FAT STUDIES

By Amy Farrell

Introduction:

Fat Studies is an emerging field important to all of us who are interested in health and wellness. Unlike the medical and public policy studies outlining the "risk of overweight" and the "epidemic of obesity," the field of Fat Studies challenges us to think about the *meaning* of fatness, the power of fat stigma, and the dangers inherent when an apparent health crisis also becomes a moral crisis. Every biological crisis, from the plague in the Middle Ages to the AIDS outbreak in the 1980s, also has cultural and ideological components. There are even health crises that we now recognize have *only* cultural and ideological components; in the United States in the 19th and early 20th centuries, for instance, physicians considered masturbation a hazardous activity, causing symptoms from acne to insanity. "Solutions" included mental discipline, painting fingers with substances that would burn or stain (so that parents would know what the children had done), or, in extreme cases for girls and women, surgical removal of the clitoris. (G.J. Barker-Benfield, 2000, pgs. 120,163-176; Joan Jacobs Brumberg, 1997; pgs. 59-94) We now perceive these practices, as well as the belief in the danger of masturbation, as ill-informed and even inhumane; nevertheless, at the time, this was mainstream thinking and practice.

Fat Studies scholars recognize that fatness has both biological and cultural components, and their own work might encompass either or both angles. Always, however, Fat Studies scholars are attentive to the strength of cultural meanings, and the ways that these shape even the most apparently "objective" studies of weight and size. Many Fat Studies scholars have come to their research through the experiences of their own bodies; as fat people who have experienced discrimination, poor medical treatment, and the difficulties of what one writer called "living large," they have turned their attention toward academia and the careful exploration of the meanings of fat, the lives and experiences of fat people, and the methods by which medical and public policy might work to end discrimination against fat people and support health in the broadest sense. Others working in this newly emerging field have come to Fat Studies through their previous work in academia, in psychology, sociology, literature, or, like myself, cultural studies and history. What follows is a brief overview of Fat Studies, so that readers will have an

understanding of some of the key issues and scholars in this newly emerging field, as well as some new questions to consider when engaged in discussions about fatness and health.

First, however, a discussion of language and terms is in order. Readers might note that up to this point I have only used the term fat, avoiding medical phrases like obesity and overweight as well as euphemisms like chubby, heavy, rotund, or full-figured. Except for places where I am quoting another source that uses these terms, I will stick to the term fat. The reason for this is that Fat Studies is a field with an activist position, one that challenges the stigma and discrimination that fat people face. Fat Studies scholars eschew the medical terms of obese or overweight, arguing that they are infused with an alienating and clinical focus that lays blame and judgment. Likewise, Fat Studies scholars prefer the term fat over “full figured” or “chubby,” or other phrases that many people use in a good natured way to soften the blow of calling someone fat. (S. Solovay and E. Rothblum forthcoming 2008). Just as scholars in gay and lesbian studies reclaimed those terms in preference over homosexuality, and scholars in African American and Africana studies chose those terms (and earlier chose Black Studies or Afro-American Studies) over the term Negro, Fat Studies scholars have chosen the straightforward term “fat,” wanting to reclaim it as a descriptive term that neither hides nor judges. Writer and activist Marilyn Wann explained the use of the term fat, in her witty and insightful book *Fat? So! Because You Don’t Have to Apologize for your Size* (1998), like this:

> Practice saying the word *fat* until it feels the same as *short, tall, thin, young, or old.* Chat with your fat. Give it pet names. Doodle *fat* on your notepad during meetings. . . *Large, big-boned, overweight, chubby, zaftig, voluptuous, Rubenesque, plump, and obese* are all synonyms for fear. (p. 28, 29)

Most scholars in the field of Fat Studies, particularly those within the humanities and cultural studies, but also those in the social sciences and sciences if their particular journals or disciplines allow, will use the term fat in preference over other phrases.

