# Transcript: Fatphobia in Public Health and Dietetics, What Dietitians Need to Know with Marquisele (Mikey) Mercedes and Monica Kriete, MPH

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**Vincci**: Okay, well welcome everyone, and thank you so much for taking the time out of your day to come to our presentation today. My name is Vincci Tsui, and I'm the founder of Weight Inclusive Dietitians in Canada. And yes, welcome to the Fatphobia in Public Health and Dietetics: What Dietitians Need to Know Webinar, with Marquisele Mercedes and Monica Kriete.

Just a few housekeeping things: if you can all just leave yourselves on mute. It's okay if you want to turn on your video but we just want the audio to work okay so if everybody could be on mute, that would be ideal.

And if it's okay for me to just start with a bit of a land acknowledgement. So I want to acknowledge that most of us gathered here today are settlers on the traditional lands of a number of different Indigenous peoples. I personally am calling in today from Treaty 7 territory, which are the traditional territories of the Niitsitapi, or Blackfoot Confederacy, which consists of the Siksika, Pikani, and Kainai peoples, the Tsuu T'ina and the Iyahe Nakoda, which consists of the Bearspaw, Chininki and Wesley First Nations. This area is also home to the Metis Nation of Alberta Region 3.

And just to introduce our speakers, although I think they probably don't need an introduction: So, Marquisele, or "Mikey" Mercedes, her pronouns are she/her, is a fat liberationist writer, creator and doctoral student from the Bronx. As a presidential fellow at the Brown University School of Public Health, her work broadly focuses on how fatphobia, racism, and anti-Blackness has shaped healthcare research, promotion, and training. She is passionate about using public scholarship in various mediums to make science and research more accessible to those outside of

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academic institutions and make the world safer for fat people of colour. Her ultimate goal is to push the field of public health in alignment with the values of longtime movements for liberation and abolition. Most recently, she was nominated as an inaugural junior fellow for the New Centre for Fat Liberation and Scholarship.

And Monica Kriete is a researcher and consultant from Central Pennsylvania, dedicated to challenging weight stigma in healthcare and public health. Monica completed her MPH at the Harvard T. H. Chan School of Public Health, where her work in social epidemiology and health communication classes focussed on reframing weight stigma, not weight as a public health problem. As principal of Fatty MPH, LLC, Monia works with researchers to design and conduct studies of medical fatphobia and produces educational content geared toward health professionals, students and early career clinicians.

I'm totally excited to have them both presenting today, and I'll let them take it away.

**Mikey**: Hi everyone. I'm Mikey.

**Monica**: And I'm Monica.

**Mikey**: And we've prepared a presentation today and you know, it's…what is the word for that? Just like, it winds a lot. There's a lot of twists and turns, so strap in, you're gonna enjoy it, it's gonna be great. And I'll start by reading over the agenda we prepared that pretty much provides a basic breakdown of what we're going to cover, and then I'll let Monica take it away. Oh, whoa, what is that? Okay, here we go.

So, we will start by covering general definitions for public health, and the sort of mainstream mind, and then we'll be doing a reframing of public health and dietetics using a critical framework that is inspired by fat liberation principles. And then we'll be moving into understanding the consequences of the weight normative paradigm for dietetics and dietitians, looking at how the weight normative paradigm and also the critical framework that we're going to present sort of presents itself still. And then we'll move into concrete actions that dietitians can take to intervene on anti-fatness, either in their practice or beyond. So, and then we'll move onto question

and answer. So if you have any questions, save them for the end. And with that I will let Monica take it away.

**Monica**: Okay, so we are going to start by talking about, very broadly, what is public health and what is dietetics and how are the two related. Yes. So, in my introductory public health education, we began with a commonly used metaphor in public health, and this is one telling of it here on the slide, that I'm just gonna read it out:

*My friend, Irving Zola, related the story of a physician trying to explain the dilemmas of the modern practice of medicine:*

> "You know", he said, "sometimes it feels like this. There I am standing by the shore of a swiftly flowing river and I hear the cry of a drawing man. So I jump into the river, put my arms around him, pull him to shore and apply artificial respiration. Just when he begins to breathe, another cry for help. So back in the river again, reaching, pulling, applying, breathing then another yell. Again and again, without end, goes the sequence. You know, I am so busy jumping in, pulling them to shore, applying artificial respiration, that I have no time to see who the hell is upstream pushing them all in."

And that river metaphor is used a lot in public health, to understand what is public health, so the idea is that public health is the people looking upstream. We use it to understand the ideas of primary, secondary, and tertiary prevention, so that is: primary prevention is preventing a problem altogether or reducing its incidents as in vaccination. Secondary prevention is detecting a problem before clinical signs and symptoms arise, to minimise the actual impact on the person, as with a pap test that detects cervical cancer before you notice anything is wrong. And then tertiary prevention is preventing death or other so-called poor outcomes.

And so, depending on where you look, you might find a definition of public health that includes things like monitoring illness, making changes to the environment, and disseminating information, but these categories of prevention and the competing definitions of public health offered by various agencies and nonprofits obscure broader questions about who decides an outcome is preventable, and how we decide an outcome is worth preventing. That's like a whole different talk, but these

are just the unspoken questions that kind of drive the practice of public health. In other words, public health is inherently political, but public health practitioners as a whole are presently not doing a great job of understanding and embracing that, and imparting it to the next generation of practitioners.

And like, in retrospect, it's kind of suspicious to start an introduction to a scientific field with a metaphor, right? So to me, it speaks to not fully understanding and grappling with the oppression and especially the racism in the systems that we inherited and continue to maintain.

So, to return to the river metaphor, who is falling in the river? What is this river? How did we all get here? What happens when you go upstream and you start building a bridge and somebody else comes in and like, attacks you? Because that's a thing that happens, certainly in the way we practise public health now, right? Like if we're looking at what is happening with Covid, there is a tonne of political opposition to what we consider basic public health interventions.
So getting back to the point, what I have come to understand is that public health happens where eugenics meets infrastructure. And that's happening under surveillance and with the data provided by surveillance. So, here we have a diagram showing basically that like, there's a Venn diagram right and public health is at the intersection of infrastructure and eugenics under surveillance. Mikey did you have something to add here?

**Mikey**: Yeah. So this figure is...it's a way of representing not only what influences public health actions and planning, but it's the essence of public health work in relation to its origins. So when we're having discussions about what public health is or how to define it, and we ignore historical roots, and we ignore its start as a science or practice of oppression, then we're actually attempting to maintain public health's false image as an altruistic field. If you're trying to define or reform, or change public health, without acknowledging its long tradition of violence, then you're ignoring most of the picture.

And this gets back to, I think, the utility of using a metaphor as an introduction to the field. When you're unwilling to grapple with major influences that inevitably they really highlight sort of the morally grey or morally bad stakes of what you're doing,

then you're more likely to use language and metaphors that obscure the actual goals of, like, actions like certain public health policies like certain public health interventions. And so, we'll dive into a little bit of what each of these mean in the context of public health, and then we'll talk a little bit about anti-fatness in relation to these constructs.

**Monica**: So infrastructure has kind of always been at the heart of public health, right? If you think back to the upstream metaphor, you could build a bridge, right, you could build a railing to keep people from falling in. Historically, we're often taught that the "father of epidemiology", quote/unquote, was John Snow, who ventured into a poor neighbourhood in Victorian London to investigate a cholera outbreak. By collecting data on various patients and observing their daily practices, Snow eventually traced the diseases spread to a water pump in the centre of the neighbourhood. He famously removed the handle, so that people could no longer access the tainted water, and London was saved or something.

**Mikey**: It's all very heroic.

**Monica**: It's all very heroic–

**Mikey**: And convenient.
**Monica**: Yes, it's all very 1850s, except that according to historian Jim Downs, and his new book *Maladies of Empire* – everybody go get it – the first epidemiologists were actually the doctors who served on slave ships in colonial regimes and throughout the Empire. So in 1783 and 1784, like, a lifetime before John Snow, physician Thomas Trotter was assigned to oversee the health conditions aboard the Brooks, a slave ship that transported captive Africans to the Caribbean and southern United States. That's the picture. In the historical example, you can see that there's not a lot of space for people. And Dr. Trotter detected and cured an outbreak of scurvy among the people he was helping to hold captive, but he didn't do anything about the space issues.

And in contemporary day to day life, infrastructure really shapes the choices that we can make, right? Infrastructure, the definition here, from Merriam Webster is "the basic definition of basic equipment and structures such as roads and bridges that

are needed for a country, region or organisation to function properly". I did a little crowdsourcing on Twitter this morning, 'cause the thing about infrastructure is that like, everybody knows what it is but nobody really can name it, and we put together the idea of a collaboratively developed systems and policies that determine what choices are available to individuals. And so, where the bus goes, how often the bus comes, but also how big are the seats on the bus? Who made that choice?

**Mikey**: What goes into the social construction of what an average size seat is?

**Monica**: Right. Right. And it's, you know, some of these things public health is willing to embrace as part of its practice, like looking at when the bus comes or where it goes, but other parts it's really totally unwilling to grapple with. Like, who decides the average seat size or like, who decided that there's exactly one, you know, room for like, exactly one or two wheelchairs on a bus? You know? Like, all choices. All choices.

**Mikey**: And then getting to eugenics, the definition that I've provided here: "a population level, prevention focused approach to health that aims to create a better populace by suppressing, removing or changing undesirable problem groups, for example racial ethnic minorities, disabled people, poor people, fat people, via police power, policies, and interventions varying and scale".

So, I think it's important to orient ourselves with this specific definition of eugenics, because there's this enduring idea that eugenics is really just about like CRISPR and gene editing. Or in the case of the Holocaust, just like, outright murder. But there's actually a lot more nuances to how it exists and operates. Public health and eugenics actually matured simultaneously in the 1800s and beyond then, and leaders in both fields, shared a real passion for prevention based methods that promoted health outside of the confines of the hospital or the doctor's office. Both fields held that halting disease spread by prevention was more efficient than working to discover a cure to apply person by person. To the public health community, a vaccine, for example, would prevent disease in a way that was better than a medicine to treat disease and that's because of the different layers of prevention that we discussed earlier.

Eugenicists, similarly, considered expenditures on hospitals and asylums to care for the ill to be less efficient than controlling reproduction among those who they thought were likely to have kids who would populate institutions like hospitals and asylums. Eugenicists also promoted the idea that crime, poverty, disease, and the suffering they generated could be eradicated. Along with the notion that as social quality improved, the burden of taxes paid to combat negative conditions could be diminished. And they often took what was a, at the time, extremely normal public health approach to those issues. Like segregating people from the general population and isolating them in institutions so that they couldn't spread disease or breed.

And it's just important to recognize that, because I think that in line with this, these constant attempts to uphold the idea that public health is a purely altruistic endeavour that's like, constantly hampered by funding shortages and good intentioned people who like, can't do the work they want to do. It's like, no, it's more complicated than that. There are plenty of people who believe it is fully good and justified to create programming, interventions, policies, obstacles for people who are marginalised, to have to deal with, so that they can't live their lives and they can't, like, reproduce and become more and more present in our populations.

Fun fact: the guy who coined the term eugenics in 1883, Francis Galton, was a pioneer in the field of biostatistics. So that's a field of public health that's specifically, exclusively focused on using statistical methods to study and analyse health related issues and so yeah, eugenics, public health, they're very tight. Yeah.

