The racist origins of anti-fatness: its effects on Medicine

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1. **What is the issue?**

Several studies have shown that healthcare providers, including physicians, nurses, and medical students, have negative attitudes and biases towards patients in larger bodies, which often leads to poor communication, stigmatization, and discrimination. Anti-fat bias has been tied to delayed and missed diagnoses. Evidence also shows that anti-fat bias can lead healthcare providers to make assumptions, ascribe less value, and have less trust in their larger-bodied patients. Anti-weight bias impacts their quality of care.

In recent years, medical researchers and social scientists have looked into the roots of antifatness (antifat bias) and have found strong ties to antiblackness, eugenics, and medical apartheid. In her book *Fearing the Black Body: The Racial Origins of Fatphobia (2019)*, Sabrina Strings documents the evolution and creation of anti-fatness as a system that originated through European anti-blackness and the construction of racial categories. Dr. Strings connects racism, the slave trade, and how colonizers and colonized mingled for 200 years and how this made skin color no longer an effective way to recognize who was enslaved or who was free. New dividing categories had to be created. White Europeans began using eating and size to position themselves as a superior race by morally and physically reshaping the idea of what constitutes the perfect, beautiful, healthy body to continue subjugating and exploiting the black and brown body.

While the slave trade eventually ended, the racist biases and attitudes toward body size remain today. Dr Strings argues that fear of fatness and preference for thinness is, principally and historically, not about health but a way to legitimize race, sex, and class hierarchies. She also states that anti-fatness, while used to delegitimize the black body, is also a tool to discipline whiteness. Da'shaun Harrison, in their book *Belly of the Beast (2021)*, explains: "Discipline that shows up in the medical, industrial complex, the healthcare industry and the diet industry all exist to maintain a culture intended to discipline those whose bodies refuse to - and for many simply cannot - conform to the standards of health."

Dr. Strings also clearly traces how anti-fat attitudes worked their way into modern medicine and are showing up today in hospitals, doctors' offices, and emergency rooms. Cross-cultural studies confirm that socialization to fatphobia is not limited to North America. Data from the Harvard Project Implicit study demonstrate consistent pro-thin, anti-fat biases globally. While limited research data focuses on antifat bias in the Global South, we can

assume that medical personnel trained in the Global North will carry this bias in their patients' interactions and work in the Global South.

The most straightforward example of antifat bias in healthcare settings is using the Body Mass Index (BMI) to determine obesity. The body mass index (BMI) is currently used for defining anthropometric[1] height/weight characteristics in adults and categorizing them into groups. The standard interpretation is that it represents an index of an individual's fatness. It also is widely used as a risk factor for the development of or the prevalence of several health issues. In addition, it is commonly used in determining public health policies. The BMI has been helpful in population-based studies by its wide acceptance in defining specific categories of body mass as a health issue. However, it is increasingly evident that BMI is a relatively poor indicator of percent of body fat. BMI is an inaccurate measure of body fat content and does not consider muscle mass, bone density, overall body composition, and racial and sex differences.

While doctors and healthcare personnel are currently trained to use the BMI as an indicator of health, very few know that the inventor of BMI, Adolphe Quetelet, was a Belgian mathematician and sociologist, not a medical doctor. Quetelet created the BMI for his sociological work. He wanted to identify the characteristics of l'*Homme Moyen* — the average man — who, to Quetelet, represented a social ideal. Quetelet only considered and measured the average white European male body in his studies.

In March 2004, during a news conference with widespread coverage, the US Centers for Disease Control and Prevention (CDC) published a report that claimed that obesity was "killing 400,000 Americans a year" and that it was becoming America's "number one preventable death"—surpassing tobacco. Because top scientists at the CDC coauthored the report, it had the credibility for the media and the public to be taken seriously. Even though, in the next few months, other reports came out, calling the CDC report flawed and the data weak, many politicians, healthcare professionals, and the media had already started talking about a "war on obesity."

A detailed analysis of the CDC 'Obesity Kills' Statistic' demonstrates that the study relied on outdated data and that the correlation between death and obesity was flawed. As J. Eric Oliver, in his book *Fat Politics: The Real Story Behind America's Obesity Epidemic (2005),* explains: "… the CDC researchers did not calculate the 400,000 deaths by checking to see if the weight of each person was a factor in their death. Rather, they estimated a figure by comparing the death rates of thin and heavy people using nearly thirty-year-old data. Although heavier people tend to die more frequently than people in mid-range weights, it is

[1] of or relating to the scientific study of the measurements and proportions of the human body.

by no means clear that their weight is the cause of their higher death rates. It is far more likely that their weight is simply a proxy for other, more important factors such as their diet, exercise, or family medical history. The researchers, however, simply assumed that obesity was the primary cause of death, even though there was no clear scientific rationale for this supposition."

In 2005, the CDC admitted that the 400,000 was a mathematical error. However, the damage was already done. The media and the public were not exposed to the retraction, and the myth of obesity as the leading cause of death in America was cemented.

