the participant's relationships with their health care providers will attempt to answer the question: Do fat women trust their providers, are they comfortable discussing concerns openly? Finally, this study will assess the consequences of anti-fat attitudes on the health care provided to them and analyze the implications of anti-fat care on the participants' physical and mental well being.

The objectives listed will allow the following goals to come to fruition. This study seeks to give fat patients a voice, allowing them to discuss their experiences and learn what would make seeking medical care better for them. In doing so, we will understand the different ways anti-fat care affects the patient's experience. Second, we will center fat

women rather than doctors in the solution by using an intersectional, feminist analysis that includes an awareness of socioeconomic, cultural, and institutional factors that impact a person's weight and experience. I hypothesize that with the reduction of medical weight bias, a cultural reduction of weight bias will occur.

Key Terms

Participants must have been diagnosed as 'overweight,' 'obese,' or 'morbidly obese' by a health care provider in order to be eligible. Having a medical diagnosis of 'overweight' and/or 'obese' follows patients on their medical charts and weight is one of the first things doctors see before entering the examination room. However, fat studies researchers do not use the medicalized terms 'overweight', 'obese', and 'morbidly obese,' for many reasons including the fact that the word 'obese' is derived from the latin *obesus* which means "having eaten until fat" (Brown, 2015). This alone conveys both moral and clinical messages. In an effort to de-medicalize body diversity, the terms small fat, medium fat, large fat, and super fat are used to describe different body sizes. There is an important distinction between someone who is small fat and someone who is super fat. While weight stigmas affect everyone, a small fat person will experience weight stigmas differently than a super fat person.

Often, in polite conversations, people use words such as 'fluffy', 'curvy', or 'big' in an attempt to avoid the descriptor fat. People often cringe at the word fat. Fat is no longer a simple description of the way someone looks. The diet/exercise industry combined with popular culture and the biomedical community have turned fat into a

word with underlying negative connotations. Fat has come to imply lazy, lacking self control, disgusting, unattractive and undisciplined, among others (Saguy, 2013). Fat activists and Fat Studies scholars hope to reverse this, returning the word fat to a neutral descriptor (Cooper, 2016).

For these reasons, this paper will use the term fat as a size descriptor. Obese will only be used in direct quotes or names.

CHAPTER TWO

The medicalization of fatness has had far reaching consequences. Medicalization is the process of formalizing a condition into a diseased state. Prior to the categorization of overweight and obese as diseased states, a person's weight was not considered something for doctors to treat. By using the medicalized term 'obesity', doctors became the most qualified 'experts' to fix fat (Saguy, 2013 & Brown, 2015). By creating this discourse, the medical community was able to brand themselves as the only qualified experts to treat obesity, thereby assuming a monopoly. The medicalization of fatness has impacted our perception of weight dramatically and can be seen in all aspects of culture from fat jokes and weight loss shows in media to fully legal employment discrimination. Gender also plays a large role in how a person experiences weight stigma (Farrell, 2011, Drury & Louis, 2002, Brown, 2015).

History

Doctors first began giving their patients weight loss drugs in the 1920s (Brown, 2015). At that time, doctors did not have the specific weight loss drugs we have today. Rather, doctors would prescribe thyroid medications to completely healthy patients in an

attempt to make them thinner (Brown, 2015). Fatness can be measured in a number of ways, but is most often measured by health care providers using the body mass index (BMI). In 1942, The Metropolitan Life Insurance Company used five million policies from both Canada and the U.S. to determine (or rather create) height and weight charts. This standardization of body size allowed doctors to compare their patients to this newly categorized 'ideal' body.

There is significant research condemning the use of BMI to determine anything linked to overall health (Tomiyama et al., 2016; Nuttall, 2015; Wray & Deery, 2008). The BMI scale was not created to determine a person's future risk of disease or death, and it doesn't (Brown, 2015). Adolphe Quetelet, a mathematician, created the BMI chart in 1830 to follow population trends. In their critique of the BMI, Wray and Deery (2008) argue "BMI as a measure of fatness is at best a blunt instrument and at worst a tool that might create moral panic". In fact, the BMI chart has had several changes in the last twenty years that arguably have little medical reason but that create the need for more medical intervention. For example, in 1998 the World Health Organization (WHO), along with the International Obesity Task Force (IOTF) and the National Institutes of Health (NIH), lowered the cutoff for the overweight classification from 27.8 (men) and 27.3 (women) to 25 for both men and women (Saguy, 2013). Overnight, millions of people were now classified as overweight. The only reason the WHO, IOTF, and NIH gave for changing the cutoff was that 25 was an easier number for people to remember (Saguy, 2013). This has extraordinary implications. First, doctors were suddenly 'given' millions

of new patients to treat for being overweight. Second, the seemingly easy change in cutoff implies they are quite meaningless in the first place.

The use of BMI to determine someone's health, or future health, is both inaccurate and dangerous. A bodybuilder's BMI could label them 'morbidly obese' on paper. This label affects many aspects of a person's life, including their ability to access insurance. Recently, the major grocery retailer Whole Foods introduced an 'incentive plan' for its employees (Sandoval & Lucadamo, 2010). Employees' BMI would be measured and recorded. Based on a sliding scale, individuals with lower BMIs would receive larger employee discounts. While some may initially view this as a reasonable incentive plan, a further investigation reveals that it further perpetuates the assumptions we hold about what it means to be fat. I would even go as far as to argue that the Whole Foods plan is discriminating against employees they deem 'unhealthy'.