**Monica**: Besties!

**Mikey**: Yeah. [laughs] Besties. So the top image over here, the historical example. That's a political cartoon about the Chinese Exclusion Act. The Chinese Exclusion Act in 1882, essentially, placed a moratorium on the immigration of Chinese workers, and it did that for a 10 year period. There was a provision that was renewed in 1892. It was made permanent 1902 and then it wasn't rescinded until 1943. So, the 1882 Act also denied the possibility of US citizenship to resident Chinese immigrants. And so this act was only possible because of the work of California public health authorities at

the time. And that's something that's often not mentioned, because again, constantly trying to uphold the image of public health as a purely altruistic area of practice.

There was a concerted effort on behalf of California public health departments to promote the idea that Chinese immigrants were diseased. And we can actually see the modern repercussions of this idea in conversations about Covid, especially like all of the ways that terms like “yellow peril” have been brought back and used without a single idea of how those terms actually originated.

There was, at the time, in the 1800s there was an increase of Chinese migration that coincided with basically the the rise of public health as a prominent urban institution in the US, and as early as, like, 20 years before the Act, there was very specific concentrated efforts to study Chinese immigrants in relation to certain health outcomes. There were studies like, that had titles like *Chinese immigration and the physiological causes of the decay of the nation*, and those were like, normal titles. And there were also other racist works that helped promote the idea that the Chinese were responsible for the spread of numerous diseases, like smallpox leprosy, that were common at the time. And because of the work of public health officials, specifically in Los Angeles and San Francisco, white people across the country were both bolstered in the racism and they began to specifically perceive Chinese immigrants as characters of disease. In LA and San Francisco, by the 1870s, officials in the county and city health departments had built up enough credibility to essentially say that being Chinese was equivalent to being dirty, depraved and disease ridden.And these stereotypes in turn justified segregating Chinese people so that they wouldn't taint white city residents, or it was believed that Chinese immigrants could also ruin the air, water, climate and soil of white neighbourhoods.

And so, they essentially forced Chinese residents into what will be the first Chinatown, as a short term “solution” – quote/unquote “solution” to this issue, while they also built enough authority and resources and political power to advocate for quote/unquote “longer term fixes”, like tighter controls over immigration, stronger municipal codes that would prevent Chinese immigrants from working, living, or moving anywhere. And it was also how they set the stage for the Chinese Exclusion Act in 1882. A few years before that, Congress passed the Page Law, which limited

the number of Chinese women being granted entry to the US, and then seven years later they were able to pass the Exclusion Act that curtailed all Chinese migration. And it's telling that the first law, Page Law, that they really managed to get past, was specifically targeting Chinese mothers who were seen as not only like the carriers have a quote/unquote "inferior" or "diseased" race, but they were also highly criticised for child rearing practices like how they fed their kids. So, Just an example of how dietetics and public health authorities sort of work together to to further, essentially, racism.

And then the picture on the bottom, for the contemporary example, is of Kelli Dylan, who, she was forcibly sterilised in a California prison while she was incarcerated in 2001 when she was 24 years old. As late as 2010, hundreds of incarcerated people were forcibly sterilised in California prisons, either without their knowledge. during other procedures, or they were coerced into doing so by physicians. One of the prison doctors actually told the Center for Investigative Reporting, – which helped with the broader investigation on the sterilisations once Kelli Dylan and her lawyer actually got the case started – this prison doctor said that he viewed sterilisation as a way to prevent prisoners from procreating and having unwanted children that would cost the state money.

And this was only possible because of long existing laws, specifically the Eugenics Order in California lasted from 1907 to like, 1943, I think. And by the time that these forced sterilisations happened, that law was done; it was repealed. But just because you repeal a policy that has existed for a very long time, and washed your hands of that very dark history, does not mean that people aren't going to act in the interest of quote/unquote "public health", which, a lot of the time, tends to amount to eugenics.

So, okay. With that. Let's move on to surveillance.

**Monica**: You were not kidding when you said you have  a lot to say.

**Mikey**: I told you [laughs].

**Monica**: So, surveillance. We have a definition: it's the ongoing monitoring of behaviour, activities and populations. And public health surveillance often has the

end result of maintaining concentration of power among hegemonic capitalistic entities and ensuring population fitness for labour. So, we track diseases ostensibly to manage outbreaks and keep them from happening, but actually, like everything else, public health surveillance is political.

So you might have heard the phrase, “what doesn't get measured doesn't get fixed”, but there is no corollary that things that get measured do get fixed. And we also see resistance to measurement when such measurement is politically inconvenient. So for instance, there was a serious pellagra outbreak in the United States, from the early 1900s to about 1940, and according to a Dr. Abbott, “political influences interfered and not only with surveillance as a disease but also in its study recognition of its cause and the institution of preventive measures, when they became known”.

So in other words, just because pellagra was hypothetically being surveilled, does not mean it was actually accurately being reported, and does not mean anybody was like, doing anything meaningful about it.

**Mikey**: Oh. I have something about pellagra.

**Monica**: Yeah, hit me!

**Mikey**: So, around the same time that Chinese immigrants were effectively being excluded from the country, and then the long lasting repercussions of that decades later, whatever, in LA, there was a pellagra outbreak, specifically in East LA, where it was majority Mexican immigrants that were living. And public health, and this is an example of how just because you measure something doesn't mean it's going to be intervened on. And that sometimes is fully dependent on whether or not the population who's suffering is seen as deserving of that intervention.

**Monica**: Exactly.

**Mikey**: Pellagra was a really, really, really big problem in East LA schools, which, of course, had majority Mexican students. And while pellagra in the rest of, like, students - specifically we're talking about white students – pellagra and white students was known, well known, undisputed, to be a result of whether it was just

like poverty and the inability to keep a steady diet, it was it was known to be a socially developed issue. But when public health authorities were investigating pellagra among Mexican children specifically, they acknowledged that it was likely that kids were just like, starving and we're not eating regularly. But then of course they couldn't restrain themselves from blaming Mexican parents for their kids starving, even though they were also starving.

And in official reports about pellagra in this, like, East Atlanta area, East Los Angeles – I don't know why I'm thinking of East Atlanta – East Los Angeles area, they wrote that "surely it was also the result of their parents withholding two or three vital diets diet foods" Like, they could not restrain themselves from blaming this outbreak, that was affecting everyone but predominantly the poorest that were in this community. They had to throw in that kick, for like, extra insult but okay. Monica, you go ahead. Sorry. That was my thing.

**Monica**: Yeah. Points are being made. Yeah that pellagra really ended, the outbreak really ended, when the United States in the early 1940s was like, oh, nobody's fit to go in the army - everybody's malnourished. I guess we better do some niacin supplementation. And that was how it ended, according to Sarah Tabor who is a very great and very knowledgeable farm person for you guys to follow on Twitter.

So, contemporarily speaking. we are surveilling BMI. Like, we only detect the things we're looking for. So, if we are surveilling the population's BMI to look for weight changes all we're going to find is we changes. And you know, the United States' CDC, does this, and publishes these reports where they're like, making assertions about how behaviour informs body weight change, but they didn't collect any actual data on behaviour. They're literally just drawing inferences and treating them as fact and like, it's made up.

The other thing that we don't surveil for is eating disorders, right? So like, we're doing all of this work like boogie boogie boogie fat people, and doing nothing about whether eating disorders are growing over time, and whether they're growing in response to fatphobic messages, which I'm sure they are, personally.

**Mikey**: Absolutely. I mean, and similarly, we don't systematically track, like, weight stigma, even though we go, there have been plenty of consensus statements, plenty of position papers, plenty of research done on weight stigma's existence, and yet there have been no systematic efforts to to collect data and to analyse that in a way that could lend itself to interventions for example, if we're working within like the frame of mind that if we have data, something's going to happen. Right? If we are working within that idea, then there has been no attempts to track weight stigma's existence, growth, how people have been exposed to it, on like, a large, like, national scale, like these kinds of studies that specifically exist to like, characterise a population, and draw conclusions.

So, yeah, just because something is important, doesn't mean it's going to be studied, just because something is studied, doesn't mean it's going to be intervened on. Yeah, and it's not only about what gets studied and measured it's about what doesn't, as well. So, yes. Okay, so let's move on.

**Monica**: So we have a little slide that just kind of brings anti fatness into the model and sort of how do we conceptualise anti fatness and public health, that surveillance has basically generated a moral panic about very, very mild changes in population body size distribution, in a way that overlooks the species level value of body diversity. And what I mean by that is that people get fat because they're not starving, you know what I mean? And I don't understand how you're in better health, if you starve a little, and like, your body can't tell the difference between a real famine and a diet. Like it's just, let's make our species less fit for evolutionary survival and then we'll be better somehow. Like that doesn't track to me. But the thin ideal that signals reproductive fitness under white supremacy, and I mean, Sabrina Strings' *Fearing The Black Body* is *the* text on whiteness and how those two things came to be linked.

Infrastructurally, fat people are sized out of participation in everyday life through things like the bus seats, and also through, like, a lack of clothing that's made in, like, the very largest sizes. And they're also sized out of getting good health care, like a lot of the time. Like, there is weight limits on exam tables and on, like, MRI and CT scanners, and all these kinds of things that are totally unnecessary. I mean that we basically have a two tiered system of healthcare that nobody acknowledges or talks about. And the end result is that public health treats fatness as a modifiable risk

factor for illness, despite a lack of compelling evidence and an abundance of critique of the evidence that we do have, right? An abundance of information about how the evidence we do have is low quality, and it intervenes accordingly.

The obesity prevention basically boils down to get rid of all the fat people. Like, it does. And that's what public health is trying to do right now. And it's gross and bad and not effective and makes people sad and angry and sick.

**Mikey**: Yeah, that just about sums it up. Um– yeah, no, I mean just just a small note on this: we included this specific slide because we wanted people to sort of see, like, …public health…no, let me fix that. Obesity prevention is not bad, just because of what it does to fat people, how it targets fat people, how it essentially provides a justification for the eradication of anyone who does not fit into a specific body ideal. Obesity prevention is bad, also, because it's one of those things that exists in public health that is just another one of the bad things that is in existence because of how public health is. Like it's not….in and of itself, it is bad. Obesity prevention, by itself, is horrible, because of its goal, because of its methods, because of how it insists on proceeding, regardless of potential and actually exercised harm, right? It's bad on all those fronts, but it's also evidence of how public health in its entirety is flawed because it comes from–

**Monica**: It's so messed up.

**Mikey**: It's so messed up, because it comes from a foundation that relies on eugenics infrastructure, under the influence of constant unwitting surveillance, and it's just one example of how public health works to both warp our sense of like what is good for our bodies, but also, like, draw divisions in the sand about who is worthy of, like, a good, happy life and who isn't. So yeah. Obesity prevention is bad because of what it is but also it's bound to be bad because of the tree it's like, growing out of. Public health at its core is pretty flawed and you know, the insistence on behalf of those who treat it again, like a purely an altruistic science, it's what's really getting in the way of making progress and moving on from this mess. [laughs] Like just like, this mess.

Okay. So, with that, we can move on to where dietetics fits into all of that. And let's talk about it. So dietetics is, as it says here: "it's a multi faceted science that focuses on how nutrition can be applied to promote health, but it is also a common vehicle for implicit and explicit scientifically driven anti fatness that uses racist logics to exact violence on those who do not meet hegemonic body ideals. That is to say that it is a science, and it is also a weapon of harm. So, and that's and that's the lens from which we want you to walk away, that we want you to examine the work you're involved in, from a critical perspective. For those of you who are dietitians, it is something that you trained for, it is something that you try to do good with, but it has also, historically, and is commonly, a weapon for harm.

