

Failing Women – an ethnography about the experiences of
women with larger body sizes in Southern Ontario health
care settings

by

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Abstract

This thesis explores the experiences of fat women in Southern Ontario health care settings and their relationships with their bodies. It is an ethnography of thirteen women who identify as curvy or fat and currently use Canadian medical care. It shows how fat women's relationships with their bodies are multifaceted and shaped by external influences, and the ways they experience denial in their access to health care because of their body size. This thesis ultimately points to how historical and cultural constructions of body size ideologies, power relations, and understanding of the physical form as a determinant of "health" impact fat women's health and well-being through structural violence and biases in health care. It argues that there is a need for fat cultural safety programs, along with other changes to current practices to improve care, and, as a result, the health and well-being of people with larger body sizes.

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Chapter 1: Introduction and Literature Review

This thesis examines the experiences of fat women in Southern Ontario health care settings, addressing the question: What are the experiences of fat women in Ontario health care settings and how do these women conceptualize their body and health? Intrigued by the concept of cultural competency and safety in health care, I wondered whether health care practices acknowledged the dominant norm, which discriminates against, and stereotypes larger body sizes. In particular, I wanted to focus on the Canadian context of fat denigration. This thesis therefore aims to examine the inequalities that fat women experience in Canadian health care settings and proactively provide solutions to address these disparities.

In this thesis, I convey the historical and cultural context of body size ideologies in Western societies, how these ideologies impact women's understanding of their bodies and selves, and the significance of anti-fat beliefs as they impact women's experiences seeking health care in Southern Ontario. I use this framework to understand how body size ideologies impact my interview participants' health and well-being, particularly when seeking treatment from health professionals. I also discuss the main contributors to the participants' fat experiences that shape their lives and the internal and external influences that play a role in their health and well-being.

I chose to focus on the health care experiences of women with larger body sizes for several reasons. First, my life experiences surrounded me with women who struggled with their body size in a constant battle with fat. In part due to the "heroin chic" female figure era I grew up in, but also watching the women in my life struggle with their well-being by believing "thin was healthy," I was influenced to reflect upon how society

valued women and how I, and so too it appeared, the other women in my life, placed our focus on visual appearance. Second, as an eventual fat woman, I also believed my worth was based on my body size, at least until I wrote an essay on obesity in a medical anthropology undergraduate course which altered my viewpoint. My entire world, which claimed fat was unhealthy, harmful, and unappealing, turned out to be a cultural construction and not a medical reality (which I detail later in this chapter). Endeavouring beyond this initial paper, I continued to explore the intersectionality of body size with relationships, advocacy and activism, and global differences, to understand the outcomes of body size ideologies.

Third, after taking an undergraduate course in cultural competency, I wondered if these medical practices aimed at making health care more sensitive also considered body size, only to discover minimal research. With an awareness that women are a vulnerable population (Nyamathi and Koniak 2007:4), the main target of thin body size expectations (Wolf 2002), and that health care professionals are more likely to discriminate against a woman's body size (Haque 2020:8), I developed an interest in understanding how a woman's fat body influenced her experiences in health care settings – particularly as research does not often explore the voices of those targeted to lose weight (Greenhalgh 2015:viii).

To do so, in this chapter, I detail a literature review in three sections. I begin with the section “As Fat [Denigration] Grows,” which explores the background of body size ideologies, detailing the centurial history of body size othering originating with the growth of the slave trade to trace biomedicine's incorporation of the female figure into its practices. Next, in the section “Cultural Competency and Safety Programs in Canada,” I

explore the current research on cultural competency and safety, which confirms the use of cultural competency practices in medicine and the limited research which recognizes the benefit of medicine adopting these practices with regard to larger patients. Additionally, the minimal research on fat cultural competency reveals the importance of understanding medicine's body size perspective. Finally, the section "Fat and Health in Canada" analyses the research which explores fat in health care. Here, I elaborate on the two patterns associated with the conflation between fat and health, which either discuss fat discrimination in health care or emphasizes fat people as bad citizens by suggesting these individuals are a burden to the Canadian health care system.

1.1 As Fat [Denigration] Grows

To discuss fat denigration in Canadian health care settings, I believe it is necessary to establish how fat became a medical "problem." Anti-fat beliefs have a complicated historical presence. In addressing the origins of anti-fat ideologies entering the biomedical field, I draw on three books that trace the historical views of the body in Western societies. The book *Fearing the Black Body: The Racial Origins of Fat Phobia* by Sabrina Strings (2019) details how Western societies valued voluptuous figures at the beginning of the slave trade, but as the centuries continued, skin colour became associated with body size through the connection of darker tones with fatness and eventually larger body sizes became a social symbol of "less than." Critiques of fat bodies began shortly after the English entered the slave trade, which coincided around the time the country began the Reformation – a religious revolution from the errors and abuse of the Church and the beginning of the domination of Protestants (Strings 2019:104). As part of the Reformation, there was an issue of "intemperance," or the wealthy's abuse of

food and drink, and, as such, Puritans – those seeking to purify the Church of England – began the narrative that God created regimented eating and people should not overindulge in food (Strings 2019:104-105). Though the notion of a fat body applied to all people, Strings (2019:105) articulates how men would wear their excess adiposity as a badge of honour, yet they deemed fat women undesirable. Thus, to cleanse religious errors, body size became a way to determine the “worthiness” of a woman.

Maintaining the “righteous” path of the female body, Joseph Spence, elected to the Oxford Chair of Poetry in 1728 due to his connection with the Pope, deemed that females have the proper white colour and thin symmetrical figure (Strings 2019:111-112). Spence created a scoring scheme to determine the hierarchy of beauty in which women were judged based on their skin colour, shape, expression, and grace for their overall “sum of excellence,” with English women at the top, followed by other European nations, and the bottom including Asian and Black women (Strings 2019:113). In this sense, the ideology of othering through race extended to body size, where Western societies’ patriarchal colonizers enforced the notion where white became conflated with thinness and civility, and dark became conflated with fat and primitivity, implicated in the process of racial othering.

In the 19th century, the term “Anglo-Saxon” entered the discussion of race, which disparately valued different categories of white people. For instance, Anglo-Saxons were considered tall and robust, whereas Celtic Irish were gluttonous and stout (Strings 2019:131). This idea of body size as an indicator of race came from an association between large body size and “lesser” Black people; this physical attribute further established the “superior” traits as white and thin. Strings (2019:134) articulates that “the

racial lore of the time suggested that the English were a stouter breed of Anglo-Saxon than the Americans. By the mid-nineteenth century, this supposed general sparseness of constitution, especially among women, would become a basis for extolling native-born Anglo-Saxon Protestant American women.” In this sense, body size determined which white people were considered the most “superior” by establishing the superiority of Anglo-Saxons through thin bodies. This idea was reinforced in women’s magazines, pictures of clothing models, articles emphasizing the ideal beauty as white and thin, political campaigns, well-known artist paintings and drawings, and the appearance of public weighing scales (Strings 2019:135-165). Body size further exacerbated racism by ranking people beyond their skin colour and providing additional criteria for people to be deemed inferior or superior.

Of particular interest in String’s book outlining the racial origins of anti-fat ideologies is the connection to the medical field and health. Dr. John Harvey Kellogg – the inventor of Cornflakes – became concerned about white women’s dietary intake as he believed a lack of nutrients from a poor diet threatened their ability to give birth and, therefore, also threatened the existence of the white race (Strings 2019:178). Though Kellogg’s concern was the thinness of white women, his focus as a physician on diet and too-thin white women’s reproductive ability initiated the concerns of medicine with body size. The next step in medicalizing body size began with the creation of health insurance companies. Specifically, health insurance companies created standard tables where, in 1883, policyholders outside the average weight range - constructed from middle-class white male statistics – were found to have the greatest mortality (String 2019:188). As insurers refused to cover people above the “average” weight range, physicians began to

select whom they would take on as patients based on who had health insurance (Strings 2019:188). A patient's weight now became a concern for doctors, not because of adiposity and health, but because of medicine's relationship with capitalism. However, against the widely accepted insurance companies' revised standard height and weight table, doctors still advocated for body size diversity, believing a "standard" height and weight for women was not possible, and focusing their concern on the health of those who were too thin (Strings 2019:189).

Physicians continued to critique body size, particularly women's body size, because of their fertility. Similar to Kellogg's claim, another physician, disgusted by the appearance of fat women, claimed adiposity caused infertility (though without any evidence to prove such a claim) (Strings 2019:193-194). Ultimately, Strings (2019:194) summarizes that physicians' focus on body size stems from a "belief that the bodies of elite women needed to be regulated by medicine." Men in power needed to control women to ensure the successful continuation of "superior" races. Of particular interest in the incorporation of concerns with body size into biomedicine is the absence of non-white races. At this point, the medical professionals were not concerned about caring for racial "others" under the assumption that these groups would naturally die off (Strings 2019:195). Nevertheless, physicians began to connect "inferior" races to diseases by targeting people's cultural practices considered "less than" as the cause of ill health and immorality, believed to be related to their "gluttonous" larger body sizes (Strings 2019:196). This targeting would continue for decades, influencing research studies on Black people, particularly Black women, as they had been symbols of untamed aesthetics and immoral appetites since the slave trade (Strings 2019:203). Though, as discussed

above, fat would not become a health problem for at least a century, the seedling of fat as a medical issue began through the racist medical othering of Black women.

In a powerful conclusion, Strings (2019) reiterates that anti-fat ideologies and the obsession with fat bodies did not begin in biomedicine, but rather with racism. Concerns with body size and weight were not about health; they helped reinforce the social hierarchy of Western societies' colonial powers. Nonetheless, biomedical models continued to press the idea of fat as bad because, ultimately, health and well-being were about maintaining the survival of "superior" people and their positions of superiority.

Amy Erdman Farrell (2011) reiterates the connection of race with body size and gender in the second book I draw upon, *Fat Shame: Stigma and the Fat Body in American Culture*. In tracing the historical connection of body size, belonging, and social status to culture and the idea of citizenship, Farrell (2011) reveals how colonial powers in Western societies weaponized fat to exacerbate race, class, gender, and any other attributes deemed unworthy by those in power. Through a historical understanding of fat denigration, Farrell (2011:174) illuminates the connection between fatness and ideas about inherent inferiority, including a background to understand how Western societies use the Body Mass Index (BMI) to oppress people.

Essentially, body size concerns have not originated in worries about health; stigmatizing and discriminating against larger body sizes has been about maintaining positions of superiority. Specifically, the author (2011:176) suggests that "reinforcing the dangerous idea of the 'civilized body,' fat denigration intersects with and exacerbates racism, sexism, classism, and homophobia, and all the other means by which our culture classifies and oppresses people based on bodily attributes and social standing." Through

stereotypes, fatness was not just a tool to stigmatize larger bodies but also ridicule women, people of colour, and immigrants. For example, Farrell provides a cartoon that depicts a fat female Irish servant breaking the homeowner's property after falling down the stairs. Depicting the fat body as an immigrant, an "outsider," of the working class, reinforced the ideology that fatness is a marker of an uncivilized person. Along these same lines, the figure of the mammy – an overweight black woman subservient to her white family – links larger body sizes to other physical characteristics deemed "less than" and "inferior" by influential powers (Farrell 2011:74-75). The thin civilized body allowed the colonizing powers to connect the fat uncivilized body to other "less than" physical characteristics personifying these traits as unworthy. Western society weaponized fat bodies as a tool of power to legitimize racism and affirm white's racial "superiority."

Though Farrell does not explicitly address the historical evolution of medicine incorporating body size into their health concerns, the author does articulate that fat is not about health risks but about the horror of a stigmatized identity (Farrell 2011:176). Pretending that fat stigmatization and discrimination encourage health ignores the historical context and reality in which the influential powers of Western societies' have vilified fat.

In the last book I draw on, *Fat Politics: The Real Story behind America's Obesity Epidemic* by J. Eric Oliver (2006), the second chapter details how fat bodies moved from a medical problem to a "global epidemic." As a medical concern, larger body sizes did not become a problem until the beginning of the 21st century (Oliver 2006:39). It was a "problem" that all began with a map. In cooperation with the Centre for Disease Control (CDC) in the U.S., a pediatrician, Dr. William Dietz, published a map that displayed the

increasing number of states with an average BMI over 29 through a colour-coded system (Oliver 2006:40-43). The “high” BMI states appeared red, and as the years continued, so did the increase in BMI rates making adiposity visually appear as if it spread throughout the country through the growing number of red-coloured states (Oliver 2006:40-43). Essentially, fat appeared to be contagious. This map prompted biomedicine’s labelling of adiposity as a “disease” to eventually become an “epidemic” (Oliver 2006:40-43).

However, the “epidemic” of fat bodies did not end with the map, as adiposity as a disease was beneficial financially to a myriad of people in medicine. Oliver (2006) articulates that the societal understanding of health and medical care changed over time. Health and medical care were not about what caused a disease. Instead, they became about the treatment of symptoms. Academic researchers connected diseases (such as fat) to mortality, their efforts driven by the need for funding and publishing, and pharmaceutical companies, in all their capitalist glory, depended on fat as a disease to market and sell diet products (Oliver 2006:45-46). Additionally, certain medical professionals needed to become relevant again once other diseases, such as polio and typhoid, were eradicated from the advancement of medical technologies such as vaccinations (Oliver 2006:44). The focus on diseases which could not be prevented but where symptoms could be “cured” was beneficial to the medical industries. Along these same lines, health professionals would claim superior knowledge – based on scientific research and the societal understanding that people have power as physicians and researchers – which made obesity as a “disease” hard to dispute (Oliver 2006:50). Essentially, the framing of adiposity as a health problem was beneficial to medical

professionals. Regardless of evidence to prove such a claim, people would fight the fat on their body in the name of health.

In Canada, the Canadian Medical Association's (CMA) (2015) policy document on obesity expresses concern over the rising number of "obese" people in the country (approximately 62% of the population) and discusses adiposity as a disease which increases the risk of developing comorbidities. The policy concludes that "obesity" is a severe concern for health care practitioners. However, recently, the organization Obesity Canada advocated for clinical guidelines changes, which the CMA published in August 2020, to recognize that it is possible to be fat and healthy. These guidelines, further explained in the section "Fat and Health in Canada," have since been adopted by Chile and Ireland as a pilot project to create action for improved evidence-based and person-centred obesity care (Obesity Canada 2022). These changes to the battle of fat are new and the outcomes of their implementation currently unknown.

The war on fat has victims. Fat bodies deemed undesirable and bad citizens are a societal construction originating in the historical ranking of bodies as superior and inferior, a process tied to colonization, which began a century before larger body sizes became a "health problem." Anti-fat ideologies began with the slave trade, and exacerbated racism to stigmatize women, immigrants, and people of colour. After decades of body size othering, medicine eventually labelled body fat as a disease because people's body masses continued to increase. This labelling began the war on fat, the obesity "epidemic," and the necessary medical authoritative confirmation that larger bodies were "unhealthy" and, therefore, "bad." However, with the changes to Canada's

clinical guidelines, there are also existing programs in health care that have the potential to minimize victimization from the war on fat.

1.2 Cultural Competency and Safety Programs in Canada

In this section, I explain “cultural competency” and related program concepts. These programs are critical skills for health providers in multicultural societies to ensure access to medical care by prioritizing the understanding of diversity in cultural beliefs and practices, as well as power relations in clinical settings, and can, in turn, support marginalized communities (Hart-Wasekeesikaw 2009). Given the history of fat denigration, rooted in racism and sexism, and the incorporation of body size ideologies in medicine, cultural competency programs may present the opportunity to minimize the victimization that occurs from the war on fat. A review of the literature revealed three common patterns in discussions of cultural competency in Canadian health care. First, cultural competency programs in Canadian health care practices have been found to be beneficial for health care providers and patients. Second, the minimal research on cultural competency in Canada focuses on the Other (specifically, Indigenous peoples). Third, body size and adiposity-focused cultural competency practices specifically, can be concluded to be beneficial to Canadian health care practices in reducing weight-biases (though the research still maintains weight-based bias).

Developed in the 1980s, the concept of cultural safety by the Māori people of New Zealand intended to address the poor health of their people to demand better delivery of health care (Guerra and Kurtz 2017:129). With health systems improving in New Zealand from the incorporation of cultural safety training, a myriad of professional organizations, educators, and policymakers adopted the concept to address inequalities in

health care for marginalized populations (Guerra and Kurtz 2017:129). Cultural competency is a “set of congruent behaviours, attitudes, and policies that come together in a system of awareness and knowledge, enabling an agency or professionals to work effectively in cross-cultural situations” (Hammer 2007). Along these same lines, the concept of cultural safety extends beyond cultural competence to help understand “power differentials inherent in health service delivery and redressing these inequities through educational processes” (Hart-Wasekeesikaw 2009:2). Essentially, cultural safety is about moving beyond looking at cultural differences between providers and patients, and addressing the power imbalances in health care.

Cultural competency and safety are not the only concepts to address the intersectionality of culture with medicine. Building upon the cultural competency models are the notions of cultural humility and structural systems. The concept of cultural humility raises awareness about cultural factors that may impact health by incorporating health providers’ knowledge and life-long learning with self-reflection (Ingraham et al. 2016:S41). Essentially, cultural humility builds upon the knowledge that culture is not static and maintaining cultural competency is a constant and ongoing process. It requires one to be humble, recognize one’s own biases, and be curious about others while recognizing that one cannot ever understand another’s experiences completely.

Beyond the cultural considerations of patients and providers, the structural systems in place also require attention to ensure the health and well-being of people. Jonathan Metzl and Helena Hansen (2014) examine the need for cultural competency in more structural terms through a five-step conceptual model. The authors (2014:128) define structural competency as “the trained ability to discern how a host of issues

defined clinically as symptoms, attributes, or diseases also represent the downstream implications of several upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health.” The conceptual model begins with recognizing the structures that shape clinical interactions, where economic, physical, and socio-political components impact medical decisions. Second, this approach focuses on developing an extra-clinical language of structure in which attention is placed on public-health and biomedical literature on genetics, social determinants of health, and health disparities. The intent is to expand medical education to help clinicians understand the structural disparities which decrease health. Third, the structural approach rearticulates “cultural” presentations in structural terms to understand how “cultural” barriers occur due to structural forces such as communication and institutional practices. Fourth, this approach requires that we observe and imagine structural interventions in which practices are put in place that recognize cultures are not static or timeless. Fifth, the approach requires developing structural humility with a critical awareness of the nuances and changes because there are limitations to structural competency.

Through these five steps, Meztel and Hansen (2013) indicate that medical education for practitioners is necessary to help them understand and address the social structures which impact health. The ability to enhance the health and well-being of people is not limited to the actions of practitioners or patients, but depends upon addressing the structural forces which change the outcome of medicine. For instance, the Indian Act in Canada and the country’s policies deliver health care based on assimilation, ignoring the holistic approach to Indigenous healing (Rand et al. 2019:31). Essentially,

the historical influences of cultural body size biases are missing from the overarching systems which provide health care in Canada, as are considerations of the structural determinants of health and health behaviour. Structural cultural competency extends the need to consider different and diverse cultures, from the patients and providers to broader policies and systems.

The Canadian Medical Association (CMA) (2020) acknowledges that the profession must incorporate cultural safety by using the practices of cultural competency and humility to obtain and maintain equity and diversity in medicine. To hold health care institutions and professionals accountable, the CMA (2020:2-4) articulates four guiding principles: 1) fostering diversity in medicine, 2) promoting a just professional and learning culture, 3) fostering solidarity within the profession, and 4) promoting professional excellence and social accountability. These principles have led to four recommendations: 1) co-create policies and processes to achieve better equity and diversity in an accountable and transparent manner, 2) research and fund the collection and use of equity and diversity data, 3) hire, select, appoint, and promote practices which support equity and diversity, and 4) provide medical education training (CMA 2020:4-6). Ultimately, the CMA's (2020) goal is to obtain, improve, and maintain equity and diversity in Canadian medical settings.

Research on Canada's cultural competency practices recognizes the beneficial use of these programs (Churchill et al. 2020; Rand et al. 2019) and the need for health care facilities and professionals to increase cultural competency awareness (Almutairi et al. 2017; Guerra and Kurtz 2017). To take a case in point, in a literature review of cultural competency studies in Canadian health care, Crystal Jongen and colleagues (2018) argue

that, while practitioners' knowledge has increased about cultural differences, actual care outcomes require additional research on the result of these interventions. Historically, the critique of cultural competence programs includes the oversimplification of culture as a static phenomenon, the improbability of being familiar with all cultural perspectives, and possible reinforcement of stereotyping through cultural misunderstanding (Jongen et al. 2018:2). Nevertheless, cultural competency programs and training exist to tackle racial and ethnic disparities (Jongen et al. 2018:2). In a sense, while Canadian cultural competency programs attempt to improve health care for diverse populations, the programs require enhancement to address inequalities, adequately train health professionals, and improve the health and well-being of citizens.

Specifically, most research that addresses cultural competencies and safety programs in Canadian medical systems focus on Indigenous peoples. Policies published by the CMA (Global Search n.d.) on cultural competency or equity and diversity focused on Indigenous peoples, the Truth and Reconciliation Act, or cultural and religious differences. However, the issue with cultural competency and safety focusing on the Other, such as Indigenous peoples, ignores the culture of biomedicine and fails to address other biases within health and medicine, such as body size ideologies. Indeed, the "culture of biomedicine" is often ignored to focus solely on the patients' culture (Taylor 2003:559), which can impede cultural competency and safety in health care by not recognizing how whiteness obscures understanding racism in medical practices (Holland 2015; Lee and Rupaleem 2013). This failure suggests that health care may not be fully decolonized when body size as a determinant of health maintains thin supremacy ideologies.

Canadian literature on cultural competency and fat studies, additionally limited, recognizes the benefit of addressing body size ideologies in health care settings. There is a correlation between weight discrimination and increased risk for morbidity through an increase in chronic and oxidative stress, adverse psychological outcomes, binge eating, unhealthy behaviours, and weight gain (Kirk et al. 2020:3), particularly when specific populations face additional stereotypes regarding their weight. To take a case in point, lesbian and bisexual women face double barriers as health care professionals may have biases against both non-heterosexual relationships and the tendency of these women to have higher rates of adiposity (Ingraham et al. 2016). In a study comparing two unique provider training programs, a traditional medical model with a weight-centred health perspective versus a cultural competency Health at Every Size weight-neutral health perspective, Natalie Ingraham and colleagues (2016) found that while both programs reduced negative interactions between patients and providers, the cultural competency program additionally changed the way providers viewed body size in relation to health. Specifically, they found that recognizing the connection between sexual orientation and body size in cultural competency practices is a key tool for respectful, patient-centred care (Ingraham et al. 2016:S41).

In developing obesity-focused competencies, Robert F. Kushner and colleagues (2019) established six core domains specific to working with fat patients. These domains include 1) practice-based learning and improvement, 2) patient care and procedural skills, 3) systems-based practice, 4) medical knowledge, 5) interpersonal and communication skills, and 6) professionalism. Within these six domains, Kushner and colleagues acknowledge some key concerns when working in a respectful manner with fat patients.

These include, for example advocating for policies free from weight bias, ethical behaviour and integrity when counselling fat patients, and showing respect and compassion towards patients with obesity (Kushner et al. 2019). The authors (2019:1067) articulate that these competencies increase the capability of health providers to help larger body-sized people and standardize the process of evaluating fat as it impacts health across the myriad of health-related disciplines.

Nevertheless, though the authors may have good intentions in discussing cultural competency with obesity to understand the patient's perspective, the biases of fat as "bad" still exist in the research. For example, in the medical knowledge section the competencies include using nutrition, physical activity, behavioural, pharmaceutical, and surgical interventions to care for obesity (Kushner et al. 2019), suggesting the goal of obesity treatment is weight loss. However, focusing on weight loss as a "solution" to obesity is more likely to result in a weight gain cycle – where people lose weight and then gain weight – without any health benefits (Gaesser and Angad 2021). Additionally, the core competencies ignore the structural violence of medical equipment that does not accommodate larger body sizes. The incorporation of cultural competency, though beneficial in an effort to encourage health care professionals to be compassionate and respect fat patients, fails to address the bias in medicine toward encouraging weight loss, rather than health, in fat patients. This perspective reflects medicine's current anti-fat bias.

Though the available research on cultural competency and fat in Canada is modest, the results demonstrate the benefits of health professionals and systems adopting these practices to benefit the patient's health and well-being. Incorporating cultural

competency practices that recognize body size ideologies into Canadian health care provides the opportunity to improve the quality of care for fat people. Such an improvement also provides the opportunity to decrease the sexism and racism associated with body size ideologies. However, additional research is required to understand the complexity of body size expectations in medicine, particularly given its historical and cultural background, and the limited research that exists may not accurately reflect the complexity of the cultural construction of body size othering.

