

“That could have killed me.”  
How anti-fat bias can be dangerous, even deadly, for heavier patients

by

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B.A. Chemistry  
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SUBMITTED TO PROGRAM IN COMPARATIVE MEDIA STUDIES/WRITING IN  
PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

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## ABSTRACT

We live in a society that values and treats people differently based on their body size. Such weight stigma can affect a person’s relationships, career opportunities, and daily life. And when this bias infiltrates a doctor’s office or hospital, it puts heavier patients at risk. Discrimination of any kind is bad for a person’s mental and physical health, but weight discrimination in medicine can also discourage patients from seeking care, exclude them from certain treatments, and lead to dangerous misdiagnoses. Drawing from the knowledge of a dozen experts and the experiences of a dozen patients, this thesis explores the myriad ways that medical weight bias can gravely impact the health and well-being of larger-bodied people. It also asks: where do we go from here?

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Elizabeth Riley has trained her lungs since she was eight years old. She was a professional singer and needed every ounce of her breath to carry each note to the back of the opera house or the last pew in the sanctuary. So, when she developed an unrelenting cough and a hard lump at the base of her throat, Elizabeth knew something was seriously wrong.

It was 2014, and Elizabeth was enduring a sweltering summer in downtown Tulsa, Oklahoma. She and her husband had just decided to embark on a thrilling new journey together: parenthood. “I wanted to be a mom more than anything in my life,” Elizabeth says. But first, Elizabeth wanted to ensure her body was ready for pregnancy.

According to just about every doctor she’d ever had, Elizabeth was overweight. Despite efforts to lose weight, her body always settled around the same size. But Elizabeth had always been active and healthy—she particularly loved hiking and swing dancing—so it came as a shock when she began struggling to climb the three flights of stairs to her apartment, wheezing and hacking by the time she reached her front door.

So, that October, Elizabeth visited a pulmonologist about her symptoms. The doctor did one assessment—a lung function test—and found that Elizabeth had just three-quarters of her typical lung capacity.

The doctor told Elizabeth she was suffering from “obesity-induced asthma.” The weight of her chest and stomach must be too heavy for her lungs. “That doesn’t make any sense,” Elizabeth remembers telling him, “I am the same weight I’ve always been. I’m an opera singer.” He responded, “Well, you’re getting older now,” though she was 27 at the time.

The pulmonologist prescribed Elizabeth weight loss and an inhaler and gave her the green light to pursue motherhood. A couple of months later, Elizabeth and her husband received the best Christmas present: two little red lines on a pregnancy test. They were going to have a baby.

However, the early glow of Elizabeth’s pregnancy was muted by her ever-worsening cough and a growing lump in her throat. The mass began to trigger her gag reflex when she swallowed, which only exacerbated her morning sickness. She became severely dehydrated and lost 30 pounds in a single month. By January 25<sup>th</sup>, she couldn’t eat or drink anything without vomiting and had to go to the ER.

This time around, Elizabeth underwent a battery of medical tests. A CT scan finally revealed the true cause of her symptoms: a half-foot-long tumor wrapped around her esophagus. Elizabeth had cancer.

By that point, the tumor had halved her lung capacity. “I was basically functioning on one lung because of this mass that I had gone to the pulmonologist for. And they said, ‘Well, you’re fat,’” Elizabeth recalls. “They didn’t even give me a chest X-ray, and if they had, I would have been diagnosed just months and months and months earlier.”

Instead, Elizabeth had lost precious time to treat the rare and aggressive form of non-Hodgkin's lymphoma. Now, the doctors told her she might have to abort her baby in order to receive the appropriate treatment. But she wasn't ready to give up on her dream of motherhood yet.

Elizabeth—and her baby—were put at risk by a medical system blinded by Elizabeth's size. They're far from the only ones.

Studies dating back to the 1980s have illustrated how weight stigma permeates healthcare. They've shown that doctors on average spend less time with heavier patients, more often describe them with negative terms like “weak-willed” and “noncompliant,” and can be less likely to order them diagnostic tests. Doctors are encouraged by government recommendations and insurance payments to counsel heavier patients about their weight. But from patients' perspectives, this practice can feel like doctors only focus on their weight and not their concerns, which can discourage them from seeking care.