And with that, we can talk about a historical example. So this is a quote from a book that I've already pulled a bunch of stuff from during this talk. It's *Fit to be Citizens*, by Natalie by Natalie Molina. She is a historian in the University of California system. It is a brilliant book that talks about how the race and subjugation of Chinese, Japanese and Mexican immigrants were constructed at the end of the 19th century and early 20th century. If that is your thing, I recommend that you pick it up.

But this is sort of a quote that I'll get to in a minute, but I want to talk a little bit about the dietetic profession. It's something that really came into being with World War One. So, World War One brought a real kind of coherencey to the field. Cultures around the world had already been experimenting with food as solutions to, like common elements or rare ailments, but in terms of the creation of the dietetics profession in the US, World War One was the catalyst. White Protestant women in the field served in areas related to diet and nutrition of soldiers and through that experience they were professionally organised into a network of dietetic experts, and they were also thoroughly trained in administration and professional codes of conduct.

So, following the war, in the 1920s and beyond, they had more professional power than ever, and they often used this power to collaborate with institutions to, unfortunately, draw lines between good eating and bad eating that were really just reiterated racial boundaries. For instance, In the early 1930s. There was a sharp increase in tuberculosis rates in LA among their Mexican population. And this specific quote here, displays how dietitians and nutritionists, in conjunction with LA

County Public Health Department decided to handle the crisis - basically by blaming it on the cultural diets of Mexicans. So I'm going to read the quote:

“Analysis of family nutrition during the Depression, resulted in a list of explanations accounting for resident’s inadequate diets. Racial customs emerged as a negative factor, which prompted the agency to develop nutrition classes and programs of home visits designed to teach tuberculosis patients the American ways of cooking. Across the 12 county health department districts, the largest percentage of nutritional classes and home visits took place in predominantly Mexican communities.”

So, first, the use of racism as an explanation for how an illness and infection happens, is not only just like, incorrect, but it also leads to terrible interventions because tuberculosis is like, it happens by infection. And they're developing nutrition classes and home visits to monitor the way people are cooking in order to cure tuberculosis. Unsurprisingly, there was no change in the rates of TB cases, following that intervention. And so, so we have this example of one, how racial logics were used to, racial logics were used to first of all blame Mexican communities for their disproportionate rates of TB, even though those were caused by the intense segregation and poverty they faced, due to the meddling of the LA public health department who, again, promoted the idea that they were diseased, lazy, inferior, in ways that were similar but also distinct from the way that they discriminated against Chinese immigrants.

So we have an example of that. And then, this, like, development of nutrition classes and home visits is so creepily similar to how we approach issues today, still, in the same kinds of populations that are essentially suffering from systematic oppression. Instead, let's develop nutrition classes. [laughs] And so this is just an example of that. And this sort of, I wanted to talk again about pellagra. There was a jump in pellagra cases from 1934-1935, and as I mentioned before, despite the knowledge that Mexican families who had mostly been sequestered to one side of Los Angeles and they lived in deep poverty, were just not getting enough food in general, officials claimed that it was really the fault of Mexican parents, who again “omitted one or two of the three diet essentials”.

So this isn't anything but racism and xenophobia, and when you put these two events next to each other, and when you place them into a much bigger context of public health sponsored racism, then it becomes clear how eugenics, infrastructure and surveillance sort of combined together to create the public health strategy as we know it, still. Yeah, I think I'm going to move on from this now. Monica?

**Monica**: So let's talk about understanding the consequences of the weight normative health paradigm. So, when we come back to our infrastructure eugenics surveillance model, we see that dietetics today has some infrastructure issues. There have been long standing efforts by food justice activists and advocates to address food apartheid. And what we generally see his refusal or failure to mobilise our direct institutional resources from places that practise public health dietetics to those efforts that are already ongoing. We are saturated with low quality, misleading research, focusing on nutrition and weight loss that is usually funded by people who have a financial stake in promoting the idea of weight loss. And we do have practice advances, like the invention of weight neutral care paradigms that are being disseminated and implemented pretty slowly. Not a lot of pep there.

**Mikey**: To add to what you said about research being funded to those who have a stake in obviously food related inequalities, there is also a similar issue among organisations that claim to sort of be working to address gaps in food access or food equity. It's a phenomenon that's really, really popular and public health too. People don't want to work themselves out of a job. As long as inequality exists, there will be a need for organisations that address it. There will be a need for researchers that talk about it, there will be a need for those who invest in it to keep investing in it. And so as someone who has, like, spent some time really examining food apartheid from a fat liberation perspective, what happens is there is an initial burst of energy to, you know, that's spurred usually by like, a cheap notion of like, awareness. Like, oh we know about this problem now we want to talk about it.

So, there's awareness and then what follows is people who have been doing this work for a really long time, are asked for their input for their analysis for their advice on how to tackle it, and for their perspective on what has been done, what hasn't been done. And then people are like, hey, thank you so much for your perspective, and then like nothing happens. So there's, in line with this flawed kind of

infrastructure, there's this constant extraction of labour and energy on behalf of those who are trying to actually address those gaps by other people who are claiming to address those gaps, but really profit from them and our stakeholders in that issue in a very specific way. Just wanted to mention that.

In terms of eugenics, we've talked about this. There is still an emphasis on enforcing correct individual behaviour instead of ensuring social access to nutritional adequacy and variety. In a way, this is a manifestation of the idea that only the best should survive, only the best are allowed to move on, are allowed to procreate,

**Monica**: Social Darwinism! Boo!

**Mikey**: Literally social Darwinism. That's where this emphasis on correct behaviour is. It's like it's rewarding those who can adapt to what is seen as correct behaviour and punishing the rest of us for not falling in line. And also depriving us from releasing ourselves into the future, because it's not like systematic oppression is bad just because of what it does to us, like, when we're alive. It's bad because of the way it seeks to erase us from the world, and beyond us. So there's that. There's the conflating of cultural value of food with nutritional value; healthy food is white people food. And I don't think I need to make the case that this is a thing. I think that anybody in the audience who is not white, and has, like…like myself, has experienced a normally eaten cultural food become appropriated by white audiences, can see that the, the way that we define what is healthy and not healthy food is directly and approximation to like how much white people like it. So. I've seen it happen with avocado, I've seen it happen with collard greens. I've seen it happen with kale, and now I'm seeing it happened with like, goat meat which is like, really…it's disheartening.

So yeah, that's that. And then, um, the meaning of behaviour depends on who's doing it. So of course we go back to this concept of good or bad that is wholly dependent on, like, the deservingness, the vulnerability, the goodness of the person who is exposed to it or is doing it, ie: for example dietary restriction is bad in thin people but good in fat people. It's bad in thin people, good in fat people. I forget who said it - was it Lisa DuBreuil, who said that we punish–

**Monica**: It's Deb Bernard. "We prescribe for fat people what we diagnose in thin people." Yeah.

**Mikey**: Yeah, that hits that hit so hard. Every time I hear it.

**Monica**: Every time, every time. So surveillance wise. We have the continued reliance on body mass index and routine weight. I don't know how much people get weighed in Canada but it has recently come to my attention that it's like, only in America that they insist on weighing us at like, every single doctor's appointment, But they do. They insist on weighing us at every single doctor's appointment. We have a lot of surveillance of weight and no surveillance of weight stigma, even though weight sigma confounds all research and observations related to associations between weight and health. And what that means is that weight stigma causes the problems that have historically been blamed on fatness. It does that through mechanisms of minority stress. So weight stigma, like racism, like, homophobia, transphobia is just this ambient toxic thing that we're all exposed to all the time, and it attaches itself to our psyche and it gets into our bodies.

There are also pathways that involve discrimination. So like, fat people are frequently, just like, not offered jobs, not offered promotions, paid less, etcetera, etcetera. And we know that money and health are very correlated, because our society has terrible values. Like I just have to acknowledge that.

**Mikey**: Too real. Too real [laughs].

**Monica**: So like, bad choices all around. And then we have just like the continual, like, measurement and overemphasis on these really mild, mild changes and like the shape of the curve, like the curve just got a little smushed, guys, that's all, when it comes to body size distribution. It just got a little flat. And like, there are so many explanations for why that might have happened, and none of them get considered other than like people are eating incorrectly, people are exercising incorrectly, ie: not enough. And it's like, well, medical advances mean that very sick people live longer than they used to and you know, we know from the obesity paradox that like, very sick people who are fat live longer than very sick people who are thin. So like, there you go right there.

**Mikey**: It's only a paradox because it exposes a flaw, a systematic flaw and thinking right no one wants to admit to.

**Monica**: Right. The paradox is that people are more healthy than thin people sometimes. How dare we.

**Mikey**: Right?

**Monica**: I was having another thought that I wanted to share and now it's gone.

**Mikey**: It'll probably come back to you, we should move on I think.

**Monica**: It will. Wunderbar.

**Mikey**: Okay, cool.

**Monica**: So, the thing that I really want everybody on this Zoom to take away, more than anything, is that fat liberation predates the anti diet approach to dietetics by decades. So, NAAFA the National Association to Advance Fat Acceptance, was founded in 1969, in the US. They did events in the 60s and 70s. There was a group called the Fat Underground that I believe was like a West Coast spin off of NAAFA. They published a fat liberation manifesto in 1973. And I just want to read you a little excerpt. I do have to get very close to my computer to read this 'cause it's small font:

"We make this demand knowing that over 99% of all weight loss programs, when evaluated over a five year period, fail utterly and also knowing the extreme proven harmfulness of repeated large changes in weight."

In other words, people have been making the same argument that I went to grad school to rediscover how to make, for like, twice my lifetime. Like this stuff has been around for so long. Marilyn Wan, in the 1990s, published a zine that was then bound up as a book called *Fatso*. It's really good - everybody check it out. There is a book called *Fat Activism* by Charlotte Cooper, that is a history of the movement. Strongly encourage folks to check that out.

**Mikey**: The thing that I think that we, that *I* really wanted to get across by including this. Yeah, and Monica too, was like, I, yes, both of us: In order to appropriately intervene on anti fatness, you have to decenter your personal hopes and expectations for what a weight inclusive approach can do for you, or even for your patients. Like you have to step away from that and you have to locate yourself within the decades long movement that is the movement for fat liberation. There is no intervening on anti-fatness in any profession, in any context, by anyone, unless you understand what we have been fighting for for decades, and also understand that you are a tiny part of that very long tradition. That is pretty steadfast about the ideals that it holds dear. Fat liberation is anti fascist, it is anti racist, it is anti classist, it is anti capitalist, it is anti sexist. Like it–

**Monica**: But it's pro trans!

**Mikey**: But it's pro trans! All right. We….anyway…

**Monica**: We do like things sometimes.
**Mikey**: [laughs] Right. Um, and so you have to locate yourself within the longer tradition that is fat liberation movement, in order to appropriately intervene on anti-fatness in your profession, from wherever you are. And with that I think we can actually get on to the next slide.

**Monica**: My God, the stuff that everybody actually came to hear.

**Mikey**: I know! [laughs]

**Monica**: Challenging Anti-Fatness in Dietetic Practice! How do you do it?

**Mikey**: Here we go!

**Monica**: So this first slide reads: do you notice and critique the exclusion of fat people in your workplace, your classroom, etcetera? Try to reflect on whether and how you support, tokenise or alienate fat people in your life. And what we are trying to get at here is the idea that it is easy to critique a system, it is easy to name a

problem. It is much harder to translate that into what you value and then live out those values on a day to day basis. And so it is totally, totally possible to be like, intellectually very opposed to fatphobia, and also to treat the fat people in your life very badly, because you were socialised into doing it before you could notice. Because unfortunately, that's the culture that most of us I think were raised in.