1.3 Fat and Health in Canada

In this review of the literature on fat and health in Canada, two common patterns appeared. First, people with high body fat are viewed as “harmful” to Canada’s economy. Second, fat discrimination is prevalent in Canadian health care practices.

Interestingly, research that discussed fat bodies as harmful often focused on body size as an issue to the economy rather than health. While the research may have good intentions, focusing on capitalist structures and concerns may have harmful impacts when addressing body size. This focus personifies the notion that the “good citizen” exists within a specific state of physical being – an ableist approach as recognized within critical disability and critical fat studies (Mackert and Martschukat 2019). In addition, not recognizing the historical creation of fatism, rooted in racism and sexism, means the research treats people homogenously, regardless of background and circumstances. To take a case in point, studying the financial cost of obesity in Canadian health care, Ian Janssen (2013:96) estimates that patients categorized as “obese” account for approximately \$7 billion in direct/indirect health care costs. This estimate stems from multiplying the attributable population by the costs of eighteen diseases “associated” with

obesity (Janssen 2013:95). This cost-based estimate assumes that all obese people have eighteen adiposity-associated diseases, and those with one or more of the eighteen diseases are assumed to be obese. Additionally, these costs are based solely on estimates as Janssen looks at the risk of being obese as applied to the risk of obtaining obesity-related diseases to calculate the costs. Unfortunately, there is no accurate estimation of how many patients with these diseases meet the criteria of being “obese,” nor does this study acknowledge the additional costs incurred from the structural violence people with larger bodies experience in medical institutions (which I detail further on).

In a similar study of larger bodies as a “problem,” Meghan O’Neill and colleagues (2019) address the “burden” of obesity to estimate the increase of adiposity in Canada’s populations. Indicating that obesity contributes to the burden of disease, the authors applied the Obesity Population Risk Tool (OPoRT) to a ten-year prediction of Canada’s population to indicate an increase in overall obese cases across age, sex, ethnicity, immigrant status, food security, and behavioural (smoking, physical activity, and alcohol consumption) categories. The study may be correct in its population estimations, but the concern is its assumption that fat people are a problem by continually referring to obesity as a “burden.” While these studies may have good intentions, there is bias in the conclusions, which assume that adiposity is a problem for Canada through economic language of “cost” and “burden.” In contrast, the literature does not consider the financial cost or burden of weight bias in health care or in society, such as the impact of delayed health care when fat patients’ problems are inaccurately dismissed as weight-related or when fat patients avoid health care due to stigma, as well as the economic effects of workplace discrimination and social prejudices against fat people.

The developing discipline of critical fat studies aims to examine fatness beyond the medicalization of adiposity and body size as an indicator of "health" or a "problem." Scholars in this field argue that obesity is a culturally constructed, social category that is not about health but instead, is about gender, race, class, and sexuality (Ellison et al. 2018:4). Jenny Ellison and colleagues (2018), in their book *Obesity in Canada: critical perspectives*, bring together cross disciplinary research studying the micro and macro effects of obesity as a discourse in Canada, detailing the myriad of ways obesity can be understood beyond the field of medicine. Along these same lines, Charlotte Cooper (2010) argues research should use fat as an interrogative lens to study the cultural production of fatphobia through commercial, ideological, and institutional interests. Researching anti-fat bias further in critical fat studies, Erin Cameron (2015) argues for the importance of acknowledging the necessity to reduce obesity stigma in higher education, which plays a role in forming the attitudes and beliefs around fat people. Critical fat studies recognizes that body size is not about health, but about the historical construction and cultural creation that vilifies adiposity and maintains fat denigration.

Research on the fat patients' experience in health care settings focuses on fat denigration, particularly with regard to women's reproductive rights. Concerning women's reproductive rights, an irony exists within the discrimination against larger body types. When heavier women seek to stop pregnancy, their options are limited and restricted. To take a case in point, available emergency contraceptive pills (such as levonorgestrel) in Canada are only suitable for up to 165 lbs or a maximum BMI of 25, which leaves fat women with minimal or no options to terminate pregnancy easily (Vogel 2015). However, when heavier women seek care to become pregnant, their options are

once again limited and restricted. Andrea E. Bombak and colleagues (2017) conducted semi-structured interviews across two cities in Canada with women who self-identify as overweight and obese seeking reproductive health care, where fat stigmatization was both covert and direct. For instance, the women were told their weight was a problem by physicians, denied medical procedures which would allow them to conceive a child, immediately classified as a high-risk pregnancy, informed their body size caused “birth defects” in children, and constantly tested for gestational diabetes (Bombak et al. 2017). In a similar study, Deborah McPhail and colleagues (2016) suggest that health professionals denied fat women access to fertility treatments, refused to remove birth control devices, and maintained the discourse that these women are bad mothers because of their body size. The authors articulate that prohibiting fat women from having children is a form of biopolitics, or “new eugenics,” where health care practitioners exert control over people producing offspring. Specifically, while biopolitics cannot “actively prevent reproduction in those considered ‘obese,’ the control is exerted upon women who look to the medical institution for reproductive care” (McPhail et al. 2016:110). As a result, fat women face barriers trying to stop pregnancy and when attempting to become pregnant or during pregnancy; a form of selective sexism in which women may have reproductive rights in Canada, but body size discrimination denies fat women those rights.

Beyond reproductive rights, fat denigration is a common theme among studies about body size and health care in Canada. For example, Lauren Vogel (2019) indicates that personal and clinical biases against larger body sizes cause physiological and behavioural changes, with a link to depression, low self-esteem, eating disorders, and exercise avoidance when people are fat shamed. Similarly, Lauren Munro (2017) applied

the notion of microaggressions – intentional or unintentional interactions which communicate hostile, derogatory, or negative insults to a targeted group or person – to the understanding of fat health, where even health professionals hide behind microaggressive messages that fat bodies are a “concern for health,” where fatness is labelled as a “disease,” and with food categorized as healthy or unhealthy. These medical microaggressions lead to inadequate health services and often stop fat patients returning for care (Munro 2017). These studies demonstrate not only the existence of fat denigration in Canadian health care settings, but the negative consequences when fat people are stereotyped and stigmatized. Fat denigration in health care is not simply about discrimination, but about the barriers to accessing care for a fat person’s health and well-being which may have damaging results.

Along with the acknowledgement of fat denigration is the advocacy for change to Canadian health care to ensure equitable treatment of larger body sizes. For policymakers and health providers, Obesity Canada recommends reflecting upon their attitudes and beliefs regarding excess adiposity, avoiding using stigmatizing language and images and assumptions that healthy behaviours will or should result in weight change, acknowledging weight bias and discrimination, and ensuring the clinic environment is accessible, safe, and respectful for all patients regardless of body size (Kirk et al. 2020). For people living with adiposity, the organization outlines that weight bias may affect the quality of care, harm health and well-being, and, as such, it may be necessary to talk to health care providers about internalized weight bias, and to focus on improving healthy habits and quality of life instead of weight loss (Kirk et al. 2020).

In a study on the impact of quality care for fat patients, S. M. Phelan and colleagues (2015:322) advocate for improving provider attitudes, altering clinical environments and procedures to be body-size inclusive, and empowering patients to cope in stigmatizing situations and attain better health care. The authors (2015:321) detail the harmful impacts of the lower levels of care, where patients may struggle to effectively communicate their issues and experience increased physiological health issues (such as heart disease, stroke, depression, and anxiety). Along these same lines, Friedrich Schorb (2021) articulates that public health inappropriately rejects the idea that fat bodies can exist and be healthy, maintaining adiposity is temporary, and, as such, advocates for the World Health Organization to change the discourse around universal weight loss and, instead, provide a holistic approach to health care to acknowledge fat discrimination as an obstacle to the fulfillment of the right to health.

The recognition of fat denigration in Canadian health care extends beyond research, to actual policy change. As previously mentioned, the CMA recently published new clinical guidelines which recognize that it is possible to be fat and healthy. In particular, the guidelines redefine the medical label of “obesity” to the abnormal or excess adiposity that, as a complex chronic disease, impairs health, increases medical complications, and reduces lifespan (Wharton et al. 2020). A person is obese if the additional fat on their body negatively impacts their health. However, if a person’s health is not impaired by their fat, they are not clinically considered “obese” and, as a result, do not require medical professionals to treat their fat as a disease. This change is a significant departure from the previous definition that indicated all excess body fat was a risk to health (World Health Organization 2014). The new clinical guidelines, initiated by

the organization Obesity Canada, intend to improve the standard of care for people living with obesity. However, the quality of care will ultimately depend on how Canada implements its new guidelines (Obesity Canada 2020), which may not be as simple as a change in diagnosis. Real change will be challenged by the historical context of fat denigration as a form of structural violence rooted in colonial racism.

The research on Canadian medical settings acknowledges the existing fat discrimination and stigmatization that denies fat women equitable health care. However, the research to understand the practices which improve equitable care for larger body sizes is minimal. Recognition of body size discrimination is a step toward providing people with equitable health care. Ending fat discrimination and stigmatization requires additional research on implementing practices, such as cultural competency and safety, for equitable health care in Canada.

1.4 Conclusion

The historical construction and cultural ideologies of fat bodies are vast, with a century of larger body size othering occurring in conjunction with racism and sexism. Current research either recognizes fat denigration in health care or maintains anti-fat ideologies by suggesting fat people are bad for the economy. To provide equitable health care for all people in Canada, it is necessary to recognize how body size ideologies adds to racism and sexism in the country. However, the available research is minimal and may not accurately reflect equity and diversity in Canadian medical care, particularly when considering larger body sizes. As such, there is a necessity for additional research on body size ideologies in health care, including this thesis, to help understand and improve the overall well-being of fat women as they access health services in Canada.

The second chapter of this thesis particularizes the ethnographic methodological approach, explaining the recruitment process, in-depth interviewing, online discussion group, qualitative coding, and participant demographics. In the third chapter, I take up Judith Butler's embodiment theory which details the body as a material performance of gender as applied to the fat body. I begin by explaining the emotional implications of the research, the various body types of the interviewed women, their experiences which shaped their relationship with their body, and finally, analyze the fat body as a societal performance.

The fourth chapter focuses on the interviewed women's experiences in health care. As health care is not one defined area of expertise, I list the discussed areas of health services the women accessed for their well-being. Next, I examine the practice and meaning of being weighed in health care settings and how this act impacted the interviewed women. Then, I utilize Paul Farmer's concept of structural violence to elucidate the medical barriers the women faced because of their larger bodies. Then, I analyze cultural competency and safety practices, discussing the consequential medical harm experienced by the women. Finally, I discuss the desired health care services the women either experienced or wanted to maintain their health and well-being as fat individuals. In the last chapter, I recommend steps forward for women with larger body sizes when seeking health care and conclude by detailing the significance of body size ideologies in Southern Ontario medical settings.

Chapter 2: Methodology

My research focused on the experiences of women with larger body sizes in Southern Ontario health care settings, utilizing an ethnographic study with semi-structured interviews, an online focus group discussion, and a literature review. Ethnographic methods were essential to this research as health outcomes are often quantified in health care research, without providing an in-depth understanding of patients' experiences (Gallis and Turner 2019). Researchers may quantify the data with risk and odds ratios (Gallis and Turner 2019), a numerical value used to measure health and health outcomes. Yet, an individual's health and well-being are significantly more complex than a binary result. Nancy Scheper-Hughes and Margaret Lock (1987:30) articulate the problem that biomedicine is based in a Cartesian dichotomy, arguing that rather, the mind and body are inseparable in the experiences of sickness, suffering, and healing. Medical anthropology has the potential to bridge the artificial separation of mind and body, as the authors suggest (1987) embracing embodiment theory to understand the individual body (lived self-experience), the social body (the body as a natural symbol of social worlds), and the body politic (regulation, surveillance, and control of the body). Beyond quantification, qualitative data is essential to understand curvy women's health, well-being, and health care in Canada.

2.1 Recruitment

The target population for this study was individuals who identify as women with larger or above-average body sizes, over the age of eighteen, and located within the province of Ontario. I employed three strategies for participant recruitment. First, I

displayed recruitment posters on the City of Ottawa's designated poster collars¹ located on Bank Street, Confederation Boulevard, and in the Byward Market. Poster placement was limited to the poster collars as the City of Ottawa had restrictions in place with regard to business openings and use because of the coronavirus pandemic (COVID-19). As the collars are located along streets filled with shopping and restaurant businesses, the location of the collars suggests a possible limitation to the sampling strategy. While I cannot say for sure, the narrow area of poster placement may account for the fact that participants were homogenous with regard to race, that is, they were all white women.

Second, to expand my research recruitment beyond the city boundaries of Ottawa, I contacted potential organizations which focus on weight discrimination or women's health. Of the organizations I contacted, Obesity Canada, Rise Up! (a digital archive of feminist activism), and the Association for Size Diversity and Health (ASDAH) agreed to provide their members with my research recruitment information through their social media accounts or website. Additionally, I utilized the Carleton Research Participants Facebook group to display my recruitment poster.

Third, I employed the process of snowballing. The sampling technique "snowballing" provides an opportunistic strategy in contacting hard-to-reach populations, expanding the recruitment area, where a participant informs another individual that meets the sampling requirements of the research for their potential participation (Pelto 2016:149). This sampling technique was beneficial for my research, as curvy women are

¹ Poster collars are aluminum cylinders on lamp and utility posts found throughout the city of Ottawa. The city provides these designated posting areas, in which posters may stay up until the collars are cleared on the first and fifteenth of every month.

part of a stigmatized population (Gillon 2020:218; Puhl and Heuer 2010:1019) and, therefore, this suggests they are a harder-to-reach population. Consequently, women may be less likely to identify as having a larger body size (or admit to having one) due to sociocultural stereotyping and discrimination, limiting my access to the potential sampling population. To employ snowballing, I asked my fellow master's graduate peers if they happened to know of any individuals who may be interested. Additionally, I asked participants to mention my study to their known peers if they felt comfortable passing along the recruitment information after I had completed the interview.

With each of the three recruitment methods, I employed two forms of contact information for potential participants to join the study. First, I included my Carleton University email address. This option allowed participants to contact me directly. Second, I created an online form that the women could fill out to submit their contact information and details. To access the recruitment form, I included a Quick Response (QR) Code on the recruitment documents which could be scanned utilizing a Smartphone. This option allowed me to contact the participants after they indicated their interest in the study. Recognizing that women with excess adiposity face discrimination and stigmatization in Canada, employing this dual method provided the women with a choice of how to gain access to participate in the study: contacting me directly, or having me contact them.

Posters and snowballing proved to be the most effective method in obtaining participants, as demonstrated in Table 1 Participant Sampling on page 29,² with twelve

² Participant names are pseudonyms, as further detailed in Chapter 4.

women recruited from both methods combined. Only one participant was recruited through the third-party organization sampling method.

<i>Participant</i>	<i>Poster</i>	<i>Snowballing</i>	<i>Third-Party Organization</i>
<i>Alethea</i>	X		
<i>Aubrey</i>	X		
<i>Bridget</i>		X	
<i>Colette</i>	X		
<i>Freya</i>	X		
<i>Haley</i>	X		
<i>Imara</i>		X	
<i>Joleen</i>		X	
<i>Lyssa</i>		X	
<i>Phoebe</i>			X
<i>Selene</i>		X	
<i>Thalia</i>	X		
<i>Veera</i>	X		
<i>Total</i>	7	5	1

Table 1 Participant Sampling

2.2 In-depth Interviews

I conducted in-depth, semi-structured interviews with thirteen women who identified as having a larger body and who used Ontario health care. The interviews took place over six weeks, beginning in July and finishing at the end of August in 2021. I interviewed each participant individually, with interviews lasting between thirty to seventy minutes, exploring the participant’s relationship with her body, experience in health care settings, and the desired changes to medical services and practices to support overall health and well-being. Due to the coronavirus (COVID-19) global pandemic and the safety restrictions required by Carleton University and the City of Ottawa, I conducted all interviews over phone or video call. Of the thirteen interviews, two took place over the phone and eleven through a video call via Zoom. Interviews were recorded using the application Voice Memos on my MacBook Air, with the participants’ permission.

During the interviews, I addressed both the participants' medical experiences and desires, along with the relationship with their body size. I sectioned the interview into two sets of questions: the participants' relationship with their bodies, and their experiences seeking and receiving health care in Ontario. In the first section, I wanted to establish an overall reflection of how the participants understood their excess adiposity and what influenced their knowledge. To do this, I asked them questions about how they would label and describe their body, what made them love and hate their body, in what ways did their excess adiposity affect their life, and their experiences with their body growing up. In the second section, I focused on the health care experiences, opening the conversation to any type of treatment the women received from a professional to benefit their health. Essentially, I did not limit the conversation to biomedical treatments. Here, I asked participants to walk me through their last health care appointment, recount a time when they received positive and negative health care, reflect on the ways in which their excess adiposity influenced their interactions with health care, and how they feel when a health care professional addresses their weight and weighs them. Additionally, I asked them what advice they would like health care practitioners to have when treating people with their body type.

I wanted to ensure minimal risk to participants during the interview given the potentially adverse experiences of women with adiposity due to sociocultural stigmatization and discrimination in Canada. In addition to providing the participants with several mental health resources, at the beginning of each interview, I ensured the participants understood they did not have to answer every question and that they could end the interview at any point. If a participant appeared distressed, I paused the interview

and asked them if they wanted to pass on the question, if they needed a moment, or if they would like to end the interview. While most participants cried at least once during the interview process, only one participant chose to pass on a specific question and then requested that I continue with the interview. Participants were also offered a debriefing document at the end of the interview, which detailed my research and provided them several mental health resource options. Though most participants indicated they would not use the document, they still wanted to receive the debriefing details. Twelve of the thirteen participants chose to receive the debriefing document.

After a completed interview, I transcribed the audio recordings through an automated process in the software NVivo and edited the transcribed documents for accuracy. Each woman was given a pseudonym to protect her privacy. I randomly chose feminine names with the meaning of strength or bravery. Given the subject matter of my research, I wanted to ensure pseudonyms represented the women's resiliency as a sign of respect and a tribute to their participation.

2.3 Online Discussion Group

In addition to the in-depth interviews, I employed a group discussion option for participants. Focus groups can add to ethnographic research, with participant ideas and opinions as valuable sources of information (Pelto 2016:99). Unfortunately, due to the ongoing pandemic restrictions, I could not conduct the discussion in person. Accordingly, the focus group occurred through an online text-based platform/ application (app) called Keybase used through either the participant's phone or computer. Keybase is a secure text-based messaging platform with end-to-end encryption. The app does not collect data from the participants or the conversations, which helps secure participants'

confidentiality and research information. I provided access instructions to participants who consented to the group discussion, detailing the sign-up process and how to create an anonymous username. The women could design their non-identifiable username, though I suggested using the formula colour-animal-number to aid their efforts. Once participants created a username, I invited them to be a part of the private group I created in Keybase. Of the twelve women who consented to join the group discussion, six created a Keybase account, and five participated in the discussion.

Similar to the interviews, to maintain minimal risk to participants I employed two strategies during the online discussion group. First, I included group discussion rules in the Keybase app. These included instructions that they could leave out answering any questions they wished, that participants should be kind and courteous in the discussions and avoid any hate speech or bullying, that participants are using pseudonyms and to respect their privacy, and if there are any concerns to report them to me. Second, I provided the same mental health resources from the debriefing document within the group discussion.

In the focus group, I asked five questions. The questions focused on participants' understandings of health, as well as the advice they would give health professionals and other larger women when seeking health care. I enquired into what being "healthy" meant to them, what advice they would give to their younger self about body size and health, what advice they would give to women with larger body sizes when dealing with health care professionals, and what they thought is a priority to improve health and well-being for larger bodied women. Each question was placed in a separate tab in the discussion group with the participants able to access and respond to the question prompts. As the

discussion group was online, the participants answered the questions in their own time. As such, I found discussion limited to the women answering the question individually rather than interacting with one another. I did send encouraging messages as the women responded, highlighting important points they brought forth. When interaction did occur, it was through the reaction portion of the messaging platform. Participants could respond to a message by “liking” the answer. About half of the participants utilized this feature, liking certain answers provided by the other women, though interaction with each other in the group format was minimal.

Initially, the online group discussion was planned to ask each question approximately a week apart, or when discussion slowed, whichever option came first to ensure conversation continued smoothly. The women indicated their hesitation about the potentially lengthy period, as it was possible for the group discussion to occur over a period of five weeks if the participants discussed the individual question for seven days. As such, I opened each of the discussion tabs in the beginning and left them open for a week. Participants could answer in their own time. Most of the responses occurred in the first two days of the group discussion, with a few answers appearing later in the week. Ideally, this could have worked better had all the participants been gathered online during the same time to talk with one another. Though their responses were still thoughtful, unfortunately limited interaction occurred among the women.

2.4 Qualitative Coding

To analyze and code the ethnographic data, I used NVivo, a computer software program for qualitative data analysis. With the transcribed interviews uploaded to NVivo, I employed two levels of qualitative coding to analyze the interviews and discussion

group transcriptions. Coding is a qualitative inquiry that symbolically assigns an attribute to a specific portion of language-based or visual data (Saldaña 2016:4). The assigned codes allow researchers to identify patterns, categorize data, and interpret the information (Saldaña 2016:5-10). Johnny Saldaña (2016:69) articulates that coding occurs in two cycles, with the first cycle a direct form of coding and the second cycle, a type of recoding, a process of "classifying, prioritizing, integrating, synthesizing, abstracting, conceptualizing, and theory building."

My first coding cycle identified fifty-five codes and thirteen subcodes that either described or summarized the data. I coded the transcripts using NVivo coding in the first cycle. NVivo coding utilizes short words or phrases from the participants' own words to code (Saldaña 2016:264). After I completed the first coding cycle on all thirteen transcribed interviews and the focus group discussion, I began the second coding cycle. In the second cycle, I focused on causation and evaluation coding. I addressed the outcomes from the women's experiences in health care by initially focusing on causation coding. Causation coding extracts participant data about how and why particular outcomes occurred (Saldaña 2016:261). I then applied evaluation coding to the outcome based on the women's stories from this focus. Evaluation coding applies codes that assign a judgement about the merit, worth, or significance of a program or policy (Saldaña 2016:263). After the second coding cycle and an in-depth analysis of the transcripts, I reclassified and clarified the coding to twenty-seven codes and sixty-four subcodes.

Codes that emerged in the analysis focused on health care and well-being, with medical access and health being the theme that generated the most codes, as

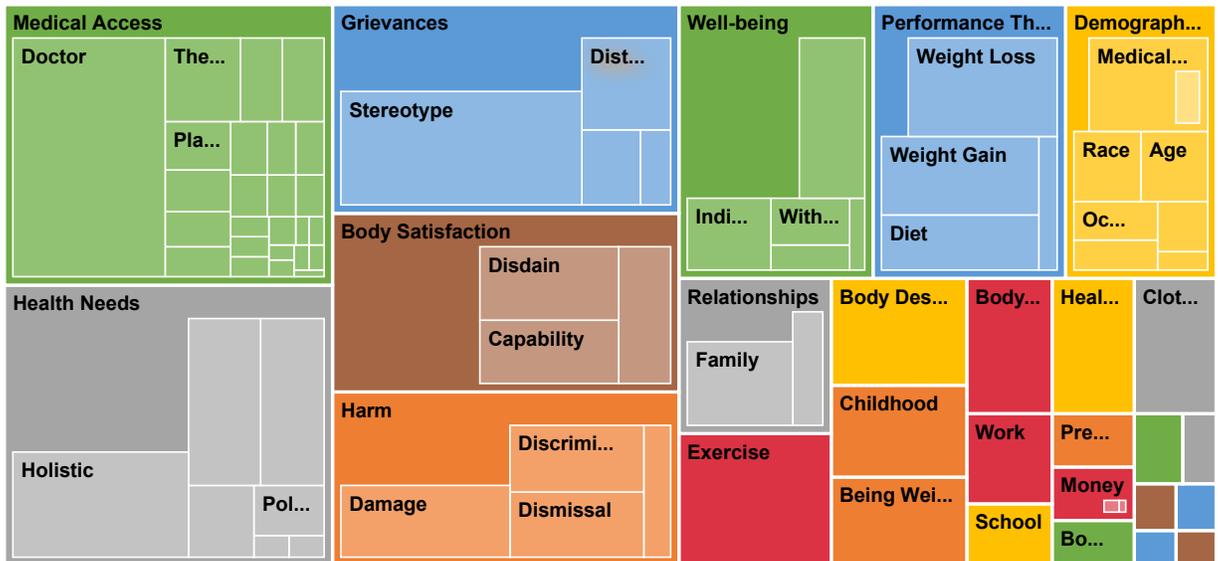


Figure 1 Coding Matrix

demonstrated in Figure 1 Coding Matrix. The main themes that emerged from the coding included their body understanding, environmental impacts, medical access and experiences, and health needs and expectations. Within these themes, the main topics that were discussed included what health care the women accessed, what they considered were their health needs (current and future), the grievances they had with current medical systems, how they felt about their body, and what harm they experienced due to their body size.

