Rethinking how we see and respond to fatness

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The four themed articles in this issue have at their heart concern for people's health, in particular how best to advise patients about weight and nutrition. They outline opportunities such as multidisciplinary teamwork and specific training to improve the health promotion advise offered to patients and their whanau.[1–3] Crowley *et al.*[3] suggest using free annual diabetes reviews as a vehicle that removes the cost barrier and offers the time necessary to provide whole person care. Perhaps, according Meredith-Jones *et al.*,[4] by this point it is too late and earlier interventions are required. The articles highlight many barriers to delivering appropriate care: time, knowledge, skill, remuneration, space, funding, conflicts of interest, lack of integration and inflexible contracts.[1–4] The articles also discuss responsibility, choice, and risk.

Some troubling assumptions around lifestyles, physical activity and bodies underpin weight (and by proxy, nutrition) research. Such research suggests that good health is something within our power to achieve if only we are prudent, disciplined, and control our impulses. In an era where health is increasingly at risk from global dangers, we are '*exhorted ever more to take individual responsibility for our bodies by engaging in strict self-care regimes*'.[5] To engage in 'risky' behaviours is seen as irrational and irresponsible. The notion of risk contributes to a moral panic about obesity. It compels a solution of surveillance and treatment, and an understanding that interventions relating to body shape, size, and fatness are crucial. 'Lifestyle' is blamed by many of the participants in the studies[2–4] but a universal healthy lifestyle does not exist. The focus on lifestyle conceals power and economic imbalances within society and these discourses have arguably been appropriated by government to justify the retreat of the welfare state from social responsibility for health.

Gard and Wright[5] argue that there is minimal evidence to support the energy-in-energy-out equation, which some of the studies in this issue reference explicitly and others more subtly, and that physical activity does not affect bodies in predictable and identical ways. This equation offers a medicalised view of physical activity to expend energy for the purposes of weight management rather than more holistic understandings of the purpose and potential of physical activity such as enjoyment, mastery of skills, and social contact. It presupposes that each person's priority is to be active over other commitments and pleasures. Eating becomes unable to be thought of without reference to achieving 'health', with little consideration for the cultural, religious, or social significance of food. The equation reduces people to 'bodies' rather than individuals with diverse needs and interests, shaped by particular socio-cultural and economic circumstances. Focusing health promotion advice on understanding our bodies as 'doing' rather than 'being' may help to shift the emphasis from appearance to function and provide a more joyous approach to activity and eating.

In Western contemporary contexts health is mainly regarded as something that is located within the body, with weight and size functioning as visual markers of healthy or unhealthy selves. Intensifying these beliefs is the historic notion that the body - its shape, surfaces, size - is representative of the inner self.[6] The socially ascribed meanings of fat can be 'read' from one's body as confessing the 'truth' about a subject, that is, lazy, self-indulgent, and greedy.[7] Implicit in obesity discourses is a belief that obese bodies not only *can* be worked on but a moral imperative is implied that such a body *should* be worked on (thereby publically expressing virtues of self-control and willpower). At the extreme, this mentality may exhort people to develop relationships with food and their bodies based on guilt and anxiety.

The use of the term 'obesity' in the media, the medical establishment and among laypeople

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has transformed it, giving overweight a disease status yet obesity itself is not a disease; its status as such is contingent on correlations with various illnesses.[5] While overweight is a description of someone's weight, not of a disease, the disease status it has acquired has important consequences for sufferers because their daily social reality is modified.[9]

As a response to this climate of fat abhorrence and medicalisation of weight, fat activism and acceptance movements emerged such as Health At Every Size, National Association to Advance Fat Acceptance and more radical movements.[8] Each has beliefs about how to best achieve fat acceptance but the overall goal of the movement is one of ending fat discrimination and embracing body diversity. Many fat activists posit that fat is not something negative that one must come to terms with and instead argue that fat should be celebrated in its many forms and through a wide range of activisms. Reclaiming the word fat is one of the ways these ideas are subverted.

This may all seem like heresy to some, especially people, institutions, and organisations with vested interests in fighting obesity. However, risk and obesity discourses have come to be understood as 'truths' so much that they are often regarded as 'common-sense' and relatively impervious to challenge. Voices of biomedical experts hold power, authority and appear to contain no uncertainties.[5]

Without adequately addressing the barriers that the articles identified, more harm than good may come of attempts to 'empower' patients to make 'good' choices. The ability to choose is the essence root of the word 'power' and paradoxically to presume we can empower someone to make the 'good' choices we would make, disempowers them (threatens their ability to choose for themselves). There are other unintended consequences of advice around weight and nutrition; according to research cited by Meredith-Jones *et al.*[4] restrictive eating can cause additional weight gain.

The notion of competence, that Crowley *et al.*[4] emphasise, is crucial when it comes to sensitive issues such as weight and diet. Weight bias, even subtle, occurs even in people who are otherwise nonjudgmental, including health professionals, and impacts negatively on health outcomes.[10] There is considerable evidence that health professionals' attitudes towards fat influences what, how and whether care is provided.[10] Health professionals need to become aware of their own implicit assumptions, beliefs and biases about fat in order to be able to best help their patients.

Body prejudice and widespread denigration of fat people is still a socially acceptable form of discrimination. Growing stigmatisation and cultural abhorrence of fat can be attributed to scientific research about weight as it, in effect, rationalises the judgementalism and makes it acceptable to stigmatise fat people because it is good 'for their health'.[5] Most fat (and even not so fat) adults and teenagers will be well aware of their weight, and may not welcome uninvited comments on weight by others, for example pharmacy assistants.[2] If 'obesity' is still considered a burgeoning issue, then perhaps it is time we rethink how we see and respond to fatness.

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