And, you know, something else that I want to say here is that it is not thin people's jobs to manage fat people's feelings about our fatness or to introduce us to fat liberation, but it is thin people's job to support us when we initiate fat liberation activities, that like… we are definitely not encouraging you to just go up to fat people and be like, have you heard about fat liberation? Are you into it? Can I help? Because that's not your job. You know, if a thin person had told me about fat liberation I would not like them very much. Part of fatphobia is the belief that thin people are, like, inherently better than fat people at having bodies and that fat people are kind of presumed and competent, about a lot of things, because of the size of our bodies, and so you have to be really careful to presume competence, with the fat people that you're interacting with. Mikey, what do you want to add?

**Mikey**: Yeah, I wanted to add, just because this might be applicable for those of you who are trying to challenge anti fatness whether it's with colleagues that you already work with, or if you manage students, for example, like through an educational program or if you do mentoring, etcetera. It's not easy to get on board with a weight-inclusive approach a lot of the time, I've seen, in my experience, for thin people. It's a challenge for them, because it often pokes holes in a lot of what they find their self worth in. And that's, that's like that is a consequence of anti fatness of societal level fatphobia. Um, but once you are in that place where you can question sort of anti-fatness, fat phobia on an intellectual level, it's really important that that transfers over to your personal life, because the changes that it would take to truly transform the profession of diabetics into one that is fat inclusive or weight inclusive, or even just weight neutral, like, the, the amount of change it takes to do that kind of thing on a professional level scale requires a complete reformation of how you approach not just your professional work but also your personal life, because if the ideals of fat inclusiveness of fat inclusiveness, of weight inclusiveness only sink as much, like into your into your professional consciousness, but they don't

actually penetrate all the way down deep, then the harm just replicates on itself. Like it's, we're not actually going to get anywhere.

The things that transform a profession into something that is violently fat phobic to something that is inclusive of fat people; it's not just about language, it's not just about how you talk to your patients who are non white, it's not just about, you know, trying to increase diversity on – like in private practice if you have your own practice it's not about diversity in a university; it's not about any of that. It's about fundamentally changing the ways you associate self worth and human value to body size. And like, changing the way you see those things in relation to weight; that is what's actually going to challenge, remove, reform fatphobia in dietetics.

**Monica**: Can I share a really…sorry.

**Mikey**: Go ahead, go ahead!

**Monica**: Can I share…something concrete. So, an example of how to do this, like sort of in the day to day is, you know, people are socialised into like literally not noticing that weight stigma exists. It is designed to be like, invisible to thin people and extremely visible and painful to fat people. And just learning how to notice what you're not supposed to notice is huge.

So something really concrete that a very petite friend of mine consistently does and it always makes me feel so good and so seen, is that when, you know, back when we were allowed to eat at restaurants, she would always offer me first choice of seats and if there was a question about where to sit she would always defer to me, you know, do you want the tall table or do you want the short table? And it was just like you are more likely to be uncomfortable than I am so please take the first dibs on not being uncomfortable. Like, so easy, so simple; not something anyone in my life had ever thought to do before.

**Mikey**: Wow.Dang, that kind of hit me like… [laughs]

**Monica**: Right?

**Mikey**: Yeah, it's as simple as that, sometimes, like, yeah.

**Monica**: But like anti-fatness, material, infrastructural, anti-fatness is painful on our physical bodies in a way that doesn't get talked about a lot.

**Mikey**: Yeah.

**Monica**: And so, like, embracing and noticing that…miles…takes you miles.

**Mikey**: Absolutely. I think we should probably move on.

**Monica**: Moving on.

**Mikey**: Okay, I'll read this one. Do you rely on Health at Every Size, anti diet or weight neutral practice paradigms?Try embracing fat positivity and fat liberation, to ensure your practice is non stigmatising. No, Monica, do you want to unpack this one for us?

**Monica**: I do want to unpack this. So, something to be aware of is that tools and techniques that you see as weight neutral or you perceive as weight inclusive, especially if they were originally developed by dietitians and pretty normative bodies, may not feel or read as inclusive or neutral to clients who are actually fat. There are a lot of ways that these paradigms can get co-opted and taken over by diet culture, right? Because diet culture is all about finding ways to like, resell diets back to us using anti diet language now. But it's also just that going back to the length of the history of that liberation, that compared to what there is out there, the kind of like, we're going to, like…it's better to engage deeply or not engage at all, than it is to sort of gesture at fatphobia, but not really be prepared to unpack it. And that is what I think a lot of these weight neutral paradigms do, unfortunately.

I also just want to touch on the idea that the anti diet specific approach can be perceived as ableist by a lot of people because, like, it is great to be anti weight loss diet but not every diet is for weight loss. And in a way, it kind of seems like an extension of anti-fatness to make that assumption, to me. That like, the anti diet approach has meant that people like with celiac disease may have a harder time getting the accommodations that they need or like, people with food allergies don't

have their request taken seriously, because, because the path to fat liberation has been presented as going through anti diet. And I think…like obviously, restrictive diets can be contiguous with disordered eating, but when you scapegoat the diet instead of the culture that demonises fat people and fatness, you missed the point. And like, similarly, I think Health at Every Size is a nice starting point, but it, I mean like, if I never had to fight with someone about whether health and every size means you can be healthy at any size it would be too soon. Like, way too soon, like I could truly, truly go the rest of my life without having that conversation. It would be amazing.

That weight stigma and ableism, like, go together. Weight stigma and healthism - the idea that you need to be healthy to be worthy, go together and so centering health as the goal or the achievement is not necessarily liberatory. And like, I understand that the intention is to treat health as a resource, but unfortunately that just isn't how it plays out. I've said before that I wish Health at Every Size was called "Care at Every Size", because it's really about – Mikey doesn't like that…

**Mikey**: I… OK

**Monica**: Mikey doesn't think the name is the issue, Mikey thinks the paradigm is the issue…

**Mikey**: [laughs]

**Monica**: And that's also a perfectly wonderful perspective. I think the name issue would help with 5% of the problems, but it's the 5% of the problems that I find personally annoying. And it's definitely not really a good way to do theory anyway. Mikey, what did I miss?

**Mikey**: [laughs] Sorry. No, no. In terms of…right, I wanna get back to what you said about these alternative, presumably more fat friendly paradigms, and their application. And I'm gonna use HAES as the example, because I think it's sort of reached…not critical mass, but like, enough people have heard of it that it has implicitly become connected with like, size acceptance and fat acceptance in a way that like does not make sense. There are, and this is an example of embracing fat positivity and fat liberation, to ensure your practice is non stigmatising. There are fat

liberationists who have written about the limitations of the Health at Every Size movement. They have done that. They have critiqued it. They have turned it over inside out and been like, a body like mine cannot find a place in health because health is in opposition to everything that I am. That is something that fat liberationists talk about, have written about, have created media about. Go out and seek that work.

The first person that comes to mind is Da'Shaun Harrison. They are very brilliant. Their recent book *Belly of the Beast* is very good. Please, engage these perspectives that might seem in contradiction or opposed to the weight neutral or anti diet or Health at Every Size paradigm you're using, because those opposing sort of perspectives, specifically from fat liberationists, those are the oppositions you want to hear because that is the surefire way of making sure that you are doing the least amount of harm possible.
I think that in a profession like dietetics, it's hard to get away from, like, the concept of health, because essentially it's regarded as a health science, you're regarded as health professionals, and there are there are certain criterion goals, etcetera, that aligned with seeking health or seeking wellness, that are like essential to the field.

But…but, there doesn't have to be a health moralising aspect to your work. Like, there doesn't have to be like such an emphasis on health, when, honestly, any popular notion of that is going to be inherently opposed to a lot of the people that are charged with your care, especially if you are somebody who works with people of colour, because health is everything in opposition to anyone who is racialized this black, brown Asian etcetera.

I think a lot of fat liberationists would argue, and quite convincingly in my opinion, that there is just no way that a fat, Black person can ever be seen as healthy, and to continue to use that as the avenue to help or harm, etcetera, is a form of violence and a form of erasure. It just doesn't have to be there. I think that Health at Every Size in particular was like, probably – not probably –  it was very revolutionary at the time that it came out, okay? It did its job. But as I've said before, you don't set up camp halfway through the journey. Like you have to move beyond it. And it's okay if HAES or the anti diet approach is something that opens the doors for you to evolve and you're thinking, that's okay. But like..'cause that's the goal, for you to evolve in your

thinking, but don't make a home in HAES because that feels like the most appropriate thing according to what your profession is, to what your professional goals are. Just because it has health in the name doesn't mean it's the best avenue to care for your fat patients, so engage other perspectives, always read, always listen. Did I miss anything?

**Monica**: I mean, I don't think so?

**Mikey**: Okay.

**Monica**: I got caught up listening to you.

**Mikey**: Oh, no, stop it, you. [laughs]

**Monica**: Alright. Okay, next?

**Mikey**: Let's keep going.

**Monica**: Remember when I was worried we'd run short? That was funny.
**Mikey**: Ha! [laughs]

**Monica**: Okay. This one's an easy one. Do you routinely use your thin body in order to promote your services or demonstrate your diagnostic expertise? Because if you do, you need to stop.

**Mikey**: Absolutely.

**Monica**: Unfortunately, thinness still gives people credibility, especially in dietetics, and if you care about addressing fatphobia, the first thing you're going to want to do is like, stop cashing in your thin privilege, all the time. And like, this is a really, really obvious, easy way to do it.

**Mikey**: And going back to the part about, like, credibility or legitimacy. If you are somebody who does this, to put it in less abstract terms, you are actually actively

harming your fat colleagues, like, you're actively doing harm to someone that you probably trained with, work with, etcetera, by using your body as your calling card. I have seen in many, many discussions among dietitians and like, just in that space, about how there are certain people who are seen as more able to go into private practice, for example because they have the body for it, or because they look the part. And if you are someone who uses your body to do that you're, enabling, like the continuation of that idea.

And all it does is perpetuate the lack of fat people in the, in the profession, it perpetuates the idea that then this means credibility in many different domains, not just limited to dietetics, nutrition, etcetera. And honestly, like, I have a suspicion, or at least in my experiences with dietitians, I can personally tell you that seeing a professional who is caring for me use their thin body to like, garner my attention or garner my business, that's actually like, deeply harmful. It immediately creates this differential in power that makes your fat patients or your fat clients into deficient, and you being like, the arbiter of what is good, or what is bad for their body. It's just, it's not good practice. You should stop if you're doing it. Please stop. Don't do it.

**Monica**: Please stop.

**Mikey**: Okay. Um, I think we can move on from this one.

**Monica**: I think we can move on from this one.

**Mikey**: Okay.
**Monica**: The rest of them are not this direct.

**Mikey**: Yes it's true. Do you want to start? Or I can read this one.

**Monica**: Oh, I'll do this one.

**Mikey**: Alright.

**Monica**: Do you accept compensation from nonprofit or commercial entities, seeking your expertise in weight inclusive approaches to dietetic healthcare etcetera? In

other words, are you doing enough in the weight inclusive, weight neutral space that you are getting paid for it? Because if so, you should really – and, like again, this is for thin people – you should be referring to or partnering with fat experts for those opportunities.

You don't have to turn down every opportunity that comes your way to be like, a good ally, but you do need to share the benefits you're getting with the people who are originating the work, because again, like most of what you see in this space, originates with fat people. And fat people may lack the skills and knowledge that you have, because you got access to those things through thin privilege, right? Like, there is so much discrimination in employment, that it is entirely possible that you have learned like, networking skills from being in the kinds of working spaces that fat people are consistently excluded from, and it would be helpful and nice and kind if you would share that information with us.