“For years I just didn't like to go to the doctor, because the first thing they would tell you is, well, ‘Of course you have a problem: it's your weight,’” says Louise Seguin, a retired administrator in Quebec, Canada. “I just dreaded going.”

I spoke with a dozen patients who have experienced medical weight bias. Because of the personal nature of these conversations, some of them asked for their names to be shortened or changed. Each of them had avoided medical care at some point—sometimes for years at a time—because they felt doctors would not listen to them and instead fixate on their size.

These patients also reported being told to lose weight to treat myriad symptoms, including menstrual cramps, knee pain, hair loss, ear pain, incessant cough, jaw pain, and heart attack symptoms. (These ailments were eventually diagnosed as endometriosis, a torn ligament, hypothyroidism, bacterial infection, pneumonia, a tumor, and gall bladder attacks, respectively). Doctors suggested they lose weight during stressful and vulnerable circumstances, like while being admitted to the hospital with a collapsed lung, when seeking treatment for a festering wound, midway through a cervical examination, and even while pregnant.

Experiences like these can cause heavier patients to feel unwelcome in clinics, hospitals, and other medical facilities. But patients are also told they don't belong by distasteful expressions from nurses, by the chairs, gowns, and blood pressure cuffs not made to accommodate them, and by hurtful comments from doctors themselves. An allergist told one patient that no man would ever love a woman at her size. A cardiologist described another as “fat and lazy” during a physical examination.

Like other forms of discrimination, weight stigma harms a person's mental, physical, and social health. It contributes to mood and eating disorders and can cause chronic stress, which triggers a host of harmful physiological effects. And when weight stigma infiltrates the medical system, it can gravely threaten patients' lives. Yet weight bias is a growing phenomenon—it is the only form of implicit bias, including bias based on race, gender, and sexual orientation, that has increased over the past ten years.

According to Jeffery Hunger, a weight stigma researcher at the University of Miami, “We have an epidemic of anti-fat bias and fatphobia in our country, more so than we have a quote-unquote epidemic of obesity.”

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Wendy Reaser felt hopeful the day she made her appointment with the plastic surgeon. Her back pain had gotten so bad that she could hardly stand long enough to cook a meal or wash the dishes. She hoped a breast reduction might allow her to move through daily life without pain.

On a sunny day in June, Wendy and her husband walked into the surgeon’s office in downtown Saskatoon, Canada. The waiting room had a minimalist, modern aesthetic, which put Wendy on edge. “I just had this gut feeling,” she recalls. She didn’t even bother trying to sit in the white leather chairs perched on thin metal legs.

A nurse called Wendy and her husband into a small examination room and instructed her to put on a gown that Wendy knew wouldn’t fit. It didn’t. “It’s happened to me for so many years that I don’t even think about it anymore.”

After a few minutes, the doctor walked in, and Wendy’s stomach sank. “As soon as she looked at me, any feeling of hope that I had went out the door,” Wendy remembers. “I felt like she was looking at me with disgust.” Wendy locked eyes with her husband and nervously shook her head. She knew what was coming.

“Oh, you’re a big girl,” she recalls the doctor saying in place of a greeting. The surgeon approached Wendy, grabbed her by both nipples and lifted her breasts. “Those suckers are heavy,” Wendy says, “and so to hold them up by the nipples is painful.” The doctor released Wendy’s breasts and told her, “There’s nothing I can do to help you.” Unless, she said, Wendy lost 30% of her body weight.

“Well, if I could lose that much weight, I wouldn’t need the breast reduction,” Wendy remembers thinking.

Wendy’s hopes of living without daily pain vanished, and she began to cry. The doctor sat down across from her, looked her in the eye, and said, “I don’t know why you’re sitting in my office crying. I didn’t make you fat. You made that choice.” As Wendy began to sob, her husband—the “gentlest man on the face of the Earth,” according to Wendy—stood up and asked the doctor to leave.

As the doctor walked out, she said, “Take some time to compose yourself, but when I come back, you better be gone.”

