

5. Dangers of Weight-Centric Health Paradigm

The weight-centric paradigm, and its myopic focus on shrinking the bodies of higher-weight people, harms higher-weight people, and people of all sizes, in myriad ways.

1. Health (and overall) Discrimination and Disparities Due to the Weight-Centric Paradigm

A. Disengagement for healthcare and self-care: When higher-weight people are given the message - early, often, and by everyone from family and friends to doctors - that their bodies are wrong and that their existence constitutes a “dangerous epidemic” that must be eradicated, it can lead to internalized oppression. As a result of healthism, as higher-weight people absorb incessant negative messages that encourage them to place individual blame on themselves, they start to agree that their bodies are bad, wrong, and unworthy of care or love.

When patients experience weight stigma and fat-shaming from their healthcare providers, when no matter why they are going to the doctor they know that they will be getting a lecture about their weight (often to the exclusion of whatever they actually made the appointment to discuss,) they begin to avoid healthcare. This causes missed preventative care, screenings, and early disease interventions.

B. Structural bias: Structural bias occurs when the things that higher-weight people need or want in order to fully participate in the world, including healthcare, either don't exist in ways that accommodate them, or don't exist in the spaces in which an individual needs them. In healthcare this can mean a lack of sturdy armless chairs, properly sized gowns, blood pressure cuffs, surgical tools, imaging equipment, and durable medical equipment. It is also a lack of research that includes higher-weight people, meaning that the tools, best practices and pharmacotherapies that are developed from the research are not tested on higher-weight people. Beyond healthcare, structural bias includes a wide variety of accommodation failures including restaurants, theaters, amusement parks, public and private transportation, and more that fail to accommodate higher-weight people (or are significantly more expensive) which interferes with their equal access to the world. Further, higher-weight people often find themselves blamed for their own lack of accommodation, for example being told “You are too

big for the MRI” rather than “The MRI fails to accommodate you.”

C. Healthcare provider weight distraction: When healthcare providers’ education is steeped in the weight-centric paradigm it can cause them to see their higher-weight patients as walking, talking pathologies, or “ticking time bombs”. This can lead to them telling higher-weight patients to try to lose weight to solve current or imagined future health problems, rather than giving them the ethical, evidence-based interventions that are recommended to thinner people with the same health issues. This can lead to thin people beginning treatment the day of their appointment, while higher-weight people’s treatment is delayed indefinitely while they try to lose weight to solve a health problem that people who weigh less than they do also get. The weight-centric paradigm in healthcare can be fatal to higher-weight people as in the case of [Ellen Maude Bennet](#) who went to multiple doctors over multiple years and was only ever told to lose weight to feel better. When a doctor finally took her seriously her cancer was so advanced that she had only days to live.

D. Weight cycling: In the weight-centric paradigm, weight loss attempts are recommended to higher-weight people. A century of research has told us that the most common outcome of these weight loss attempts are weight cycling, losing weight short term and regaining it long-term. Weight cycling is not benign, it is independently linked to negative health impacts including increased inflammation, cardiovascular risk, and overall mortality. In fact, [Bacon and Aphramor](#) found that “Weight cycling can account for all of the excess mortality associated with obesity in both the Framingham Heart Study and the National Health and Nutrition Examination Survey (NHANES).”

E. The hypothetical future thin person fallacy: The weight-centric paradigm claims that fat people can become thin people. In addition to this claim not being supported by evidence, it created untold harm by treating higher-weight people not as valid humans who deserve equal access to the world (including healthcare,) but, rather, as potential future thin people who can have equal access if, and only if, they become thin. This can cause everything from a lack of interest in improving healthcare practice for higher-weight people to the denial of life-changing and even life-saving surgeries for example joint surgeries, spinal surgeries, and reproductive care such as hysterectomies and IVF. For example, higher-weight trans and non-binary people are routinely denied gender affirming surgeries on the basis of BMI.⁸ In essence, these practices hold patients’ healthcare hostage for a weight loss ransom that most will not be able to pay.

F. Poor Research Methodology: The research around weight and health is characterized by consistent issues. The first is naming higher-weight as the “risk factor” without mentioning, let alone controlling for, confounding variables including [weight stigma](#) and [weight cycling](#). Both of these factors are correlated to the same health issues that get blamed on being higher-weight, including high blood pressure, Type 2 diabetes, and depression. Conversely, most people who begin weight loss attempts make behavior changes. They typically lose weight short term but gain it back long-term. Often they experience improved health. Any health improvements tend to be credited to the (small, simultaneous, and

temporary) weight loss, ignoring the behavior changes that preceded both the weight loss and the health changes. [Research finds](#) that it's more likely the behavior changes, not the weight loss, that create the health changes that are associated with weight loss attempts.

G. Adding insult to (sometimes literal) injury: One of the most dangerous aspects of the weight-centric paradigm is that it creates all of the harms we've listed (and more) but then blames the negative impacts on body size. In this way it creates a vicious cycle wherein it creates weight stigma, weight cycling, and inequalities, then it blames higher-weight bodies for the negative impacts of the things it creates, then it uses those negative impacts to justify additional weight stigma, weight cycling, and inequalities.