After decades of purposeful propaganda, the biomedical community has become the singular authority on fatness and its alleged health consequences (Wray & Deery, 2008). There is an assumption that obesity, as a disease, is both preventable and curable (Throsby, 2007). In addition, the framing of fatness is two fold: a disease in and of itself, and as risk factor for other diseases (Saguy, 2013). As such, the fat body is a manufactured financial and social problem in Western society. When we frame fatness as something that can and should be cured, fat people become coded as failures. As Abigail Saguy (2013) explains, when fatness is framed as a health issue,

It becomes a matter of life and death. At the same time, the reframing of fatness as a health problem, rather than, say, as a feminist issue, obscures the ways in which women are judged more harshly based on their appearance than men.

Fatness has morphed into an assumption of low character; fat people are fat because they are unwilling to make a lifestyle change (Throsby, 2007). Fatness is a spoiled identity. It is socially acceptable to both blame the person for being fat and then shame them. This is only worsened by the use of the term 'obesity epidemic'. An epidemic implies imminent danger, that tragedy is near, reinforcing the omnipresent fear of fat (Farrell, 2011).

Stigma

Weight stigma, like other stigmas, is relative depending on time and place. Amy Farrell (2011) explains

[F]at stigma is deeply rooted in the development of ideas about race, gender, and civilization. Fatness was a motif used to identify 'inferior bodies' those of immigrants, former slaves, and women- and it became a telltale sign of a 'superior' person falling from grace. In today's terms, fat, if it had a color, would be black, and if it had a national origin, it would be illegal immigrant, non-U.S., and non-Western.

It has been found that a person's own weight does not determine the weight stigmas they hold towards themselves and others. Fat and nonfat people typically hold the same beliefs and biases toward weight and fatness (Pausé, 2007).

Fat bias in the medical community has been studied, but often the study designs are highly problematic. For example, Kushner et al (2014) conducted a study to evaluate medical student's attitudes towards fat patients after structured educational interventions. This team of researchers found a very small improvement in stereotyping immediately after educational intervention but one year later any improvements were lost. Additionally, after the study medical students rated their confidence in treating fat patients higher. Their attitudes returned to baseline mean at the end of the first year. This study is problematic for several reasons. First, Kushner et al (2014) consider fatness a "worldwide problem" and the authors are only concerned with medical student's ability to treat an increasing patient population. Thus, treating obesity becomes the primary goal at the expense of comprehensive patient care. In this way, doctors neglect the actual reasons fat patients seek medical care, not out of careful study or evidence, but out of flawed ideological beliefs. Not only does this significantly decrease the quality of care for fat patients, it disempowers them through stigmatization.

The idea and widespread reporting of obesity as an epidemic began in the late 1990s, though the use of scare tactics against fat people started much earlier. The unique problem with discussions on fatness has to do in large part with how pervasive the idea of an 'epidemic' has become. We are bombarded daily by news of 'obesity' rates and the

supposed links between fatness and a range of other co-morbidities. Fatness is also unique in that it is highly visible and there is no way to hide it. Further, the discourse on fatness, dominated by the diet/exercise industry, identifies fatness as something every fat person wants to change. Thus, it is almost as though people feel they have a right to make assumptions and statements about a fat person's body. These ideas have become so pervasive that many people do not think twice about offering diet and exercise advice to fat people even if they have no substantial knowledge on these topics themselves. Consequently, fatphobic discourse and rhetoric replicates itself through these interactions. It has been shown that when a person experiences weight stigma, they are at an increased risk of weight gain, disease burden, poor psychological health, and mortality (Himmelstein et al., 2015). Unfortunately, medical providers are the most frequent source of weight bias encountered by fat people (Puhl et al., 2014).

Gender

Women are particularly affected by fatphobia. Patriarchy dictates that they are expected to meticulously maintain their physical selves to a point of obsession. Women are more likely to go on diets specifically to lose weight, use weight loss drugs, and undergo weight loss surgery (Saguy, 2013). In the West, a man is judged by how powerful and dominant he is, while women are judged based on their appearance, more specifically, their attractiveness to men (Hesse-Biber, 2007). Fat women are significantly less likely than their thin counterparts to partake in annual breast and pelvic exams for

fear of being weight shamed (Drury & Louis, 2002). This might be an explanation for the link between BMI and cancer deaths, one that is ignored because it does not support the narrative of fat as a death sentence (Brown, 2015). When they do muster up the courage to attend an examination, “obese female patients are more likely to be advised to lose weight than men with an identical BMI” (Drury & Louis, 2002). While women have always been especially scrutinized by the medical community, this obsession with weight has only increased biomedical control over women's bodies while simultaneously excluding them from health care access. One study found that, on average, there need be only a 12 pound weight gain for women to experience weight discrimination from health care providers (Brown, 2015). This was not the case for men. In her analysis of fat women’s experiences, Cat Pausé (2008) found many women were stigmatized by their health care providers and often refused diagnostic procedures. One woman encountered a pulmonologist who began her appointment by saying “I knew your problem before I even saw you, all I needed was to see that you weighed over 300 pounds to know why you are short of breath” (Pausé, 2008). Not only did the doctor assume a diagnoses without any medical testing, but she also refused to treat the patient as a person rather than a condition.