FAT STIGMA:

In U.S. culture, fatness is, to borrow a phrase from the psychologist Erving Goffman in his important book *Stigma: Notes on the Management of a Spoiled Identity* (1963), a “discredited

attribute." By this he refers to attributes that are perceived to be negative, shameful, and that reflect poorly on the person bearing them. Fatness in U.S. culture connotes a whole range of negative qualities: weak-willed, gluttonous, sick in body and in mind, ugly, mentally unstable, out of control, and uncivilized. Because fat is a physical and highly visible stigma, and thus difficult or impossible to hide, it means that fat people face a particularly difficult situation working to manage the cultural and social consequences of their "discredited attribute." In other words, unlike people with "discrediting attributes" that can be hidden, fat people rarely get a break.

One might think that the negative connotations surrounding fatness emerged simply as a result of our recognition of the apparent health risks associated with fat. My own research, forthcoming in a book entitled *Fat Shame* (forthcoming 2009), suggests otherwise, however. What is clear from the historical documents is that the connotations of fatness and of the fat person—lazy, gluttonous, greedy, immoral, uncontrolled, stupid, ugly and lacking in will power--preceded and then were intertwined with explicit concern about health issues. Throughout the 19th century and well into the 20th, physicians generally were rather lax in their concern about weight. Indeed, physicians' pamphlets like "How to Get Fat" (Smith 1865) suggest that *gaining* weight was a much more pressing concern for doctors; "wasting" diseases like tuberculosis and malnutrition made doctors much more concerned about encouraging their patients to eat than losing weight. The American physician Dr. S. Weir Mitchell, famous for the "rest cures" he prescribed for women with hysteria and other nervous conditions (another diagnosis that was clearly cultural as well as biological), explained in his 1877 book *Fat and Blood* that dieting was a 'rarely needed process" for Americans. "[A]s a rule," he added, we have much more frequent occasion to fatten than to thin our patients." Physicians perceived it as "natural" that one would gain weight with aging. The ritual of the weigh-in, so key to our understanding of how physicians perceive and diagnose us as patients, was not at all a part of the medical lexicon until far into the 20th century. Indeed, even as late as the 1950s, minutes from meetings of the Chicago's American Medical Association indicate that many doctors needed to be convinced of the relevance of weighing children.

Significantly, two of the earliest marketers of diet programs and products—William Banting and Helen Densmore-- rejected their own doctors' advice about the naturalness of their hefty and aging bodies. Considered the "father" of dieting, William Banting enjoyed a successful business as a casketmaker. By the time he reached middle age, Banting was quite fat, despite continued attempts at vigorous exercise to reduce. Physicians' reassurance that weight gain was a natural part of the aging process failed to persuade him; these doctors, he wrote, didn't understand the "parasite of barnacles" that promised to destroy him. He explains that from his "earliest years [he] had an inexpressible dread of such a calamity". In 1863 he published his "Letter on Corpulence," which became a bestseller for decades first in England and later in the United States. "Corpulence" spoke in no uncertain terms about the "crying evil of obesity." "Of all the parasites that affect humanity I do not know of, nor can I imagine, any more distressing than that of Obesity", he wrote. (p. 11) Banting searched from doctor to doctor until he found one who offered a successful weight loss diet: avoiding starches, eating lean meats, and limiting liquids, along with a "morning cordial" (p. 5) that counteracted the constipation that resulted from a diet so high in protein and low on liquids. By the end of his pamphlet, he celebrated the regiment that had freed him from the "that dreadful tormenting parasite on health and comfort," that caused such "bodily and…mental infirmity" (p. 20).