Wendy’s doctor disparaged and refused to treat Wendy because of her size. There’s no evidence that people above a certain BMI can’t have breast reduction surgery, says Ximena Ramos-Salas, the director of research and policy at Obesity Canada. However, some practices set arbitrary

weight cutoffs. In 2019, Ramos-Salas and Obesity Canada successfully lobbied to remove any weight limits on breast reductions in the Canadian province Nova Scotia.

The experience with the plastic surgeon stuck with Wendy. “I felt like a worthless human being for quite a while after that,” she says. But weight bias doesn’t have to be so conspicuous to have a serious impact. Even subtler forms, like a *tsk* from a nurse at the scale or a doctor’s hesitancy to touch a heavier patient can leave a lasting impression.

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Weight stigma has proliferated in medicine under two major assumptions: that a person’s weight is entirely under their control, and that significant weight loss is attainable for most and imperative for good health.

There are many factors that determine body size. A person’s genetic makeup plays a big role. Scientists have identified more than fifty genes associated with higher body weight. Studies of twins raised in different households show that genetics are a better predictor of body size than upbringing. Physical and mental health play a role, too; medications and chronic health conditions can contribute to weight gain, as can experiences of trauma and mental illnesses like depression, binge-eating disorder, and food addiction.

An often-overlooked factor in a person’s size and health is their environment and socioeconomic class. Do they have access to fresh fruits and vegetables or a safe place to walk? What about clean water and air?

Blaming people’s weight or health status on bad personal choices is “a real slick way to just ignore the fact that people are poor, or people are living with unimaginable stress...or people are living in areas with high pollution,” says Nancy Ellis-Ordway, an eating disorder psychotherapist and health educator. Because addressing the root of these issues is much harder, says Ellis-Ordway, “We just say, ‘Oh, well they’re just unhealthy because they’re fat, because they don’t behave like they should.’ That’s a real easy cop out to not address social determinants of health.”

A person trying to lose a significant amount of weight must battle the odds, and their own body. “Once we gain weight, our bodies are set up to defend that higher weight,” says Rebecca Puhl, deputy director of the Rudd Center for Food Policy and Obesity. “Anytime someone’s trying to lose weight, they’re fighting their body’s biology.”

Weight loss slows your metabolism and increases your drive to eat food—physiological responses that were likely helpful earlier in human history when food was scarcer. But today, this explains why most dieters can lose weight in the first few months, but eventually regain it and then some. A woman classified as “obese” by her body mass index (BMI) has just a 0.8% chance of achieving a “normal” weight in her lifetime, and more than about 5% weight loss is unlikely without an intervention like medication or bariatric surgery.

The good news is that weight is not synonymous with health. Studies have shown that a considerable portion of people considered obese (from 10% to 50%, depending on the criteria)

are healthy based on measures like blood pressure, heart rate, and cholesterol. Meanwhile, about a quarter of thin people can be considered metabolically unhealthy. Plus, [studies show that] a person's risk of dying early only increases at the lowest and highest ends of the weight spectrum. "You have no idea what that person's health is based on just looking at them," Ramos-Salas says.

Increasingly, evidence shows that healthy behaviors matter more than just the number on the scale. A 2012 study of nearly 12,000 participants showed that people with healthy habits like eating fruits and vegetables, exercising, and not smoking lived longer regardless of weight class. "If you increase your physical activity, your health is going to improve," Hunger says. "If you increase the quality of your diet, your health is probably going to improve. But this isn't something that's just an issue for higher body weight individuals. We've got an issue of physical inactivity and poor diet across the spectrum."

The eight weight stigma researchers I spoke with agree that we need to remove the hyper focus on weight and take a more holistic view of a person's health. This would benefit people of all sizes, since framing weight loss as the central goal can discourage people from continuing with healthy habits if they're not seeing the weight loss they were told they should.

Alternatively, patients may take drastic, unhealthy measures to try to meet their doctor's weight loss directive. "It should come as no surprise that either experiencing or anticipating negative mistreatment translates into something like disordered eating, because folks may see that as a way to escape the stigma," Hunger says.