Fat women especially are encouraged to downplay their weight as much as possible. Many fat women are under the impression that their bodies are something to be ashamed about. This impacts how they discuss interactions with health care providers,

shifting the blame for what is likely malpractice onto themselves. These factors demand an exploration of fat women's experiences with health care providers.

Culturally, fat bodies are simultaneously hyper visible and invisible. There exists a fetishization of weight loss stories in popular culture. "Fatness is often used as a motif to tell the story of one's upward , or downward, mobility" (Farrell, 2011). Like rags-to-riches stories, these serve very specific hegemonic purposes. One, it perpetuates the idea that if one hasn't lost weight it is because they haven't had the discipline or mental fortitude to lose weight. This functions to blame fat people for their fatness, thus justifying any discrimination that may result from it. Also like rags-to-riches stories, weight loss stories serve as a control mechanism. They are presented as feel-good narratives, often parroting the idea that if they did it, anybody can. Thus, people who are fat, become people who are just in transition to becoming thin. One such example of this is the show *The Biggest Loser*. Contestants are put on near starvation diets and are expected to exercise up to ten hours a day- all while getting fat shamed by the show's combination hosts-trainers. Farrell (2011) describes the way contestants are humiliated by weigh ins on freight scales while wearing form-fitting spandex and argues that the spectacle of degrading fat bodies is a media ritual.

In a recent article published by Esquire UK, a father writes about his concern for his "fat son" (Coren, 2017). Coren's article is riddled with fatphobia, racism, transphobia, and sexism. Coren referred to his four year old son as a "Fat little bastard", and continues by describing "each actual fat person is blatantly just a badly brought-up, greedy little son

of a bitch committing the unforgivable sin of gluttony in a world where there is not enough food to go round. I'd kill them all and render them down for candles". Coren's violent words illustrate the very real disgust (and fear) of fatness in the West. This article was posted both online and in a print version of the magazine. This article illustrates the very current, socially acceptable hatred of and disgust towards fatness.

Employment

Not only does the diet industry have massive stakes in perpetuating a fatphobic culture and discourse, employers may, unconsciously or not, be benefitting from this mechanism of oppression. Fatness is frequently linked to poverty. The pay gap between thin women and small fat women is roughly 6%, while super fat women experience a pay gap of 26% (Roehling, 1999). In addition, fat employees, compared to their thin co workers, are less likely to receive a raise (Loh, 1993). The hiring prejudice against fat people is widely documented. In employment, the same assumptions of what a fat body implies are seen.

Hiring staff usually chose the thinner applicants with equal qualifications, and made unfounded assumptions about the larger applicants—such as that they were too aggressive, difficult to work with, lacking in self-discipline, less productive, or less determined—even if they had never met or spoken to the applicants. If they are hired, fat employees are relegated to positions with little or no contact to those outside the business

(Kristen, 2002). Fat employees are more likely to endure workplace harassment and, even when qualified, fat people are less likely to be promoted (Kristen, 2002).

As of 2017, city-wide weight discrimination laws are in place in Washington, D.C., San Francisco, C.A., Santa Cruz, C.A., Binghamton, N.Y., Urbana, I.L., and Madison, W.I.. The only state that designates weight as a protected status is Michigan. Outside of these areas, fat employees can be terminated at any point based solely on their weight, with no regard to job performance (Rothblum, et al., 1990).

As part of the discourse on fatness, the relationship between fatness and poverty is assumed with little critical analysis. The assertion here is that it is equally as likely, if not more so, that the inverse of this relationship is true. That is, given the documented discrimination toward fat people in the workplace, this very discrimination toward fat people in hiring and compensation may provide a much more accurate picture of the relationship between fatness and poverty. Understood this way, there is a material incentive to discriminate against fat people in the workplace. As is the case with all other forms of oppression, somebody stands to benefit from it.

CHAPTER THREE

Methods

Several previous studies have utilized interviews of fat patients to understand medical weight bias, (Pause, 2016, Brown, 2015). These interviews, however, have largely focused on the medicalization of fatness rather than the level of care fat patients receive and the impacts of that care. This study focuses instead on the *patients' experiences*, giving insight to the short- and long-term effects of weight stigmas on patient's health.

This study implemented snowball sampling to recruit participants. Snowball sampling was used due to the sensitive nature of the study and interview questions. Participants were recruited by word of mouth and a recruitment poster that was shared on Facebook. The online post was only shared in fat-specific Facebook groups including a Fat Studies group and several fat acceptance groups. Participants self reported their size, and thus their eligibility for participation in the study. This was in an attempt to prevent participants from experiencing any shame in calling attention to their size. In all, 20 women responded and 11 in-depth, one on one interviews were conducted. Informed consent was obtained from all participants prior to being interviewed. Participation was

voluntary. Of the 11 interviews, seven were conducted in person and four were conducted over the phone due to the location of the participant. For participants interviewed on the phone, informed consent documents were emailed prior to the interview and reviewed over the phone. All participants reside in the continental United States and identify as women. Participants' age ranged from 22 to 56 and were English speaking. Participants were not compensated. Each participant was given a pseudonym to protect their identity and ensure confidentiality.

All interviews were audio taped and lasted between 45 minutes to 90 minutes. Transcription occurred as soon as possible after the interview. No data analysis software was used. Participants were asked how frequently they sought medical care, to describe their interactions with health care providers, and discussions of weight with their health care providers. A full interview agenda is available in Appendix A. These interviews have provided a platform for fat women to tell their stories. After transcription, the following themes emerged: avoidance, weight loss, malpractice, quality time, accessibility, improvements. These themes followed what participants spoke most about and were most affected by in their experiences.