Obesity as a "crying evil", a "dreadful tormenting parasite", a "calamity" that he wished to avoid—these were all the exact phrases that would recur in writers on fat and weight loss in the next seventy years. It is important to realize that it was at first middle class patients who put pressure on physicians to take seriously the "crying evil of obesity", not physicians who urged their patients to lose weight. For decades—indeed, continuing into the present day-- doctors have debated the significance of weight for a patient's health, but there was no such lack of clarity when it came to a popular consensus about weight and beauty. A lean, youthful body was definitely more desirable than an aged, fat one. Fatness began to be seen less as a fine embonpointment than as Banting's "parasite of barnacles." Many of the themes that we see in today's dieting literature and propaganda we see in Banting's early material: the sense of fat as somehow a leach that doesn't belong to the "real" person (a "parasite of barnacles"), the sense of

doom associated with fatness (“a dreadful calamity”); and finally, the sense of sin and immorality associated with fatness (“a crying evil”). Fat is not just a state of matter, or even a health risk factor, but is a marker of one’s immorality and evilness.

Like Banting, Dr. Helen Densmore, another early marketer of diet products, also refused her physician’s advice to “submit to the inevitable, and let well enough alone.” She rejected the idea that it was natural, as her doctor told her, for some people to be fat, and she decried the “nameless something departing from me that every woman holds dear—the lines of beauty and grace of movement…” (p. 1). Working to update the Banting system, she began selling her weight loss tea (a laxative) in 1896, in both England and the United States. She explained that the problem with the Banting system was that readers frequently failed to take the “draught”, “wrecking havoc with the system” (p. 4), as she explained. In other words, people suffered severe constipation. She began selling packets of her herbal tea laxative for $2.00 and advertising for “agents” to sell her solution. It is no wonder that people might have lost weight with her new Banting system. Not only were they given what was supposedly a strong laxative, but they were also told to eat two small meals, skip breakfast and limit liquids. If that failed, they were told to eat one small meal. If that failed, they were told to reduce the size of the solitary meal. And if that failed, she encouraged fasts of up to 30 day! (p. 5)

A careful inventory of the entire litany of diets in U.S. history indicates that the same methods continue to reappear, albeit with different names. William Banting’s 19th century high protein and no starch diet became today’s South Beach and Atkins diets. The milk diets of the early 20th century became today’s Slim Fast and Nutri Slim liquid diets. (Schwartz, 1986, p. 198) The incongruous mixture of whole grain foods and Christianity of Sylvester Graham, Horace Fletcher, and John Harvey Kellogg became today’s wheat and fig “Bible Bar” marketed by Tom Ciola, the author of *Moses Wasn’t Fat*. (2001) One-food fixes for obesity have remained a constant, though the specific item has changed: in the early 20th century it was the banana; in the 1960s melba toast and cottage cheese; in the 1970s, grapefruit; in the 1990s, cabbage; in the first decade of the twenty-first century, olive oil. Mechanical “flesh reducers” have long remained popular, from the obesity belts of the 19th century to the French originating “Bergonie” chairs of

the early 20th century, to the recently marketed "Ab Energizers," the electric stimulating abdominal belts. Difficult as it is to mark a clean line between the dieting industries and the medical industries, one must include as well the long history of pharmecutical products designed to suppress appetite (from arsenic to Phen Fen and Lepin) or "burn off" fat (from tapeworms to amphetamines to Ephedra), as well as the surgical procedures focused on excising fat (the gynecologist Howard Kelly performed the first fat removal surgeries on fat women in the late 1880s) to contemporary liposuction (Schwartz, 1986, p. 178). Even reconfiguring the digestive tract has had a long history, from Kellogg's anal sphincter surgeries to the stomach stapling of the 1960s to the increasingly popular gastric bypass surgery of today. While each of these methods promises weight loss through a different avenue they all share one important point: Each has come with a larger social agenda and cultural meaning. In all of them, fat is a social as well as physical problem in which the social stigma of fatness—and the fantasy of freeing oneself from this stigma—is as important as or even takes priority over issues of health.