2.5 Participant Demographics

As fat is a feminist issue since it discriminates, stigmatizes, and enforces body size ideals on women (Fikkan and Rothblum 2011), this study focused on participants who identified as women. Of the recruited participants, all the women identified their race as "white" and nationality as Canadian, and currently used health care in Ontario. Beyond those hegemonic traits, participant identities varied. Of the thirteen women, two identified as bisexual and one as queer. The age range spanned over fifty years, with the youngest participant 23 years old and the oldest participant 76 years old. The average age

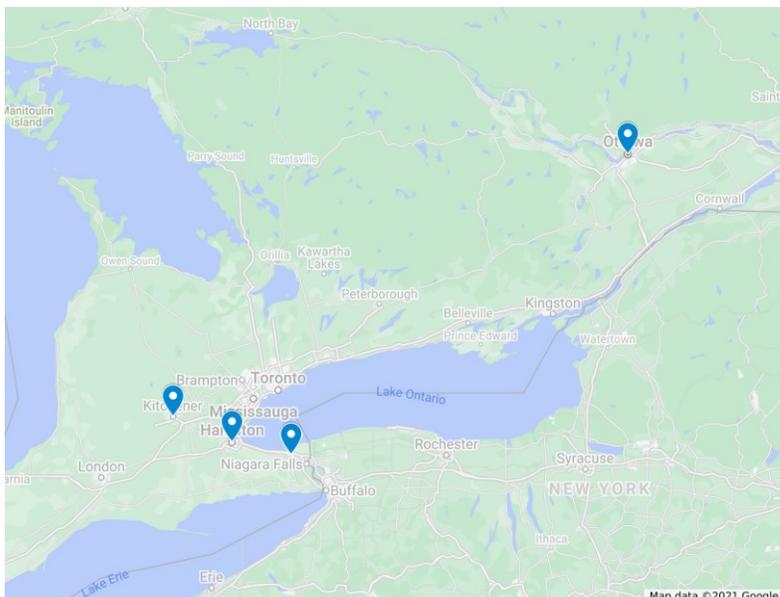
of the participants was 46 years old. Occupations and income varied, with participants coming from a range of classes. Details of the women's demographics are found in Table

2 Participant Demographics.

<i>Pseudonym</i>	<i>Age</i>	<i>Gender</i>	<i>Occupation</i>	<i>Race</i>	<i>Sexual Orientation</i>	<i>Location</i>
<i>Colette</i>	41	Woman	Not identified	White	Not identified	Ottawa
<i>Bridget</i>	58	Woman	Not identified	White	Not identified	Ottawa
<i>Haley</i>	24	Woman	Student	White	Bisexual	Ottawa
<i>Imara</i>	51	Woman	Not identified	White	Not identified	Hamilton
<i>Joleen</i>	76	Woman	Retired	White	Not identified	Ottawa
<i>Phoebe</i>	64	Woman	Retired	White	Not identified	Ottawa
<i>Aubrey</i>	52	Woman	Stay at home mom	White	Not identified	St. Catharines
<i>Freya</i>	58	Woman	Researcher	White	Not identified	Ottawa
<i>Lyssa</i>	23	Woman	Student	White	Not identified	Kitchener
<i>Selene</i>	36	Woman	Engineer	White	Not identified	Ottawa
<i>Alethea</i>	34	Woman	Researcher	White	Not identified	Ottawa
<i>Thalia</i>	48	Woman	Not identified	White	Queer	Ottawa
<i>Veera</i>	37	Woman	Lawyer	White	Bisexual	Ottawa

Table 2 Participant Demographics

Initially, the study intended to explore the experiences of curvy women across all of Ontario. Although the study was open to eligible participants across the province, the



study area focused on Southern Ontario, with participants located in Ottawa, Hamilton, St. Catharines, and Kitchener, as shown in Figure 2 Participant Locations.

Figure 2 Participant Locations

Each recruited woman believed she had a larger body size, though their actual body sizes varied significantly between participants. The self-identification of their body types fell under two categories: 1) ten women identified as having an above-average body type but also made the distinction that their body was not so fat as to experience significant discrimination, and 2) three women declared their bodies “fat” and noted that they faced significant problems because of their body size. Across all the participants, I surmised the women were either visually, or by medical categorization, “overweight” or “obese.”

2.6 Conclusion

Ethnographic methods for this research provided the opportunity to obtain qualitative data, through in-depth interviews, an online discussion group, and data coding and analyzing. Though the provincial response to COVID-19 and public restrictions limited in-person contact and recruitment options (potentially limiting participant diversity), the obtained data from the women’s narratives provided insightful and essential information into answering the question “What are the experiences of fat women in Ontario health care settings and how do these women conceptualize their body and health?”

In the next chapter, I introduce the women, their bodies, and the ways in which cultural biases of body size have influenced them. I begin by detailing the emotional significance of retelling their stories, introducing their chosen body labels, and, utilizing them, describing the women and their respective bodies. From there, I look back into how their formative years influenced their bodies, through to the current influences they deal

with as adults. Finally, I conclude by addressing fat embodiment by drawing on performance theory and what a body means in Western societies.

Chapter 3: Understanding Their Body and the Influences that Shaped the Women

This chapter examines the relationships the participants had with their bodies. The body and the individual are not separate from one another. They exist with each other. Women are more than their bodies, yet they cannot escape their form. I found it necessary, therefore, to understand the participants' relationships with their bodies to understand their experiences with health care. I sought to establish how the women thought about their physiques and the external factors that influenced their perceptions of their body size. To do so, I explored how they defined their body, what made them love and hate their body, their experiences growing up with their body as a child, and how they understood their body size affected their life. The women's understanding of their physical form influenced their experiences, and their experiences influenced their understanding of their bodies.

Our conceptual understanding of ourselves is influenced through shared meanings and cultural perspectives. Body size and the meaning behind the labels "fat" and "thin" are cultural manifestations that can be found globally due to the influence of authorities in Western societies. The influences of body size ideals are far-reaching, and the biases of body size ideologies influence the science of health care. Indeed, to truly comprehend women's experiences with health and well-being when utilizing medical care in Southern Ontario, it is also necessary to understand the women's total body relationship. They are more than their form. Yet come what may, they are not without their form.

I begin with the section "Laughing Through the Tears," addressing the difficulty of the subject matter by describing the participants' attempts to deal with their emotional

distress during the interview through emotional resiliency. This discussion is essential to understanding the harm women experience in Canada from fat denigration. I discuss the mental health repercussions of retelling their experiences or, in some cases, being unable to tell their experiences. Next, I explore the rhetoric of body size labels in the section “Defending My Body.” As larger body sizes face judgement in Canada, I explore the meaning behind the women's labels for their bodies and how they understand their bodies through their chosen label. This discussion respects their choices in body labels and recognizes what it means to define their bodies as larger. After, in the section “All Kinds of Fat,” I detail the chosen body labels of the women along with their described body shapes and sizes. From there, I explore the participants' narratives under the category of their chosen body label in the section “Shaping Women.” This section establishes the significance of the women’s body size and shape and how societal influences impact their experiences with a larger body. Finally, in the last section of this chapter, I utilize Judith Butler’s performance theory to describe the women’s relationship with their bodies in the section “Fat Embodiment.” Here, I illustrate their multifaceted relationships with their bodies through how they feel about their visual appearance, their thoughts on what their body does for them, and what they do not understand about their body in relation to adiposity. I explore the complex intersectionality in which they exist in the dominant sociocultural narrative of thin bodies while also navigating their larger body sizes.

Ultimately, I discuss the sociocultural contexts which influence the women’s relationships with their bodies and how they sometimes embrace or reject those influences—beginning in their formative years, continuing through their entire lifetime, in the eternal battle of navigating their body sizes. This lifelong battle depicts the

women's understanding of their body from three perspectives: as visually unpleasing, as something they appreciate for its capabilities, and as something they have a desire to know and understand better. These sociocultural influences ultimately shape medical care and the health of the women who seek support in Southern Ontario health systems.

3.1 Laughing Through the Tears

The women's emotions during their interviews conveyed the influences fat denigration had on them. Telling their stories was more than a simple moment in their lives. The experience had a profound effect on the women. Through tears, anger, and humour, these women protected themselves. They chose not to relive some traumatic events, made it clear what in their lives caused anger, and eased their stories with laughter. As I explored their experiences, I found their body a site of resiliency. A fortress, if you will, against fat denigration.

Emotions are essential in ethnography because they are interwoven in the participants' lives and help tell their stories (Beatty 2011:430). Without recognizing emotions, the ethnographic information may lose its essence (Beatty 2011:440). Indeed, the importance of their stories goes beyond the narrative. The participants' emotional narratives provided insight into their mental health and, in part, their well-being.

"It was just so humiliating," said Aubrey. She held back tears as she recounted the doctor's denial of surgery because she had to lose ten pounds. She recounted her bafflement with the situation and the invalid justification from the doctors. There was pain in her interview. There was pain in all the interviews I conducted. As Western societies influence the stigmatization and discrimination against larger bodies, the participants are a vulnerable population, and the participants expressed distress in

retelling their stories. The women faced castigation due to the fat on their bodies.

Through tears, anger, and deflective humour, the women recounted their distress with how other people treat them because of their natural body fat.

The tears and crying varied among the participants. Seventeen minutes into the interview, Selene started to tear up after explaining how angry she used to be with her body and the weight she had gained. I asked if she needed to pass on the question, but she tearfully laughed that she was perfectly comfortable crying. Lyssa entered the interview as if she had been crying, a sense of anxiety about the situation in her tense body. Her eyes were slightly pink and shiny as soon as her face appeared on my laptop screen. The participants often cried or hid their tears—each at a different point in the interview.

Out of the thirteen interviews, only Phoebe requested to pass on a question. When I inquired into her relationship with her body growing up, she abruptly indicated she matured early. Then, in a moment, there was an anguished silence. Phoebe turned her head over her right shoulder, hiding her face from the camera. Bright red, her eyes immediately filled with tears. She placed her hand over her mouth to muffle her sobs. Her response was intense. I gave her options to end the interview or pass on the question. Phoebe chose to pass, requesting I ask the following question so we could move on. There was an air of hurt, a memory that is never forgotten but not spoken aloud. I did not probe further. I respected her privacy in the matter, wanting to ensure she felt safe and comfortable. Whatever happened to Phoebe, I will not know. But her rapid and intense response suggests that the memory still causes grave distress. Indeed, the tears participants expelled or frequently hid in the interviews created a sense of dejection.

Through their tears, the emotional stress seems quite prevalent—negatively affecting their mental health and overall well-being.

Tears were not the only sign that suggested emotional distress. Anger was also prevalent throughout the interviews. Joleen would tell me about her medical experiences with a fury in her voice. She recounted filing an ethics claim against a surgeon for his poor treatment of her. Bridget shared in the anger as she stated, “Yeah. And you know, and you don't even know if [the diet plan is] going to work,” dismayed at the impossibility of her body in the face of the medical advice that continually let her down. Similarly, Aubrey recounted her medical experience with exasperation and indignance. Constantly rejected and turned away, she heatedly recounted, “But it was just this dismissal of [help].” Similar to the tears, their anger suggests the women suffered, at the very least, emotional distress from the memory of their experiences, in addition to the health consequences of poor health care at the time of their experiences. Indeed, women can find a sense of power in the use of anger, particularly to restore justice, respect, and reciprocity (Thomas et al. 1998). Their emotional responses are rational from their negative experiences, the experiences of fat denigration.

Of particular interest is the use of humour in women's narratives. Women's humour can be a form of resistance to social oppression, self-deprecation in some of the most adverse conditions, and social sarcasm (Downe 1999). Pamela Downe (1999:70) articulates that “it is not only possible to retrieve women's humour from the forgotten social margins, but it is also possible to view it as a form of resistance to the oppressive conditions in which many women live.” Women's laughter and humour may be an expression of resiliency in the face of their emotional distress. Indeed, Thalia laughed as

she described her body as having “a lot of shape going on.” She frequently laughed throughout the interview, including after indicating her go-to position is to hate her body. Now, hating one’s body is not overtly humorous. But as Thalia talked, she joked in moments of negativity, as if she were using laughter to lessen the pain of those moments.

Veera laughed after declaring, "I just dodged a bullet. Like I could have, you know, I could have died on the operating table." I laughed along with her. Her potential death is not funny, but her exclamation at the ludicrous nature of wanting a surgical procedure to address her weight was a humorous tale. Her laughter was contagious as she detailed her realization the day before her scheduled surgery, her choice to suddenly not have it, and the way in which she cancelled the procedure. In a similar fashion, Imara awkwardly laughed after telling me about the pain she underwent during her Intrauterine Device (IUD) removal procedure. Again, laughter appeared as a tool to soften the severity of the situation. Finally, Aubrey laughed that she is tremendously impatient in the form of self-deprecating humour, joking at her own expense.

The women revealed their resiliency in their emotions, displaying anger, sadness, and humour when discussing their experiences and understandings of their bodies. This resiliency suggests their bodies are a site to be protected – a protection revealed through their emotional hurt. There are consequences to the war on fat. These consequences meant the women had to find ways to cope against fat denigration. Fat denigration risks their well-being, denying them the rights and privileges of those with smaller bodies. Anger, sadness, and humour were emotional tools to confront this denigration and serve as indicators of its severity.

3.2 Defending My Body

Throughout the initial process of designing my research, I chose the terms “larger body size” and “above average body type” as descriptors to not place stigmatizing labels on the participants. However, I want to respect the participants’ chosen body size labels when discussing my research. Understanding their use of language provided an opportunity to recognize the impact of fat rhetoric, such as refusing stigma and valuing their bodies. In an exploration of which label and why that label, the participants discussed a total of five descriptors as detailed in Table 3 Participant Chosen Label Descriptors.

<i>Pseudonym</i>	<i>Athletic</i>	<i>Curvy</i>	<i>Fat</i>	<i>Rubenesque</i>	<i>Voluptuous</i>
<i>Alethea</i>		X	X		
<i>Aubrey</i>			X		
<i>Bridget</i>	X				
<i>Colette</i>					X
<i>Freya</i>				X	
<i>Haley</i>		X			
<i>Imara</i>			X		
<i>Joleen</i>			X		
<i>Lyssa</i>		X			
<i>Phoebe</i>			X		
<i>Selene</i>		X			
<i>Thalia</i>		X			
<i>Veera</i>					X

Table 3 Participant Chosen Label Descriptors

When asked what label the women preferred to describe their bodies, the participants emphasized a way to exert a position of power by defending their bodies. The women chose descriptive words that reflected a positive expression of their body size, such as curvy, Rubenesque, and voluptuous. In parallel, some chose the label “fat” before it could be used against them. In one instance, the participant rejected a body descriptor label. When I explored the reasons for their choices, the women thoughtfully

articulated the necessity to accept their bodies in a positive fashion rather than allow external influences to dictate their bodies' acceptability.

Five participants chose to acknowledge the term “fat” as a descriptor for their larger bodies. Imara aptly explained her chosen body label “because it is a word that has been used against me in the past and I prefer to think of it as a neutral, descriptive word, like tall, short, thin.” Imara’s response suggests that, like the other four participants, rather than allow the hostile rhetoric to shame her body size, they embraced the label “fat” as their reality. Joleen echoed this consideration, stating:

I do say fat because I am very much a proponent of Anne of Green Gables it-is-better-I-say-it-than-somebody-else-says-it so. And Anne was talking about her red hair, even though she hated it, but she'd rather refer to it than other people. It's the same for me. It's the obvious. So why not acknowledge it.

Indeed, people, organizations, and movements – such as the Fat Acceptance Movement – believe fat is just a word, nothing more than a descriptor (Meadows and Daniélsdóttir 2016). Fat acceptance is an acknowledgment of a fat body without the insult. Along these same lines, the rhetoric of fat as unhealthy acts as a tool for fat activists to alter the discourse beyond health (Casadó-Marín and Gracia-Arnaiz 2020) and to reframe the word as a cultural production of fatphobia rather than a global epidemic (Cooper 2010). Consequently, the participants who selected the word “fat” chose, aware of the stigma, to reclaim the word and refute the associated stigma. Instead, they chose the label “fat” as a descriptor, an act of defiance against the societal creation of a pejorative label.

Nevertheless, “fat” is a bad word in Western societies. The stigmatization of body size is, in part, built upon the microaggressions that treat fat bodies as undesirable (Munro 2017). Beyond a description of body size, the ideologies of fat creates a negative association with the word. To be fat or labelled fat is derogatory. As such, it comes as no

surprise that most of the participants chose a different label to recognize their shapely figure. Deliberating what label best described their body, eight women chose curvy, Rubenesque, or voluptuous. Declaring the word friendly, Freya chose Rubenesque as her body label. Haley and Lyssa chose curvy because of its positive association, particularly with social media. Haley mused,

So I pick that word because I guess it has more of like a positive association now, especially with like social media. So, I'm thinking like, mostly Instagram and more like body positivity type stuff on Instagram, like a little bit Twitter maybe, but I would say like less so Facebook.

Voluptuous, chosen for the alliteration, is Veera's preference. In each instance, the women did not want to be labelled "fat" despite knowing their bodies were viewed as deviant. Instead, they gravitated towards words with a positive association. This positive label suggests the same defiance towards the negativity of the word "fat" as those who chose the label "fat." Through both choices, the participant's label choice suggests protecting their identity from the sociocultural understanding that "fat is bad." This protection allows the women to value themselves despite the stigmatization.

Diverging from a label that recognizes her appearance or size, Bridget chose a label based on her body's ability. Without hesitation, Bridget declared her chosen body label as athletic, elaborating, "I'm pretty like toned and pretty athletic. I'm just, I'm pretty solid." Though the frustration with her body size is evident throughout her interview, specifically about her inability to lose weight, Bridget's choice of body label recognized her body for what it did rather than its appearance. Though she is the only participant to shift away from an appearance-based label, her choice seems to follow the same intent as the other fat and curvy women. Acknowledging her body for what it does (specifically her athletic ability) rejects the rhetoric of a lazy fat person—a rejection of

the negative labels associated with the idea of being fat. Bridget challenged Western societies' ideologies of fat bodies by embracing a body label beyond size.

In their choice of label, all the women recognized affirmative rhetoric. This recognition suggests a defiance of the negative discourse of fat bodies. These women are not undesirable, they are not merely their stigmatized bodies, and their self-awareness acknowledging a positive relationship with themselves is the beginning of maintaining their health and well-being.

Of particular interest is the lack of labels “obese” or “overweight” in the terms women selected for themselves. These labels denote a medical classification that the body is abnormal, unhealthy, and at risk of disease, further propagating fat bias (Freeman 2020:13). Indeed, the use of “fat” can be far less stigmatized than the words “obese” or “overweight” (Freeman 2020:13). Preferring the label “fat,” Joleen was apprehensive about the word “obese.” She felt that “fat” is a temporary label, and the possibility existed to still lose weight, whereas the label “obese” is a permanent affixture. This affixture would declare that she would be fat forever. Similarly, Imara also discussed the label “obese.” Her aversion to it was because of its medicalization which comes across as accusatory. While “fat” may be contextually a bad word but also sometimes embraced, “obese” and “overweight” were labels that should not be spoken.³ Subsequently, in this thesis, I will discuss the women using their chosen body labels, especially “curvy” and “fat” from the chosen categories in my discussions, as these were popular self-identifiers. I will also draw on the notion of a fat body as a deviant body to further discuss body

³ I like to metaphorically think of “obese” and “overweight” as “Voldemort.”

types. Additionally, given the participants' aversion to "obese" and "overweight," I will not use these medical classifications when discussing body size.

3.3 All Kinds of Fat

Body size is not static, and fat distribution may change throughout a woman's lifetime. Weight gain can occur in a woman with pregnancy, hormonal changes, menstruation, fluid retention, medications, lack of nutrients, stress, sleep deprivation, depression, and certain diseases and illnesses (Fitday n.d.; Sampson 2019). The idea that a woman can and should maintain a thin body throughout her life seems at odds with the myriad factors that cause weight gain. For the participants, their bodies varied in size and fat distribution. Two women indicated their bodies had been larger their entire life, seven stated their bodies grew with hormonal changes (puberty or menopause), two women's bodies changed after injury, one participant increased in size due to trauma, and two increased in size due to a prescribed medication. Of the thirteen women, eleven discussed their weight cycling, experiencing weight loss and weight gain. Only two participants discussed their body as a site of weight gain but a lack of weight loss.

The amount of fat on a woman's body matters. That is to say, the more fat, the more fat denigration a woman may experience. As I analyzed the women's experiences, I found that the larger the body, the more negative their experiences. As such, I consider it necessary to provide a literary visualization of the participants' bodies. Physical appearance impacts women's experiences in their communities and medical care, and my

research reveals that how much adipose tissue they had was reflected in how much harm they experienced. Below, I discuss the women's bodies by their chosen body label.⁴

3.3.1 Call Me Curvy

For the women who chose the word curvy, their bodies varied significantly between the participants. Alethea indicated she had an hourglass figure where the adipose tissue was evenly distributed over her entire form. As one of my two phone call interviews, I could not see her body, but she revealed her breasts are quite large, and though her body size varied through her lifetime, she has always been a big girl. In a similar fashion, Selene also described her body with the adipose tissue evenly distributed across her form. Selene's height makes her stand out from the other participants. Selene is six feet tall, and while she is almost at her largest size, she surmised that her height impacted how other people see her weight. Her friends refer to her as an Amazon warrior because of her appearance.

The two youngest participants, Haley and Lyssa, also chose the label curvy. Haley followed suit with most participants, explaining her body size is slightly above average with large breasts. Lyssa, however, provided a most unusual response when I inquired about her body. As the first of my video interviews, Lyssa has a cherub-like appearance. While I saw Lyssa's body had an even distribution, with larger breasts, Lyssa articulated she was not fully aware of her body's appearance. Over time, she found she was unsure

⁴ I do want to be clear that, while I discuss the women's bodies, they are more than their physical form. I do not want to imply that the women should be reduced to their physical appearance, but their body shape does matter in the context of this research. Nevertheless, I have provided a participant description which can be found in Appendix A to describe the women beyond their bodies.

how her body size appeared. While this response may contrast with the other participants, her reply does answer the question. Of the curvy women, the only participant to indicate her body had an uneven distribution of adipose tissue was Thalia, who enthusiastically explained her body is pear-shaped. She gestured emphatically at her upper body, the only portion I could see on the video meeting, indicating she was smaller on top but bigger on the bottom.

Of interest to note with these participants is their affirmation that, while they are not skinny, they also make it clear they would not consider themselves “fat.” Often, I found these participants acknowledging that a woman with an even larger body than them would have a harder time than they did in their experiences. Their clarification suggests a sort of liminal state of their body. They are not skinny but also not so fat as to face the ramifications that much larger women experience in Canada. Perhaps, an illustration that thin privilege is not necessarily about the opposition to being fat but about the binary ideology of skinny or not skinny. As such, the women face discrimination despite not being “fat” simply because they are not thin.

3.3.2 An Athlete

Bridget is the only participant to choose the label athletic. She recognized her body for what it does rather than its appearance, where she detailed the weight is distributed on a big-boned body. Bridget could not fathom why the unwanted adipose tissue remained on her body because she exercised and ate “right.”

3.3.3 Va-Va-Voluptuous

With contrasting bodies, two women chose the word voluptuous. Veera, in all her vivacious glory, countered my question with the philosophical retort, “what is a body

type?” She then discussed the health education she received about the “useless” three body types: ectomorph, endomorph, and mesomorph. She avoided answering my prompt. But the interview was by video chat, and I could see her. Veera appeared to have a body type slightly above average. However, I could only see her upper body, so her weight might be evenly distributed or potentially concentrated in her lower body.

In contrast, Colette described her body as very heavy on top. She summarized that her weight is between her hips and her breasts. She laughed in explanation, specifying her large breasts, stick legs, and almost barrel-like upper body. Like Thalia, she also gestured to her body when contrasting the different sections of her form. Veera and Colette also indicated they are “not fat” in the “societal” sense. They recognized that they had an above-average body type but were not willing to classify their body as fat.

3.3.4 Rubenesque Ready

The only participant to choose Rubenesque, Freya made it clear she would not classify herself as fat but indicated her body is pear-shaped. With her lower body possessing most of her adipose tissue, having recently lost weight, she clarified she is slightly above average but still “knows that she is fat.”

3.3.5 Fat and Fearless

Of the women who embraced the word fat, these women undisputedly exist in bodies that do not meet the societal thin ideologies. The women who chose this label made it clear in their interview that one could not debate to what extent they could be considered fat. Accepting her body as is, Phoebe described her body as chunky, fat, and saggy. After this description, she laughed a little, explaining that a stranger recently called her body toned, which she attributed to the swimming she does five days a week.