That's what happened to Wynter, a graduate student of medical social work in Virginia. Every doctor's appointment, Wynter would hear the same thing: you need to lose weight. Wynter had tried before and figured she just needed to try harder. And so, Wynter began restricting herself to eating just 450 calories per day (the equivalent of less than two Clif bars), even as she competed on the rugby team, gave miles-long walking tours of campus, and worked as a full-time student. "Surely I'm going to lose some weight," Wynter remembers thinking. "Then, you know, maybe the doctors will stop harping on it."

Heavier people are often congratulated for the same disordered eating behaviors that thinner people are hospitalized for. "They go to the doctor and the doctor says, 'Wow, great, you're losing weight. Keep up what you're doing,'" Ellis-Ordway says. "The assumption is that weight loss is always good and weight gain is always bad. And so, people who are engaging in horribly disordered behaviors are getting praised for it."

That's exactly what Wynter experienced. "I thought I was just being good," said Wynter, when in reality she had developed atypical anorexia ("atypical" only because she didn't classify as underweight). Even as Wynter began losing hair and had hardly enough energy to make it to class, people would tell her, "You're doing so good. You have so much willpower."

It wasn't until she passed out in the middle of a rugby game that anyone noticed Wynter had been starving herself.

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“Fat shaming doesn’t need to end; it needs to make a comeback,” Bill Maher declared on his talk show in September 2019. He, like many before him, argued that denigrating people for their size is helpful. It will motivate heavier folks to lose weight, he claimed, and will ultimately benefit the health of individuals and society at large.

Decades of weight stigma research contradict Maher’s declaration. Not only does “fat shaming” fail to achieve its desired effect of weight loss, but it’s also actively harmful to larger-bodied people. “Weight stigma has real consequences for the health and well-being of higher bodyweight individuals,” Hunger says. Ironically, Hunger adds, studies have shown that people who experience weight stigma gain more weight over time.

One of the main ways that weight discrimination affects a person’s health is through something called the social identity threat response. It’s the sudden realization, says Sean Phelan, a weight stigma researcher at the Mayo Clinic, that someone is categorizing you or making negative assumptions about you because of your social identity—in this case, for being fat. “It’s almost like having the wind taken out of you,” Phelan says.

If a person experiences weight stigma during a doctor’s appointment, it can trigger this identity threat. Patients will have “an anxiety or stress response where they are just unable to really be present and fully participate in the encounter,” Phelan explains. “People immediately lose track of what they’re doing, can lose the ability to communicate effectively, and forget the questions that they meant to ask.” This means patients may not get the information they need from their appointment or be so disappointed with the encounter that they won’t return.

Like any other stress response, social identity threat has physical and mental health consequences. It boosts adrenaline and cortisol production, which can increase inflammation, appetite, and fat deposition. Experiencing weight stigma can contribute to anxiety, depression, and eating disorders and encourage exercise avoidance, binge eating, and social withdrawal.

On the day of her bariatric surgery appointment, Lesley Scherer recalls the anesthesiologist telling her, “I wasn’t the fattest patient she’d ever worked on, but I was close.” Lesley had been on a liquid-only diet for a month in preparation for her surgery, but this comment nearly put her over the edge. “I literally almost blew my entire surgery,” she says, “because the first thing I wanted to do was go and eat.”

Mistreatment from doctors takes a serious toll, Lesley explains. “It makes you feel so worthless. It penetrates every single part of your life because when you feel worthless to professionals who are there to help you, you feel worthless to people who certainly aren’t there to help you. And you just retreat even more into yourself.”

With repeated exposure to weight stigma, the identity threat response can become chronic, producing an enduring stress about experiencing discrimination. This could have long-term health effects. A 2016 study of more than 21,000 people found that, even after controlling for weight, physical activity, and socioeconomic status, experiencing weight discrimination was



associated with increased risk for obesity-related conditions like heart disease, high cholesterol, and diabetes.

New approaches to healthcare look towards weight neutrality. One example is Health at Every Size (HAES), a methodology created by physiologist Lindo Bacon. HAES doesn't focus on weight loss, instead encouraging people to foster a healthier relationship with food, movement, and their bodies.