**Mikey**: And it also…when you go and make an effort to incorporate fat experts into these opportunities, when you go out of your way – well, not out of your way – when you just do the right thing, and like, try to give your fat colleagues the professional grace that is so often not given to us, that helps with just like our presence, and our professional prospects. Because if…okay, think about it this way. I have routinely had issues getting, you know, like, letters of recommendation or whatever, from people when I wanted to apply to grad school. I don't know why did that anyway, but. [laughs] I had a lot of trouble getting people to vouch for me, because people just look at fat people and they're just like you're not an expert, you don't even know how to control your own body.

And so when that's the kind of culture a fat person is in. hey one, like you, like Monica mentioned, they don't have the opportunity to learn skills and knowledge that allows them to navigate these environments that are usually like, governed by pretty specific professional rules and customs and cultures, etcetera. But also it just contributes to our invisibility and exclusion, when there isn't someone to be able to give us, like a hand up, or just be like, hey, I have this thing, and you should tag along for it, or you should collaborate with me on this. Like it's mentorship, but it's also just redistribution of professional fortune. That's like a weird thing to say but like, you know, none of the opportunities we receive exist in a vacuum. They're all impacted

by social forces that govern what we think are, I don't know, the ways to describe who experts are and who experts aren't, and like, unless somebody decides to take the steps to disrupt that kind of like, seemingly random but actually very calculated system, then nothing ever changes, if that makes sense.

So, shall we move on?

**Monica**: Let's move on.

**Mikey**: Alright, cool. So, I'll read this one. Okay, do you work with offices or organisations to develop food access programming like pop up farmers markets nutrition education classes or grocery store tours? Try instead, or in conjunction with – no, instead – I'm pretty I'm pretty firm on this being an 'instead' [laughs]. So, support community driven initiatives that need funding, publicity, and other forms of assistance, such as: community fringes community gardens, urban farms, cooperative grocery stores or direct aid, which isn't something that – by direct aid I mean like literally distributing, redistributing funding to residents specifically in an area – versus like, putting your energy into a pop up farmers market that is going to show up once a week, in a hard to reach location, and not actually produce any sustainable impacts or improvements on the community you're working for.

I'm getting like, really riled up about this. Monica, do you have anything to say so I can gather my thoughts? [laughs]

**Monica**: I don't have anything to say but we can, I mean, like, I think you've covered it and I think we can…things are already happening in communities and communities, know what their real problems are.

**Mikey**: Communities just lack the resources to get it done.

**Monica**: Right.

**Mikey**: Because that's the thing. So you like – you re centered me, thank you so much.

**Monica**: You're so welcome!

**Mikey**: [laughs]

**Monica**: I'm gonna recenter myself.

**Mikey**: [laughs]. Communities lack resources to get things done. It's usually in the areas with the most forced and most resistance against hegemonic influence and culture. Those are the places that have like, the least resources to get anything done. And it would be really helpful if, instead of operating like paternalistic, food moralising, eating moralising settlers in a space, those of you who work with public health departments or work with nonprofit organisations who do this kind of work, it would be really helpful if there was somebody on the inside to disrupt the cycle of okay well how are we going to teach the brown people how to eat right? It's really not helpful, it's not helpful. It also contributes to this conflation of like, fatness as the "problem", because fatness is quote/unquote the result of food inequities, and so people target fatness instead of the system that creates food inequities.

And I've written about this before. If you're interested you can go on my website and look at it, but the basic point is, people don't need to be taught how to eat, and people don't need to be taught how to buy groceries and people don't need to be taught how to budget, and people don't need to, you know, find their way in a far off farmers market that is going to provide them quickly rotting produce that they won't be able to get to because they work too many hours at their shittily paying job.

People need resources. People need money. People need like, institutional buy-in; the kind of the kind of resources that only come from an organisation or institution backing your initiative. That's what they need. They don't need your ideas, and they don't need you to tell them how to eat. They really just need the money, the space, the land, the time freed up to be able to work for the betterment of their own communities. And like, that will produce way more long lasting change than anything that a group of eight white people like, sat around a table can come up with.

And I say this as someone who has been in those spaces with the white people, planning these initiatives, and who has also been on the receiving end of plenty of these interventions that do not work, and only go so far as they can stigmatise someone. So, that's it.

**Monica**: And as a white person I will just say, we love to try to reinvent the wheel and it's like the wheel's right there, guys.

**Mikey**: Mhmm.

**Monica**: Last one.

**Mikey**: Oh, yes, yes, yes. Okay.

**Monica**: One more.

**Mikey**: Yes.

**Monica**: Do you invest energy in creating public facing education or content on fatphobia and diet culture towards lay audiences? Are you doing Instagram influencing and tweeting a lot? are you are–

**Mikey**: Or providing content for a website that you might have?

**Monica**: Right. Are you doing website content creation, are you on Patreon, are you filling out your own website, whatever whatever? Work on educating your fellow clinicians about the value and necessity of a fat inclusive approach to diabetics and health care, instead, The 101 stuff is really well covered by fat people. When you work on basic education around issues of fatphobia and diet culture, you're actually speaking over the fat people who have been doing this work for, in most cases, a longer period of time. And we don't get traction, because we don't have thin bodies for the algorithm. And it's really frustrating for us and it's also not the best use of your energy.

When we talk and think about movement strategy right, like, the work of allies, is to do the work that the people who are actually marginalised can't do on account of their being marginalised. So in the case of weight stigma and how that manifests in the world, your voice matters the most in the rooms that we are not in, and the real work requires you to risk something, even if that something is like, the disapproval of a colleague or disruption in one working relationship.

The way I see it is that weight stigma and healthcare legitimate all the other forms of weight stigma that exist, and so until we can address the idea that fatness is a health problem, we're going to continue to see quote/unquote "diet culture" grow and expand around that idea. This is the other reason why, like, challenging diet culture on its own doesn't work, is because like, what's motivating that? Where does it come from? Why are people invested? They're invested because of anti-fatness. So it would be so much more meaningful and helpful, if you would – and it's hard to, because like – I can see that people are asking about like, how do we do this? And I'm like, I don't know; I'm still figuring it out. You know, talks, content creation, that kind of stuff…

**Mikey**: Coalition building, really.

**Monica**: Coalition building.

**Mikey**: Right?

**Monica**: Or, like, relational organising.

**Mikey**: Yeah.

**Monica**: Finding the people around you who are receptive and nurturing them, and educating them, rather than focusing on the people who are never ever gonna get it, I think is the other really important piece of that.

**Mikey**: Absolutely.

**Monica**: But just, you know, building power and finding support for yourself too, 'cause the other thing is that, like, it's not easy to be in a profession that has historically done harm and you're trying to change that. Right? Like that's not an emotionally easy experience for anyone and so you need support and you need help, you need like minded people around you.

**Mikey**: It's also just a lighter burden when you spread it out amongst more people, honestly.

**Monica**: Right? Like, Mikey and I had so much fun doing this.

**Mikey**: Yeah, we had a bunch of fun and but it's like…it makes it easier to talk about topics like these, but it also just…it makes more sense and it seems more doable when you have more people on your team. So like, yeah, your first stop should be your fellow clinicians, your colleagues, the ones that you work with all the time, because those are gonna be your best teammates, if they can get on board.
**Monica**: I can't believe I almost didn't say this, but like, the other thing to understand is that the medical industrial complex creates eating disorders. The medical industrial complex promotes eating disorders. Like paediatricians are just out here giving anorexia to kids by showing them growth curves at times that are developmentally inappropriate. Ask me how I know.

So like, be ready to have those conversations. Be ready to have conversations like, with providers who are being harmful, knowing that it's not going to go anywhere, 'cause the other thing is like, people need to hear a new idea a lot of times before it sinks in, and it can feel like you're not getting anywhere, and then suddenly you're somewhere. And like, again, being somebody who has relative professional power and relative body privilege, you are a lot better situated than other people to be that first attempt that goes nowhere, because it sounds more legit coming from a thin person which is very annoying to me, but it does. And clinicians respect other clinicians more than they respect patients.

But anyway, bringing it back. This is also a great place to bring fat people in, right? It's like, make a fat friend, do the clinician work together.

**Mikey**: And when it comes to public facing education to people who are lay audiences, you should be referring them to somebody who's been doing this work for a really long time.

**Monica**: Yeah.

**Mikey**: This is like, a whole slide, full of fat creators, fat experts in their fields, who are doing really critical work and breaking down, sort of the the wisdoms we take for granted with regards to body size and weight. And like, these are just some of the people that I know on Instagram. Like, they're all here, they're all doing things, and they all have their own expertise, and honestly with matters of fat liberation, you should be referring to them, period. Always.

**Monica**: I guess the other thing to say is that like, no group of people is a monolith–

**Mikey**: Absolutely.

**Monica**: And that includes people and fat liberationists.

**Mikey**: Mhmm.

**Monica**: And like, one one side of liberationist's opinion is one fat liberationist's opinion.

**Mikey**: Yes.

**Monica**: So, you know, pick a few.

**Mikey**: Mhmm. And–

**Monica**: I think we probably have left that up enough times to be…

**Mikey**: Well, it'll be in the recording so it's there.

**Monica**: It's in the recording.

**Mikey**: Feel free to pause.

**Monica**: Mikey's smarter than me.

**Mikey**: [laughs]. And these are just like a bunch of the sources we used in very small print. Sorry, it's probably better to look at the recording. And we are open for questions, I think.

**Monica**: Okay, there's already some good ones in the chat.

**Mikey**: Okay [laughs]. Okay.

**Monica**: I'm gonna, I'm going to scroll up and just start reading…

**Mikey**: Am I good to stop sharing?

**Monica**: I think you're going to stop sharing, yeah.

**Mikey**: Cool.

**Monica**: I think we can just be having a conversation now.

**Mikey**: Nice.

**Monica**: Okay. So our first question – [to Mikey] control your face –
**Mikey**: [laughs] What? [laughs]

**Monica**: If someone living with obesity/overweight would like to lose weight, and get advice from their dietitian, should the dietitian help with their weight management or should the dietitian say love your body, no matter what the size is just love yourself, you do not need to lose any way to be healthy and beautiful?

Honestly, neither of those options is good. The thing to do is to educate about the science of weight loss, which again, you know, people…you know you may need to do some reading yourself in order to be able to do that, but most attempts at intentional weight loss do not work.

**Mikey**: Yeah.

**Monica**: And it's pretty unethical to me, to be giving somebody a treatment that again, like evidence says, more likely to backfire and cause weight gain in the long run, which like, is a thing I hate sharing because I hate the idea that diets are bad, just because they make people fatter, when in actuality, diets are bad because fat people shouldn't be expected to conform to the norm of thinness in order to be treated like human beings. But no, it is not thin people's job, and it is not like, a dietetic professional's job to manage a fat person's feelings about their body.

**Mikey**: Yes.

**Monica**: Um, it's also…you know the other thing that I thought we had emphasized that I guess maybe not, is that weight discrimination has material consequences on people's lives, and like, it is not uncommon for doctors to tell fat people they will not provide certain kinds of health care, until we lose a certain amount of weight. And so on the one hand, body autonomy has to include the option to crash diet, knowing it's not going to lead to long term weight loss, because you need the care that's being promised and you don't have another way to get it.