A number of historians have explored why it is that fatness became such a stigma in the 19th and 20th century. Scholars such as Hillel Schwartz in his now classic *Never Satisfied* (1986) and Peter Stearns (1997) in his *Fat History,* have argued that fat denigration in the U.S. emerged with industrialization and the birth of a consumer culture. The processes of industrialization and urbanization at the turn of the century depended upon an expanding consumer culture. This meant buying more products, engaging in commercial leisure activities, augmenting one's standard of living as a sign of one's success in life. This was the birth of the advertising industry—encouraging us to buy, to keep our consumer based economy moving. This new imperative—to buy, to spend, to enjoy—came in direct conflict, however, with an older, Victorian, Protestant ethic of deferred gratification, of containing one's impulses and desires, of working continually and diligently. Interestingly, this cultural conflict got played out—and continues to get played out—on the body, as the individual was considered responsible for maintaining control, for not exhibiting that cultural excess. The individual bore the responsibility of the guilt of our cultural excess. What Schwartz and Stearn argue, then, is that the United States' cultural fixation on the pursuit of thinness is a product of capitalism's need to make us feel dissatisfied with our bodies—

so we will spend money to "fix" them-- coupled with guilt induced by a society of excess. Other scholars, such as R. Marie Griffith in *Born Again Bodies* (2004), focus on religious reasons why fat denigration emerged. She argues that the valorization of thinness and the development of fat stigma are the consequences of the continuing force of Protestantism's "craving for a perfectible, eternal, living, breathing, disciplined yet sensual body, along with its obverse, the sinister repugnance toward deficient, impoverished, or languishing bodies" (p. 18).

My own research in *Fat Shame* develops the work of these scholars further, tracing the ways that fat stigma emerged simultaneously with the powerful discussions regarding race, gender and civilization that were prevalent in the 19th and 20th centuries. Physicians and essayists of this time period often linked fatness to lower levels of civilization and the primitive, and thinness to progress and civilization. In 1864, for instance, a Dr. Bradshaw wrote that in "advanced nations" (and by these he meant England, the United States, France) a "multiplied chin and an abdomen of enormous periphery do not entitle the possessor of any distinction." He compared this to "primitive cultures" where a big stomach bestowed cultural status. Over sixty years later, in 1926, a Dr. Williams explained that the men of "savage tribes" (p. 77) preferred women who were fat and round; in England and the United States, however, Williams noted approvingly, women were fighting their "endocrinal" tendency to gain weight because they knew that fat women were "repulsive sights, degrading alike to their sex and civilization" (p. 67). These writings coincided with significant fields of study popular in the 19th century that have become collectively known as scientific racism: phrenology, which classified "types" of people by their physical features; early anthropology, which grouped racial and national "types" into hierarchical structures of civilization; and, finally, eugenics, the science of human breeding for "improvement" in the human race. All three of these popular areas of study emerged during a period of widespread colonization of other non Western countries and territories by the United States and England, as well as fear about the contamination threatened by the influx of immigrants to the United States and, particularly in the post Civil War Era, by the newly emancipated African Americans. (Brown, 2001, pgs. 101-131) Within the context of increased waves of immigration from Southern and Eastern Europe and migration from the South, nativist critics and health

professionals argued that everything from health and fortitude to intelligence and character were inherited traits, in low supply among the immigrants and migrants, in high supply among native born Americans of Northern European stock. There was significant attention paid to those supposed signs that would clarify the identity of the "superior" vs. the "inferior," the "norm" from the "other." Within this context, fatness became yet another signifier of inferiority, a line demarcating the divide between civilization and primitive cultures, whiteness and blackness, good from bad. These writings, I remind readers in *Fat Shame*, had nothing to do with "health," but everything to do with justifying the differential and unfair treatment of certain people. Fat Studies asks us to look for the ways that our contemporary culture continues to harbor these ideas that have such strong historic roots.