But these approaches can make people involved in weight management nervous, says Angela Meadows, a stigma researcher at Western University in Canada who used to work in the weight loss industry. They'd think, "We can't have fat people accepting themselves, because then they'll just get fatter and fatter and fatter. We need them to be a little bit ashamed so that they'll actually become thin people." However, Meadows began observing in public forums that, "Once [people] stop hating themselves, they actually start taking better care of themselves. They might start moving their bodies whereas before they had been too ashamed to do that."

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Amanda was sitting in her house in Vancouver when she felt her chest tighten and ache. She began to gasp for air as sweat gathered on her brow. She thought, "I'm having a heart attack."

When her symptoms didn't fade, Amanda took a taxi to the ER. She waited anxiously in the lobby, fearing for her life. Finally, they called her in.

"It's acid reflux, you're fine," the doctor told her. "It's your weight." They gave her an antacid and sent her home. Amanda already took medication that kept her acid reflux under control, so she left feeling confused and uneasy.

A few months later, Amanda had another intense bout of the same symptoms. When she went to the ER, she received the same diagnosis. She kept having these attacks every few months for two and a half years, but each time doctors told her that she was overreacting, that it was acid reflux and she just needed to lose weight.

"It was painful. It was horrible. I had never felt like that before in my life," Amanda says. "It left me wondering what the hell is wrong with me and why isn't it being taken seriously. Because it felt serious."

It wasn't until Amanda went to a new ER in a small city south of Vancouver that she finally got a proper diagnosis. Amanda had been experiencing gall bladder attacks. But by the time she had surgery a few months later, so much scar tissue had built up from her repeated attacks that the surgeon couldn't remove the whole organ. This has left her with gall stones and recurring inflammation of what remains of her gall bladder, which cause her bouts of stomach pain, nausea, and vomiting. To fix the issue, she'll have to go back under the knife.

"It has had long-lasting effects because it wasn't diagnosed properly," Amanda says.

Two years after this ordeal, Amanda developed an intense cough and began hacking up yellow and green phlegm on a daily basis. When she went to an ear, nose, and throat specialist, he told her that, once again, this was due to acid reflux. When Amanda tried to explain that she didn't think that was right (particularly given what she'd been through with her gall bladder), she remembers the doctor putting his hand up in front of her face and saying, "Yes, it is. You need to lose weight."

Less than a month later, Amanda rushed to the ER hardly able to breathe. During a walk test, Amanda's heart rate skyrocketed, and her oxygen levels plummeted. She was immediately hospitalized with pneumonia and a partially collapsed lung.

But before she admitted her to the hospital, the doctor leaned over and whispered to Amanda, "Oh, and you should really lose weight," and then walked away. *Thanks, I never thought of that*, Amanda thought sarcastically.

"I've had so, so many interactions and complete misdiagnoses that could have killed me," Amanda says. In some ways, Amanda is lucky — she survived. Not everyone does.

Studies estimate that 80,000 people are disabled or killed each year due to medical misdiagnoses in the US alone. It's difficult to put a number on how many people suffer or die from specifically weight-related misdiagnoses, but anecdotal stories have circulated, like Ellen Maud Bennet, 64, who died from cancer after years of being told she just needed to lose weight, or Jan Fraser, 59, who had her complaints dismissed by doctors until it was too late to treat her endometrial cancer. (By the time they found her tumor, it had grown to the size of a volleyball). A study of over 300 autopsy reports revealed that people classified as obese were nearly twice as likely to have significant undiagnosed medical conditions like lung cancer and heart infection.

Other studies have shown that doctors spend less time, provide less health education, and are less willing to prescribe certain screening tests with their heavier patients. According to a 2015 research review published in *The Lancet*, doctors report having less respect for and less desire to help their larger patients, saying that treating them is "a greater waste of their time than is the treatment of their thinner patients."

Bacon, the HAES founder, witnessed this inequity firsthand. Bacon and their father share a genetic condition that makes their joints vulnerable to overuse injuries, but Bacon is slender while their father is heavy. When Bacon's father visited an orthopedic surgeon seeking help for his knee pain, the doctor told him that he'd brought this problem on himself and needed to lose weight. The visit "just triggered his eating disorder. It did not help his knees get better in any way," Bacon says. "Even if his weight is contributing to the knee problems, prescribing weight loss was not at all effective."