However, that is not her opinion of her body. When I enquired further into her appearance, she laughed and indicated there was not enough time in the interview and we did not need to go there. Joleen indicated her body had always been chunky or chubby in a similar description; a self-proclaimed short, fat, little gray-haired woman. The last of the participants under the fat label is Imara. Imara described her body as plus-sized. A perpetual reality of her childhood, Imara stated she has always been fat.

3.3.6 Discussion: Fat Spectrum

Although the women's verbal description, and my written reiteration of their bodies, may not be the most descriptive representation, the differences in body shape and fat distribution detail the ideology that one size does certainly not belong to all. Indeed, though the labels are similar, the women come in all shapes and sizes. Therefore, a label is not a reliable indicator of a woman's figure and certainly not her experiences. However, labels do matter, particularly as the women selected their bodily labels to defy the negative stereotypes of fat bodies to value themselves in a positive manner.

3.4 Shaping Women

People's responses to body size are frequently not about health; stigmatizing and discriminating against larger body sizes is about maintaining positions of superiority. Amy Erdman Farrell (2011:176) articulates, "reinforcing the dangerous idea of the 'civilized body,' fat denigration intersects with and exacerbates racism, sexism, classism, and homophobia, and all the other means by which our culture classifies and oppresses people based on bodily attributes and social standing." It is possible to address the problem of fat stigma as a tool of oppression rather than hiding behind the health message by understanding how those in power use fat, stigmatizing larger body sizes, and

exacerbating other stigmatized and discriminated physical attributes. Pretending that fat stigmatization and discrimination encourage health ignores the historical context and reality in which fat is weaponized. Fat is not about health risks but the horror of a stigmatized identity (Farrell 2011:176). Labelling the fat body as immoral places human lives in danger. Given that fat denigration began a century before the “fat epidemic” (Farrell 2011; Strings 2019), people must understand that the fight against fat is about cultural ideologies. This section details the myriad factors that influenced the women’s relationships with their bodies. From childhood to adulthood, with peers and family, workplace and schools, there was no shortage of ways in which the societal expectations of thin supremacy appeared in the women’s lives. Beginning in childhood, I describe the influences of family, strangers, and education systems on the self-body relationship. Into adulthood, the struggles of fashion and clothing and the workplace demonstrate the enduring thin ideologies and the complex relationship to body size standards.

3.4.1 For Families’ Sake

Mother-daughter relationships when it comes to body size are complex. In a dedicated chapter on family and relationships in the war on fat, Susan Greenhalgh (2015) articulates that a mother’s responsibility is both to her own body size and the bodies of her family. Western societies consider mothers without skinny daughters as failures and bad parents (Greenhalgh 2015:214). As such, mothers may take it upon themselves to correct their daughters’ body size. This reality was Veera’s childhood. She acknowledged,

I always thought I was fat. I had a mother who was really controlling and emotionally abusive, and she always made me feel like I was fat and I was worthless because I was bigger than she was. Like, she would always throw that in my face.

Following her mother's judgement, Veera did everything possible to obtain and maintain the "perfect body." Her actions included constantly dieting, finding every opportunity to go for a run, and wearing compression shapewear to hide the fat she thought was present on her body. Her body size struggles continued to the time of the interview; a lifelong struggle that began because her mother shamed her once thin body size as fat.

Freya's family also impacted her relationship with her body in childhood. She depicted her child body as "not chubby," but her sisters relentlessly teased her about being fat. Though she does not discuss her parents in her reflection, it is possible to infer their involvement. While I cannot say for certain, I suppose the continued relentless fat teasing from her siblings suggests Freya's parents chose not to intervene and provided a subtextual agreement about her body. Freya's family taught her that her body was a problem because it was "fat."

In certain instances, it is not the mother's intervention but the mother's struggles that passed on to the daughter. Both Lyssa and Alethea watched their mothers struggle with their body size. Their mothers' diet exertions and negative body images impacted how they thought about their bodies. Haley hinted at this same influence, though she does not directly implicate her mother. She deliberated,

Like growing up around even like other female influences within like my family and hearing the way that they would say negative things about themselves. And I think that has an influence as to like how you grow up and perceive yourself too.

These women still experienced the shame of fat bodies through their mothers' and female family members' struggles.

However, mothers can also protect their daughters from the harsh influences of body size expectations. Thalia did not think about her body as a child, and Joleen was raised not to place importance on her physical appearance (a memory she connected to

her premature birth and her mother's gratitude for her survival). Selene's mother also protected her from thin ideologies. She portrayed a moment when her family was at a restaurant, where her father allowed her three brothers to have dessert but then denied his only daughter. Selene asserted that "[my mother] put a stop to *that*," with her parents eventually divorcing when she was thirteen. For these women, their bodies just existed. As they grew through childhood, their body was not a site of visual importance. Rather, they were allowed to live as children instead of forcing a premature fat identity upon them.

Families had a positive and negative influence on the participants. Body size expectations are inescapable, as the following sections will demonstrate. But how those closest to the women addressed their bodies could have harmful or protective results.

3.4.2 Stranger Danger

Outside the involvement of family members in body size recognition, non-familial relationships may bring awareness to the body's visual importance. Alethea was embarrassed about her body as she was "too tall" as a child, explicitly recounting she felt too big to fit in. She associated her childhood with Alice in Wonderland, identifying with Alice after eating the cake, which made her body grow with her arms and legs sticking out of a house. Alethea literally did not fit into the child-sized furniture, designed for a specific height, which made her aware of her body. In opposition, Haley was small as a child. She recounted how people were concerned with her size. While she felt safe with her body while playing sports, her tiny body was a constant concern for outsiders to the extent that the discussion of her size eventually resulted in Haley developing an eating disorder. A relentless focus on her size had dire consequences. Imara stated she had

always been fat. Bullied by the other children, she found herself alienated and not accepted. The ability to exist as children without focusing on their body size was challenged when they did not fit into a world built for specifically-sized-children and when other people continually pointed out that their bodies seemed “abnormal.” In their childhoods, “too small,” “too tall,” and “too fat” all drew focus to their bodies. The ideology that somehow children should fit into a homogenous body size brought attention to their forms, creating an unnecessary and sometimes harmful focus on their physical appearance.

When it comes to the liminal stage of puberty, as the women’s bodies developed from the androgynous child forms to the feminine figures of womanhood, the participants recounted a mostly negative transition. In particular, the development of breasts forced these women to acknowledge their bodies because influential people (i.e., family members) noticed and drew negative attention to those natural body changes.

When I asked about her relationship with her body growing up, Colette recalled that her body was never a concern as a child. That is, not until puberty and her breasts started to grow. With her feminine curves growing significantly at a young age, Colette recounted a lot of shame and sexual harassment. She was aware of her body because people objectified her development through puberty. When I asked Phoebe, who also matured early, she articulated her self-consciousness as a child, as she matured young at the tender age of eleven. As previously mentioned, this is the moment in which Phoebe chose to pass on the question. I jumped right into the next question, respecting her request. I have no idea what happened to Phoebe in her youth to prompt such a wounded response.

Interestingly, Colette and Phoebe indicated that the issue was developing their bodily curves early. Yet, there is no set age for puberty. Canadian girls tend to experience puberty between eleven to fourteen years of age, with early puberty occurring before eleven and late puberty occurring after fourteen (Al-Sahab et al. 2010). Truly, Phoebe and Colette were within the normal range to experience puberty. The issue, I argue, is not that they approached puberty too soon but that they were sexualized too soon and objectified early. The women's experiences were unfavourable when exposed to people and systems which deemed fat bodies as undesirable.

3.4.3 Teaching Thinness

Education systems also proved to be a problem for these women and their bodily relationships in their youth. Focusing on the body's visual appearance, educational institutions initiated negative body awareness for three participants. The Ontario Curriculum: Health and Physical Education (2019) still focuses on the issues of fat, claiming larger body sizes exist due to increased food energy intake and decreased physical energy output (which correspond with societal notions of sinful behaviour – for example, two of the Christian “seven deadly sins” are “gluttony” and “sloth”). The curriculum (2019:147, 258-60) provides contradicting information, claiming students may not be able to control their heredity body size but should be able to alter their body shape by balancing their diet and exercise. The subtext of Ontario's education is clear: fat is bad and unhealthy, and the student is responsible for changing it. While this information is formally taught to current students, the participants also experienced issues of body size expectations through sexualization, shaming, and bullying in school.

In high school, Alethea stopped taking gym classes. She implied that this choice was made because she hated the class and had no interest in the gym. However, later in the interview, when I asked about her body growing up, she divulged sexual harassment, which occurred in gym class. In grade three, her male teacher told her not to wear a particular shirt to gym class because it was too revealing of her breasts. This moment, Alethea observed, forced her to be aware of her larger breasts. It was a moment when a teacher sexualized a child.

Imara's education experience is heartbreaking. Once a week, the school, initiated by her home economics teacher, decided she had to be weighed and lectured at the nurse's office. Without her parents' permission or knowledge, the school took it upon themselves to control Imara's body size and enforce thin supremacy. She recounted the experience in disbelief, as if her memory attempted to repress the tragedy unsuccessfully. I paused at this moment, shocked with disbelief. Imara had no choice, with the school shaming her body weekly. In response, I told her I was sorry her teacher thought it was appropriate to do that to a child. The contempt was firm in her voice, and she replied that she was "sorry the whole school thought that was appropriate."

Thalia, a diplomat's child, remembered attending a school in Geneva, Switzerland, where she started not liking her body between the ages of ten to twelve. Her fellow students, particularly the girls, claimed she was too fat—a proclamation which became Thalia's reality; her belief about herself. For children, having a fat body means they are more likely to be victims of bullying, with girls more likely to be bullied for their larger body size than boys (van Geel et al. 2014). Of course, each of their experiences was different, but they were horrible experiences, nonetheless.

3.4.4 It's Not Like I Can Be Naked

Fashion and clothes came up frequently with the participants. In all their societal necessity, clothes were a significant problem for the participants and their relationship with their bodies. In a book detailing Canadian fat activism, Jenny Ellison (2020:162) articulates that the importance of fat fashion for women lies in the connection between the body and self-relationship. Fashion is an act of self-expression. As clothes can represent a person's identity, fat women do not have the option to express themselves when fashion and retail companies do not carry larger clothing sizes, increase the costs of plus size fashion, and provide limited and ill-fitting clothing options, which creates feelings of embarrassment and shame (Ellison 2020). Indeed, the participants are no exception to the tribulations of fat fashion. The women discussed the problems of finding clothes that fit, size inconsistency and the need to wear "slimming" garments, and how clothing may be a gateway to additional discrimination.

For clothing fit, the issues included unavailable sizes and the necessity to try on a significant number of items to find a single piece that fits. In response to this discrimination, Alethea sews her clothes. Even then, sewing patterns are often not available in her size, so she must adjust the designs. When I inquired further, she associated clothing back to her childhood in which the clothing was either too expensive or too small. She elaborated on the problems trying to fit in with the cool kids in school, but her stomach sticking out over the top of the in-fashion low-rise jeans proved an embarrassing dilemma. Additionally, stores did not carry above a size "large," which prevented her from buying clothing and caused further embarrassment when she tried to

find her size when shopping. Now, she sews about half of her clothes and finds the rest at thrift stores.

Aubrey's frustration stems from the need for a sports bra above the cup size D. A well-fitting sports bra is essential. Without proper support for larger breasts during physical exercise, the force of breast movement increases, and women's discomfort is intensified (McGhee et al. 2013). Thalia agrees with Aubrey. As a triathlon athlete, she found athletic clothing a challenge to locate. There is an irony to excluding fat women from the necessary sports clothing and then shaming them as lazy for not engaging in sports. Unfortunately, when it comes to plus-size athletic wear, women face price discrimination, limited choices, discouraging shopping environments, and are often forced to buy male clothing (Christel et al. 2016). A lack of clothing options, either in selection or sizing availability, tells women with larger bodies that they must lose weight to find the necessary garments.

The participants' struggles continued with the complex and confusing message of garment sizes for the women who could find clothing. Both Haley and Selene had a hard time separating their self-image from the negative impact of the clothing they could not find. While finding an item that fits made Haley appreciate her body, she mused that "trying on a million different pairs of jeans to find one that fits" made her super self-conscious. Despite her positive body relationship, Selene admitted to struggling with clothing. Weight gain tends to come with the necessity to buy new clothes that fit correctly. Yet, finding those clothes is a challenge. On top of existing with a larger body size, Selene is also six feet tall. She confessed to trying not to value herself based on her body size but ultimately found it challenging.

Clothing sizes are also inconsistent. Veera laughed a little at the ludicrous situation. Bewildered, she explained, “I have the size ten shorts. I have a size eight jeans. I don’t know how it fits me, but it fits me. And, you know, I have size fourteen blazers and bought size twelve dresses. Like my [clothing] sizes are all over the place.” Indeed, the array of clothing sizes on the same body would provide a confusing experience. Clothing manufacturers do not adhere to standard size charts in Canada (Faust et al. 2006). When attempting to find clothing with already prejudiced options, the women struggled even to know which size to choose, making their experience even more difficult.

Clothing apparatuses also exist to intentionally decrease one's body size and make it conform to societal expectations. Continuing the discussion of clothing size problems, Veera admitted, “You know what is really fucked up? I was 130 pounds, and I was wearing Spanx⁵ in a size six dress.” Before the weight gain, already conditioned to believe her body was fat, Veera hid her body. The fat is sucked and held in by clothing designed to decrease body size to “flatter” a woman’s form.

The struggles of clothing are not limited to body size issues. As they can represent a person’s identity, clothing is more than its availability. Of particular interest is Phoebe’s take on clothing. Phoebe related clothing to her confidence and ability to obtain jobs. As companies do not cater suits or business clothing to women of larger sizes, her confidence decreased. Despite knowing she has the smarts to do the job, the insecurities

⁵ Spanx is a brand of shapewear, which is undergarment clothing designed to smooth the body and provide for a “shapely” figure.

created from clothing struggles hindered her ability to go out, meet people, and perform the necessary tasks of life.⁶

When clothing is a representation of identity, then what message do fat women receive when they cannot find clothing? I would infer that the message is that these women do not belong and that they are unworthy of the same experiences as their thinner peers. Indeed, the ability to function in their daily lives is not limited to clothing. The world is literally not built for fat people, supporting stigmatization and fat shaming (Farrell 2011:158). For example, automobile industry standards state that seatbelts only have to fit people up to 215 pounds (Farrell 2011:158). As with clothing, industry standards shape accessibility for deviant bodies. However, in this case, the barrier to access is not about self-expression but safety. While the women focused on clothing, an everyday and consistent battle for them, fat denigration makes it a challenge to exist in their worlds. The ideology of thin supremacy restricts clothing and so much more for fat women. Companies tell them they cannot shop in stores, or they have to make their own clothing. Inconsistent sizing messaging, unavailable clothing options, limited selections, garments designed to make bodies smaller, and restricting industry standards send a message about what identity curvy women should seek – a thinner one.

3.4.5 9 to 5 – Making a Living

Career discussion was not a frequent topic for the women. And yet, I consider the instances of workplace narratives help understand the full breadth of environments that influence the relationships women have with their bodies. Though discussions of

⁶ Foreshadowing!

employers did not directly endorse thin supremacy, there is a relationship between the workplace and the women's bodies. Places of employment impacted how much time could be given to the care of one's body and fitness. Employment environments that created stress, homogenous expectations, or alternatively, inclusivity, determined the care that the women could give themselves. Positive work environments meant an appreciation for their body, whereas adverse work environments meant ignoring the body's needs to the detriment of their health.

Stress plays a significant role in health and weight gain (Fohr et al. 2016; Jang et al. 2020; Torrers and Nowson 2007). For Phoebe, she dedicated her life to her tobacco control career. Believing smoking cessation was a mission in her life, consumed with its importance, she got minimal exercise and poor nutrition. Every day she would eat a chocolate bar as a pick-me-up and often did not eat dinner until eleven o'clock at night when she finally got home. Phoebe dedicated her life to ending tobacco consumption for five years, but, as she puts it, her career was "a total lifestyle screw up." Eventually, she changed roles in tobacco control to have a better lifestyle balance. Yet, the effect of her stressful job remained on her body. The physical effects of stress appeared in the increase in adipose tissue.

Freya's career was the reason for her previous physical prowess and her current weight gain. In the military, Freya had to complete physical training to maintain her position. This training partially included running, rucksack marching, jump courses, twenty-kilometre distances, and basic officer training. In certain instances, military personnel must carry an extra 60 to 70 lbs of weight from the rucksack, weapon, and helmet while training. In each of these occurrences, Freya had to keep up with her male

counterparts. Given that the men were almost a foot taller than her, Freya’s difficulty with the homogenous physical fitness expectations jeopardized her health. After thirty years, a doctor medically discharged Freya from her career as she lost the cartilage in her knees and could no longer complete the fitness tests. Recalling the experience, she described, “The pain was just horrible. I couldn’t sleep. I was taking oxycodone, which would just take the edge off. The [drugs were] not a high at all. It just would take the edge off.” Unable to walk correctly and requiring two knee replacements, Freya gained weight. Her health plummeted because her workplace expected her to meet fitness expectations which harmed her body and, ultimately, her health.

In contrast, Colette’s experience with an Olympic organization⁷ is vastly different from the military's homogenous fitness expectations. Having completed her career as an athlete and focusing on being a coach, she moved to Vancouver for a job. Colette detailed how the Olympic games employ a range of people, from professional athletes to those who run the cafeteria, all of whom have different physical fitness levels. As an employer, Colette explained that the organization understands the differences in people’s bodies and would create a happy and social atmosphere. Unlike her other employers, who expected a single fitness level for their employees during social activities (which required similar physical exertion from the employees), working at the Olympics broadened Colette’s experience as they provided opportunities for everyone to work together at their own pace. There was something for everyone to be a part of with employer-provided activities. Explaining, Colette affirmed,

⁷ Colette did not name the organization, merely stated that she had a job in Vancouver at the Olympics.

Whereas when I was at the job in Vancouver, it was very inclusive, and there were different levels of doing things. And so there was no kind of ‘you either do it this way, or you don’t do it.’ We’re all going to go and meet here, and we’re going to do this [activity]. There’s going to be, you know, and there’s going to be people posted at various locations so that if, you know, if you can only go at one kilometre an hour pace, there’s people with you. If you can, if you can go at a 10-kilometre an hour pace, there are people with you. So, there was just much more...it was set up much more inclusively. And I think it was just a by-product of that particular environment.

She elaborated that this environment is so welcoming that people (dubbed Games Gypsies) would travel to different international sporting events to work because of that inclusiveness. In her description of this past employment, Colette recognized that it was this environment in which she enjoyed her body. An inclusive environment, without a focus on body size or a homogenous fitness level, provided her with an opportunity to thrive in her body.

While workplace environments may not specifically influence the thin ideology, they directly impacted the health and well-being of these three women. The inability to have an appropriate work-life balance and the destruction of body joints due to homogenous physical ability expectations are all factors which contributed to the decrease in health and well-being. Keep in mind that, in the previously discussed fashion section, clothing also posed a problem in the workplace. There is a dual problem where not only can fat women face barriers to maintaining their health, but they may not be able to meet organization expectations of corporate dress codes. Certain jobs require a professional appearance, not only with clothing but additionally, a fat body may be considered “unprofessional” (Farrell 2011:159). Making a living for fat women is not an easy achievement when workplaces impair their ability to take care of themselves and have appearance expectations that may not be achievable for larger bodies.

3.4.6 Discussion: Fat Not Allowed

What is essential to understand from the external influences on body size acceptability is that family, friends, teachers, education systems, and the fashion industry believed they could limit the women's body size or their opportunities to exist comfortably in their bodies. Additionally, employers could make health and self-care a challenge (though, thankfully, not all of them). These women experienced a continual bombardment of messages of thin supremacy and women's objectification from their formative years onwards. Mothers projected their insecurities onto their daughters, schools and teachers focused on the body's appearance, and clothing garments and fashion companies challenged fat women's ability to exist as themselves. Even workplaces did not accommodate their bodies' needs and ignored body diversity. In each aspect of the women's lives, they faced fat denigration in some form or another.

3.5 Fat Embodiment

A fat body has a meaning. Western society's cultural norms of visual appearance lead to fat denigration. Additionally, people may embody their physical size by internalizing and adopting the stereotypical traits of fat people (Greenhalgh 2015). Susan Greenhalgh (2015:96-97) details the four characteristics of a fat identity where a fat person believes they are "bad," engages in body modifying behaviours, socially withdraws, and experiences emotional suffering due to their body. Fat becomes not just an appearance but an identity. However, how do people know they have a fat identity? Unlike some other identity markers, "fatness is a corporeal constant that must be attended to and dealt with in the maintenance of an individual's unique sense of self on a daily basis" (Peters 2014:66). Certain aspects of a person's physical appearance can change, but fat is not very likely to be one of them, as the majority of weight loss attempts fail –

people diet themselves into weight gain (Greenhalgh 2015:240). As such, a fat body is a perpetual reality. In this sense, when one is unable to hide a larger body size, this suggests the potential for a fat identity regardless of an individual's chosen position about their character. The historical shift toward thin body size superiority suggests that the fat body is complex, and the adoption of a fat identity is an act that embodies the dominant cultural assumptions in Western societies.

As with gender, fat is visible to others on the body. Butler argues that forms of identity – such as gender – are “in no way a stable identity or locus of agency from which various gendered acts proceed; rather, it is an identity tenuously constituted in time—an identity instituted through a stylized repetition of acts” (Fischer-Lichte quoting Butler 2008:27). A person is not born with their gender. Instead, they learn to perform their gender through cultural influences. How to perform the fat body is learned through similar cultural influences. Whether people identify as fat may rely significantly on outside perceptions of their body. Fat is visible. An individual cannot hide their fat body, nor hide from the connotations that exist about the fat body. Consequently, a person with a larger body size may be labelled as fat and assumed to have a fat identity based on their visual appearance. On a visual level, Graham (2015) suggests that Western culture reads people based on their size, calling this “lipoliteracy.” The author's research revealed that, at least in English, people verbally focus on the downside of fat (Graham 2015). As such, people read the visual appearance of a fat body in a negative way. Influenced by Western societal expectations, people read fat people as ugly, disgusting, inferior, and unworthy (Greenhalgh 2015:76) and associate curvy body sizes with the assumed “immoral” traits of a fat individual.

Fischer-Lichte (2008:27) articulates that Butler focuses on the phenomenal conditions for embodiment, where identity occurs through the process of embodiment. In a discussion of fat embodiment, Colls (2007) examines fat conceptualization through the ideology of fat body capabilities and the spatial awareness of fat as it exists both inside and outside the body. Utilizing Butler's performativity to discuss making sense of the body, Colls (2007:356) articulates that "bodies are made intelligible through specific discursive registers which already presupposes that human bodies inhabit a distinct ontological realm characterized by historical production, power and ideal forms." Like Butler's notion that gender identity does not pre-exist, Colls (2007) expresses that fat bodies do not inherently have a fat identity. Instead, the fat body materialization emerges as a distinct spatial form on the body and is conceptualized as a barrier (Colls 2007). As with gender, a person learns and performs their fat identity.

The negative conceptualization of larger body sizes in Western societies creates the stereotyped fat identity, which people embody as performance in their discourse, actions, and personal and public lives. Some participants rejected being labelled "fat" and chose another label such as "curvy." Their discourses attempted to reject the stigmatization that comes with being labelled "fat;" they resisted a fat identity. In contrast, Phoebe's inability to find acceptable business attire for her larger body meant she felt she was not good enough to perform her job. She adopted the idea that she was not good enough, and, in a sense, "bad," simply because her outward appearance did not meet business attire expectations due to fat biases in the clothing industry. Phoebe performed a fat identity, adopting the stereotypical ideas about her character that people in Western societies assume of larger bodies.

Thus, when the women discussed their bodies, I found both an acceptance and rejection of a fat identity in which they accepted the stereotypes about their body and associated character flaws, or they rejected the stereotypes, which influenced how they saw themselves as a fat woman. As such, in this section, I discuss the women's bodies in three forms. First, I discuss the women's understanding of their visual appearance. I discuss Judith Butler's arguments about gender performativity as they apply to the cultural influences on fat bodies. Specifically, I address the visual appearance of the women's forms as a site of perceived unworthiness that women then performed as an extension of their fat identity. Second, I discuss the women's recognition of their bodies' capabilities where they understood they are more than a fat identity. Third, I discuss their bodies as a site of confusion, partly due to the contrasting negative 'visual' and positive 'ability' identities, but also due to the bodily knowledge that left them with questions.