FATNESS and DISCRIMINATION:

Fat Studies scholars pay close attention to the widespread discrimination fat people face. Much of this scholarship focuses on discrimination in the workplace. Shelley Bovey's *The Forbidden Body*(1989) for instance, gives voice to numerous women who recount explicit encounters with prospective employers who told the women flatly that unless they lost weight they would not be hired. The comments ranged from euphemistic references to the "image the company has to maintain" to explicit suggestions for diets and weight loss clubs. In her pathbreaking book *Tipping the Scales of Justice: Fighting Weight-Based Discrimination*, legal scholar Sondra Solovay explains that fat people often find themselves rejected for jobs for which they know they are well qualified. Many stop even trying for jobs that require a "professional appearance," because they know that potential employers will see their fatness as, defacto, unprofessional. Solovay argues that employers see fat people as inherently morally defective, lazy, out of control, certainly not qualities associated with "professionalism." One comprehensive survey (Rothblum, 1990) of fat people done in the late 1980s found that 60% of the female respondents said they had lost work opportunities because of their size; even more, 78%, said that their professional confidence had been severely damaged over the years due to office taunts and injustice. A 1992 study (Kolata) demonstrated that employers are reluctant to hire a person they find "unattractive;" fatness leads the list of unattractive traits, and, moreover, is seen as one

for which the person is responsible, unlike, say, scarring or deformed features. Fat men, a *New York Times* study found, make $100 per year *per pound* they are overweight (Kolata). A *New England Journal of Medicine* study (Gortmaker et al, 1993) found that fat women make $6710 less in income per year than thin women.

These statistics regarding employment discrimination are one key example of the way that Fat Studies scholarship makes us question what we "know" as common sense. That is, the fact that poverty corresponds with a population's fatness is well-known. Many health practitioners and public policy makers presume that this correlation is due to the poor health and eating habits of the poor—a new version of the "culture of poverty." These figures regarding employment discrimination, however, allow us to see the way the equation might work in the opposite direction; in other words, poverty does not make people fat, but, rather, discrimination against fat people makes them poor.

For fat people in the United States, there is very little legal protection against employment discrimination. Unlike federal legislation that bars discrimination on the basis of sex, race, national origin, and religion, there is no such national law that prohibits discrimination on the basis of body size. (There are a few local governments, such as Santa Cruz, California and the District of Columbia, that do legislate against height and weight discrimination.) Antagonism toward the development of legislation barring fat discrimination resides on a number of fronts. Unlike sex, race, and national origin, fatness is seen by most as a mutable condition which one chooses, despite the fact that dieting and other weight loss measures have been shown over and again to fail. Unlike religion, which presumably one should not *have* to change though one can, at least in the United States, fatness is seen as something that one would be crazy to want to hold on to. In other words, one can't expect a Catholic or Jew to want, or to have, to convert, but one of course would expect a fat person to *want* to become thin and to be *working toward* that end. Fat stigma, then, legitimates the discrimination.

Employment is not the only arena in which Fat Studies scholars have identified discrimination. Sociologists, political scientists, economists, psychologists, and legal studies scholars have documented the discrimination that fat people experience in health care (both

physical and mental), education, housing, and legal arenas. One of the most pressing and alarming areas of concern to Fat Studies scholars relates to the rights of parents and children, as the legal system is increasingly willing to terminate the custodial rights of fat children, arguing that parents are at best negligent, at worst abusive, if they “allow” their children to be fat (Solovay, 2000, pgs. 64-77). Other scholars look at what appear to be less glaring areas of discrimination, but that nevertheless shape and hurt the lives of fat people. One excellent example of this type of research regarding access issues is that of Ashley Hetrick and Derek Attig, who in their poignant essay that begins “Desks hurt”, point out the ways that small desks discipline and humiliate fat students (forthcoming 2008). Taken together, the scholarship on discrimination against fat people is key for understanding the ways that *the life chances of fat people are limited,* not because of medical problems, but because of the differential and unfair treatment that they receive.