A lot of times fat people will be told to find a new doctor, but all the doctors are going to the same medical schools that are sharing the same biased education about how fat people are fat and it's a health problem. So, sometimes going to the doctor, you know, sometimes finding a new doctor just means paying twice to get the same stigma twice.

**Mikey**: Yeah.
**Monica**: So it's really about, you know, digging into what are the health goals beyond weight loss, what are the motivations for weight loss, understanding the motivations for weight loss

**Mikey**: Motivations are really, really important, because like…yeah.

**Monica**: …and then…sorry, go ahead.

**Mikey**: No, I was just going to say, because if it's if, if someone is motivated – "motivated" – really like they're being coerced and they don't have a choice – if someone's being motivated to lose weight because they need like a critical health treatment or like, they have legitimate concerns that really boiled down to like, what other people won't provide them if they don't lose weight, then like, that's obviously someone who's clearly in duress, in crisis, and like, you can always fall back first of all you can always fall back – first of all, you can always fall back on the scientific literature that like, challenges the idea that weight loss is predictable reliable and formulaic. You can always fall back on those kinds of justifications that don't mean you have to resort to like, overstepping and telling a patient that they should love themselves regardless. Like that, again, is not your job.

And it's really overstepping for that to be something that you do with your fat patients, because, again, as somebody who is probably ostensibly thin, it's not your place to manage about people's feelings about their own fatness, and it's really not your place to provide empty platitudes for them to deal with the brunt and burden of weight stigma in the world. Yeah.

**Monica**: Weight stigma is pervasive. It is distressing. And if you do not have lived experience with it you have no business telling someone how to cope with it.

**Mikey**: Yeah.

**Monica**: I mean, there's just…you know, we're trying to help you understand, but there is an enormous amount of pain you can never understand.

**Mikey**: Yeah.

**Monica**: So, good question.

**Mikey**: Yes,

**Monica**: Good dialogue. Next question is from Boomy Kabocha. How do we bring this approach out with community healthcare, dialogue, presentations? Discussing cases or evidence still doesn't seem enough, because surely working alone as an RD is not enough in one's own space practice. We need to get other healthcare providers on board. And I just want to say I love you. I love you.

**Mikey**: I love you too [laughs].

**Monica**: Right? I think we kind of already touched on these answers, but just, I love the way you're thinking. I think finding people around you and brainstorming together, because we don't…you know like…I still kind of don't know, but…

**Mikey**: No, but also, don't underestimate the networks you can build online too.

**Monica**: Yeah.

**Mikey**: Like, a lot of fat lib activism is done online, and it's because, like…I hate to say that this is like a relatively new form of discrimination that people are learning about, but people are still learning about it, in general, if you if you compare it to like, other forms of discrimination that have reached like, critical mass in the past few years; homophobia, transphobia, racism. Like, none of those things are solved, but people have heard of them and generally, like, understand them in some way, depending on the person. But like, with fatphobia, people are just like I don't understand what you mean – it's bad to be fat.

And so, when you're up against something like that, that's seldom challenged and is basically unheard of challenging, in the very specific profession that you happen to be in, sometimes you just have to like, find and build your network online and figure out how you can create coalitions that eventually do get on the ground and like, advocate for change at a basic level. On a basic level in your job, the one thing you can absolutely control is not abiding by stigmatising and harmful practices that seem to be the norm. So like, if that brings you any comfort at all, be a good practitioner for your patients and work to build coalitions online, and then hopefully

you know by the time you have the resources, backing, and space to like, pursue lasting change in your specific region and context, then you'll be ready for that

**Monica**: Something kind of unrelated but also related I just wanted to add is that I have seen a tremendous change in how clinical students and early career clinicians interact with this kind of information, as opposed to older generations. And like, med students are with it, y'all!

**Mikey**: Some of them.

**Monica**: Like, residents. I told a resident I was getting a healthcare, I was at a doctor recently – please clap – and it was on the second floor and the first one was a weight loss clinic and I pointed to the ground and said all they're doing downstairs is hurting people. And you know what that lady did. She said, "huh". And then she ordered me x-rays. And like, I don't think you realise that like, It's rare for doctors to order tests for fat patients, but like this was a big deal.

**Mikey**: Yeah.

**Monica**: So the other thing I will say is like, are you near a med school? Can you work with them on their curriculum because that's a place where we'll see forward movement and lasting change. We have so many more questions and only 18 minutes.

**Mikey**: Oh my God. Okay, we should probably move on.

**Monica**: Elise asked: "What is your opinion on person first language eg: using the phrase "people living in larger bodies" instead of fat people?"

Love that she specified that, because if I–

**Mikey**: I was thinking "people with obesity", to be honest. I was.

**Monica**: Right. I was thinking you were going there. We definitely don't like "obesity" or "overweight". Obesity is Latin for gross fatties. Like it translates to like, someone

who has eaten themselves fat. It's really a judgmental word that then we attached to the BMI and it sounds more scientific ‘cause it's Latin, but it's really just Latin for being a jerk.

“So on one hand I find that patients appreciate the disconnection between who they are as a person and the body they live in. On the other hand, does this language perpetuate the idea that weight is a modifiable factor?”

I love this question and there's no good answer.

**Mikey**: Like most good questions.

**Monica**: Right? Right, like most of the questions, there's no good answer. because you know, as we've already said, fat people are not a monolith and people are in different places with their fat liberation journey, right? Like some people are born into fat affirming households and some people are not. And some people are exposed to fat liberation ideas really early and some people are not. And so everybody's just in a different place. So, the rule of thumb that I use is generally I just say fat people because at this point I don't think about it anymore ‘cause I've been, you know, I've been in fact liberation for like 12 years.

**Mikey**: But there are some fat people who are never going to want to be called fat.

**Monica**: Right. And so, the rule is if somebody calls themselves fat, you call them fat. If somebody does not refer to themselves as fat you refer to them using language they use. I think when we are talking about groups of people, “fat people” is perfectly fine, because it's never going to become a truly neutral word unless we can use it like it's a truly neutral word. Um, you know like, like, not conveying that you think fat is unspeakable is important. But like, yeah, I'm not separate from my body. Cartesian mind-body duality is bad.

**Mikey**: Right but I think there's also like, a good case to be made for just like, thin people not calling fat people fat until like, there is huge changes and how we regard the word fat. Because there is a...it's different when fat people don't want to call themselves fat or when fat people want to call themselves fat. There are different

reasons there, there are different relations to words, right? Like, the word fat has been used on us, it's been pejorative; all that. But thin people haven't been called fat ever, and they've also likely never use it positively. So, I think that there is… sometimes I'm of the opinion that like, I don't want anyone thin calling me fat, ever. Period. But I think it depends on the person and usually I just want to be called fat, 'cause it's a neutral term that we are reclaiming. So it depends on the day, honestly, and it depends on the person and how engaged they are with, like, fat as a neutral term, I think.

**Monica**: We are context dependent.

**Mikey**: Yes. So just like, ask the person; ask them, maybe. Depends on the setting. I think if you're a clinician, probably just…I would probably stray to using language that doesn't refer to weight at all, or just like, just using "people in larger bodies". I feel like that's perfectly respectable in a clinical situation in which like, you don't have that much time with the person, you can't really develop a relationship with them, you don't know what their preferences are, etcetera. It depends, really. But we should probably move on. We don't have that much time.

**Monica**: Let's move on. Caitlin asks: "When looking at educating fellow clinicians, what would you say are the best resources to forward onto them and doing MPH work – Yay! – I am always looking for information to forward on when I speak up about anti-fat bias and fatphobia that would be considered scholastic and evidence based. Often they aren't going to read an entire book. What would you suggest as a good place to start?"

Good news for you, Google Scholar has stuff on weight stigma. That wasn't always the case. If you look up weight stigma on Google Scholar or PubMed, there are like many, many papers about it.

**Mikey**: I like the one that's about re-evaluating the evidence of—

**Monica**: Yes, *Re-evaluating the Evidence for a Paradigm Shift* by Lindo Bacon and Lucy Aphramor is a really solid one. There's one called *What's Wrong with the War on Obesity* that I love, because the title scans to a Tina Turner song. So that's like, a

fun song that I can think to myself. There is a really good one called...I don't remember exactly what it's called, but it's by Paul Campos and his friends, and has 'moral panic' in the title.

**Mikey**: Oh, yeah, is that like the one....

**Monica**: It's like, Epidemiology of Overweight and Obesity and Moral Panic a Real Thing?

**Mikey**: Is that the one Oliver or no?

**Monica**: Yes. I think so. I think Oliver is one of his friends.

**Mikey**: Okay, Eric. J. Eric Oliver...he wrote the book *Fat Politics*, I think. I think that's what it's called. But he also has a bunch of articles that basically reiterate what's in the book. So if you find that, like, you're trying to explain this stuff to somebody who does not want to read a full book, one of those articles may be a good idea. Should we move on?

**Monica**: Yes, I'm looking at other questions.

**Mikey**: Okay.

**Monica**: "Any resources you can share on education, specifically doctors positions on the necessity for a fat inclusive approach? The approaches I am using are not getting traction ie: speaking individually with doctors about harms of not having a fat inclusive approach. I usually use the example of people in bodies that are not thin not having any access to care for eating disorders."

Um.That's a tricky one. I mean...

**Mikey**: Yeah.

**Monica**: ...again there are many papers about how like, BMI based restrictions don't improve outcomes for people getting knee surgery, or like, this and that and the

other thing. Eating disorders is hard because doctors don't give a shit about eating disorders and fat people.

**Mikey**: Yeah that's what I was gonna say.

**Monica**: I can't say that any more nicely but like, they just don't care, They just…they don't think it's a thing. They don't care. So I would suggest using literally any other outcome, or if you look at the paper *What's Wrong with the War on Obesity*, they really look at how there are known mechanisms of minority stress, so like racism and homophobia cause negative health outcomes, just from like, being exposed to the messaging that like gay people are bad or whatever. And the same thing happens with anti-fatness. It's, you know, like, I hear fatphobia and then I get stressed and then my cells are like, ah, but science.

So I would maybe try that. But I mean, the other thing is like, not every doctor is going to get it. You have to have discernment and if it's like talking to a brick wall you have my permission to give up.

From Holly Ann on Facebook – hi, Facebook, hi Holly Ann – "I'm not sure how to best word my question. I am a cis white woman in a thin body. I see many patients who want to lose weight and eat healthier. I have often introduced the concept of using moving away from using body size as an indicator of health is making me a thin person, suggesting to a fat person that we work on their health goals without focusing on weight. Should I stop this, like the stop slide?"

I love that people are listening. I'm tempted to say no, it's different, that this constitutes patient education about what the science is. This is the place where Health at Every Size is actually really, really useful, I think. That Health at Every Size really is all about you want to improve your health, that's the value that you hold that's great. When people focus on the behaviour, rather than the outcome of weight loss, they tend to find that those behaviours yield as good or better health improvements in terms of like your blood pressure and like, feeling good in your body, when people don't focus on the weight, and that when people focus on the weight, doing the things becomes very unpleasant, because you're always thinking about your weight, and then you don't want to do them when it becomes evident

that you're not losing weight, because people don't lose weight because we didn't starve in the tundra.

**Mikey**: Right. And also just as a note like, there's, there's a difference between like, learning beyond HAES and using it to your advantage.

**Monica**: Yeah.

**Mikey**: Sometimes, like, you just have to like, break out the big gun or like, the thing that you don't really like, but like people generally like, support and find legitimacy in, and then you can sort of move on from there. Yeah, it's all about using the tools that we have. HAES can be really helpful if it's someone who is just like really in distress, and wanting to lose weight because again, there is a serious, serious emotional, psychological, physical toll that fatphobia brings, and sometimes it's just okay to be like hey there's this thing that like, people use now and acknowledge now, and it can be helpful for you in focusing on your health goals without centering your weight, so. That might be useful.