Despite considerable evidence of weight bias in the United States, currently, limited work has examined its extent and antecedents across different nations. The study, *International Comparisons of Weight Stigma: addressing a Void in the Field,* provides the first comprehensive comparison of experiences of weight stigma across multiple countries in the Global North. In Canada, France, Germany, the UK, and the US, weight stigma is a prevalent experience for adults who are enrolled in weight management. Most participants across these countries experience weight stigma in multiple and diverse interpersonal relationships, ranging from family members to doctors. These findings indicate more cross-country similarities than differences in weight stigma experienced by adults engaged in weight loss.

There is also limited but highly suggestive data that obesity stigma is an emergent phenomenon that begins to affect populations across the global south. The evidence includes implicit and explicit measures showing very high levels of weight stigma in middle and low-income countries. The studies underscore the need for collaborative, multinational initiatives to address antifat bias and implement supportive interventions to help individuals who experience it along with its harmful consequences. With weight stigma growing in the global south, recognizing it as a global health challenge is crucial.

2. What has to be changed?

In the interest of public health, healthcare professionals should focus on the fact that study after study in the past 20 years has demonstrated that intentional weight loss is unsustainable, counterproductive, disruptive, dangerous, and unnecessary. Studies have shown that between 80 and 98% of people who engage in intentional weight loss will regain all the weight within five years. Up to two-thirds of those who engage in some form of dieting will end up heavier than when they first started. Repeated attempts at losing weight have been shown to cause permanent physiological changes in how we absorb, store, and expend energy, making further weight loss attempts less and less feasible.

Those who can maintain the lost weight have been shown to have developed disordered eating and exercise patterns that share a lot of similarities to eating disorder behavior. Even though limited, research demonstrates that explicit and implicit weight bias exists among healthcare students in the global south. But many countries are moving forward with public health campaigns to address obesity, and the early signs are that messages appear to similarly link to notions of *blame and shame* as they have in many prior campaigns designed for and implemented in the global north. The exhibited weight bias has the potential to negatively impact the care that people living with overweight or obesity receive, contributing to worse health outcomes and quality of life.

Numerous studies show how lifestyle interventions (for example, improvements in physical fitness) improve health outcomes irrespective of weight loss or changes in BMI. Weight is controlled by many other things, including genetics, environment, lack of rest/sleep and high levels of stress, underlying physiological changes (e.g., insulin resistance), medical conditions (e.g., PCOS, hypothyroidism, type 2 diabetes), medications (i.e., Iatrogenic weight gain), and a history of childhood trauma.

In the US and the rest of the global north, the 'epidemic' of weight stigma grew unrecognized for decades, with *apparent* complicity in medical and public health norms and practices that reflected the cultural view of obesity as a moral failing. The "responsibility" perspective has had potent political effects. In a nation that has long viewed health as a proxy for success and even virtue, given the moral/religious cast so often coloring American political debates, the overweight individual's struggle with obesity is portrayed as a personal failure. Consequently, it can be challenging to mobilize even sympathetic people to combat an issue successfully portrayed as the afflicted's fault. A personal responsibility frame also points away from robust legislative solutions**.**

It is now crucial to learn from the Global North's mistakes and avoid repeating them altogether or preemptively mitigating them. The Middle East, East Asia, the South Pacific, and Africa are home to billions of people who are and can be emotionally and physically negatively impacted by the antiweight phenomenon. While more studies about the impact of antifat bias in the Global South are needed, preventing and mitigating action is already needed as outlined by researchers, medical professionals, and fat activists.

3. How can we change it?

In the paper, *Weight Bias and the Training of Health Professionals to Better Manage Obesity: What Do We Know and What Should We Do?*, Ian Brown and Stuart Flint report that: "As attempts to reduce medical students' weight bias have shown partial success or

were unable to produce long-term reductions in weight bias, future research to develop new ways to reduce weight bias is warranted. Additionally, educators must devise methods to reduce students' weight bias in classroom, practical, and curriculum settings."

Because it is easy to increase resistance among healthcare professionals since they may interpret the need for training and interventions as a message that they are prejudiced or less caring about obese patients, any training must include a sophisticated sociological understanding of stigma to reduce this resistance.

Doctors and nurses must be supported with funding for education and research, especially in immediate impact areas. This should be an area of focus for aid and development organizations operating in the Global South.

Priority should be on training medical and nursing students on more critical health indicators and in making the connection between anti-fatness and anti-blackness (racism), de-stigmatizing fat through awareness-raising campaigns and a robust research agenda on the implications of globalizing obesity stigma for obesity prevention and treatment in middle and lower-income countries.

Training should also focus on the need for better evidence of a problem for patient outcomes, and how to have a holistic approach to patients' health, for example through deemphasizing weight and weight loss, considering better indicators to support patients' health and improving rapport, communication, and relationships with patients and their satisfaction with experiences of health services.

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