HEALTH at EVERY SIZE

Many Fat Studies scholars are part of the “Health at Every Size” movement, which provides a new paradigm for health care practitioners and public policy makers. The Health at Every Size movement shifts our perspective from “How do we make fat people thin?” to “How do we make fat people healthy?” They first point to the myriad studies (Cogan and Ernsberger, 1999; Berg, 1999; Cogan, 1999; Gaesser, 1996; Campos, 2001) that indicate that fatness is not particularly malleable. That is, dieting might cause a short term decrease in weight, but eventually the weight will be regained. Overtime, the fat person remains fat, or becomes fatter. They emphasize the numbers of studies that suggest that dieting itself creates a biological reaction among many people that create food cravings, binge eating, and a slower metabolism, and that over time will generally result in a fatter body. They challenge the “assumed” relationship between weight loss and decreased mortality, pointing out that no studies have actually shown that fat people who lose weight will necessarily live longer than fat people who stay the same weight. And, most specifically, they stress the ways that medical studies showing the dangers of a sedentary lifestyle and eating junk food are misinterpreted, so that headlines

scream out the "dangers of obesity" and the "need to lose weight" when the studies really showed the need to exercise and eat well, both of which may or may not actually result in weight loss.

Health at Every Size advocates point to a recent two year study completed by nutrition researchers at the University of California, Davis, to support their perspective. Published in the the *Journal of the American Dietetic Association*, and funded by the National Institutes of Health, the U.S. Dept of Agriculture, and the National Science Foundation, the study (Bacon et al, 2005) included 78 fat women, half of whom were assigned to a dieting group and half to a non dieting, "Health at Any Size" group. The dieting group was counseled to restrict their calories and to increase their exercise, and was offered the option of support groups for weight loss. The non dieting group was given information on healthy food choices, but were also encouraged to "let go" of eating restrictions, and, instead, to pay close attention to bodily cues on how eating made them feel, when they were full, when they were hungry, and so on. They also took part in a fat acceptance support group, in which participants discussed the discrimination they faced, and were encouraged to increase their self esteem and fight the barriers that prevented them from participating in physical activity.

The results of the study were rather remarkable. The dieting group initially lost weight, but by the end of two years, had regained it all, their cholesterol levels remained the same, and their blood pressure, while showing a temporary improvement, had returned to baseline by the end of the study. Almost half of the dieting group dropped out of the study by the end of the first year. Depression levels among the dieting group dropped with the temporary weight loss, but then skyrocketed with the weight regain. Self-esteem levels plummeted among the dieting group. In contrast, the non-dieting group *never lost any weight*. For those in the medical profession who emphasize weight loss and certainly from the perspective of those in the weight loss industry, the non-dieters had failed. But by other medical measures they were far more successful. Unlike the 42% of the dieters who dropped out of the two year study, almost all (92%) of the non-dieters stuck with the program for two years. The non-dieters *quadrupled* their levels of moderate physical activity, in contrast to the dieters, who initially increased their exercise levels but then returned to their pre-study levels. The non-dieters sustained their decrease in blood pressure

throughout the two year period, showing a marked decrease in "bad" cholesterol and a marked increase in "good" cholesterol levels. Depression had decreased and self-esteem increased among the non-dieters as well. In conclusion, non-dieters, who were encouraged to pay attention to their bodies, to stop restricting calories, to fight the discrimination they experienced as fat people and to *enjoy* their bodies through physical movement and eating well showed significant health improvements. But, and this is the key point, they never became thin.

For those who are fixated on the "thin equals healthy" equation, this study, and others that have shown similar findings, might cause some surprise. Cultural stigma surrounding fatness might even cause them to ignore the findings. A telling example of the way that fat stigma affects physicians' perceptions was published in the letters section of *Time* magazine. In response to an article on the Center for Disease Control study that challenged the correlation between fatness and mortality, Amir Mehran (2005), a surgeon from UCLA responded,

> In "Is It O.K. to Be Pudgy", you reported that a new study from the CDC concluded that people who are overweight but not obese are at no greater risk of dying prematurely than those of normal weight. You also reported the views of the food industry-sponsored group Center for Consumer Freedom (CCF) which says there is no obesity problem and it is all hype. The American public does not need the CDC, the CCF or anybody else to tell them what to think. Just spend a few weekends observing the crowds at amusement parks, the local zoo, or other popular spots. The obesity problem is glaring. If you don't believe your own eyes, ask foreigners visiting our country what they notice most about us.