3.5.1 Monster in the Mirror

When my research explored the moments in which the women hated their bodies, most participants discussed their bodies' appearances. Haley and Veera discussed their bodies in terms of specific parts they disliked. Bridget and Freya both remarked they are uncomfortable with their bodies, with Freya adding that she does not feel attractive. In a similar fashion, Phoebe tried not to understand her body as a material object. Aptly worded, Phoebe stated, "I'm just trying to take a different approach to it so that I don't end up loathing myself any more than I already do...so I'm not proud of my body." As a visual representation, the women discussed their bodies with hatred. The women loathed what their bodies represented in its larger form.

And yet, their bodies are not just a source of visual displeasure. A fat identity includes adopting the negative character stereotypes that Western societies assume of larger bodies. When I inquired about how body size affected her life, Thalia elaborated,

Well, it has affected my self-confidence. It's taken me a long time to have self-confidence and esteem. Actually, when I was [a] younger woman, I attribute a lot of my...I was fairly active sexually, and looking back, there's a lot of mistakes. But I was having a great time, that was fantastic. And that was super and I was leading these things. But I think at a certain point I would accept situations that weren't so great simply because I felt that I should because my body type, because of how I felt about my body. I [do] not have many choices or like, you know, like I would just be like, oh yeah, well, you know, this is the best I can do kind of thing because I can't access this particular level of respect of a situation.

Thalia thought she did not deserve respect, particularly during sexual encounters. Her actions suggest she embodied a fat identity, allowing other people to sexually disrespect her simply because she existed in her curvy body. She believed she was unworthy.

In the group discussion, Aubrey wrote that she hated her body and never had the chance to enjoy herself because she felt she was not good enough. Veera, so frightened of weight gain, stated, "I didn't allow myself to get over two hundred because I was too afraid that the universe will implode if I go over two hundred pounds." She was taught that being bigger was a catastrophe, constantly dieting and exercising for the "perfect body." She expressed this through the idea that a fat body was so negative that she could destroy the world if she gained enough weight.

In situations where Imara was continually denied medical care, she blamed her body. Angry, she felt hopeless and helpless, turning the blame inwards on herself for the cause of her problems rather than the actual perpetrator. Lyssa, insecure in social situations, also blamed her body size. Though she tried to be body-neutral, the fat identity caused problems in her attempt to date. These were problems, from both sides, where potential partners rejected her body as undesirable, and she considered herself unworthy.

Similarly, Selene struggled with depression after gaining weight and listening to people in her social network comment on her body. She remembered,

It was horrible. And like I put on a bunch of weight, and everyone was commenting on it and like and everything. I was struggling with depression, like it was. Yeah. I was like really angry with my body. Like it let me down.

Undeniably, cultural influences impacted how these women understood their bodies as the notion that “fat is bad” meant they thought they were unworthy because of their bodies. As material objects, their bodies signified the negative stereotypes that Western societies emphasized. The women acted as if they were unworthy, undesirable, and could not disconnect their bodies from the negative connotations which come with being fat. Despite the reality that not a single participant identified as lazy, unintelligent, or lacking self-discipline, the cultural associations with their visual representation created a source of burden for the women. They blamed their bodies as the cause of their problems – social situation insecurities, inability to receive medical care, allowing people to take advantage of them because they felt unworthy of respect, sinking into a depression, or believing continual weight gain was a catastrophe. They viewed their bodies, and therefore themselves, negatively. Indeed, the fat experience, or the embodiment of a fat identity, is often tied to issues of surviving and negative self-image (Cooper 2010:1025). The women’s understandings of themselves were tied to their physical form, manifested in a way that negatively impacted their well-being by acting as if they were not as capable or admirable as their thinner peers. When the women thought about their bodies as “fat,” they acted according to the negative stereotypes. They embodied a fat identity— not just physically but morally.

3.5.2 I am Capable

In contrast to the visual understanding of their body as a site of negative stereotypes due to fat denigration, the women's relationship with their bodies also extended to what their bodies did for them. The women also embraced their forms as more than fat. While the women adopted a fat identity, they also simultaneously rejected it. The women appreciated their bodies for what they could do rather than how they appeared on the outside. After Freya's knees gave out, she explained the pain, struggle to fit in, and inability to ski or run. Eventually, even walking became a problem. She also ended up medically discharged from her career in the military because of her injury. Her whole life changed. However, her story does not end there. Freya compared her past to her present, explaining she is thrilled she is in less pain, her strength is improving, and she can work out again and go for walks. There is disbelief when she compares her struggles a year ago and her progress now. Freya's body can do more, and while her physical fitness severely declined from her incredibly impressive military training, she still appreciated her body for its capabilities. Appreciating her body's adaptability to her changed physical abilities, Freya appreciated her body beyond its appearance.

Freya is not alone in her body appreciation. Despite the difficulties the women experience because of appearances, it is their body's abilities, how it functions, and what it does for them that they appreciated. Sharing an appreciation of physical movement, Alethea, Aubrey, Haley, Imara, Phoebe, and Selene discussed their movements with gratitude. Selene loves belly dancing, Imara and Haley enjoy swimming, and Aubrey and Alethea love yoga. These physical forms of exercise rejected the idea of fat bodies as lazy. The women recounted the moments when they loved their bodies with these activities.

The body's capabilities are not limited to movement. Thalia recounted a cherished memory of her dying friend, so small and fragile. She remembered hugging and holding her friend, thin from cancer. Thalia reminisced about an appreciation for her body, lush with fat, that could comfort a dying friend. It was a moment where she truly loved her body. Along these same lines, Colette loved her body for creating life: when she was pregnant and breastfeeding. And the best part? She did not care what other people thought. Colette explained she wore a bikini to the beach because breastfeeding was more accessible, and people could either take it or leave it. She did not care. Her happiness with her body, in part, was because outside influences did not matter, and Colette loved her body for the life it created. The women did not discuss themselves as lazy, unintelligent, underserving, or any of the fat stereotypes when they talked about their bodies' abilities.

While their relationships with their 'visual' bodies were challenging, the women had a different view of their capabilities. Their bodies allowed them to give birth, provide comfort, recover from an injury, and move in ways that brought them happiness. Furthermore, acknowledging their bodies for what they do allows them to reject the socially-expected fat identity, which tells them they are lazy because of their body size. The activities they participated in were far from lazy, and their bodies were a source of strength and ability, in spite of the stigma they experienced. Often, women with larger body sizes have adopted the idea that their larger bodies meant they were unfit and, as a result, this has dissuaded them from participating in physical activities (Rice 2007). However, despite the rhetoric of "anti-fat messages [compromising] their physical abilities and identity choices, women show creativity at selfmaking, mediating

differences with improvisational identities as a constant and dynamic process” (Rice 2007:158). When the women thought about their bodies’ abilities, they rejected the negative stereotypes of fat bodies, defying the ideology that a fat person is supposed to be lazy and gluttonous.

3.5.3 Contrasting Confusion

Though I did not inquire into their knowledge about body size changes, the women often indicated that frustration stems from a lack of understanding about the changes in their bodies. Repeatedly the women commented, “I don’t understand” or “I don’t know why.” Specifically, I found the women wanted to know more about the causes of weight gain and the reasons their bodies changed. Given that the women often embraced a fat identity based on their visual appearance but rejected the same identity because of their body’s capabilities, the contrasting experiences of a fat identity suggest the women’s confusion may stem from how they experience their bodies versus the discourse around being fat.

Concerning weight gain, Bridget, Phoebe, and Veera commented on the problems of their weight increases. Bridget and Phoebe shared the same exasperation; their efforts felt futile. They exercised, ate right, and their body size did not decrease. The unwanted weight remained. Phoebe stressed she felt like a “freak of nature,” wondering why weight loss was hard. Despite her efforts, the number on the scale did not budge, down to the decimal point. I could hear the anguish in her voice. When medical professionals declare eating right and exercise the cure for “excess” adiposity, how come the cure does not work? For these two women, their body is a site of perplexity. The education they are

provided declared the body a site to be manipulated into the ideal thinness. And yet, that is not their reality.

Colette is dissatisfied with her body, as the changes that occurred during her pregnancies were more prevalent now (at the time of the interview), and she had no idea the cause. Thalia also admitted her confusion, revealing,

I don't think I'm alone in the world for having struggles with my body and my weight and acceptance. And, um, and even as I approach my fifties and my body is changing in ways that no one has ever told me it would change, it's still a struggle... It's still, it's hard to detach one's discomfort with one's body from like logical reasoning.

Indeed, after centuries of fat denigration, stereotypes, and discrimination, attempting to understand oneself outside of the cultural influences about fat bodies may be problematic.

Although a couple of the younger participants also struggled, Selene and Lyssa took a different approach to their body fat. In a discussion of weight fluctuation, Selene aptly explained that she does not know how her body will change as she works on healing her injury. Despite listening to her family and peers telling her, "Not to worry, that she'll get back [to her smaller size]," Selene wisely retorted that maybe not. Regardless, she is okay with how her body might change. Lyssa, after researching the subject on her own, aptly stated,

Like if everyone has different like hair types and hair colours and eye colours and skin tones and heights, why would like weight and size be the one thing that we all have in common? It's like it just doesn't even make sense.

Indeed, there may be only so much control one has over their body. For Selene and Lyssa, they were not sure how their body would change in the future.

In contrast to the other women's personal sense that they did not understand their bodies, Freya talked about the failure of her employer to understand body diversity. In her case, the physical requirements of her military career showed a lack of awareness of

body diversity. Freya's knee injury occurred because of her time in the military. Freya explained that women are not built the same as men, their physical strength is different, but the military has homogenous fitness expectations. The repetitive training set at the standard of a six-foot male pushed Freya's body past its limits. Eventually, her knees could not keep up with the requirements of her career, and her doctor medically discharged her. The homogenous ideology of what a body should be changed her life. This harmful homogenous outlook on fitness suggests that the understanding of body capabilities is unclear to individuals and communities.

As the women talked about their confusion about body changes and how their bodies may change, or in some cases, do not change, their narratives suggest that the thin supremacy ideologies overshadowed how the body functions. They embraced a fat identity and yet, continued to struggle by believing they are not the stereotypes given to larger bodies. The women suggested the need to understand their bodies beyond its appearances and stereotypes, to how the body form may or may not change in their lifetime. As such, reframing the health messages that predict the ways of being fat may be necessary through alternative considerations for knowing and embodying fatness (Rice 2015:395).

3.5.4 Discussion: Am I worthy?

The body is experienced as a complex intersectionality of appearances and capabilities, as well as a site of confusion. Despite hating their visual exterior, the women loved their bodies for their abilities, even if they genuinely did not understand how their bodies would change throughout their lifetime. As a visual form, the women acted as "less than" and adopted the negative fat stereotypes. They performed fat identity based on

what they saw in the mirror. And yet, they also rejected a fat identity based on what their bodies were capable of, contrary to the stereotypes.

3.6 Conclusion

The women in this study had relationships with their bodies that are multifaceted, a complex, conflicting association that began in early childhood and continued throughout their lives. The cultural influences of thin body size expectations are numerous, with families, strangers, education systems and teachers, clothing industries, and workplace environments displaying a typically normative understanding of the body. The women described an understanding of their bodies in three forms: a visual disdain for their fat, an appreciation of their capabilities, and an overall lack of desired body knowledge and understanding. The body is more than its visual appearance. How the women understand themselves in relation to their body is not as simple as what their body does for them. They cannot escape the cultural influences which emphasize their outside appearance as of substantial importance. This complex reflection is a site of confusion in which both their selves and society condemn them for existing as deviant.

In the next chapter, I detail the medical experiences of the women. Initially, I discuss the areas of medical care the women accessed and the issues of being weighed in health care settings. From there, I analyze the theory of structural violence to discuss the medical barriers the women experienced. Then I apply the consequences of those barriers to the tangible harm the women explained through examining the cultural competency continuum in health care. Finally, I detail the desired medical care the women wanted to address their overall health and well-being.

Chapter 4: Barriers, Harm, and Change

To explore the women's experiences with health care in Southern Ontario, I asked questions about the type of care they received, including what happened at their most recent medical appointment,⁸ a positive health care experience, and a negative health care experience. I also inquired into how they believed their body size impacted their interactions with health care professionals, how they felt when a health provider brought up their weight (including being weighed at the doctor's office), and any advice they would give to doctors treating women with their body type. Similarly, I utilized the group discussion to explore further advice the women would give to others with similar body sizes when dealing with health professionals, how they would design health care for larger bodies, and what they thought were priorities to improve fat women's health and well-being.

I thought I had an idea of what information the women would share with me, having already researched fat denigration literature in health care settings. While I knew fat denigration existed, having personal experience with deviant body discrimination, I did not know the extent to which it existed in Canada, much less within Southern Ontario. I wanted to understand the local context of deviant bodies in health care and how this may be reflected in health treatments. The women's discussions, thoughts, and narratives provided an insightful understanding of fat denigration. As these women's bodies existed in different areas of the fat spectrum, their experiences addressed a broad

⁸ Often, with this question, the participants were unsure if phone call appointments should be included because of the new COVID clinical procedures. I left the option open to the participant to either use that appointment or choose another in-person appointment they preferred to discuss.

range of health service access. Nevertheless, despite the range of body sizes and body size understandings, whether the women conformed to or rejected the thin ideologies of Western societies, their narratives were relatively similar when it came to seeking and receiving health care.

The following sections detail the accessed medical services, implications of body weight examination in medical settings, and the problem of anti-fat health care in Southern Ontario. First, I list the health professions the women discussed in the section "Medical Access." Then, I detail the women's experiences and thoughts about being weighed in a medical setting in the section "BMIinsolence." Here, I elaborate on the negative associations people have with body weight and the experience of how being weighed impacted the women's well-being. Then, in the section "Medical Barriers," I draw on the concept of structural violence to examine the barriers the women endured in various medical situations. In these medical situations, different barriers are intertwined, causing further difficulties when accessing health care. Next, in the section "Medical Harms," I build upon the discussion of medical barriers to discuss the tangible harm of anti-fat health care, using the concept of cultural safety. Here, I demonstrate the consequences of the medical barriers the women discussed in the interviews and the damaging effects which resulted in harmful outcomes. Lastly, I detail the women's desired solutions to gain equal access to health care in the section "Medical Care for Health." Ultimately, I argue that anti-fat health care maintains thin supremacy ideologies that expect women to lose weight and consequently harm fat women. Therefore, health care in Southern Ontario needs to decolonize thin supremacy ideologies to enhance medical services in the diverse societies of Canada.

4.1 Medical Access

Medical care is not as simple as accessing biomedicine or Western medicines. Biomedicine is not the only accessed service for health care, as people practice medical pluralism where they search for health care from different practitioners (Baer 2011:407). Medical pluralism can include three domains: popular, folk, and professional (Chrisman and Kleinman 1983 in Baer 2011:409). Within the popular sector, people seek care from families and social networks. The folk sector includes treatment from informal (and sometimes not entirely legal) practitioners such as mediums or herbalists, and the professional sector encompasses biomedical and heterodox medical practitioners and bureaucracies, including allied health professionals such as physical therapists (Baer 2011:409). Therefore, I allowed the interviews to include any type of care the women received from practitioners for their health. In essence, I let the women define what they considered to be health care during the interviews.

In the interviews, the women discussed twenty-three health care professions, as detailed in Table 1 List of Discussed Health Professions.

Health Professional
Acupuncturist
Dermatologist
Dietician
Doctor/ Physician
Eating Disorder Clinic
Hospital Emergency Department
Gastroenterologist
Gynecologist
Kinesiologist
Massage Therapist
Naturopath
Nurse
Obstetrician
Optometrist
Orthopedic Surgeon

	Table 4 List of Discussed Health Professions
Physiotherapist	The participants discussed biomedical health care the most, with doctors mentioned in the majority of their discussion and, consequently, the discussions throughout this chapter will emphasize physicians.
Plastic Surgeon	
Podiatrist	
Radiologist	
Reflexologist	
Somnologist	
General Surgeon	
Mental Health Therapist	
Urologist	

However, the women did converse about more than biomedical health care. Professions discussed and accessed by more than one participant included dietician, physician, massage therapist, naturopath, nurse, physiotherapist, plastic surgeon, radiologist, general surgeon, and a mental health therapist. The remaining professions were discussed and accessed by a single person. The women's access to medical care for their health is vast, utilizing both the folk and professional sectors.

This multi-layered approach to their health by utilizing a plethora of health care services suggests a complex understanding of their well-being. The women did not reduce their health to physical or body ailments. Instead, they discussed health care as it addressed their overall well-being, and they accessed health services that addressed broad concerns. As such, I use the term “health care providers and systems” to encompass this broad range of accessed medical care.

4.2 BMInsolence

"I'm not going on the scale; I'm not playing that game. That bitch lies; the scale," Freya concluded after we discussed her knee injury and the impact on her mobility. She indicated that she tried to value herself based on her abilities rather than her weight. Many of the participants shared her sentiments. When they discussed the doctor's weight scale, they did so with embarrassment and shame.

Body size as a marker of health in biomedicine cannot be understood without reference to the Body Mass Index (BMI), where medical facilities weigh and measure patients to categorize their bodies. Previously, the Canadian Medical Association (2015) focused purely on the relation of height to weight, classifying people with a BMI >30 as "obese" and >40 as "extremely obese." However, with changes to clinical guidelines, people now only receive those classifications if their weight directly impairs their health (Rueda-Clausen et al. 2020). Therefore, as I interviewed curvy women, I thought it appropriate to discuss their views about being weighed in medical settings, especially given this recent change in medical perspective. Out of all thirteen participants, not one thought being weighed was a good experience.

The two younger participants cannot remember the last time they were weighed at the doctor's office. Both Haley and Lyssa remembered the measurement of their height and weight as children, but after they turned eighteen, this form of tracking seemed to stop. Interestingly, both later admitted to the presence of a weight scale – Lyssa with a mental health therapist and Haley for a surgery consult. In both instances, the women negatively recalled the use of the scale to provide health treatments.

In contrast, the older participants remember being weighed often. Thalia recalled the frequency before the pandemic and the shift to video and phone call appointments which stopped the option of weight tracking. She recalled that being weighed made her feel like she should take up less space. The ideology of taking up less space is not specific to Thalia. As part of the "traditional female gender role," women are supposed to take up as little space as possible (including via their body size) (McKinley 1999:100). The scale is a medical device which can tell women how much space they “take up.”

Veera, declaring the ritual of being weighed as all shame, detailed how she prepared for such an event,

Oh, I hate getting weighed. Yes. Oh, it's like the source of... Oh! And I do all kinds of things to trick the machine. I like, I take off my shoes, I take off my jacket, I stand like a little bit back from the machine. So, I believe that I, I do all kinds of crazy shit. Like I have a digital scale in my bathroom which I have not used in a long time, like a couple of months. And so, yeah, I'm terrible. And, you know the old-style weigh scales where they have to like, yeah, move the thing along.⁹ I remember like watching the nurse and being like, [it's] moving a little left. A little left. Little left [laughter]. Oh, I fucking hate it. And like, you know, sometimes my psychiatrist weighs me, and I just feel like that's just... it's like a conflict of interest. Like you're giving me the drugs that are making me retain water, and now you want to fucking weigh me. Like, fuck off!

There is no love between the participants and the weight scale at health care facilities; they feel shame and embarrassment. Their feelings suggest the scale may do more harm than good—a device that causes psychological harm simply through its medical use. Indeed, anti-fat medical equipment is well documented. Medical equipment that informs fat patients that their bodies are unacceptable includes weight scales, blood pressure cuffs, examination gowns, pelvic examination instruments, MRI and CT scanners, rollators, wheelchairs, hospital beds, and even waiting room and doctors' office chairs (Shanouda 2021). Indeed, there are several ways medical devices maintain thin ideologies, with the weight scale being a significant problem for the participants.

Of particular interest in the discussion of weight was Aubrey's recollection of the time a nurse measured her waist. Laughing at the memory, she stated,

Although, so, the last time I had a physical nurse come in, and I mean, there's a part of this where she's not really at fault because the exam room isn't particularly large. But she had to measure my waist, so she took the measuring tape, and she

⁹ Veera refers to the physician's balance beam scale, which uses a poise bar and weight to measure a person's mass. The poise weight moving left on the bar means a higher mass.

said, 'here, hold this, hold this at your belly button and just spin. I can't walk around you.' Like I am a mountain of humanity and the journey around my girth is too much to take on without a power bar and a bottle of water.

I laughed along with her, and she continued to joke at her own expense. Aubrey reflected that the room was too small, but the nurse's word choice left her aghast at that moment; like a hunk of meat tied up by a butcher. While I did not ask, and I probably should have, as I reflect, I cannot help but wonder why the doctor required Aubrey's waist measurement. New research suggests that visceral fat is harmful to health because it surrounds and impacts organ function (Ribeiro-Filho et al. 2003). However, the research is conflicting on whether this fat is visible or measurable. Certain health professionals believe visible stomach fat is a sign of visceral fat (Koot et al. 2014; Ribeiro-Filho et al. 2003). In contrast, other health professionals believe stomach fat is not an indicator of visceral fat, and additional means of measurement are necessary to determine the presence of visceral fat (Carroll et al. 2008; Nakamura et al. 1994). Given the history of fat discrimination in health care, it is hard to say which of these recent studies is correct or without biases. I cannot help but wonder, are waist measurements the new form of body size discrimination?

Other than a cause for emotional distress, being weighed at a health professional's office is problematic. Health and individuals cannot be reduced to a number, as the new criteria for obesity, described above, indicate. Patients should feel like they have been treated with respect and dignity (Canadian Medical Association 2020).

4.3 Medical Barriers

The women had no shortage of concerns and issues regarding their medical care. As I listened to their stories, I found myself nodding my head and agreeing with their narratives. Larger body sizes face a plethora of health care barriers – barriers formed

from the incorrect assumption that body size determines health. Barriers are not a new concept in medicine. Paul Farmer (2004), with his efforts to improve health care systems, found that barriers to health care are a form of structural violence that systematically exerts violence on those who belong to a specific social group. Central components of structural violence include the erasure of history, social inequalities (such as racism, sexism, and poverty), a natural expression of the current political and social order, and geographical breadth (Farmer 2004). For example, as outlined in Chapter 1, medical systems ignore the racist and sexist history of thin body size expectations, which maintains social inequalities and hierarchies (Strings 2019). The notion that a thin body equals a healthy body is genuinely an expression of inequality through oppression and harm in medical care.

This section addresses the barriers the women experienced in Southern Ontario health care settings. These barriers of structural violence appeared in four different forms, which I label Dictatorial, Distrust, Inequality, and Stereotype.

4.3.1 Dictatorial

"Nope, no. [The doctors] are the boss," Joleen heatedly stated as she reaffirmed her position that physicians do not listen to their patients. The other participants' narratives reflected a similar sentiment. I found the women detailed their issues with how doctors treated their experiences as a "dictatorship." Though perhaps not intentionally, the biomedical practices seemed to place the medical power in the hands of the health practitioner rather than the person whose health is under consideration. Having taken health classes in her pursuit of a psychology degree, Lyssa explained the patient model of biomedicine. She articulated the doctor's perspective as "I'm the authority figure. You're

the patient. I'll tell you what's best for you." Before her education and research expanded her knowledge and understanding of health, she previously thought doctors knew best and would follow their direction. She recalled one medical appointment,

But [the doctor] said, like, 'your weight is high, so keep like moving and, you know, taking care of yourself kind of thing.' But then I definitely interpreted that as like, oh, I need to go home and lose weight and, like, go on a diet. And I thought that it was like the gospel truth. Like I had nothing in my mind that was, like, a doctor could be wrong. It's just like she's the doctor. I have to do what she says.

Lyssa further declared that she thought it is possible for the doctor to be wrong or have their own biases, particularly after learning about the Health at Every Size movement and intuitive eating.¹⁰

Thalia's response was immediately negative when health practitioners told her what to do. Then, laughing, she explained, "Rather than having someone tell me, 'Oh, you need to do this and this.' And my first reaction is like, you know what you need to do? You need not to talk like *that*." Thalia does not want health practitioners to rule her health. Imara, similarly, stated she gets pissed off and angry when doctors continue to push their ideologies and ignore her concerns.

The dictatorial health care of the biomedical model does not end with health professionals stating health requirements, ignoring the women, and causing mental harm. To continue Joleen's story, she recounted a time with a surgeon¹¹ who repeatedly showed

¹⁰ Health At Every Size (HAES) is a social justice movement to help people with all body sizes compassionately care for themselves. Intuitive eating is a positive approach to food that also promotes body image confidence.

¹¹ While I cannot name the physician for ethical reasons, Joleen affirmed that he still practiced medicine at a hospital in Ottawa at the time of the interview. Her experiences with him were so horrendous, she continued to check and see if he provided medical care, hoping he would one day retire (and with him, his supremacist ideologies).

up in her narrative about her negative experiences. She indicated the countless thoughts about how she'd like to tell him about his issues. She scoffed,

He thinks of himself, and apparently, all surgeons think that they're gods. He's seriously overvaluing himself when he so devalues the patient. The other thing he told me at [my strangulated bowel surgery] follow-up appointment was, 'Hmm, that's healing good, I guess. I was going to get rid of those [belly buttons]. So I'm going to eliminate those belly buttons. So, I was going to eliminate those two and tidy up. But then I thought, oh, I didn't get her permission. I guess I better not.'