**Monica**: "What's your opinion on Diabetes Canada's recommendations that losing 5% of your body weight would better help manage blood sugar levels?" Garbage, garbage. Next.

This is from Tara Lynn Frakas: "You have both raised so many great points and I agree it takes some distortion to the middle of the system to making change. This is a loaded question, so bear with me. I am a dietetics student and I feel like many of my classmates are super supportive of this entire dialogue, however I find the most resistance in changing the systems comes from those who are already situated within the profession, such as practising RD's, professors and folks involved in the associations that we will eventually have to answer to in this profession. How can we begin to make meaningful change in terms of fatphobia in public health and dietetics when we are in a place of power struggle? Hope that makes sense."

Makes perfect sense. Love the question. Great question.

**Mikey**: Very good question.

**Monica**: I think the answer might actually be in the question and those associations that you answer to. Do they have a student section? Can you get involved in that student section? Can you start making friends? Can you start producing student section content for the other students about weight stigma? Because then eventually the association will notice. And having worked at a health association, one of the only things that can convince an institution like that to change is fear that they are going to lose a significant portion of the next generation that they are counting on for their membership.

**Mikey**: Oh yes.

**Monica**: So like, lean into that. There is a lot of power there, in those institutions, even though they can be very annoying to navigate.

**Mikey**: Yeah, you're wonderful position…that your, your classmates are interested and can be supported, and so you know, that's so much more power than you understand now, because it's frustrating to be like people in power want things to stay the same way, because that's what benefits them and that's what they know. And that's really frustrating. But finding community amongst your classmates when it comes to these really loaded issues is so wonderful and there's strength in numbers, although the power struggle thing is, is really, really real.

**Monica**: It's also if there is enough of you, can you start talking about the curriculum? Can you identify like, what's the worst thing we're studying and can we get it eliminated? What's the second worst thing we're studying? Can we eliminate it?

**Mikey**: You can only come up with programming that counteracts a lot of this stuff. Like at least…you and I, Monica, we spoke at the Radical Public Health thing as part of UIC. UIC, like…loves them some obesity studies, but that student run group brought us, and as a result, like, got the conversation going and that builds traction. And you actually don't wanna underestimate that power that student groups have, that programming has, that just like…absolutely, use the people around you to your advantage.

**Monica**: Okay, Hannah Robinson. “How would you navigate a situation where an eating disorder program has insufficient infrastructure and equipment, ie: chairs with insufficient weight limits? The delay of ordering appropriate furniture and equipment is preventing an individual from accessing necessary care.”

Yeah, that's really unfortunate. It's a great example of exactly what we've been talking about. I would write a spicy letter to the administration of the program, and be like, what the hell and why is this taking so long; there's an Office Max down the street?

Like, institutional processes only have to take as long as they take when somebody wants them to. You know what I mean? Like, if they really wanted to serve your client, they would already have the chairs in place.

**Mikey**: Yep.

**Monica**: And they would, you know...if they really, really wanted to rectify this oversight, they would have gone to Office Max, or Canadian Office Max. I apologise for my Americanness. And it's like, a bummer to be like, there is no good answer here, but like, you know, like sometimes going public can be a thing. You could write an op ed?

**Mikey**: Yeah. Pressure.

**Monica**: Right? Like, pressure. Yeah, you know, name names, embarrass people who need to be embarrassed.

**Mikey**: Yeah. And at the end of the day it's an accessibility issue, although most people treat it, weight, in terms of accessibility, as some kind of grey area, but all patients are, in theory, guaranteed care, like, so you should lean into that. It might not get you anywhere but it is a legal justification. And that's what matters.

**Monica**: Right. Like similarly, if there's an ombudsman's office and you haven't involved them, or like, a patient advocate, like, definitely let them know. Something I've been thinking about a lot lately is complaint and sort of what we can expect

from it and what we can't, and I don't think we can expect complaining to a healthcare institution to actually improve health care for the person who's complaining. I think it's really hard to complain in a timely enough fashion to actually influence the direction of your care, but also institutions are just so resistant. But if everybody starts getting a critical mass of complaints about fatphobia I think eventually it has to become like, a liability issue.

You know, they don't know because we're not telling them, but if we tell them, then they're ignoring…

**Mikey**: Right.

**Monica**: …I think is my logic and my point. Let's see how many questions we can get to in the next two minutes. "Any suggestions on how to include fat liberation and a college nutrition science course – this is from Carolyn Connor – ? I've been introducing HAES. Nutrition textbooks seem to all be very weight normative."

I would start with the *Fat Liberation Manifesto* and the chunk that I read about weight loss programs failing and I would get really into those data, and then be like what does it say that people in 1973 knew this, and what does that say about what we're doing now? That would be a really fun class discussion. I'd take that class.

A question submitted beforehand from Mun: "How should dietitians respond when Obesity Canada uses patient advocates to label weight inclusive, to label weight inclusive providers as obesity deniers who operate from thin privilege?"

**Mikey**: Okay, I have–

**Monica**: This is new to me and my brain is broken.

**Mikey**: I was recently on a panel with someone who is a patient advocate, and also thinks that the obesity designation is a good thing, because for some reason they think that the obesity designation guarantees people care, is less stigmatising, etcetera, etcetera, a bunch of bullshit that has been disproven by research, time and time again.

The solution to this is literally to just…like, you have to gather enough voices and actively and incisively challenge the assumptions that they have underneath, like, the position that they're taking with regards to fat inclusivity, fat acceptance, or even the promotion of the obesity paradigm. There are, again, lots of people who have done and are doing fat liberation work in relation to dietetics and nutrition. I would recommend seeking them out, and like, actively like, developing an action in response to that specific criticism, because hey, anybody who is actually advocating for their patients is not going to advocate for them to be discriminated against by an inherently stigmatising label, and the people who find themselves in those positions to be able to say something in opposition to fat inclusivity in opposition to weight inclusivity is because they are toeing the line.

They know that because of their position as someone who was supposed to be an advocate, and because of their held opinions about like, the helpfulness of the obesity designation, or their negative opinions about fat liberation, they know that they're good that they have a platform to speak because they're like, the one, right? They're like, the anomaly that's like, well, I'm a patient advocate and I think obesity is good, like the obesity label is good. And it's not. And there's plenty of people who would be willing to be like, no, it's not - shut the hell up [laughs], as long as you gather them. Because, like, the more we allow those voices to permeate the space and be loud about it, then, the more people start to believe like oh wow, this is a legit thing. And it's not. It's just credibility, privilege, and like shitty counter medical activism, at work. Does that make sense?

**Monica**: I think an important concept to have in your back pocket here is medicalisation or pathologisation.

**Mikey**: Yeah.

**Monica**: Which is when, when the medical world asserts  authority over a characteristic in order to exercise control. That's an inherently stigmatising process and Rachel Fox, who I think was on this call might be gone now, wrote, just an incredibly slamming paper–

**Mikey**: We're talking about this paper every chance we get.

**Monica**: Literally every chance we get. We're just like, Rachel Fox's paper! But Rachel Fox did a paper basically doing an intervention with medical students that resulted in this theory that as long as weight is considered a medical condition, the stigma will persist.

**Mikey**: Oh, Rachel put it in the chat! Yep, that's it.

**Monica**: Aw, Rachel put it in the chat! Anyway, Rachel's paper…Rachel's paper will help you. Vincci said that we're okay to go over time, and I'm okay to go over time.

**Mikey**: I'm okay to go over time.
**Monica**: So I'm just gonna keep going until somebody stops me, 'cause these are good questions and I'm having fun. So Aaron Reece said: "I work at a small health unit in Northern Ontario and we have done some work raising awareness about weight bias and stigma in the healthcare system. We have support to prioritise this work, which is great. We have identified that there are issues with our physical environment that are not weight inclusive and we would like to engage a group of folks who have bigger bodies to help assess our environment and influence changes to become more of an inclusive space. How would you recommend going about this in a sensitive way, recruiting and engaging people who are living the experience of navigating health care access in a bigger body?"

**Mikey**: I was gonna say, like, my first question is is there a fat professional in that space to guide that work?

**Monica**: Right.

**Mikey**: Like, to guide outreach, to guide assembling like, whatever, because–

**Monica**: That would be optimal. I mean like, my first question is honestly like, yes, it's good to talk to fat people to get our opinions, but also, do you really need to ask fat people to unpack their medical trauma in order to decide how many gurneys to buy? Like, do you really, really need that, or can you make do with the resources that

already exist? Like, NAAFA has some stuff for health care providers about increasing weight inclusivity. Because medicine is a site of trauma for so many fat people. And like, a lot of us have had experiences of like, recounting that trauma and then nothing happens.

**Mikey**: Yeah.

**Monica**: So like, Mikey's suggestion of finding a fat professional who can, like, lead or consult on the team I think is a great suggestion–

**Mikey**: If it's something that like, needs that kind of information gathering, then there should be some body fat at the helm of that, period.

**Monica**: Yeah.

**Mikey**: But yeah, the question is, is it even necessary?
**Monica**: Is it even necessary? But also if you decide it is necessary, pay, people so much money, pay them so much money. Pay them, like, no less than $50 an hour, I would say, as a starting point. Like as a starting point, because you are asking for something really important and really difficult.

**Mikey**: Yeah.

**Monica**: Like it's great, it's great to hear also that like, hospitals are taking this seriously. That's huge. That's news to me.

**Mikey**: Yeah, that's wonderful.

**Monica**: "Thoughts on BalancedView out of BC as a resource to educate ourselves on the impact of weight stigma?"

I'm not familiar. The name does not give me any kind of hope.

**Mikey**: Wait, what is that?

**Monica**: BalancedView.

**Mikey**: No. Never heard of it.

**Monica**: As a resource out of British Columbia. I would say unless you can tell that there are fat people behind it, it's not a good resource.

**Mikey**: I'm really tempted to just look the thing up right now [laughs].

**Monica**: Yeah, look it up right now. We're literally doing this research in time, real time.

**Monica**: Real time research. "Just a comment: One thing we don't talk about enough is how big pharma is insidiously spinning our discourses of fatness,

**Mikey**: Whoo!

**Monica**: "...They really really want to sell weight loss drugs for our entire lifespan." Natasha Wiebe, you're my friend now!

**Mikey**: No, I said, there— So an example of this, an example of what you just brought up: has anyone seen that new Novo Nordisk campaign about weight stigma that's, like, starring Queen Latifah?

**Monica**: I have a story to tell you about that offline.

**Mikey**: [laughs] Yeah, so, um, that is a perfect example of people who have a direct stake in the anti-fat paradigm, using the appearance of inclusivity, of advocacy, and diversity in order to explore and pillage markets that like, they rely on being pillaged and fucked over, basically. Like it's, it's a very, like...and it's something that I've seen that come up more and more often, like, especially in public health because I have seen this happen with many people who study race – people who study race using obesity as like, evidence of race, and therefore that thing that happens with food access movements again, where they like, instead of targeting racism calling it out and coming up with action steps, they're like, no, we should be focusing on obesity

because that's the evidence of like, the inequity that we face, the racial inequity we face. Like, I hate the term 'racial inequity' - it's just racism.

But the point is yes, big pharma sucks. I wrote a whole thing about Wegovy and all the money that they spent to pay researchers to do favourable research on it, and Novo Nordisk is terrible, and so it's big pharma. And they hate fat people and love killing them and extracting money from them. So, yeah.