What is so striking about Mehran's comments is that he focuses on the *existence* of fat people as evidence of the *problem* of obesity. For him, fat people *are* the problem. The *Time* article in question never challenged the numbers of fat people who live in the United States, just the consequences of that fatness. Mehran could not see this distinction clearly, however, because for him, the fat body is the problem itself. He has confused an aesthetic preference for thin bodies with a "scientific" knowledge that a fat body is diseased.

Health at Every Size advocates ask whether fat people would experience as many medical problems if they were treated with dignity rather than discrimination and stigma. In other words, how many of the medical problems they face relate to the stress of living in a hostile world? They point out that the “war on fat” often translates into a “war on fat people.” As physician James Levine said, “Obese people are so stigmatized that even some doctors, perhaps unconsciously, withdraw from them” Levine further said that for many of his fat patients, he was the first doctor to actually shake their hand or examine them. (Grady, 2005, pgs. D1-6). Many fat people find themselves avoiding the doctor for fear of “scoldings” or other humiliations, or because they think it is futile to seek treatment from doctors like Mehran.

Those working within the Health at Every Size paradigm find especially troubling the increasing rate of bariatric surgery, a radical procedure in which surgeons completely reroute and damage the complex digestive system in order to induce weight loss. In 1992, the American Society for Bariatric Surgery estimated that physicians performed 16,200 weight loss surgeries. In 2003, the ASBS reported 103,200 weight loss surgeries; by 2004 that number had jumped phenomenally to 140,640 procedures, with an average cost of $25-$50,000 per procedure (Gawande, 2001, pgs. 66-75).

Interestingly, physicians first recognized extreme weight loss as a dangerous “side effect” of intestinal and stomach surgery performed to treat cancer and other diseases; by the 1950s, some physicians began to practice stomach and intestinal surgery in order to create this “side effect” of weight loss as a “primary effect” to treat their obese patients (Flancbaum, 2001, p. 35). Today, organizations like the American Obesity Association suggest bariatric surgery as the treatment of choice for individuals who are at least 100 pounds “overweight” or have a BMI of greater than 35 with “co morbidities” or have a BMI of greater than 40 (*Physician’s Guide, p. 28).*

The advertisements for weight loss surgery suggest that the surgery itself somehow magically induces weight loss. As the surgeons (Mason, n.d.; American Obesity Association, n.d.; Mayo Clinic Staff, n.d.) themselves disclose, however, weight loss surgery is not magical, but works either by reducing the possibility of food intake—what is popularly known as “stomach stapling” or vertical banded gastroplasty—or by radically changing and decreasing the body’s

ability to digest food, nutrients and calories through a rerouting of the body's intestinal system, what is known as gastric bypass surgery. In the patient who undergoes gastric bypass surgery, weight loss occurs both because of volume restriction and malabsorption. The advertising literature for bariatric surgery describes patients' "change in appetite," which is actually a change in eating behavior that is enforced by severe physical limitation in the ways the body can tolerate certain foods. The redesigned intestinal system no longer has the valve that shunts sugary foods slowly into the small intestine so that the body can moderate sugar and insulin levels. As a result, sugary and fatty foods cause what is commonly known as the "dumping syndrome." The person will experience severe diarrhea, nausea, chills, and exhaustion if they eat too many sugars or fats. Weight loss surgery, then, forces patients to "diet" and provides a built-in and severe physical punishment for going "off the diet."