H. Incidents of medical weight stigma are neither [rare, nor benign](#). A recent article in *Cosmopolitan* drew this into [sharp relief](#). Moreover, it is important to recognize that weight stigma intersects with medical misogyny, racism, transphobia, and ableism. Many lower-weight people experience barriers to healthcare as a result of other stigmas. However, when these diverse stigmas interact they can produce deadly effects, particularly for fat queer disabled people of color.

2. Case Study of COVID

Weight stigma is rooted in and inextricable from racism and anti-Blackness and as such, it does disproportionate harm to higher-weight People of Color. One example of this could be found in care rationing protocols for COVID-19 which were successfully changed via community action in California. The [California Crisis Care Coalition](#) was an intersectional working group which included disabled activists, anti-racist activists, and fat activists to change California's care rationing recommendations and closed backdoors to medical racism. This coalitional work not only successfully defeated harmful policies but built the steps for longer lasting intersectional community-based work.

Care rationing protocols provide the criteria by which healthcare facilities decide who will get care in the event of a shortage of staff and/or resources. In addition to directly discriminating against disabled people, the protocols may also use Body Mass Index (BMI) as one of the criteria by which they triage care. When high BMI, irrespective of meeting other care rationing criteria, is used to limit access to care, higher-weight people, are turned away from hospitals in the midst of a life and death situation. The racist origins of BMI mean that more Black and Latinx people have high BMIs, and thus higher-weight Black and Latinx populations are disproportionately affected by crisis care protocols which use BMI. In this way, regardless of intention, size based discrimination can become a proxy for racial discrimination, which would otherwise be prohibited. Disability activist, [Alice Wong](#), identified care rationing protocols as a form of eugenics which indicate it "isn't a relic from World War II; it's alive today, embedded in our culture, policies, and practices." The California coalition showed that this can be changed.

Consider also the ways in which research impacts outcomes. Both higher-weight people and People of Color have been drastically under-represented in healthcare research. This has led to a healthcare system largely created by and for thin, white people in ways that harm higher-weight people, People of Color and even more disproportionately, higher-weight People of Color. One example of this is pulse oximeters. These are the devices that go on the tip of your finger to measure heart rate and blood oxygen saturation. For COVID cases, blood oxygen saturation was often used to determine if a patient should be admitted to the hospital, or sent home. Pulse oximeters were created using white skin. When used on a patient with darker skin they will show an artificially elevated number. [This meant that people with darker skin who should have been admitted were sent home](#). This issue had been [known since at least 1976](#) but no effort had been made to correct it. So even if a higher-weight Person of Color wasn't denied care because of their BMI, they might still be denied care because of the racism inherent in medical equipment. Even if that patient was admitted, they are still being cared for in a healthcare system that was developed using research that largely excluded them. Further, they are likely to experience structural oppression, weight stigma, and racism that could impact their outcomes. In the event of a negative outcome, they will likely find that their race and weight are blamed, rather than the racism and weight stigma they experienced.

3. Eating Disorders

Given the significant overlap between symptoms of eating disorders and recommendations and side effects of weight loss interventions, it is not surprising that the weight-centric paradigm can drive disordered eating and eating disorders. Research finds that 5% of those considered "normal dieters" progress to pathological dieting. Of those, 20-25% progress to partial or full-syndrome eating disorder. Other studies have found that adolescents who diet at a "moderate level" are five times more likely to develop an eating disorder, while those who diet at a "severe" level are 18 times more likely to develop an eating disorder. As psychologist and fat activist Deb Burgard, PhD, FAED [has explained](#), the weight-centric paradigm prescribes to higher-weight people that which it diagnoses and treats as eating disordered in thin people.

Here, too, we see disparities based on weight, race, and gender. Even though data suggests that a very small percentage ([estimated at 6%](#)) of people with eating disorders are medically "underweight," higher weight people with eating disorders are exponentially more likely to be encouraged to engage in eating disorder behaviors (calorie or food restriction, over-exercise, etc) in order to lose weight than to be screened for an eating disorder by their doctors. Data also shows racial disparities, for example, [one study](#) showed only 17% of Black women, 41% of Latina women, and 44% of white women are accurately diagnosed by doctors when presenting with an eating disorder. Trans and Non-Binary people also experience eating disorders at higher rates than their cisgender peers. One study found that eating disorders in the previous year were reported by almost 16% of trans students surveyed, with 1.85% of cisgender heterosexual women, 3.52% of cisgender queer women, 2.06% of cisgender queer men, and less than 1% of cisgender heterosexual men reporting an eating disorder diagnosis within that timeframe. This makes the odds of getting appropriate care astronomically low for those at the intersection of these

misdiagnosed identities. This is also an issue for all ages as a recent article in [The Journal of Pediatrics](#) noted, there is an “alarming” rise in the rates of eating disorders among children and adolescents.

For those of all sizes and all ages who are struggling with disordered eating and eating disorders, the weight-centric paradigm can not only drive their eating disorder, but it can make full recovery impossible. It’s difficult to focus on your recovery and let your body size settle where it does naturally when the world is telling you that being thin, often by any means necessary, is the most important thing. It can be impossible to let go of your fear of being fat/gaining weight/having an “imperfect” body if you can plainly see that you live in a culture where your fear is absolutely justified.

In a weight-centric paradigm, rife with diet culture, and weight stigma, where higher-weight bodies are villainized and being terrified of being or becoming fat or gaining weight is normalized, eating disorders are an unavoidable outcome.

8. <https://dashaunharrison.com/shop/belly-of-the-beast/>