She told the story with incredulity, shocked that the doctor thought he could change her body without permission, even if only for a moment. Joleen's previous surgeries left her with what appeared to be two belly buttons, and she had no issue with this feature as she understood her belly button as a connection to her mother. While Joleen was grateful the doctor did not perform unconsented plastic surgery, her gratitude is purely for keeping her bodily features and not towards the surgeon. The notion that this surgeon could have changed her bodily features during an unrelated surgery – that the doctor thought he could do what he wanted to her body – left her unsettled.

The women do not want to be told what to do, nor do they want a health care professional controlling their bodies. Nevertheless, medical norms leave the doctor (or professional) controlling the patient. This practice, perhaps, stemmed from evidence-based medicine (EBM). Rather than base decisions on the impression of the patient, past experiences, or textbook knowledge, EBM sets the standard for "epidemiological reason: decision-making driven by quantitative data, protocols, and algorithms" (Locke 2018:112-113). Essentially, "science" became the ultimate authority in medicine. This current practice means the doctor decides what is best, whom to listen to, and what is appropriate for the patient. Unfortunately, this dictatorial approach caused barriers to good health for the participants.

4.3.2 Distrust

When health care practitioners insist their way is the only option, their insistence creates distrust with patients. Indeed, as the participants discussed their concerns with health care access, they often stated they did not trust the health care professionals. For example, Aubrey felt written off after her doctor repeatedly told her that her liver test numbers were high but that there was no need to address the issue. She watched as resident doctors noticed her high liver numbers and brought them up with her doctor in concern, only to have her doctor dismiss the issue. Consequently, Aubrey wondered, "Would that be worth investigating if I was thinner. Would it be, if my daughter came in, who's a varsity athlete, and had the same thing, would they be all over making sure [her liver is] okay?" Even without medical experience, Aubrey knew the liver was necessary to the body's functions. When I inquired if she thought about getting a new doctor, she articulated, "Well, I am now that he's retiring. You know what? My fear for a long time was I would go through changing [doctors] and end up in the same position. Like, it will ruin me if I do all of this and walk in, and [the new doctor] rolls his eyes and tells me I'm not trying hard enough." There is a plethora of fat discrimination in Canadian health care (Zen et al. 2021). Given the distrust she had for her doctor, her fear of having another doctor cause the same distrust was a source of stress. As a result, Aubrey thought she received inadequate health care.

Colette shared similar distress, recounting an encounter with a doctor who told her she had to have a Caesarean section (C-section) because of her body size. When I asked about a negative health care experience, she launched into a story,

Probably the best example would be with my last pregnancy. So, 2016/2017 [I was] referred to an obstetrician [and] given a reference from my doctor. [They]

had given me a couple of different ones. I went to the one that was closest. I was probably thinking that the proximity would be good, and I was definitely heavier. I was significantly heavier at the beginning of my second pregnancy than I had been in [my] previous pregnancy. That it was kind of was when I moved back to Ottawa that I had gained [weight]. But I'm kind of at the weight that I am now. And so even on the intake, the experience wasn't super positive. And I didn't make any comments about it. I didn't, you know, so. [*Imitating the doctor*] 'Oh, well, we're going to have to put you on a restrictive diet because, you know, you're starting off at what would be an ideal end weight.' I was like, oh, that's lovely to hear that I'm starting my pregnancy and you think I'm nine months pregnant already. You know, comments about it. I know that, you know, over thirty-five [years old] is considered a geriatric pregnancy. It's still not nice to hear that your doctor thinks you're fat and really old and all your comments about: [*Imitating the doctor*] 'oh, you had diabetes last time, so we're going to schedule you for a C-section.' I'm saying I'm ten weeks pregnant. Like, why are you making assumptions about what my pregnancy is going to be like? Ten weeks, you know? [*Imitating the doctor*] 'And we're going to have to get you on all of these medicines now.' And like you haven't done a single test, you know. Which in, you know, should have been a red flag, but it kind of went well. This is maybe it's just different in Ontario versus my first pregnancy in British Columbia, you know. And [*Imitating the doctor*] 'Oh, well, we'd like you to come in every week to get weighed.' Why? [*Imitating the doctor*] 'Well, we'd like to monitor it. And we think you need to go see this nutritionist.' Also recommended a nutritionist and the nutritionist, you know, was like, [*Imitating the nutritionist*] 'Well, you need to be eating only this many calories a day.' And I'm like, that's less than I would eat if I wasn't pregnant. It doesn't seem safe, you know? And so I was calling back on some of my coaching experience being like that does not seem right. So everything seemed to be about my weight at the beginning, which I didn't you know, I knew it was heavier than I had been, but I didn't think it was that bad. You know, it wasn't the end of the world. And so that it was really not good.

Colette could not help but wonder, after sharing this story, if the doctor treated her that way because of her deviant body. Her first pregnancy did not have the same problems, which she thought related to her smaller body. However, throughout her second pregnancy, she had to fight with the health provider – certainly not an experience that forms any trust in health providers when a mother feels she must fight for the rights of both herself and her unborn child.

Bridget had the most distrust of health professionals regarding her body size.

While she conformed to the notion that diet and exercise created a thin body, her efforts

left her with the same body size. She tried several weight-loss options to no avail. In annoyance, she articulated,

Well, like I said, I've gone to see a couple like, I think they call them weight/ life coaches or something. I went to see like a weight, uh, weight loss clinic. And I find it very frustrating because I don't believe that you can just take supplements and, you know, lose weight without offering any kind of workout routine. Like, I just don't understand how that would work. I mean, I worked out a lot. I play a lot of sports, and that's not working. And I don't know how these supplements and shakes and pills are going to work. So, I'm just a little leery of that.

Her word choice is cautious. Yet, during the entire interview, she discussed her mistrust; that the weight loss clinics did not work, the diets did not work, and the cost of spending all her money to stay the same body size seemed like trickery.

Lyssa's issues stemmed from what she described as the inappropriate use of diagnostic tools in health care. She stated,

He was like the only doctor I've had like an anti-depressant prescription from. And a lot of my other friends have kind of described like going to the family doctor and, like filling out a checklist and then be like, (*Imitating the doctor*) 'Oh, yeah, you have depression, have these medications.' And I study psychology and I know that's not right. Like, that's not an appropriate way to diagnose someone with like just [a checklist] because you have the symptoms doesn't mean you have the illness, and they need a lot more information.

The more Lyssa learned about health care, the more issues she had with these practices. Indeed, just as humans cannot be reduced to their body size, she observed that they could not be reduced to a checklist. Unfortunately, in a medical setting, when health professionals see people in isolation from the context of their life, a reduction to a

medicalized approach is unavoidable that, while at times being something that could relieve guilt and reassure patients,¹² can also oppress them (Lock and Nguyen 2018:71).

When the women were reduced to their body size or weight or a checklist, they formed a distrust in the medical system and health care providers. Trust seems an essential part of health care, with the CMA (2018:2) listing trust as the cornerstone of provider-patient relationships. Yet, how likely are people to follow the doctor's health advice if they do not trust them? The women's distrust suggests a barrier to maintaining their health and well-being. This distrust stemmed from the dictatorial approaches to medical care.

4.3.3 Stereotyped

Anti-fat and body size stereotypes were prevalent in the women's experiences. Reduced to their body size, the women struggled to get health care because of entrenched thin ideologies. Health care professionals practice victim-blaming when fat patients seek treatment (Puhl and Heuer 2010) and reduce the quality of care for larger body-sized people (Phelan et al. 2015). Aubrey adamantly stated, "Like, my IQ hasn't dropped as my weight's gone up. I should be able to have an intelligent conversation about my weight without being shown diagrams of the food pyramid or whatever." Her formative years meant an education about the Canada Food Guide and the necessity of exercise, yet doctors continued to educate Aubrey on eating "right" and exercise. Indeed, Aubrey believed medical professionals reduced her body to a stereotype. Regardless of all her

¹² The authors reference Michael Taussig (1980) which outlines patients learning that their illness is not in their head, but a reality, may help relieve guilt and reassure them.

efforts, Aubrey believed health professionals thought she just ate too much and did not move enough (and didn't know any better) because of the advice they kept providing her, implicitly labelling her the fat stereotype of gluttonous and lazy.

Similarly, Freya walked out of a doctor's office to never return from what she perceived as weight bias. With dictatorial authority, Freya recalled how the doctor made it clear that she could only be his patient if she listened to what he said and lost weight because fat was the cause of half her health problems. This was a stereotype she rejected. She believed her body size was not a health problem and that this doctor would not help her. So, she left. Indeed, the assumption that fat directly caused all their health problems seemed consistent among the participants' experiences with health providers.

Not only did doctors reduce the women to their size, stereotyping their bodies, but health professionals thought they could solve unrelated health issues by telling the women to "lose weight." For example, after Haley found out she could not have a breast reduction until she lost ten pounds, the doctor also decided to tell her that the weight loss would cure her sleep apnea. The moment shocked Haley, particularly as a sleep specialist had previously informed her that, in Haley's case, body size did not cause her sleep apnea. Yet, a health professional in a different specialty thought they had the authority to diagnose Haley in what she thought was an inappropriate act. Unimpressed with that doctor's lack of knowledge and inanity, Haley rolled her eyes and huffed as she retold this experience. Of course, it was already problematic to reduce her health problems to weight, but she also found it was undoubtedly just as problematic for health care providers to diagnose weight as the cause of a health issue outside their knowledge and expertise.

Health professionals implicitly stereotyped the women as lazy and gluttonous, assuming their deviant bodies were the source of their health concerns. And yet, the reality is far from the truth. Being fat does not necessarily make a person lazy. Nor does being fat mean a person must eat excess food. In the dominant narrative of Western societies, a body with excess fat is viewed as immoral, making that person a 'bad citizen' (Greenhalgh 2015). Being fat is existing in a deviant body, and having this deviant body meant health professionals stereotyped the women.

4.3.4 Inequality

The issue with stereotyping fat women's health problems as exclusively related to adiposity is that they are not receiving adequate health care. The reduction to their physical form from health professionals' perceptions and dictatorial methods suggests they suffered inequality. Often, I heard the women ask, "would you treat me this way if I was skinny?" or "would you give a skinny woman the same diagnosis or would you actually help her?"

Furthermore, body size discrimination resulted from the lack of appropriate equipment to accommodate larger body sizes. Without prompt, Imara admitted,

Like I have thoughts of avoiding [doctors] for sure. Yeah. I definitely have thoughts of avoiding because of the bad experience of the past and not knowing whether [medical] equipment will fit. And you know, and I'm not even like I mean I'm a pant size twenty-eight/thirty. So, I mean it's not like there are [no] other people my size or larger that would also need to be accommodated. So that's why I don't understand, like when I show up to a place, and they're like, 'Oh, you're too fat for the equipment.' I'm like, what kind of equipment are you using? Like, you know, if you're not equipped to serve people, then what are you doing right now?

Her questions are compelling. After a technician refused to X-ray her knee due to her size, Imara now calls ahead of her scheduled appointments to ensure the medical facility's equipment can accommodate her body. At the time of the interview, she had an upcoming

magnetic resonance imaging (MRI) appointment, and the facility confirmed the machine could accommodate higher weights but had no idea if it was built for the girth of larger body sizes (see also, Shanouda 2021). Consequently, Imara did not know if she would get the necessary medical tests for her health. Her experience exemplifies inequality as the medical equipment was not built to care for fat women.

When I asked Imara how her weight influences interactions with health care professionals, she responded,

I'm expecting to be mistreated and expecting to be judged. And, you know, expecting my size to be the first and maybe the only thing they see and want to talk about and not all the other things that I do for my health,¹³ you know, yeah. Other things that somebody of a smaller size might get praised for and say, oh, great, you're doing a good job. But if you're a larger person, you know, whatever you do isn't going to be enough. And, you know, it's like, well, whatever you're doing, you're still fat, so it's not good enough. So that's the way to kind of anticipate every, you know, adult health interaction is going to go.

Imara recognized that her health care quality was less than that of her thinner peers. Not only did medical equipment not meet her body's needs, but she stated that with each health professional, the chance of mistreatment was high.

Freya and Aubrey agreed with Imara's sentiment. Both reflected on the inadequate health care resolutions to their problems. Freya stated that following the Canada Health Food Guide did not address her health problems. While Aubrey felt written off when health professionals addressed her size, she indicated that the appointment generally was unsuccessful once the doctor reduced her problems to weight.

¹³ Imara was an avid swimmer, almost every day at her special spot. This was a spot she refused to tell me about because she did not want too many people taking up the water space.

Inadequate health care based purely on body size produces inequality. The lack of care the women received suggests that health is a privilege for the thin. When neither medical equipment nor health professionals are suited to deal with fat bodies, these women received inadequate medical care. Indeed, the health care for curvy women in Southern Ontario is not equal for all body sizes. Health professionals reduced the women to their body size, and, as a result, the participants presumed they did not receive appropriate care.

4.3.5 Discussion: Barriers upon Barriers

The dictatorial methods of health professionals reinforced distrust among the women, particularly when their deviant bodies were stereotyped by the people meant to help them. Those barriers – dictatorial practices, distrust, and stereotypes – meant the women experienced inequality in health care. These intersecting barriers, ingrained in medical education and reinforced by the production of medical technology that is not one-size-fits-all, represent a form of structural violence. Health professionals and practices targeted fat women (a specific social group) to reinforce the notion that health care is a privilege for thin bodies. This structural violence in health care further reinforces the social hierarchies of which body sizes are worthy of maintaining their well-being.

When health professionals became dictators, stereotyped women, created inequality, and formed distrustful relationships, it produced inadequate care for these women. Health professionals ignored the concerns of their fat patients. Assumed to be lazy and uncooperative, the women were reduced to their body size, leaving them wondering if they received adequate care. Essentially, there was no trust in the health

care relations. These barriers suggest a form of health neglect rather than health care. Indeed, the women experienced structural violence from anti-fat health care.

4.4 Medical Harm

The structural violence of anti-fat health care has consequences because it produces “avoidable harm.” Thin body size ideologies in health care do not just result in barriers for deviant bodied women. There was actual, yet avoidable, harm occurring as well. As the women detailed their concerns, they discussed negative experiences in general as I did not specifically ask the women to define the level of harm they experienced. However, as I analyzed my research, I found the issues were not just barriers to health care access. Beyond access, the issues of anti-fat health care caused direct, intentional and unintentional, and avoidable harm.

The causation of harm to these thirteen women with different practitioners across Southern Ontario suggests a cultural continuity in how fat women are treated in health care. Despite the women’s differences, with their range of body shapes and understanding of their health and well-being, there was consistent maltreatment due to their body size. There were cultural influences that shaped the care provided to these curvy women. However, those influences did not come from the women themselves. Instead, the cultural influences appeared to come from health professionals and systems. Indeed, medicine presents itself as exempt from cultural influences, while practitioners focus solely on patients' culture as a factor in health care, rather than also considering the “culture of biomedicine” (Taylor 2003:559). Recently, scholars have recognized limitations when cultural competency and safety focus only on recognizing "other" cultures. Such a focus on the "other" explicitly fails to examine how dominant cultural

ideologies within Western societies impede cultural competency and safety in health care, such as how whiteness obscures understanding racism in medical practices (Holland 2015; Lee and Rupaleem 2013).

As I will discuss below, harms, whether intentional or unintentional, occurred through cultural biases surrounding body sizes that influenced medical professionals and systems and created an imbalance in power relations between providers and patients. As such, cultural safety, as detailed in Chapter 1, is necessary to understand the power dynamics and provide equitable health care to individuals, regardless of their body size. Cultural influences are dynamic, ever-changing, and extend to considerations within medicine beyond the notion of the Other. To provide fat women with appropriate health care, health professionals should recognize the experiences of the people seeking and receiving care and how this may impact their well-being. However, there must also be a recognition of the culture within health care that impedes access for fat bodies. This section details the four harms of medical care because of anti-fat structural violence. I label these harms Dismissal, Discrimination, Delay, and Damage. I then discuss these harms in terms of the concept of cultural safety, drawing on the CMA's equity and diversity policies to discuss the current health care practices for women with deviant bodies.

4.4.1 Dismissal

Aubrey, desperate for help, frequently found herself dismissed by medical professionals. Aubrey medicated herself with food after her entire life changed with the

loss of her father and some significant losses to her lifestyle outside the home.¹⁴ Her problem began small as she cared for her dying father; she ate the treats around his house. Then Aubrey bought treats, pretending they were for him, only to eat them herself. As she experienced loss and her struggles grew, her use of food as a feel-good tool did too, and, eventually, the food turned into self-punishment. Knowing she had a problem, Aubrey sought the help of medical professionals to no avail. Her doctor told her that she was not trying hard enough to lose weight if she kept sugar in her house. As Aubrey was a mother of young children at the time, she found this comment useless and ignorant. Her problem was not losing weight; her problem was using food as medicine. Time and time again, health care facilities rejected her cry for help. Impactfully, Aubrey recounted,

I talked to so many [health professionals] and no one would move. Like I couldn't get anyone. And I finally said to someone, you know, I sit in the parking lot in the plaza near my house and I will like literally stuff a whole pizza down my throat until I make myself sick. And you've all brushed it off, but if I told you I was drinking a bottle of vodka and then going to pick up my kids, alarm bells would sound.

If Aubrey had used any other substance than food, she probably would have received help as soon as she sought it. But food? Food addiction was accompanied by the stereotyped ideologies of fat people as simply lacking willpower and, therefore, meant that health professionals denied meaningful help.

Freya sought care for her eyes, only to be verbally assaulted by the optometrist about her weight as the cause of her issues. She swore during this story, furious that the

¹⁴ As a stay-at-home-mom, Aubrey dedicated her life to her children and was involved in their schooling. When the teachers went on strike, Aubrey could no longer partake in school activities. Her entire life changed after losing both her parents and the activities she dedicated her time to at the same time.

doctor thought it appropriate to dismiss her eye concerns (which she felt had nothing to do with her weight), to instead lecture her about the need to be thin. Joleen, similarly, had a radiologist refuse to do an X-ray after stating her problem was weight-related. Imara could not get help for back pain, and Phoebe walked away from an appointment with the Heart Institute after the resident doctor continuously and profusely shamed her body, then told Phoebe to "calm down." Selene acknowledged medical professionals thought she was a drug addict, had her back pain dismissed, and found herself repeatedly in the emergency room seeking help. Told it was probably diabetes, Veera turned out to have a temporary urinary tract issue. Her urinary issues disappeared when she lost weight, and her doctor indicated this "cured" her problem. Ultimately, she felt that the health professionals did not properly investigate her physical health.

In the words of Thalia, "I think the word is gaslighting your pain, that your pain isn't real. [But] your pain is real." These women could not get the medical care that addressed their needs; they felt dismissed because of their body size. Health care professionals dismissing the women's health concerns as "weight problems" and refusing to help them was experienced by the participants as negligence. The women felt that medical professionals willingly put their health and well-being at risk by reducing their health to body size and dismissing their need for help.

4.4.2 Discrimination

Body size ideologies and stereotypes create two forms of discrimination in medical care: first, personal biases of health professionals neglecting fat patients and, second, procedural guidelines restricting medical access to particular procedures for fat

patients. This harm is more than a dismissal of health concerns—discrimination results when there is a refusal to help because the women are fat.

Health professional biases were most prevalent in the procedural realm. Weight discrimination was particularly prevalent as the participants discussed surgeries. Joleen was rejected repeatedly by the same surgeon, despite ending up in the emergency room several times. After a resident doctor discovered a strangulated bowel requiring immediate surgery, the aforementioned surgeon took one look at Joleen on the gurney and said he would have sent her home with a diet drink before he'd be willing to touch her surgically. Comparably, Imara had a gynecologist refuse to remove her IUD because she was “too fat.” It was then left up to Imara to get a referral to another gynecologist who would remove her IUD (which she was able to accomplish, and a different gynecologist had no issues performing the procedure on/for her). For Joleen and Imara, the health practitioner refused to help and told them their weight was the problem. These women were still able to receive the necessary procedures, but only after experiencing body size discrimination.

In contrast to a procedure denial, a health professional tried to force surgery on Colette due to her size. As previously detailed, Colette's size meant her doctor decided she needed to give birth via C-section. Rather than allow Colette's pregnancy to progress naturally and adjust medical intervention as needed, the doctor tried to force the surgery. In the end, Colette required no such intervention but only because she refused to accept the doctor's assessment. She experienced his refusal to allow her to try a vaginal birth as explicit discrimination.

While often the women discussed medical professionals as individuals, weight discrimination was not limited to the personal level. Beyond individual biases, the structural violence of health care in Ontario caused additional and continual health problems for the women. Breast reductions were often discussed during the interviews to reduce back pain caused by large breasts. Unfortunately, due to BMI “regulations,” all but two participants who discussed this surgery were denied access because they exceeded the regulated weight limit. Haley explained,

But like the one other thing is like my BMI is like slightly too high to qualify for the [breast reduction] surgery so I can get the referral. And then basically what the surgeon does, and I guess this is like a negative experience type of thing, but what the surgeon does is they receive the referral from your doctor and then they can take you in for an appointment and do a consult. But if your BMI is like over, I think it's thirty. I feel like it's thirty but doesn't like a hundred percent a fact. Somewhere around there, though. And if you're over, in my case, at least they were like, ‘Okay, well do you want to like try to lose like five pounds or whatever and come back in six months and then we'll re-evaluate.’ Over something silly. So it's not a medical thing. It's just like, oh, OHIP has like numbers and the surgeons have to, like, operate within the confines of overhead.

Haley further explained that curvy women could pay out of pocket for a breast reduction by going to a private surgeon, suggesting that BMI limits for surgery are subjective and variable across medical environments. These regulations or guidelines exist for several surgeries.¹⁵ For example, a gastroenterologist told Lyssa she could not have an acid

¹⁵ Of particular interest is my search to find provincial guidelines that indicate surgery BMI limits. In my quest, a physician did establish that OHIP was for billing only and they do not have surgical guidelines, though the physician also assumed the surgery I inquired about had to be Bariatric for larger women (personal communication 2022). I was able to find a clinic in Ontario which indicated surgeons set their own BMI requirements, with that clinic setting BMI limit to <35 for breast reduction procedures (The Plastic Surgery Clinic n.d.). Beyond this information, I could not find any standards or regulations that outline weight limits for procedures.

reflux procedure until she lost weight. The guidelines result in larger body size discrimination in health care.

There are health consequences to the stereotypes of Western societies' body size expectations. Health practices, guidelines and professionals discriminate against larger body sizes. For example, the women were told they must lose weight to get medical help. Alternatively, health professionals may even try to force surgical procedures on women due to the women's deviant bodies. This weight discrimination further emphasized the thin privilege of health care. If the women were smaller, thinner, and took up less space, they recognized they could receive the necessary surgeries, give birth naturally, and not wait until they lost weight to receive medical care.

4.4.3 Delay

There is an irony when health systems expect women to lose weight to get a medical procedure. The superior notion of "you are too fat to help" has ramifications. The harm of health care is not singular. When health practitioners and regulations required weight loss to gain access to health procedures, it delayed medical attention, put the women at risk, and left them in pain. While not caused by health care systems and professionals, the pain was exacerbated by their actions and procedures.

Aubrey and Haley were denied breast reduction surgery due to their size. It was not that they could not have this health procedure but that they had to lose weight to meet the required body size rules imposed by surgeons. What does this mean? Telling curvy women to lose weight to have a procedure to reduce their pain tells them that they are only worthy of help in a more petite body. It tells them that it is okay for women to be in pain when they are fat, and the only way they could reduce their pain was to lose weight.

Selene, dealing with a back injury, quantified, "Yeah, seven years and I'm finally like, within the last year, getting to the bottom of it." Seven years in pain. Realizing she had to take over her health care, Selene made significant changes to her life. She went back to school to get a degree for a government position, giving her adequate benefits to cover the cost of her now expensive health care. She also fought for medication and insisted she needed more for her pain management. At the time of the interview, Selene found that physiotherapy and a personal Pilates instructor allowed her to focus on her body and begin to fix her back problems. She wanted more than painkillers. Selene's size, with her height and weight distribution, meant she could not say for certain if her concerns were dismissed due to her curvy body (though she recognized a gain in weight after injuring herself). Regardless, the biomedical model did not help her. There is a limitation to the science of Western medicine,¹⁶ a limitation that left Selene in pain for seven years. Selene is not alone in her need to advocate for her health care. Fat activists have fought for women's health over decades, advocating for individuals and empowering collectives (Ellison 2020:110). There is a problem with health care access when women are denied help until they lose weight.