Health at Every Size advocates acknowledge that most people who undergo weight loss surgery lose weight. They point out, however, that the improvements patients see in blood pressure, glucose levels, cholesterol, and osteoarthritis can also be achieved through exercise and healthy eating, such as those in the UC-Davis study. They also point out that the severe complications faced by those who undergo weight loss surgery are underestimated as are the number who regain the weight. Depending on the statistics one looks at, either one out of 100 or one out of 200 people will die on the operating table for weight loss surgery. Iron, calcium, vitamin D and vitamin B-12 deficiencies will be lifelong, and will likely cause problems such as anemia and osteoporosis. Patients are likely to suffer from gallstones, bleeding ulcer, and possibly a narrowing of the surgically reshaped opening from the stomach to the small intestine. About 10-20% of all patients will need follow-up surgeries to correct that narrowing or the more frequent and potentially fatal leaking and bleeding from the stomach and intestines. Ironically, while many women choose to undergo weight loss surgery to increase their fertility rates, the quick weight loss and the severe nutritional deficiencies can cause significant harm to a developing fetus. Daily life is difficult for people who have undergone weight loss surgery, with the risk of "shunting" (the diarrhea, shakiness, and nausea that happen if one eats even a bit too much sugar or fatty food), flatulence, and anal leakage a constant concern. They also point out

the lack of clearly documented evidence about the long term prognosis for these patients, including weight loss after a five year period, a clear articulation of the health problems created by the surgery, and firm evidence that the surgery actually improves mortality rates.

Health at Every Size advocates point out that the rationale for weight loss surgery is as much about “culture” as it is about health. That is, experts acknowledge that modest changes in diet and exercise will improve a patient’s health, but will not necessarily make the patient *look* healthier, i.e. thinner. In a culture permeated by fat stigma, a thinner body provides the illusion of health, despite the fact that the person who has undergone weight loss surgery now has a massively debilitated digestive system and will experience lifelong chronic malnutrition and digestive problems, as well as uncertainty about how the surgically malformed body will be able to withstand the processes of aging. Considering these issues, weight loss surgery is especially problematic for children, one of the fastest growing segments of the weight loss surgery clientele. As an Associated Press article explained in 2002, “[W]ith childhood obesity reaching pandemic proportions, some families and their doctors see it as the only effective solution.” One doctor, who has operated on patients as young as 13, praised the surgery, saying, “Their life is turned around from being ridiculed at school to living a normal child’s life” (Tanner, 2002, p. A1). The reference to a “normal” childhood is indeed extraordinary, as it’s far from normal to have a body that can no longer digest calcium at a time of peak bone formation and to be exposed to a lifetime of malnutrition and its accompanying diseases. Gastric bypass surgery, creating the permanent malformation of the digestive tract, is an extraordinary measure to take on young people, before they are the age of consent, on the basis of fighting childhood ridicule. Indeed, it’s notable that the article presumes it’s “natural” that fat kids are teased and mocked; no where does the article suggest that the problem may reside in the kids who are doing the bullying. Those working within the Health at Every Size paradigm would ask that we treat the fat child with dignity; this would mean protesting childhood bullying and encouraging psychological and physical health in the child without resorting to debilitating and mutilating surgery.

CONCLUSION:

Fat Studies provides those who are concerned about health with an alternative perspective and medical paradigm to that which is offered by conventional medical and public policy. It asks us to consider the cultural and social meanings of fatness and how these meanings—particularly the stigma whose roots I investigate in my forthcoming *Fat Shame*--infiltrate our apparently "objective" health practices. Students who are interested in learning more about Fat Studies would do well to investigate the research of one of the first fat activist organizations, the National Association to Advance Fat Acceptance, the theoretical and cultural work such as that published in *Bodies Out of Bounds* (2001), the medical research by scholars such as Paul Campos in *The Obesity Myth* (2004) or Glenn Gaesser's *Big Fat Lies* (1996) , or the comprehensive set of essays published in Esther Rothblum and Sondra Solovay's forthcoming reader, *Fat Studies* (2008).

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