Results

After transcribing and coding the interviews, several themes emerged. These themes were avoidance, weight loss, malpractice, quality time, accessibility, and improvements.

Jane, Beth, Theresa, Maria, and Amanda have all been fat or super fat their entire lives. Many of them have had negative experiences with doctors since childhood. Connie, however, was extremely thin until her late thirties when she rapidly gained over one hundred pounds. Though her experience is vastly different than the other women, she is able to provide a unique perspective. Connie has experience visiting doctors as a very thin and then very fat woman. This has impacted the ways in which she seeks medical attention.

Avoidance

Most people with a stigmatized identity or condition of self avoid situations in which they are stigmatized (Drury & Louis, 2002). Several studies have suggested a fat woman will avoid seeking health care if she believes she will be stigmatized by her medical provider (Drury & Louis, 2002). In addition, as little as one stigmatizing experience with a health care provider can impact the probability that that person will seek health care in the future (Twarog, 2015). In one study, it was found that the knowledge that they would be weighed at a doctor's visit prompted 32% of fat women to cancel their appointment, and the same study revealed that over half of all women surveyed had canceled their medical appointments more than once due to their fear of being stigmatized (Drury & Louis, 2002). While the biomedical industry continues to warn of the 'dangers of obesity', the biases of their practitioners is leading fat women to avoid seeking health care at increasing rates. This was evident in the interviews

conducted, as nearly all of these women had either avoided or delayed seeking health care due to a fear of being stigmatized by their doctors.

Jane expressed a fierce distrust of providers she hadn't previously encountered.

I do not trust going to new doctors. I feel bad that that's the way it is because I don't want to make these ugly assumptions about random people I don't know but at the same time, they make these terrible assumptions about me, so too bad.

She went on to explain that the type of health care provider she was to see made an impact on how she prepared. Jane's psychiatrist asked her to visit the practice's dietician. They talked for several months about how the visit would go, what to expect, and why it was necessary, Jane was extremely hesitant to make the appointment.

She wanted me to see a dietician about supplements and changes that help your brain chemistry which is fine [from a medical standpoint], but I was super super unwilling to do so. When I finally went I brought this giant stack of papers from The Fat Nutritionist and other health articles. I came in with this armor in the form of paper.

Beth experiences severe anxiety before and after her doctors' appointments. These anxieties are often debilitating and often result in a missed appointment. In addition, Beth suffers from severe depression. Beth's anxieties surrounding medical care have led to severe medical emergencies. At one point, Beth was suffering from a urinary tract infection that went untreated. As a result, her UTI turned into a severe kidney infection.

She was told by an emergency room nurse that, had she waited any longer, she would have gone septic and possibly died.

This was not the only time Beth avoided medical attention with damaging results. Four years ago, Beth was sexually assaulted. Because of her fear of stigmatization from doctors, she avoided seeking treatment for two months. Beth did not believe she would be taken seriously about her assault, she thought that no one would believe a fat person could be sexually assaulted. Unfortunately, she was right.

My doctor had such a bad attitude toward me that I waited six more months to complete the treatment. It was only then that I discovered I had contracted an STD. I lived with an STD for nearly a year because I was scared of my doctor.

Theresa has dealt with chronic health issues for nearly ten years. During that time, her perspective on health care has dramatically shifted. Theresa recalled being excited about seeing doctors because they might actually figure out what was causing so much pain. Theresa referred to this time as the “rollercoaster era”. Doctor after doctor assured Theresa they could diagnose her problem but none were successful. The doctors grew impatient with their inability to solve Theresa’s chronic illness and eventually she stopped trying to seek new specialists.

Theresa no longer looks forward to medical appointments. Theresa's anxieties around health care providers have skyrocketed. "My palms become clammy. It infiltrates my dreams and the night before. Day of I'm a nervous, neurotic mess."

In contrast, Connie seeks medical attention once or twice a month. She visits several specialists regularly. She is unafraid to see the doctor for things like antibiotics or to check on a mole. If she encounters a fat-phobic doctor, she does not return to the practice. She says that it's a fifty percent chance a doctor will be good or bad. When asked about her relationships with doctors, Connie laughed and explained "Well, if they're contentious I don't go to them anymore. So, yes, I have had many unhappy relationships. But they don't last long anymore". Connie explains that while she visits doctors often, it's still not easy and reiterates the fact that she hates doctors. "Half the time I think they're idiots, half the time I think they don't listen to me."

Weight Loss

Every woman had encountered more than one health care provider that recommended weight loss as a primary form of treatment. There can be immense pressure from doctors for fat women to actively discuss how they are 'addressing' their 'weight problems'. Fat women are significantly less likely than their thin counterparts to partake in annual breast and pelvic exams for fear of being weight shamed (Drury & Louis, 2002). When they do muster up the courage to attend an examination, "obese female patients are more likely to be advised to lose weight than men with an identical

BMI” (Drury & Louis, 2002). The number one ‘prescription’ given to the fat patients interviewed was weight loss, even when the patient asked for further testing.

Amanda recalled a visit with her midwife where during her pap smear the midwife discussed her ‘new waist’. She lied and said she had recently lost ten pounds to appease the midwife who preceded to discuss how much better Amanda was looking.