The women were forced to live in pain because the health services discriminated against their size and delayed treatment. The notion is simple: lose weight, and health care will cure your ailments. Stay fat and stay in pain.

¹⁶ Nancy Scheper-Hughes and Margaret Lock (1986:30) articulate the issue of biomedicine as a Cartesian dichotomy, further elaborating that the mind and body are inseparable in the experiences of sickness, suffering, and healing.

4.4.4 Damage

With the dismissal, discrimination, and delay comes the inevitable tangible harm. There were times when health care systems and professionals caused harm, both physically and emotionally. There was a lack of regard for fat women, their concerns dismissed, their humanity ignored. For instance, anti-fat health care caused Imara's disability. When she was in her late twenties or early thirties, she slipped and injured her knee. Seeking medical care, an orthopedic surgeon informed her that, while they needed to scope her knee to see the extent of the injury, they would not do it because she was “too fat.” That was it. The surgeon refused, and the procedure never happened. After a while, because of the injury, arthritis set in, and her knee continued to deteriorate. Seeking medical attention from another orthopedic surgeon, she was again denied medical care. The surgeon informed her that while her knee had deteriorated to the point where she required a knee replacement, he would not perform the surgery because she was “too fat.” It was not just these two doctors who turned Imara away. She fought for her health, but she was repeatedly told she was too fat to help. Eventually, she found a doctor who was supportive of her health, regardless of her size. She recounted,

Yeah, I mean, one doctor that I did see, though, I mean, because I've been to a lot of doctors about [my knee] looking for a different answer. But I mean, I did see one doctor, and we went through the history. And I mean, he did say that you know, I did everything I could [*Imara started tearing up*]. Okay, well, yeah, I did everything that I could except for the barriers that the doctors put up to actually get the proper treatment. *All right [sarcasm]*.

The tears in her eyes and the ragged sound of her voice were a testament to her experience of discrimination. The anti-fat health profession willfully denied her medical care. At the time of the interview, Imara stated she had a permanent disability that caused much chronic pain. However, again, I argue that it is not her disability that caused her

pain but the thin supremacist ideologies that plague Ontario's health care systems and professionals.

Imara is not alone. For Joleen, her experience was so bad that she tried to take corrective action. I have already used Joleen's stories in these discussions, but the overarching harm appears when all the pieces are linked. Though she was finally diagnosed with a strangulated bowel that required immediate surgery, Joleen lived with this medical issue for years. She sought initial treatment from a surgeon, only to be told she was "too fat." She ended up in a multitude of emergency rooms only to be sent home because there was "no problem." And finally, when a resident surgeon discovered her pain and suffering existed because of a strangulated bowel, she ended up verbally assaulted and vulnerably attacked by the performing surgeon. The same surgeon rejected her all those years ago for being "too fat." Joleen elaborated,

[The surgery will be performed by] Dr. [LastName]. And I thought if I say no, am I ever going to get this attended to because I don't, like, I don't want this guy. I don't like this guy. I don't trust this guy.

But her options were limited. Take a moment and imagine that you are waiting for surgery, which like all surgeries, comes with risks, and the health professional performing the operation is someone who has previously harmed you. Would you feel safe? What kind of options are you having to choose from, refuse the surgery and live in pain, or have the surgery performed by someone who might harm you again? Afterwards, Joleen was so incensed she wrote to the hospital, where she lodged a formal complaint against the surgeon. In her words, she "thought it was an egregious wrong."

Unfortunately, the hospital was unhelpful, as they asked for what outcome she would like

– Joleen asked for cross-cultural communication training and an adjustment of his attitude – but ultimately, she could not sue the doctor for being rude.¹⁷

Not all the negative interactions described by participants were specific to physicians. The health care professionals outside biomedical systems are not exempt from causing harm to women. However, of the non-biomedical accessed health practitioners, the negative experiences were not explicitly related to weight biases. I draw on a negative experience that may or may not have been about weight but demonstrates the issues of dictatorial treatment causing direct physical harm. During a massage therapy appointment, Freya detailed her experience,

I'm like screaming and crying through the whole thing and almost threw up because the pain is so bad. He was just like, 'You're just going to have to toughen up and deal with this pain.' And I'm like there's the last two times I saw my massage therapist, I was like, I'm not willing to do this again. You have to lessen what you're doing. The last time I said if you cannot lessen [the pressure], this will be the last time I saw you. And he just kept doing that. And then I'm like, I'm done. No, you're not. I'm the patient. And I'm telling you, it's painful. Right? There was a certain massage technique where it's painful when you get it and maybe for a couple hours later, but then the next day, it's all better. Like, it really helps. It's intense, but it really helped. This guy was not doing that. It was painful and just painful.

Freya communicated her pain, told the massage therapist to stop, and was told to deal with whatever he did to her. She describes this interaction as a dictatorial method, where the massage therapist dismissed her concerns which left her in pain.

Imara contended that anti-fat health care caused her permanent disability, Joleen lodged a formal complaint against a surgeon for verbal assault, and Freya endured a

¹⁷ Consider “being rude” the polite word choice. Joleen does not like to swear, and I will respect her choice. However, she made it clear there was a derogatory label she would give to the surgeon.

painful procedure despite stating she wanted it to stop. These occurrences suggest the health professionals did damage to the women, as the women's narratives demonstrate the harm they recounted from those experiences.

4.4.5 Discussion: Harmful Outcomes

The structural violence of anti-fat barriers caused tangible harm. From the delay in treatment which left the women in pain, the dismissal of their concerns, reducing them to no more than a fat body, the dictatorial health care which discriminated against fat women, to the damage to the women's bodies from the medical practices, this violence caused harm. These harms did not operate in isolation as, often, the participants went through several of these experiences at a time. These interactions suggest a lack of cultural safety between health professionals and fat women, with a power imbalance where the actions and decisions of health professionals resulted in the participants experiencing tangible, yet avoidable, harm.

As discussed in Chapter 1, there are several concepts and associated practices that encourage sensitive, patient-centred care in Canadian medical practices, including cultural competency, cultural safety, cultural humility, and structural cultural competency, though this consideration does not currently extend to larger bodied women. From the women's narratives, larger bodies still appear to be classified as a "health problem." For health care professionals to understand the need for equitable treatment regardless of body size, there must be a recognition of the social control of fat bodies through the "medicalization" of "obesity" (Mitchinson et al. 2016:57-58).

Consider the CMA's (2019:1) articulation of the need to respect diversity and differences through practice, learning, and consideration for different societal contexts,

relating to age, culture, religion, language, gender, sexuality, health, socio-economic and family status, or geography. The examples of diversity described within the Canadian Medical Association's 2020 document look at Indigenous peoples, immigrants, marginalized ethnic groups, women in medicine, and non-English speaking patients (Canadian Medical Association 2020). These examples focus on the differences of particular groups of 'others' rather than examining the cultural biases that influence the practice of medicine and societal understandings of health. To obtain equity within Canadian medical care and address power imbalances, there needs to be a recognition of medical biases that, as the women's narratives demonstrate, harm fat people.

While the CMA's efforts recognize that an individual can be fat and healthy through clinical guideline changes and redefining "obesity," and they encourage policies which surround equity and diversity in health care settings, there may be a need to combine these concerns to better understand body size ideologies and how they combine with power imbalances in the clinic to lead to inequitable care. Currently, from the shared experiences of the women, their problems stemmed from cultural assumptions which infuse biomedicine, which led to biases in how health professionals viewed and treated their bodies. The thin supremacy ideology ingrained in health care systems and practices exacerbated inequality and structural violence for fat women to the detriment of their health.

4.5 Medical Care for Health

The women in this study wanted to improve their health and well-being beyond just fat acceptance. Fat health is not just about body size or even body size acceptance. The women recognized how health providers could improve the care of fat bodies, and

they wanted more from medicine. During the interviews, I inquired into positive health care interactions and their advice for doctors treating women with their body type. In the group discussion, I asked about advice they would give to women with larger bodies when dealing with health professionals, how they would design health care for fat women, and what they thought was a priority to improve the health and well-being of women with similar bodies.

They discussed comparable desires and needs regarding their and other women's health. This section discusses the four forms of health improvement the women detailed in their narratives. The women wanted health care professionals, practices, and systems to consider all body sizes and the individual who existed within the body. They wanted a say in health choices and control over their bodies. Additionally, the women discussed the need to address their health beyond their deviant forms and to be able to trust health professionals. I have labelled these four medical care desires as Considering Us All, My Body My Say, Health is More than My Body, and There Should be Trust.

4.5.1 Considering Us All

The world is not built for everyone, but wouldn't it be nice? When it comes to larger body sizes, the standards often exclude fat bodies. From the women's experiences, they discussed the necessity of expanding the standards to be inclusive. To take a case in point, Imara knew what she wanted as she wrote in the group chat,

From having chairs that actually will accommodate you in the waiting room to a gown that fits and covers you or, you know. Even I remember going for a massage therapy appointment. And I laugh at this one, though, because it was after the massage therapy appointment. Like, I know the table was pretty flimsy, but as I was getting off of it, of course, you know, I tiptoed all over it, and I fell. So even things like that. Right. Like having [an appropriate] table. Like I was, I wasn't injured or anything. And I actually kind of thought it was, I just, I was hysterically funny because I just kind of slowly slid off of the table. So it was, it

was okay. But like even things like that. Right. Like you might buy a table, again same thing. You buy a massage table that accommodates up to 250 pounds, and you think, "oh, I'm serving everybody. This is, you know; this is great. This is all I need." Well, you know, you have to consider that there's going to be people of all sizes and to get equipment that fits.

Imara points out that health care must consider people of all sizes to ensure the equipment, furniture, and supplied clothing fit.

Aubrey parrots this consideration, as she suggested the necessity to remove all harmful equipment from health practices. As she discussed a helpful provider, she also noted, "And, you know, there was never a scale. There was never a right or wrong or a line to get to. It was just this 'How are you feeling?' Like, oh. And it just made all the difference in the world." Her experience was good because the health professional did not reduce her to a number. Harm is not just physical. As previously discussed, the weight scale embarrassed the women and left them ashamed. Removing the mental harm by removing the weight scale suggests improved wellness. When the participants discussed the need for larger body size considerations, they wanted to ensure medical practices improved to adapt to all body sizes—that it had consideration for body size diversity, recognizing both the physical differences and the potential mental health implications.

4.5.2 My Body My Say

The women wanted control of the health decisions for their bodies. They wanted a say in their health, well-being, and the decisions which impacted their lives. They did not want the current dictatorship of health practices that tells them what to do, how to do it, and what they must change (i.e., weight) to get care. While medical dictatorship once served a purpose, this practice no longer works in a more educated society (Kennedy 2003). Ethical practices which advocate for patient empowerment and autonomy attempt to balance the power dynamics in medical settings (Canter 2001; Christensen and Hewitt

Taylor 2006; Hewitt-Taylor 2004; Kennedy 2003). Indeed, the power dynamics of medical care are already a debate, and the women made it clear that the debate should be in favour of their autonomy.

When I questioned what health care professionals could change when addressing her weight, Thalia pondered,

Hmmm. I think they could ask me first how I feel about my body, like if I if there's been, especially if I'm going to a health care professional or a center that I have a history. That I think if there's been any changes to my weight, any changes, what I'm concerned about with my weight, I think that would be a way that I wouldn't be so defensive asking me about. Yeah, asking me, well, you know, how are you? Yes. Are there any changes? Are you concerned? As opposed to, so engaging me in my experience. Because I live here [motions to her body], and if I would feel better about that, rather than having someone tell me, oh, you need to do this and this. And my first reaction is like, you know what you need to do (laughter). You need to not talk like that.

Thalia said that she knows her body; she lives in her body; the health care provider does not. In a previous comment, she mentioned, "I want to be healthy, and I want to be responsible for my health care, but I am, I'm kind of, as I'm getting older especially, I think I'm more reluctant to just say, okay, you're right, you're right." She felt exhausted to keep battling health providers about her body. Medical care should be about a collaboration between the individual and their support team to maintain their health (Canadian Medical Association 2019).

Phoebe shared the same sentiment as she indicated, "And if they would only ask, 'how can I help you?' I mean, that would just be a super opening question as opposed to you need to do this, you have to do that." This statement succinctly captures the sentiment that control should be placed in the woman's hands by letting her decide what help is needed. Indeed, while some participants wanted help in weight loss, others did not. A patient seeks medical care for a reason.

In Lyssa's wisdom, she wanted to change the approach to the biomedical model.

In an elaboration, she explained,

I think it might be, too, like the client approach versus like the patient approach, which is something I've learned about as well. Like I'm taking a class with the health studies faculty where everyone is like pre-med, and I'm in psychology, which is, for me, like pre-therapy. And so, whenever we have discussions, they would be like, 'oh, you need to tell the patient this. You need to get the patient to do this, and that like the patient has to do this.' And when I would write my responses, I would be like, 'You should ask the client what they need to like... You should work with the client to, you know, figure out what's going on.'

Lyssa felt that a health professional should not force a patient to do anything. When I had previously asked her about a time when she received positive health care, she shared,

[This psychiatrist], like, asked my opinions or would say, like, 'I want you to try this medication. Here's a website. You can go on and look it up, and it has like reliable information. And then once you've worked it out, write down your questions, see if you are okay with taking it, and then we'll talk about it more' instead of just being like, 'Have this. Goodbye.' So, he was really good.

Her experience with positive care was an inclusive setting in which she also got to choose what happened to her. The health professional let Lyssa make educated choices about the care she received from him. Lyssa wanted a collaboration between people to come to a shared conclusion about supporting her health.

The desire to control their bodies and health was a concern for the participants. Each of the participants indicated, in their way, that they wanted more control over their care from providers. The women requested that doctors listen to them and their health problems rather than make assumptions. For instance, Colette did not hesitate as she stated immediately,

Listen to what I'm saying. And don't extrapolate based on what you see. If I say that I'm here because my elbow hurts and my elbow has been hurting for a while, don't say that. It's because I've been, you know, I've been. I've been doing something else because of my weight. My knee hurts. 'Oh, well, you know, you are heavier than the last time you were here.' No, I'm here because my knee hurts. So, let's talk about my knee, and then we can get to the other things, you know,

we can talk about...is it because I've gained weight? But only after you've physically looked at and touched my knee or, you know, taken my temperature. If I'm there for, you know, for some other reason, my experience is, again, outside of the bubble that I'm currently in have been that that's not some time, 100 percent. Sometimes they're just as good as my doctor, and other times it's 'Oh, well, I see. Yes, your hips hurt, but you do weigh almost two hundred pounds.' Yeah. Yeah. But I've done that; I've been like that for a while now. I think so. For me, the key thing for doctors or any health practitioner would be to listen to the reason that people are coming to see you first before making a judgement on what the reason is.

The women often used the word "listen" in their discussion of improving health care.

And yet, they also expressed that listening is not enough.

Selene shared the other participants' desire to be heard as she elaborated,

Ask questions and listen actively to make sure you understand. Especially now, I'm pretty good at advocating for myself, but I hope people understand what their options are. Yeah, yeah. Help people understand what their options are. And I'm like, you know, like suggest resources where they can really figure out how they want to approach things. And yeah, it took me so long to get to the point where I realized, oh, I'm going to have to like take the driver's seat here to figure out where we're going because no one else is doing it. Everyone else is just like, oh, she's back. Guess we'll try this thing again. Like, yeah, okay. Um, yeah.

Their desire to be heard suggests that what they wanted was to have a say in what happened to them. The women wanted control over their health and medical care. That is not to say that women should write their prescriptions or decide they can have a surgical operation whenever they so choose. But they want options, more than "lose weight or you cannot receive health care." The women wanted adequate information to make choices about their bodies, health, and well-being. They wanted empowerment to make informed decisions regarding their health (Canadian Medical Association 2019:5). When health professionals engage patients in the decision-making process, the process is informed by the patients' experiences and values (Canadian Medical Association 2019:5).

4.5.3 Health is More than My Body

In the women's discussion of their health and well-being, they often talked beyond their physical health. While this research focused on body size, a physical attribute, the participants recognized that their bodies are not separate from their minds, nor are their environments and lifestyles separate from their health. From an epidemiological perspective, Nancy Krieger (2014:351) connects the mind and body through embodiment as a construction of “how [people], like any living organism, literally incorporate, biologically, the world in which [they] live, including our societal and ecological circumstances.” In a sense, embodiment is the body as an organism that incorporates the mind as a social being. Both are integral aspects of understanding individual and population health and well-being (Krieger 2014:351).

In connecting the mind and the body, though the women did not discuss the notion of embodiment, they did connect this understanding to holism. The women advocated for a holistic approach to their health and well-being. Holism, or holistic care, refers to considering physical, mental, and social factors when treating a person (Michaelson et al. 2019:829).¹⁸ The women wanted health care professionals to understand their health as it impacted their life and vice versa, not limiting health care to physical ailments – not limiting them to their body size.

Aubrey struggled with an eating disorder and was frequently excluded from biomedical care because she was not abusing drugs or alcohol but rather food. Finally, after trying several programs, she saw a naturopath who made a significant difference in

¹⁸Ironically, the term health derives from the Old English word *haelp*, meaning wholeness, a being whole, sound or well. So, health care is technically meant to be holistic care (Michaelson et al. 2019:825).

helping Aubrey overcome her health problems. Elucidating the positive change her naturopath made in her life, Aubrey enthused,

She approached it as a patient, she was treating me like she was my support system and not just someone who writes prescriptions, not that she can, but it wasn't about take this and go away. It's more like, 'Then if it works, we're going to do this. And if you hit a rough spot, I have an email, and you can email questions and either I will get back to you, or you're like, okay, so [continue with what you are doing]. You know, if you feel like, you know, if you get two weeks in and you've cut this stuff out and you, you're going to eat a whole cake, call me or email, and I'll help you walk you through it.' Or it just, I probably won't email her, but it felt just so nice that she was willing to take that much interest.

The naturopath offered to help Aubrey through her struggles to incorporate changes into her life rather than tell her the solution and leave it up to Aubrey to struggle through her problems alone. The offered support made a significant difference for Aubrey, where she finally felt heard and as if she could work on her health and well-being.¹⁹

Freya also insinuated a need for a holistic approach, mainly because of her family physician. The doctor asked how her mental state was during her divorce before discussing her health needs. She declared that he treated her like a person first and a patient second. When I asked her what advice she would give to doctors treating larger body sizes, she immediately responded that respect is necessary, continuing,

Culture is different. But I think that they should stop and try to understand why the person is overweight as opposed to the direct approach of you have to, you know, eat less and do this. If they understand why and added caring in there, they might end up saying, you know what, I'm also going to refer you to therapists because you're dealing with a lot of emotional stuff. And you know this at the same time as you see a dietitian and try to, you know, so I think that for many of us, emotions play a huge role and ah, and being overweight. And I think a lot of

¹⁹ At the time of the interview, Aubrey had made significant changes to her lifestyle. She joined a documentary group and her family gifted her a dog which she enjoyed taking on walks and to the park to play.

doctors ignore that. And I, I think they should take it into consideration, and it should be part of their approach when they're dealing with the person.

Freya knows that health is complex. She understood that people are different. A prescription is not always the answer, and there needs to be a more holistic approach to treatment. She seeks a treatment that recognizes the person and not just the disease.

Lyssa also articulated this need quite well, as she stated,

Because if you say, oh, you're not doing it, well, start. It's like you haven't identified why I'm not doing it. So if it's like because I'm too depressed, like maybe you should give me some advice. I'll work on that first and not just be like, work out on top of the fact that you're doing that or like you said, like I work full time and take classes and things. I don't have time on, like a regular day to be like exercising. So maybe if they asked about that, then I could, I don't know, come up with some sort of more reasonable plan, because also sometimes if they say, okay, you should exercise this many times a week, I'm like, that's not happening with my schedule. And then I just don't even think about it.

When health advice is not viable, following it may not be possible. For example, telling Lyssa to increase her exercise when her time was already scheduled did not change her reality and ultimately meant that she could not increase her exercise. An individual's ability to follow medical advice or direction depends on their daily lives. A patient's ability to manage their health depends on their social situation, routines, and comorbidities, beyond the guidance of a health professional (Bokhour et al. 2012:1632).

Health and well-being are not limited to the physical alignments of the body. Biomedicine serves a purpose, but people's health and well-being may need more than biomedicine. To truly improve and benefit the health and well-being of curvy women, the women wanted health care to look beyond the body. To understand disease, disability, death, and health, people must also be understood in their life context (Krieger 2014:354). Therefore, the women wanted an approach to their health that addressed their physical, mental, and social selves.

4.5.4 There Should Be Trust

With the need to be in control of their medical care and be supported through a holistic approach, the women also discussed the necessity of trusting the health care professionals. In the group discussion, the women wrote about their desire to have doctors with training beyond medical school. In particular, the women made it clear that health professionals needed to know how to address the health of and with fat women.

During our conversation, Freya made an excellent point as she simply stated, "And, you know, at a certain point there, you know, surgery is not a, you can't be too embarrassed because at one point you're almost naked, fully naked at various points." This is a vulnerable position to be in, particularly if you do not trust the doctor. Freya suggested the need to understand the patient's position and vulnerability so that they trust their provider when the patient is in a vulnerable state.

In the group discussion, when I asked about how health care could improve for curvy women, the participants made it clear that reducing them to their body size was unacceptable. For example, Aubrey wrote, "No one should be made to feel like their health is not worth investing in because of their size. If a woman goes to the doctor for any reason, she is concerned about their health, so treat them as anyone with a health concern deserves to be treated." Indeed, the women should be able to trust that health care professionals will help them.

During the discussions of trust, the women emphasized the need for health professionals to have proper training about deviant bodies (including knowledge and personal comfort level) and the need for health care providers who supported their quest for health improvement and did not turn them away because of their fat bodies. Indeed,

the women wanted to trust the health care systems and professionals to treat them as human beings and, essentially, provide them with health care.

4.5.5 Discussion: Improving Fat Health

The women wanted to control the decisions about their health, to have health care equipment and tools built to accommodate their body size, to improve their overall health and well-being rather than just their physical ailments, and to be able to trust professionals. They wanted equity and the same considerations as thin patients. These women are more than their deviant bodies, and they are not incompetent, lazy, or lacking in willpower. Their experiences suggest that the current health care offered in Southern Ontario needs to improve to offer equitable care for fat women. Moreover, the women expressed that they wanted adequate health care and equality in medical settings.

4.6 Conclusion

Decolonizing thin supremacy ideologies ingrained in Southern Ontario health systems will enhance medical care for women with larger body sizes. Expecting women to be a specific size reinforces hidden sexist notions that deny them their health care rights. Suffering from structural violence, the curvy women could not access equal health care. Their experiences suggested that health professionals stereotyped them as lazy and gluttonous, refused to help them until weight loss occurred, tried to control their bodies, and provided inadequate services. The consequences of health care inequality meant these deviant bodied women were left in pain waiting for medical intervention, their health problems dismissed as nothing more than "fat," they were unable to get help for their health, and, in the worst cases, their health and well-being was damaged even further by health professionals and systems. The cultural influences of thin supremacy

impacted how health professionals and systems provided medical services to larger bodied women.

These women's larger bodies do not make them less of a person or less deserving of health care. The women are not unworthy of medical help. They deserve the same treatment afforded to their thinner peers, and that is what they wanted. They wanted to trust health professionals and systems, to have a say and control over what happens to their bodies, to receive care that understands their lives are intertwined with their health, and for health services, systems, and equipment to work for all body sizes. The women wanted equitable health care for larger body sizes.

In the last chapter, I conclude the overall findings of my research, discuss the significance of the study, and outline the possibilities for potential future research.

Chapter 5: Conclusion

Health care in Southern Ontario is failing fat women. The “problem” with a fat body is not its adiposity. In this thesis, I have established the historical creation and cultural construction of anti-fat ideologies that have pervaded Canadian health care and harmed the health and well-being of fat women. I also investigated the participants’ relationships with their bodies, how they internally perceived themselves, and the external influences of body size ideologies throughout their lives. Choosing to focus on fat women allowed me to explore the sexist intersectionality of larger bodies and the current medical context that attempts to control women’s bodies. Additionally, I aimed to provide a voice to these women through an environment that allowed them to tell their narratives and experiences as fat women – their struggles, tribulations, resiliency, and successes.

With their physical form, the women hated their visual appearance, and yet, they appreciated their bodies’ capabilities and had an overall desire to learn more about how their larger bodies function. Through tears, humour, and anger, their emotional narratives demonstrated the significance of their experiences, where they formed resiliency against fat denigration. The women were more than their fat bodies, but the cultural influences which shaped body size ideologies meant the women simultaneously embodied a fat persona – believing they were “less than” and “unworthy” – and rejected it, believing they deserved more for their health and well-being. They wanted more for their health and well-being, but the century-old anti-fat ideologies have deep roots which construct a complex understanding that a woman’s body should be thin. This understanding shows

how body size desires – disguised as the pursuit of “health” – perpetuate and bleed into various aspects of the women’s lives, from childhood and beyond.