**Monica**: Womp, womp. We have a follow up question on the scenario where a client is asking for help with weight loss: "After hearing and understanding what the patient's motivations and reasons are for losing weight, where does the RD go from there?"

**Mikey**: That depends on what you heard.

**Monica**: Right. It depends on what you heard, but probably, you're going to a place where you're talking about the short term versus long term effects of weight loss and weight cycling and what those do to your health. And, yeah.

**Mikey**: I'm also going to say this, because I feel like it's something that often gets ignored in conversations about like, what providers can do. You can always draw a limit about what services you're willing to provide and what services you're not willing to provide. I think the real test comes in when like, you have a scenario where someone's like, really adamant about weight loss. If you're really against it, then you will act accordingly. And I think that's something that like, people want to avoid at all costs in conversations about this for some reason. But like, especially if you're in private practice, you are in charge of the care that you give, of what you're willing and not willing to do, so.

**Monica**: I would also...sorry.

**Mikey**: No, no, that's, that's all. Like, that's all I had to say on that.

**Monica**: I would also...sometimes I'm just very Jewish and I'm like oh I can hear that her sentence is ending so I'm just gonna start now.

**Mikey**: [laughs]

**Monica**: I was going to add that I think that in the case of the patient who was being medically coerced to lose weight, that is a prime example of an intervention on the healthcare system that you can do. And like, what can you do to advocate for that client? Can you call their doctor and tell the doctor that what they're doing is bad? Can you help them find a different doctor who will provide the same care? Can you collaborate with their therapist to make sure that we're protecting their mental health while they're in this really terrible situation, etcetera, etcetera? Okay, I think that's all of them?

**Mikey**: Okay!

**Monica**: I think that's all the questions.

**Vincci**: There's one more.

**Mikey**: Okay!

**Monica**: Okay!

**Vincci**: Just at the end...

**Mikey**: Just when you thought you were done!

**Vincci**: And I think we'll close it here. So, the question is from Ann and she says: "I'm in long term care in Ontario and the physician sometimes won't adjust insulin for high blood sugars because he says it's the residents diet/slash weight and refers to me, RD, for weight loss. I try to stay away from BMI but it's required on admission and annually."

**Monica**: That's rough, because that's the one doctor who's like, in charge of the facility, and if you're in a facility, you can't find another doctor. Um, I don't know, does the doctor have a boss? Like is there a governing body of some kind? Right? Like at

some point we have to be changing policies around how clinicians care for fat people and like what the guidelines are. And so…ah, Ann: “wasn't really a question just sharing frustration and wanted your commentary”

**Mikey**: Oh, that really sucks. That really, really sucks. Just….

**Monica**: It really sucks.

**Mikey**: It's unethical as hell, and like, yikes.

**Monica**: Yeah, that's big yikes. That seems like a patient safety issue to me. Do you have a patient safety team, because we know that weight loss doesn't really work, but like, pretending that we don't know that weight loss doesn't work, weight loss takes time and your patient has high blood sugar now, and losing weight next week, won't help them if they have high blood sugar now. Um, so I would see if maybe there's like a patient safety or quality team, and you can frame it as like this doctor is refusing to manage his patients blood sugar because they are fat. Um, and see where that gets you.

**Mikey**: Yeah. Um, I saw some, like, and about the about BalancedView, the course. out of…yeah. Um, I looked at it and it basically looks like – I'm about to talk to you all about weight stigma interventions right now ‘cause this is where we're at. So, um, these look like the kinds of courses that are developed to address weight stigma, from a…from an attribution based lens. So essentially, you know, individuals develop these self guided courses or other kinds of programming that attempt to change opinions about fatness by educating people about the uncontrollability of weight.

So, and you can tell this because when you go on the website and and you scroll like on the ‘read more’ part, and there's the five modules, you see there's a module - module three - that says “Commonly Held Beliefs; An Introduction to Health Centered Approaches”. So when they're talking about commonly held beliefs about fatness, what happens is, they're going to educate providers on how weight is like, mostly genetic, how you can't really sustain weight loss, it's like, a rare thing, and they'll also like probably throw in a few facts about weight stigma. And then they sort of expect for that self guided education or that set of facts to reduce the

amount of implicit or explicit negative anti-fat bias that the physician or whoever's taking the course holds.

So they essentially educate on how fat is like, basically genetically determined, and then they expect for that to take care of the negative opinions that providers have about fatness. It never works, ever. It doesn't work. It's the most popular form of weight stigma intervention in the realm of healthcare. They usually take that kind of approach. Rachel Fox's intervention is like, in counter to that specifically - to this attribution theory based approach. And so yeah, BalancedView looks like shit, [laughs] is my basic appraisal of it [laughs].

**Monica**: Just to add that the reason it doesn't work is because you're not actually challenging the idea that fatness is bad. you're just saying, oh, but the poor gross fatties can't help it.

**Mikey**: Yeah,

**Monica**: And like, that doesn't inspire respect at all. So, that's why.

**Mikey**: Yeah, you're not challenging the deeply held and taken for granted beliefs that the person holds about weight and size and morality and worth. so you're never going to change the anti-fat beliefs that they hold, because you're not actually addressing them. You're approaching it from an intellectual fact based perspective that doesn't really have that much to do with why people hate fat people. So like, it doesn't work. Like, it doesn't.

**Monica**: Yeah, there's like a big misconception that happens in health care spaces, that like weight stigma is just needing to talk more nicely to fat people. And like I do not need to be told to lose weight more nicely. I need to not be told to lose weight, because losing weight doesn't help. And well, because I'm fine just as I am, because it's okay to be fat, because fat people are part of the diversity of humanity.

**Mikey**: And it would be even more okay to be fat, if we could just like, have the things that other people get by virtue of their size. It'd be so much easier. But, yeah.

**Monica**: Um, we have a question – I love that people keep throwing us new questions - like that's so fun. This is a really technical one. “Diabetes management and Canada steering away from insulin due to the weight gain associated and prioritising GLP-1 RA’s, ie: Ozempic and SGLT2I’s, ie: Invokana, as weight loss is often involved with these meds. Are there any issues with suggesting them or the way they're presented?

Yes. The thing about the weight loss medications is that they make you poop themselves, right? Like, don't recommend somebody a medication that makes them poops themselves–

**Mikey**: I mean, they cause  severe gastrointestinal distress, like, severed gastrointestinal distress. Like…[sighs].

**Monica**: Right? Like, it sounds funny when I say it  but it's just because I'm being inappropriately blunt. Like, it's not a joke. Don't give people a medication that makes them poop themselves. If you wouldn't take it yourself because of the side effects, don't prescribe it to a patient. How's that?

You know, there is just so little respect or consideration for fat people like, having a quality of life at all that researchers like, assume that it's preferable to like, lose 10 pounds by pooping yourself, than severe, severe distress, than to just live life as a fat person. Like they literally can't imagine fat people being loved or having fulfilling careers or like, you name it.

**Mikey**: Oh, and by the way, like…I just, I just read the question, the whole GLP1 – yeah. So I don't know if you caught this Monica, but Ozempic is like, the thing that they rebranded…

**Monica**: As Wegovy.

**Mikey**: As…yeah. So like…and like, that specific medication in the, so this — oh God finally something I'm qualified to talk about – [laughs]. So, um…

**Monica**: Finally?

**Mikey**: Is it WEG'ovy, or weGO'vy? I don't know.

**Monica**: I don't know. I just say it the way that annoys me the least.

**Mikey**: Okay. So, Ozempic is the medication that they essentially bumped up in dosage to rebrand as Wegovy – or rebranded Saxenda in Canada, nice to know! So, in the trials that they actually did for...no wait...no I think it's Victoza – is it Victoza? Hold on. I actually have it written down here somewhere. No, Victoza, yeah, Victoza was rebranded as Saxenda, and Ozempic was rebranded into Wegovy. Yeah. That's it.

**Monica**: Thank you, Vincci.

**Mikey**: Thank you, Vincci.
**Mikey**: So, Wegovy, actually...so those controlled trials that they did that made everybody get on board, probably in Canada too, with the whole, like, let's steer towards medication based approaches to obesity – those trials were like, bought and funded by Novo Nordisk. Like they are in no way a reflection of, like, how the drug may work. They also, if you read the articles about Wegovy, there is a person specifically who was mentioned as having been involved in the clinical trial for Wegovy, and they actually regained like, half of the weight that they lost during the trial within six months following. So it's putting people into this cycle of weight cycling, which is detrimental to your body. And they're doing it under the guise of like finding a "permanent" or prescribe herbal solution to like, obesity, that is supposedly less stigmatising for people because it's a medication and that feels legitimising, when in fact it's like probably gonna really fuck with like, your body's natural processes, and also send you into a tailspin of weight cycling that is inevitably more detrimental to you than most of the things that they can prescribe to you anyway.

So like, yeah. There's lots of issues with prescribing these medications, especially with the research that they've done now, because the RCTs that they've basically used to like, get these medications past approval, they don't have very long, like, follow up times, we don't know the long term implications of this medication. We

don't know exactly the extent – [reading from the chat box: Novo is currently trying to push these drugs all across UK]. Yeah, so that's part of the reason why Novo Nordisk is doing this weird campaign with like, Queen Latifah. There's probably an equivalent in the UK that's happening right now. They're trying to get people involved in the conversation on weight stigma and then present these medications as a solution to that. It's all marketing, so please do not participate in that cycle, 'cause they're selling a dream, and it's really just for profit making purposes. It's not for anybody's benefit, like big pharma does, so, yeah. Yeah.

I have not read the new edition of Intuitive Eating, so.

**Monica**: Same. Sounded like there was a question.

**Mikey**: Sorry.

**Vincci**: Is it okay if we wrap up here, everyone? [laughs]

**Mikey**: [laughs] Yeah.

**Monica**: Yeah. Vincci has things to do.

**Mikey**: Vincci is like, I have a life, guys! [laughs]
**Vincci**: No! [laughs]. That's not true! [laughs]

**Mikey**: Oh my God [laughs].

**Vincci**: Oh my goodness. But yeah. Thanks, Monica and Mikey. Like, thank you doesn't even capture how grateful I am that you guys responded to my random Tweet, to be like, hey, would you present if I paid you? [laughs]

**Mikey**: This was so much fun. Like…

**Monica**: This was really a lot of fun.

**Mikey**: Yeah, you just gave us an excuse to hang out, that's all it was [laughs].

**Vincci**: Yeah, yeah. And, for our members, I managed to ask Monica and Mikey, they're gonna hang out with us for a Peer Support Round Table in November, so more hanging out, if you're one of our members. But yes, thank you, everyone, for coming to today's presentation. I know it was a longer one than our normal one, so I really appreciate the, you know, almost forty people who are still hanging out with us right now. And I also wanted to apologise, kind of at the beginning, when people couldn't get in. Yes, the recording will be sent out to everyone. I'll try my best, also, to include links to some of the books and papers that were mentioned. And then I don't know – Monica and Mikey, do you think you'd be able to send me a copy of the slides as well, or?

**Mikey**: Absolutely, yeah.

**Vincci**: Okay cool. So I'll also include that. So, thanks again to Monica and Mikey, like...I'm already probably gonna go back to the recording right away, because I think there's so much that I've missed and yeah. And thank you, everyone, for attending. So thanks again, and I hope you all have a great afternoon!

**Mikey**: Bye!

**Monica**: Okay bye, everybody.

**Vincci**: Bye.