While women have always been especially scrutinized by the medical community, this obsession with weight has only increased the biomedical control over women's bodies while simultaneously excluding them from health care access. Beth has struggled with her health care providers’ inability to see past her weight. During a visit to receive treatment for strep throat, Beth remembers her doctor recommending a slew of weight loss plans.

He was telling me to buy these expensive diet books and to find a gym. Like...I’m on medicaid. I have an internship with the government that barely pays anything. I’m not exactly sitting in the lap of luxury. I can barely pay my bills.

For Jane, one of the most frustrating aspects of interacting with doctors has been their lack of updated information about weight sciences. She recalls prestigious, nationally recognized health care providers telling her to monitor her caloric intake and expenditure. Jane was baffled. “How can you be so highly educated and still believe that?”. It has been proven that dieting and restrictive eating actually lead to increased

weight gain in the long term. While restricting calories and implementing strict restriction on food types may, in some people, result in an initial weight loss, it is ineffective long-term (The Center on Eating Disorders in Victoria, 2016). Most dieters will regain any initial weight lost within five years, and usually end up heavier. In addition, diet restrictions can lead to unhealthy attitudes towards food creating disordered eating patterns. In fact, young women that begin dieting are 18 times more likely than those that do not participate in dieting to develop an eating disorder within the first six months (National Eating Disorders Collaboration, 2016). Alex found herself in this very situation.

I had doctors tell me to go on sub 1000 calorie diets, I had doctors push fad diets (carb free, gluten free, paleo, Adkins, etcetera) as if just getting smaller would solve all of my problems...Dieting caused me to go from slightly low blood pressure to dangerously low blood pressure, to the point that I was passing out. I developed a sleep disorder. I am always cold and gaining weight back didn't solve that. I was told bursitis was caused by my weight, my ENT issues were weight related, my cycle issues were weight related, even though they got worse when I lost weight too. Dieting and focusing on my weight brought me to disordered eating, starving myself and over exercising, I weakened my immune system and developed new problems. Now I am bigger than I would have been had I never tried to lose weight.

Jane had been dealing with knee issues and wanted help. When she was dealing with knee issues, her chiropractor suggested exercises to make her knees stronger. “At no point was he like, oh yea and by the way you’re fat. So that was awesome, and now my knees don’t hurt anymore!”

Connie is uniquely situated in this discussion of weight loss. Prior to her diagnosis of hypothyroidism and Cushing’s syndrome she was extremely thin. Her conditions directly affect her weight and as such her weight is now discussed at nearly every visit to the doctors. Before her diagnosis, however, doctors refused to believe her weight was a sign of anything other than over eating and getting older. Now that she is fat, doctors frequently prescribe weight loss drugs and stress the fact that she needs to lose weight.

Malpractice

Fatness is seen as a master status, overshadowing any other concerns a person might have as a patient (Drury & Louis, 2002). In her analysis of fat women’s experiences, Cat Pausé (2008) found many women were stigmatized by their health care providers and often refused diagnostic procedures. Malpractice is defined by the American Board of Professional Liability Attorneys (2018) as “when a hospital, doctor or other health care professional, through a negligent act or omission, causes an injury to a patient. The negligence might be the result of errors in diagnosis, treatment, aftercare or health management”. Medical malpractice must also contain the following criteria: “a violation of the standard of care... an injury was caused by the negligence...and the

injury resulted in significant damages” (American Board of Professional Liability Attorneys, 2018).

Amanda was suffering from ulcerative colitis and asked her gastroenterologist for a celiac blood test. He refused to administer the test even though he was the one to diagnose her with ulcerative colitis. Frustrated, Amanda wanted to know why. The doctor believed that she couldn't have celiac disease because Amanda was fat, and the 'typical' celiac patient is underweight.

Instead, she was given an expensive prescription medication that nearly killed her. Amanda's doctor hadn't warned her of any side effects and she was experiencing a rare but life-threatening reaction. Amanda spent two weeks on a ventilator in the ICU. Amanda's doctor refused to take responsibility, citing the medication he prescribed couldn't have caused her reaction. It had. She later tried to sue the doctor for medical malpractice, but was told by her attorney that because she lived, she wouldn't win in court. This is, unfortunately, not uncommon.

Theresa underwent a laparoscopy to determine if she was suffering from endometriosis. Days after the surgery, she was unable to walk. When she arrived at the emergency room, her pain was not acknowledged. Theresa explained that every health care provider she encountered treated her as if she was over reacting and told her she was simply dehydrated. They also spent a great deal of time focusing on her weight, asking how frequently she exercised.

Theresa was given an ultrasound on her calf to investigate the source of her pain. The nurse who performed it was having difficulty seeing any veins, citing Theresa's large calf. This nurse decided to end the session without seeing Theresa's veins clearly. Theresa was not given a CT scan to ensure there was not a blood clot present. Theresa strongly believes she was not fully treated to the best of the staff's ability because of her weight. She was discharged, but not before the doctor blamed her pain on her weight.

A month later, Theresa visited the emergency room again, as she could not breathe. The doctor told Theresa it was probably just the weather, even though she had all the hallmark signs of blood clots. A few days later she returned to the emergency room. Theresa had a bilateral pulmonary embolus (BPE), or blood clots in every artery of both lungs. BPEs are known for causing sudden death, and 76% of pulmonary emboli are diagnosed upon autopsy.