When it came to their health, well-being, and ability to access health care in Southern Ontario, structural violence and body size biases created barriers, limited the women’s access to health care services, and, in the worst cases, caused additional harm to their physical and mental health. Despite the evidence that weight loss as a treatment is inadequate (Gaesser and Angadi 2021), thin supremacy notions impacted how health professionals and systems provided medical services to larger bodied women. This exploration demonstrated the power imbalances between fat women and health professionals, suggesting the need for cultural safety practices to administer equitable services for larger bodies, to educate health professionals on the historical and cultural context of the treatment of the fat body in medicine, and to recognize the bias of fat bodies in medicine.

5.1 Significance of the Research

The voices of those expected to lose weight are not often explored (Greenhalgh 2015; viii), and while there is some initial research on adiposity cultural competency practices (Kirk et al. 2020; Ingraham et al. 2016; Kushner et al. 2019), there is limited research on cultural safety and power imbalances between health professionals and fat patients in Canada. My research begins to explore the implications of those power imbalances through the voices of fat women, those who are vulnerable and marginalized, in health care settings. Anthropological methods, through ethnographic research, were necessary given the historical erasure of body size ideologies and the cultural influences which affects health and health care for larger bodies. This research elucidates cultural

safety needs to achieve equitable health care in Canada, and demonstrates the current context in which fat women consider they receive inadequate medical care due to their body size. Additionally, this study contributes to the field of medical anthropology and critical fat studies through research on the cultural influences of fat ideologies on health and health care. This thesis is meant to stand with existing critical fat studies literature by creating a space for the voices of women negatively impacted by fat denigration in health care. By recognizing “a holistic and historically informed biosocial approach to health” (Singer 1994:943) this study also aligns with critical medical anthropology to provide an understanding of the current cultural influences and historical context of fat denigration in health care settings.

This research presents an opportunity to understand the outcomes of current health care practices and how those practices impact fat women. This exploration is essential as implementing the CMA’s new obesity clinical guidelines demands a contextual understanding of anti-fat health care in Canada.

Finally, my research explored how the women navigated and experienced their deviant bodies through self-reflection and external influences, along with the impact of their narratives for constructing a personal, emotional resiliency. Given that health advice that encourages weight loss is inadequate, the impact of fat stereotypes and biases beyond the medical settings demonstrates additional consequences of weight-loss-based health care. This exploration is critical because it situates the cultural influences of body size ideologies beyond a consideration of health, to examine how they adversely impact women’s overall well-being.

5.2 Future Research

This study points to a need for further research on the implications of body size in Canadian medical care and the consequences of social influences for fat denigration, with further investigation into additional fat women's experiences in health care settings. My research opens several avenues for further studies, including examining additional demographics and geographical locations, as well as changes in clinical practices that might result from the new CMA obesity guidelines. Given that I conducted this ethnography during an unprecedented time when people, cities, and countries were in lockdown due to COVID-19, similar research during a period of non-lockdown could reach wider populations of fat women. This would allow for a potentially more diverse exploration of the experiences of fat women in health care settings, including examining more members of the BIPOC community, 2SLGBTQQIA+ individuals, and men. Additionally, these issues would be interesting to explore with children and teenagers with larger body sizes. These demographics could potentially offer insight to understand the implications of body size in different geographical and social contexts, all situated under the overarching Canadian medical system. These populations would benefit from ethnographic efforts that explore their experiences in health care settings and how these experiences shape their lives and understandings of their bodies.

Additionally, with the implementation of new clinical guidelines redefining "obesity" in Canadian health care, further research examining the changes to health care for fat women (or populations with larger body sizes) in Canadian medical care settings could provide a contextual examination of the cultural relationships which shape health care through new societal influences in combination with historical influences and

ideologies. Finally, while the CMA released the new guidelines in August 2020, the impending global pandemic of COVID-19 may have impacted the guideline implementation due to the prioritizing of safety measures and the need to decrease coronavirus mortality and morbidity rates (e.g., by engaging in more medical consultations by phone or online). There is a potential opportunity to study the changes to the treatment of fat bodies that may occur in Canadian health care after the coronavirus pandemic.

The scope of my master's ethnography meant I could only devote eight weeks to in-depth interviews and the online discussion group, and I had to conduct the study through social distancing to meet the ethical standards of the pandemic safety practices throughout this time. The study prioritizes the voices of those impacted by anti-fat health care and provides significant evidence to begin to address the power imbalances within health practices. However, upon the conclusion of my research, I was left with the following questions: How are the new clinical guidelines for obesity being implemented in medical settings, and how are they impacting anti-fat ideologies? Are there changes to fat women's experiences in health care settings? Given that the history of fat denigration is rooted in racism and sexism, what are the racialized experiences of body size discrimination in Canadian health care? Though I could not answer these questions within the scope of this study, I estimate they are essential to ending fat denigration, breaking down structural violence barriers, and improving equitable health care in Canadian health systems.

Appendices

Appendix A

A.1 Overview of Participants

Alethea – Curvy/ Fat, 34, Researcher, Ottawa

My first interviewee, Alethea, is direct and to the point, with a significant interest in my research results. Though she kept her answers brief, she articulated the importance of body size considerations in health care.

Aubrey – Fat, 52, Stay-at-home mom, St. Catherines

With a challenging past, having lost both her parents and the lifestyle she dedicated to her children, Aubrey's resiliency was evident in the self-care she gave to herself. She had a strong sense of self-awareness.

Bridget – Athletic, 58, Ottawa

With strong willpower and a determination to understand her body, Bridget is one of the participants who conformed to the thin ideology. She adamantly explained that she does not eat dessert, rarely treats herself, and still cannot get rid of the extra weight, despite being an avid sports player.

Colette – Voluptuous, 41, Ottawa

A previous athlete and current athletic coach, Colette spoke with a sense of humour, her voice light and delightful.

Freya – Rubenesque, 41, Researcher, Ottawa

Freya is a powerful woman. With over thirty years in the military, a Ph.D., and a fellow researcher, she spoke with such confidence and surety. The second participant to choose

a phone interview, Freya commanded the conversation. Nevertheless, she still comes across as caring and thoughtful of other people.

Haley – Curvy, 24, Student, Ottawa

Haley is a bisexual woman with an air of intellectuality and her responses thoughtfully curated. She articulated understanding the position of other curvy and fat women, elucidating the struggles those women might face.

Imara – Fat, 51, Hamilton

Having always been fat, Imara is considerate and compassionate, bruised by a traumatic past. Dedicated to helping people prevent lung cancer, Imara also participates in an organization that advocates for equitable health care for those with obesity.

Joleen – Fat, 76, Retired, Ottawa

Joleen, referred to me by her daughter, required minimal guidance in the interview. In detail, Joleen often delved into her experiences without hesitation or prompting on my part. She spoke with the wisdom of experience and the uncanny ability to convey her emotion distinctly in her tone.

Lyssa – Curvy, 23, Student, Kitchener

Lyssa's thoughts are logical and inquisitive. I found her thoughtfulness brilliant and caring for other women.

Phoebe – Fat, 64, Retired, Ottawa

Phoebe sat in a small, outdated apartment, appearing almost uncomfortable with her body with a voice as sweet as her admitted sugar addiction. She has a wonderful sense of humour and a strong sense of her self.

Selene – Curvy, 36, Engineer, Ottawa

A kindred spirit, I found the conversation with Selene quite relatable. As we are both women well above average height for our sex, her experiences of dating, fashion, and health are comparable to mine. With a presence of poise and authority, Selene is quite analytical and a thoughtful conversationalist.

Thalia – Curvy, 48, Ottawa

A talkative individual full of fervour, Thalia identifies as queer and her experiences with anti-fat health care began when her mother faced barriers.

Veera – Voluptuous, 37, Lawyer, Ottawa

As one of the participants who needed minimal guidance in telling her story, Veera is a bisexual woman who commanded the conversation. She radiated positive energy and a determination for life.

References

- Almutairi, Adel F., Abdallah A. Adlan, and Maliha Nasim.
2017 Perceptions of the Critical Cultural Competence of Registered Nurses in Canada. *BMC Nursing* 16(1):47.
- Baer, Hans
2011 Medical Pluralism: An Evolving and Contested Conception Medical Anthropology. *In A Companion to Medical Anthropology*. Merrill Singer and Pamela I. Erickson eds. Chichester, England: Blackwell Publishing Ltd.
- Beatty, Andrew.
2010 How Did It Feel for You? Emotion, Narrative, and the Limits of Ethnography. *American Anthropologist* 112(3):430–43.
- Bokhour, Barbara G., Ellen S. Cohn, Dharma E. Cortés, Jeffrey L. Solomon, Gemmae M. Fix, A. Rani Elwy, Nora Mueller, et al.
2012 The Role of Patients’ Explanatory Models and Daily-Lived Experience in Hypertension Self-Management. *Journal of General Internal Medicine* 27(12):1626–34.
- Bombak, Andrea E., Deborah McPhail, and Pamela Ward.
2016 Reproducing Stigma: Interpreting ‘Overweight’ and ‘Obese’ Women’s Experiences of Weight-Based Discrimination in Reproductive Healthcare. *Social Science & Medicine* 166:94–101.
- Bombak, Andrea E., and Lee F. Monaghan.
2017 Obesity, Bodily Change and Health Identities: A Qualitative Study of Canadian Women. *Sociology of Health & Illness* 39(6):923–40.
- Cameron, Erin.
2015 Teaching Resources for Post-Secondary Educators Who Challenge Dominant ‘Obesity’ Discourse. *Fat studies* 4(2):212–226.
- Canadian Medical Association
2015 Obesity in Canada: Causes, Consequences and the Way Forward.
2019 Statement on Equity and Diversity in Medicine.
2020 Background to CMA Policy Equity and Diversity in Medicine. CMA Policy.
2020 Equity and Diversity in Medicine. CMA Policy.
- Canter, Richard.
2001 Patients and medical power: Shifting power in favour of the patient may not be so straightforward. *BMJ* 323(7310):414.
- Carroll, Joan F., Ana L. Chiapa, Mayra Rodriguez, David R. Phelps, Kathryn M. Cardarelli, Jamboor K. Vishwanatha, Sejong Bae, and Roberto Cardarelli.
2008 Visceral Fat, Waist Circumference, and BMI: Impact of Race/Ethnicity. *Obesity* 16(3):600–607.

- Christel, Deborah A., Nicole O'Donnell H., and Linda Arthur Bradley
2016 Coping by crossdressing: An exploration of exercise clothing for obese heterosexual women. *Fashion and Textiles* 3, 1(05):1-19
- Christensen, Martin, and Jaqui Hewitt-Taylor.
2006 Empowerment in nursing: paternalism or maternalism?. *British journal of nursing* 15(13):695-699.
- Churchill, Mackenzie E, Janet K Smylie, Sara H Wolfe, Cheryllee Bourgeois, Helle Moeller, and Michelle Firestone.
2020 Conceptualising Cultural Safety at an Indigenous-Focused Midwifery Practice in Toronto, Canada: Qualitative Interviews with Indigenous and Non-Indigenous Clients. *BMJ Open* 10(9):e038168.
- Colls, Rachel.
2007 Materialising Bodily Matter: Intra-Action and the Embodiment of 'Fat.' *Geoforum* 38(2):353–65.
- Cooper, Charlotte.
2010 Fat Studies: Mapping the Field: Fat Studies. *Sociology Compass* 4(12):1020–34.
- Downe, Pamela J.
1999 Laughing When It Hurts: Humor and Violence in the Lives of Costa Rican Prostitutes. *Women's Studies International Forum* 22(1):63–78.
- Ellison, Jenny.
2020 *Being Fat: Women, Weight, and Feminist Activism in Canada*. Toronto: University of Toronto Press.
- Ellison, Jenny, Deborah McPhail, and Wendy Mitchinson.
2018 *Obesity in Canada: Critical Perspectives*. Toronto: University of Toronto Press
- Farmer, Paul
2004 An Anthropology of Structural Violence. In: *Current Anthropology* 45(3):305 - 325
- Farrell, Amy Erdman.
2011 *Fat Shame: Stigma and the Fat Body in American Culture*. New York: New York University Press.
- Fikkan, Janna L., and Esther D. Rothblum.
2011 Is Fat a Feminist Issue? Exploring the Gendered Nature of Weight Bias. *Sex Roles* 66(9–10):575–92.
- Fitday.
N.d. 11 Causes for Weight Gain in Women / Nutrition / For Women. Fitday, Accessed January 8, 2022. <https://www.fitday.com/fitness-articles/nutrition/for-women/11-causes-for-weight-gain-in-women.html>

- Fohr, Tiina, Julia Pietila, Elina Helander, Tero Myllymaki, Harri Lindholm, Heikki Rusko, and Urho M. Kujala.
2016 Physical Activity, Body Mass Index and Heart Rate Variability-Based Stress and Recovery in 16 275 Finnish Employees: A Cross-Sectional Study. *BMC Public Health* 16(1)
- Freeman, Lauren.
2020 A Matter of Justice: ‘Fat’ Is Not Necessarily a Bad Word. *Hastings Center Report* 50(5):11–16.
- Gaesser, Glenn A, and Siddhartha S Angadi.
2021 Obesity Treatment: Weight Loss Versus Increasing Fitness and Physical Activity for Reducing Health Risks. *iScience* 24(0):102995–102995.
- Gallis, John A., and Elizabeth L. Turner
2019 Relative Measures of Association for Binary Outcomes: Challenges and Recommendations for the Global Health Researcher. *Annals of Global Health* 85(1):137
- Gillon, A
2020 Fat indigenous bodies and body sovereignty: An exploration of representations. *Journal of Sociology* 56(2):213–228.
- Global Search | Canadian Medical Association.
n.d. Accessed May 14, 2022. <https://www.cma.ca/global-search?searchTerm=%22cultural%20competency%22>.
- Greenhalgh, Susan
2015 *Fat-Talk Nation: The Human Costs of America’s War on Fat*. Ithaca, New York: Cornell University Press.
- Guerra, Olivia, and Donna Kurtz.
2017 Building Collaboration: A Scoping Review of Cultural Competency and Safety Education and Training for Healthcare Students and Professionals in Canada. *Teaching and Learning in Medicine* 29(2):129–42.
- Hammer, Mitch
2007 *Intercultural Development Plan*. Berlin, MD: Intercultural Development Inventory Team.
- Haque, Ireena.
2020 *Dismantling Weight Bias towards Overweight Patients in Ontario Healthcare*. Toronto, Ontario:OCAD University
- Hart-Wasekeesikaw, Fjola
2009 *Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nations, Inuit and Métis Nursing*. Canadian Nurses Association.
- Hewitt-Taylor, Jaquelina.
2004 Challenging the balance of power: patient empowerment. *Nursing Standard* 18(22):33.

- Holland, Ann E.
2015 The Lived Experience of Teaching About Race in Cultural Nursing Education. *Journal of Transcultural Nursing* 26(1):92–100.
- Ingraham, Natalie, D. Magrini, Jacquetta Brooks, Dawn Harbatkin, Asa Radix, and Suzanne G. Haynes
2016 Two Tailored Provider Curricula Promoting Healthy Weight in Lesbian and Bisexual Women. *Women's Health Issues* 26:S36–42.
- Jang, Hye Jin, Byung Sung Kim, Chang Won Won, Sun Young Kim, and Myung Weon Seo
2020 The Relationship between Psychological Factors and Weight Gain. *Korean Journal of Family Medicine* 41(6):381–86.
- Janssen, Ian.
2013 The Public Health Burden of Obesity in Canada. *Canadian Journal of Diabetes* 37(2):90–96.
- Jongen, Crystal, Janya McCalman, and Roxanne Bainbridge
2018 Health Workforce Cultural Competency Interventions: A Systematic Scoping Review. *BMC Health Services Research* 18(1):232.
- Kennedy, Ian.
2003 Patients are experts in their own field: The interests of patients and healthcare professionals are intertwined. *Bmj* 326(7402):1276-1277.
- Kirk, Sara FL, Ximena Ramos Salas, Angela Alberga, and Shelley Russel-Mayhew
2020 Clinical Practice Guidelines: Reducing Weight Bias in Obesity Management, *Obesity Canada*:1-8
- Koot, B. G. P., R. Westerhout, A. E. Bohte, S. Vinke, T. H. Pels Rijcken, A. J. Nederveen, M. W. A. Caan, et al.
2014 Ultrasonography Is Not More Reliable than Anthropometry for Assessing Visceral Fat in Obese Children. *Pediatric Obesity* 9(6):443–47.
- Krieger, Nancy.
2014 Discrimination and Health Inequities. *International Journal of Health Services* 44(4):643–710.
- Kushner, Robert F., Deborah B. Horn, W. Scott Butsch, Joshua D. Brown, Katherine Duncan, Colony S. Fugate, Carol Gorney, et al.
2019 Development of Obesity Competencies for Medical Education: A Report from the Obesity Medicine Education Collaborative: OMEC Obesity Competencies. *Obesity* 27(7):1063–67.
- Lee, Eunjung, and Rupaleem Bhuyan.
2013 Negotiating within Whiteness in Cross-Cultural Clinical Encounters. *Social Service Review* 87(1):98–130.
- Lock, Margaret, and Vinh-Kim Nguyen.
2018 *An Anthropology of Biomedicine*. 2nd edition. Hoboken, New Jersey: Wiley.

- Mackert, Nina and Jürgen Martschukat
2019 Introduction: critical ability history, *Rethinking History*, 23(2):131-137
- McGhee, Deirdre E., Julie R. Steele, William J. Zealey, and George J. Takacs.
2013 Bra–Breast Forces Generated in Women with Large Breasts While Standing and during Treadmill Running: Implications for Sports Bra Design. *Applied Ergonomics* 44(1):112–18.
- McPhail, Deborah, Andrea Bombak, Pamela Ward, and Jill Allison.
2016 Wombs at Risk, Wombs as Risk: Fat Women’s Experiences of Reproductive Care. *Fat Studies*, 18.
- Metzl, Jonathan M., and Helena Hansen.
2014 Structural Competency: Theorizing a New Medical Engagement with Stigma and Inequality. *Social Science & Medicine* 103:126–33.
- Michaelson, Valerie, William Pickett, and Colleen Davison.
2019 The History and Promise of Holism in Health Promotion. *Health Promotion International* 34(4):824–32.
- Munro, Lauren.
2017 Everyday Indignities: Using the Microaggressions Framework to Understand Weight Stigma. *The Journal of law, medicine & ethics* 45(4):502–509.
- Nakamura, Tadashi, Katsuto Tokunaga, Iichiro Shimomura, Makoto Nishida, Shingo Yoshida, Kazuaki Kotani, A. H. M Waliul Islam, et al.
1994 Contribution of Visceral Fat Accumulation to the Development of Coronary Artery Disease in Non-Obese Men. *Atherosclerosis* 107(2):239–46.
- Nyamathi, Adeline., and Deborah Koniak.
2007 *Vulnerable Populations*. New York: Springer Publishing.
- Obesity Canada
2020 *Canadian Adult Obesity Clinical Practice Guidelines: Clinical Recommendations Quick Guide*. Obesity Canada and the Canadian Association of Bariatric Physicians and Surgeons.
- 2022 *Canadian Adult Obesity Clinical Practice Guidelines Adapted For Use In Chile, Ireland*. Obesity Canada. Accessed May 28, 2022. <https://obesitycanada.ca/oc-news/canadian-adult-obesity-clinical-practice-guidelines-adapted-for-use-in-chile-ireland/>
- Oliver, J. Eric.
2006 *Fat Politics: The Real Story Behind America’s Obesity Epidemic*. Cary, United States: Oxford University Press, Incorporated.
- O’Neill, Meghan, Kathy Kornas, and Laura Rosella.
2019 The Future Burden of Obesity in Canada: A Modelling Study. *Canadian Journal of Public Health* 110(6):768–78.
- Paradis, Elise
2016 Obesity as a Process: the Medicalization of Fatness by Canadian Researchers 1971-2010 *In Obesity in Canada: critical perspectives*. Jenny Ellison, Deborah

- McPhail, and Wendy Mitchinson eds. Pp 56-88. Toronto: University of Toronto Press
- Phelan, SM, DJ Burgess, MW Yeazel, WL Hellerstedt, JM Griffin, and M van Ryn.
2015 Impact of Weight Bias and Stigma on Quality of Care and Outcomes for Patients with Obesity. *Obesity Reviews* 16(4):319–26.
- Puhl, Rebecca M., and Chelsea A. Heuer.
2010 Obesity Stigma: Important Considerations for Public Health. *American Journal of Public Health* 100(6):1019–28.
- Rand, Michelle, Amanda J. Sheppard, Sehar Jamal, Alethea Kewayosh, and Angela Mashford-Pringle.
2019 Evaluation of the Aboriginal Relationship and Cultural Competency Courses among a Sample of Indigenous Services Canada Nurses. *International Journal of Indigenous Health* 14(1):29–41.
- Ribeiro-Filho, Fernando F., Alessandra N. Faria, Sergio Azjen, Maria-Teresa Zanella, and Sandra R.G. Ferreira.
2003 Methods of Estimation of Visceral Fat: Advantages of Ultrasonography. *Obesity Research* 11(12):1488–94.
- Rice, Carla
2007 Becoming ‘the Fat Girl’: Acquisition of an Unfit Identity. *Women’s studies international forum* 30(2):158–174.
2015 Rethinking Fat. *Cultural studies, critical methodologies* 15(5):387-97
- Rueda-Clausen CF, Poddar M, Lear SA, Poirier P, Sharma AM.
2020 Canadian Adult Obesity Clinical Practice Guidelines: Assessment of People Living with Obesity.
- Saldaña, Johnny
2016 *The Coding Manual for Qualitative Researchers*. Third edition. Los Angeles: SAGE.
- Scheper-Hughes, Nancy, and Margaret M. Lock.
1987. The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology. *Medical Anthropology Quarterly* 1(1):6–41.
- Schorb, Friedrich.
2021 Crossroad between the Right to Health and the Right to Be Fat. *Fat Studies*, 10(2):160–171
- Shanouda, Fady
2021 Medical equipment: The manifestation of anti-fat bias in medicine. *In Weight Bias in Health Education: Critical Perspectives for Pedagogy and Practice*. Heather Brown and Nancy Ellis-Ordway eds. Pp 30-42. Milton:Taylor & Francis Group
- Singer, Mel.
1994 AIDS and the Health Crisis of the U.S. Urbain Poor ; the Perspective of the Critical Medical Anthropology.” *Social science & medicine* (1982) 39(7): 931–948.

- Strings, Sabrina.
2019 *Fearing the Black Body: the Racial Origins of Fat Phobia*. New York: New York University Press.
- Taylor, Janelle S.
2003 Confronting “Culture” in Medicine’s “Culture of No Culture.” *Academic Medicine* 78(6):555-559.
- The Plastic Surgery Clinic
2021 What to Know About Plastic Surgery & BMI Guidelines. 2021. Accessed August 6, 2021. <https://www.theplasticsurgeryclinic.ca/blog/cosmetic-surgery-bmi/>
- Thomas, Sandra, Carol Smucker, and Patricia Droppleman.
1998 It Hurts Most around the Heart: A Phenomenological Exploration of Women’s Anger. *Journal of Advanced Nursing* 28(2):311–22.
- van Geel, M., P. Vedder, and J. Tanihon.
2014 Are Overweight and Obese Youths More Often Bullied by Their Peers? A Meta-Analysis on the Relation between Weight Status and Bullying. *International Journal of Obesity* 38 (10):1263–68.
- Vogel, Lauren
2015 Rethink Weight Limits on Morning-after Pill. *Canadian Medical Association Journal* 187(10):719–21.

2019. Fat Shaming Is Making People Sicker and Heavier. *Canadian Medical Association Journal* 191(23):E649–E649.
- Wharton, Sean, David C.W. Lau, Michael Vallis, Arya M. Sharma, Laurent Biertho, Denise Campbell-Scherer, Kristi Adamo, et al.
2020 Obesity in Adults: A Clinical Practice Guideline. *Canadian Medical Association Journal* 192(31):E875–91.
- Wolf, Naomi.
2002 *The Beauty Myth: How Images of Beauty Are Used against Women*. New York: Perennial.
- World Health Organization
2014 Obesity. World Health Organization. <https://www.who.int/topics/obesity/en/>, accessed September 7, 2019
- Zevin, Boris, Mary Martin, Nancy Dalgarno, Linda Chan, Nardhana Sivapalan, Robyn Houlden, Richard Birtwhistle, Karen Smith, and David Barber.
2021 Survey of Perceptions and Educational Needs of Primary Care Providers Regarding Management of Patients with Class II and III Obesity in Ontario, Canada. *BMC Family Practice* 22(1):14.