I had so many clots in my lungs that the hospitalist asked if he could write about me in an article for a medical journal, because he had never seen so many PE's in someone that was not in the morgue. It was traumatic, difficult, and it took a very long time to become whole again, because I shattered under all of it.

When she finally received the lab results from her initial emergency room visit, her blood revealed something much worse. A d-dimer is a test used to determine the coagulation level of blood. The normal range for blood is around 250, but Theresa's

blood was nearly 3250. This would have been cause for an immediate hospital admittance, but no one spent enough time investigating her pain to understand what was truly happening.

It is an absolute miracle I did not die. And this happened quite literally because my weight was regarded as the problem, not the blood clots in my body that several medical professionals failed to recognize.

Nearly every woman interviewed experienced this longitudinal neglect, even when they did seek medical attention. Jane suffered from increasingly debilitating back pain for years. Fearing she had no other options, she began the consultation process for a breast reduction. The surgeons refused to reduce her breasts enough to make an impact on her back pain, and instead suggested bariatric surgery. Not only did they cite her weight as the cause of her pain, but the doctor told Jane that she would be much happier with bariatric surgery. Jane refused, and decided to visit a chiropractor as her last option. The incredible pain she had been suffering from for years was due to a shortened muscle. It was purely genetic. Jane was furious with the doctors that failed to look at every option. “I could have undergone this incredibly dangerous surgery when the problem was not my weight but a muscle in my ass!”

For the past several years Maria has experienced ongoing, often debilitating lower back pain. She initially sought treatment for the condition but has since given up citing a lack of thorough investigation from any health care provider she has consulted. Initially,

she didn't ask for further testing because she was not sure of what testing she needed.

Doctors did not present her with options. Instead, it was always lose weight, do stretches and take aspirin. "There are so many diseases and things that people usually find too late, so it makes me worried. Why can't they maybe look into this and my symptoms to see if it's something bigger?"

Maria's insurance doesn't cover seeing a specialist and she doesn't have the money to pay for a visit out of pocket. Thinking outside the box, she purchased an online voucher that included a visit to a chiropractor and an x-ray. When she looked at the x-rays with the chiropractor, it was as though everything fell into place.

They told me, 'no wonder you're in pain!'. The top half of my back is totally straight, and from the front you can see it bends to the right a bit.

My back is legit messed up.

It took Maria several years to finally get this small piece of information; her spine was lacking correct natural curvature. Unfortunately, the x-ray wasn't included in the voucher she bought and she couldn't afford a copy. When she approached a primary care physician, they finally ordered her another x-ray. This time, though, she was lying down. Maria expressed her immense frustration with the process. Because she was lying down in the second x-ray, the scans came back normal. Again, the doctor prescribed her stretches and recommended daily aspirin.

There is so much luck involved in the whole process. Doing it the exact right way and coming across the right doctor...someone finally had believed me and it was like a tease

When asked why she did not push for more testing, Maria explained that it has been extremely hard to question the physician's orders. She has since given up any hope of curing her back pain, saying doctors are a waste of time and money. The last time Maria visited a doctor for something routine was two years ago. She needed a physical to be admitted to graduate school.

I could go to a primary care physician. I just don't feel inclined to because it's like... what am I going to go for? I don't even get my flu shot.

Maria was not the only woman I spoke to with misunderstood back pain. At a visit with her OBGYN, Alex was told that she could not continue taking birth control pills because of her BMI. Alex had been taking the birth control specifically to aid in particularly painful periods. Shortly after, Alex began experiencing severe back pain that quickly progressed until she needed to walk with a cane. She began seeking medical attention, but her pain was brushed off. Doctors would not perform any diagnostic tests, nor did they believe the timeline of her pain progression.

Alex's general practitioner told her there was no way Alex was being truthful about her activity levels and diet. The GP blamed her sudden weight gain for the back pain. Finally, after a year and a half of searching for answers, Alex visited Planned Parenthood. "They were the first ones to treat me like an actual person", Alex explained.

The doctor immediately performed an ultrasound on Alex's back, and found a massive cyst on her ovary pressed against her spine. Alex was scheduled for surgery immediately. That cyst was over six pounds. Doctors found several more cysts and had to remove both of her ovaries because of the extensive damage in the area. Luckily, they were not cancerous cysts, but the surgeon believed their rapid growth was attributable to Alex being taken off of birth control pills. Alex would have likely become paralyzed without treatment. Had any of her doctors performed diagnostic tests, Alex could have avoided two years of pain and an incredibly dangerous surgery.

The power relationship between the authority figure of the doctor is heightened when the doctor is treating a marginalized person, namely a fat person. This power dynamic leads to the patients frequently feeling like they are unable to challenge the doctor's treatment (or lack thereof) placing the responsibility on the fat person. A substantial barrier is in place for fat people seeking medical care when health care provider's anti-fat attitudes are not simply towards fatness as a health condition but rather to the person themselves.

Connie has not always been fat. In fact, she was extremely thin until about ten years ago. She laughs and describes herself as "semi-anorexic". Ten years ago, something changed. She started sleeping for 17 hours a day and couldn't get out of bed even when she was awake. She began rapidly gaining weight to the tune of a pound per day. Connie went to four different doctors who all said the same thing. "I was suddenly gaining all of this weight. Everyone said I was just getting older. I said 'bullshit!' You don't gain a

pound a day just being older!” At this point, Connie had gained 70 pounds in a matter of months and was still nearly bedridden from fatigue.

Finally, she found someone who would try tests to find out what was wrong. Connie was diagnosed with hypothyroidism and Cushing's syndrome. She finally had a diagnosis but the victory was short lived. Connie's latest doctor explained that because it had taken her so long to find treatment, her conditions were considered preexisting. She would not be covered under her insurance. Connie was in complete disbelief.

How could I have a preexisting condition if no one had diagnosed me with that before?! I was furious. To top it off, I couldn't pay for it. That was before Obamacare. Now they're going to take that away too, of course. She couldn't say I had a preexisting condition until she tested me but because of my months of weight gain, they didn't care. So that royally pissed me off.

Connie went on to discuss how she has had to be her own advocate. It has been difficult, and taken her many years to feel comfortable telling doctors exactly what tests she wants and when. Luckily Connie is extremely knowledgeable about the field of medicine.

After Connie's primary doctor diagnosed her with Cushing's Syndrome, he referred her to the nation's leading specialist for further treatment. Connie said it was the worst experience she had ever had with a doctor.

I have to talk Dr. XXX into any test I want. He referred me to a specialist who was the biggest bitch I ever met in my life. She looked at my diary of every single thing I had put in my mouth for six weeks. I mean literally everything I put in my mouth for six weeks. And she goes 'aweee' in the most condescending tone ever. [The specialist said] 'yea, well, you know you're just a product of the American diet. You're a typical American. Americans eat too much fatty foods.' I'm looking at her like what are you talking about? My husband was with me or I would have lit her up! I was born in Germany, my mother was raised in Austria, I spend summers teaching in South Korea, how am I a product of America? I think she's just an asshole. A big one. A really large asshole. I hate her.

Quality time

For Maria, an investment in her personal success is a requirement for any doctor-patient relationship. Several months ago Maria fell and badly sprained her ankle. She finally sought medical attention when she couldn't put any weight on it at all. Going to the doctor was a complete waste, Maria explains.

The doctor saw me for about one minute. I only got a note for one day off of work. I'm a fitness instructor, are you kidding me? I could lose my job over this. I had to look everything up online, how long to stay off of it, how to help the healing process, all of it

Doctors report spending less time with fat patients and perceive them to be responsible for causing additional work for medical staff (Patenburg et al., 2012). Theresa worked for a medical clinic at a university for four years and revealed that no one seemed to follow HIPPA guidelines.

One day, a physician's assistant (PA) said out loud "Now, I have to go figure out how to do a pap smear on a 350 pound patient. I don't even know how I am going to get up there! How do fat people have sex?!" I was absolutely flabbergasted. If that's what she thought then what does my gynecologist think about me?!

Beth echoed this sentiment, stating most doctors she encountered spent as little time as possible with her. She also felt like doctors weren't taking anything she said seriously because they didn't think she cared about her health. Rather than acknowledging health as a complex state of being with many moving parts, doctors seem to only focus on weight.

It bugs me when people think I don't care about my health because it is wildly false, I just care about it in ways that are not always how other people care about their health.

Beth mentioned that she had never been asked about her mental health by anyone other than her psychiatrist. She stated that this was problematic and showed the narrow definition of health for many doctors.

One of the main reasons Connie's health deteriorated so drastically in a short amount of time was because doctors wouldn't listen to her concerns.

I have had a very hard time finding a provider that takes the time [to discuss my concerns]. I now have one, though. In general they are in and out quick as can be. They don't want to talk to you, they don't have anything to say to you. But the problem is that it takes ten seconds for them to order a thyroid test. If they would have just done that when I first complained [about my symptoms] I would have been a lot healthier for a longer period.

Accessibility

Stigma is experienced in a variety of ways and in many different settings. The interviews uncovered two specific barriers to accessible medical care: physical and financial. Fat patients often face physical barriers to treatment from scales that do not measure their weight to too-small dressing gowns. When fat patients do not fit in the space provided a clear message is being sent: they do not belong. Cat Pausé (2017) writes, “[i]mportantly, stigma may also be experienced structurally, through settings and practices that privilege those without stigma and or place barriers to prohibit engagement for those with stigma”. One issue that every woman referred to early on in the interviews

were the arm cuffs used to measure blood pressure. None of the women could fit in the standard cuff offered.

The last time Beth had her blood drawn, she could barely fit in the designated chair. She tried to pretend she wasn't both extremely uncomfortable and very embarrassed. The nurse forced the arm rest over her stomach, leaving her with red marks and bruises the next day.

I would never bring it up at the office because it's just too humiliating.

Even medical professionals seem to have a weird disconnect between my fat and me. Like they don't realize it hurts when they push on it. It's fat, not literal padding. It's attached to my body!

Jane stated that gowns were a huge problem. She was annoyed that more health care offices didn't stock larger sized gowns. "It doesn't need to be a problem," she argued. "Larger gowns do exist, but places just don't carry them".

Financial constraints have been a huge barrier for Maria, Beth, Connie and Amanda. This compounds with their unwillingness to trust doctors leading to avoidance behaviors. Beth is unwilling to spend money on a copay because she believes going to the doctor doesn't help her quality of life, reiterating this fact several times.

My husband is a PhD student and I am no longer able to work due to my illnesses. So, I am a dependent on his student insurance. There's this common misconception in America that young people do not need affordable or good insurance, because when you're young, you rarely go

to the doctor. Aside from having to deal with insurance, cost, and the length of time it takes to get into a specialist or just a regular Primary Care Physician (PCP) who happens to have a side specialty (such as palliative care), it can take months to get in to see someone.

All of the women cited a lack of trust for their doctors as a primary reason health care has been inaccessible for them. For a few months after she turned 18, Maria smoked cigarettes. She describes being asked by a doctor if she smoked, to which she responded no. “I didn’t want to tell them, are you kidding? Right off the bat they say ‘do you smoke? It’s bad if you do, let me tell you why.’ So I hid it. But with weight, weight you wear on your sleeve. I can’t tell them ‘no, I’m not overweight.’ ”

Improvements

The final question asked of the women was what would make health care better for them. Their responses were incredibly powerful and often, quite simple. Every woman asked for kindness. They also asked for care without stigma. They wanted to receive high quality, accessible health care. Amanda explained, “It’s intimidating to go to the doctor when you’re heavy. It’s seemingly really easy for some of them to wholesale blame everything on your weight, including ear infections. It’s kind of ridiculous”.

For these women, the stigmas associated with fatness were not only leading them to avoid seeking health care. These anti-fat attitudes prohibited them from accessing

quality care. Jane brought up the fact that when a woman is fat, it's the only thing doctors want to treat. "Recommend things to people of different sizes. If I weren't fat, what would you recommend? Why don't we start there?" Beth reiterated this statement and added, "I work very hard. There is more going on in my life than just my weight. It is very difficult for me to seek medical attention for fear of how I may be treated or perceived. I just want to be treated like a person."

When I asked Theresa what she wanted to do to improve healthcare access, she asked direct her words specifically to health care providers.

I am a human being. I have come to you for answers and what you say to me will have an impact on me. When you cannot look beyond my weight and see how much pain and illness I have suffered through, it is soul crushing. When I come to you, I trust you will handle me with care. Since I am trusting you with quite literally my life, I am hoping the respect and trust is reciprocated. I do not need another lecture about my weight. I am fully aware of how much I weigh, what I look like in the mirror.

CHAPTER FOUR

Discussion

This study sought to fill a gap in existing literature by providing a detailed account of the experiences of fat women in health care settings. The aim of this study was to understand how medical provider's weight biases have affected fat women physically and mentally. Through in depth interviews with 11 participants. The following themes emerged: quality time, malpractice, weight loss, avoidance, accessibility, and improvements.

All of the participants discussed active discrimination they encountered when seeking health care. This discrimination took many forms that varied from physical spaces to anti-fat attitudes. Participants were very aware of their provider's weight stigmas. Experiencing weight stigma leaves many fat people desperate to try anything that they can to reduce their size, because in essence, fatness is something that cannot be ignored. When someone is fat, it's visible, and constructs the way the fat person views the world and is viewed. If we truly want fat people to have health, the way we view fat people must first change.

Suggestions for further research include an investigation of how patients interact with and challenge their care providers. In addition, educational opportunities for medical providers that challenge weight biases should be developed. A longitudinal study examining the care of fat patients may reveal a significant co-morbidity of fatness to be a

lack of care from medical doctors, something that is not discussed in current literature.

There were several limitations to this study. First, the small sample size does not allow for generalizations. Further research with a larger and more diversified population is needed to expand upon the themes uncovered in this study. It is important to note that the majority of participants (8) were recruited in fat specific spaces. This may have affected the way participants related to their fatness. Most of the women interviewed were outspoken about the mistreatment they experienced. If participants were recruited from more generalized online forums, I would expect participants to have increased levels of internalized fatphobia and subsequently a decrease in discussion surrounding medical malpractice.

Additionally, I am a visibly fat woman. These women may have felt more comfortable discussing their experiences with me, as someone they can identify with.

Conclusion

Studying fatness can be difficult. At every corner is a person who *knows* everything about the body. Perhaps they *know* that dieting works because their great aunt lost 50 pounds on Jenny Craig or that being fat *is* dangerous because of the “Obesity Epidemic” they keep hearing about on the news. Especially frustrating are those who continue to make disparaging remarks about fat bodies, shaming them and making jokes

at their expense. Most discouraging though, is the fact that fat women are experiencing this weight discrimination from their health care providers.

Our medical system vilifies fat people. Fat women do not receive the same quality of healthcare as non fat women because being fat has been medicalized as inherently “unhealthy” and the resulting vilification and anti-fat attitudes are normalized. Unhealthy, thin people seek medical care every day, but are not subjected to the same stigmatization as their fat counterparts. Whether or not being fat is unhealthy should never affect the level of care provided. Vilification, stigmatization, and censure from the medical community is violence against fat women and leads to deadly consequences. It is inexcusable.

APPENDIX

The following is a list of the interview questions used.

How frequently do you seek medical care?

Is seeking medical care easy for you?

Have you ever avoided seeking medical attention?

Have you encountered physical obstacles in the medical office?

Have you encountered non-physical obstacles?

Do you see the same provider each time you need medical attention?

How have your relationships been with your health care providers?

Does your health care provider look like you?

Do you feel as though you are treated with courtesy and respect by your health care providers?

Has your health care provider ever refused to perform medical tests?

Do you feel like your health care provider spends enough time with you to discuss any problems or questions you may have?

How often does/did your provider weigh you before an appointment?

How often does/did your provider bring up weight at your appointment(s)?

How does/did your provider handle conversations about your weight?

When seeking care for non-weight related concerns, does your provider bring up your weight?

What would make seeking medical attention better for you?

What would you like health care providers to know?

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