Bacon's own visit to an orthopedic surgeon looked very different. Their knee pain flared up because they had been overtraining for a marathon. "That was not healthy," Bacon says, "but I never got blamed for having poor health practices." Instead, the orthopedist recommended strengthening exercises and eventually surgery, which improved their pain dramatically. "My father also could have benefited from stretching and strengthening exercises...and from surgery,

but none of those were offered to him,” Bacon says. “The doctor just got distracted by my father’s weight.”

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Lynn Holloway arrived at her first radiology appointment after being diagnosed with cancer, her husband and mother by her side. The radiologist explained that the tumor growing in her groin wouldn’t respond to chemotherapy and was too big for surgical removal. Radiation was Lynn’s only live-saving option, he told her, “but I’m not sure you’ll fit on the machine.”

Lynn went into a panic attack. She paced frantically, her mind racing. “Holy shit,” she thought. “My weight is finally going to do me in.”

The radiologist decided to weigh Lynn to see if the machine would accommodate her. He took her to a scale in the hall, but the device only went up to about 300 pounds. He then led Lynn down into the basement and put her on an industrial-sized freight scale. While Lynn was too preoccupied by fear to feel embarrassed, her mother and husband were “mortified” that the doctor subjected her to this.

When the pair returned to the clinic, the radiologist said he should ask the technician who ran the machine about whether Lynn would fit. “It’s really her baby,” he said. The technician came in with a hula-hoop and put it over Lynn’s body, easily encircling her with room to spare. After being humiliated and made to fear for her life, Lynn learned that she’d fit on the machine just fine.

While most heavy patients haven’t endured an experience like Lynn’s, many know what it’s like to encounter improperly sized medical equipment. Be it hospital gowns, exam tables, or waiting room seats, medical institutions often lack appropriate infrastructure to accommodate larger bodies. Not only does this create stigmatizing situations, but it can also inhibit heavier people from receiving appropriate care.

This has been a recurring theme for Lesley Scherer. Hospital gowns never fit, narrow seat armrests jab into her sides, and blood pressure cuffs squeeze too tight. “I have literally walked out of places with bruises down the back of my arm because [the cuff] pinched me so hard,” Lesley says. “They do have bigger ones, but the nurses always make you feel like a burden because they have to go and get it.”

These uncomfortable situations are yet another reason why heavier people might avoid care. “It can signal to [patients] that you don’t belong here or at least we weren’t expecting someone like you,” Phelan says.

While inappropriate equipment can make larger-bodied patients feel unwelcome in medical spaces, certain policies actively exclude them. “There are strange policies out there that restrict access to various treatments based on BMI,” explains Ramos-Salas, the Obesity Canada director. Procedure limitations and weight cutoffs vary between institutions, but they often apply to things like knee and hip replacements, fertility treatments, and—like in Wendy’s case—breasts

reductions. Some cite infrastructure as a limitation; hospitals may lack appropriate tables and lifting aids to treat larger patients. Others don't want to risk weight-related complications. But some weight cutoffs—like those on breast reductions—lack scientific basis, Ramos-Salas says, and instead grow out of “old-fashioned beliefs driven by weight-biased attitudes that people with obesity deserve this.”

Nearly two decades have passed since Lynn's cancer treatment. Unfortunately, over those years her hip joints have deteriorated, a newly recognized side effect of radiation treatment. Lynn also suffers from lipedema—a chronic condition that causes painful fat to build up in her legs and arms—and lymphedema—major swelling of her left leg, which resulted from damage to her lymph nodes during cancer surgery. These conditions alone limit Lynn's mobility, but her degrading hips can make the simplest tasks unbearable.

But when Lynn went to the doctor to inquire about a hip replacement, they told her they couldn't help her until she lost weight. However, the weight she bears due to lipedema and lymphedema is nearly impossible to shed. “Are certain areas of health just not open to obese people?” Lynn wonders. “I'm just going to be living in agony for the rest of my life unless I can lose the weight?”

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“Doctors and medical professionals live in the same society that everybody else does,” and they are no more immune to weight bias than the rest of us, says Puhl, the Rudd Center deputy director. Puhl's research has shown that students enter medical school with these biases built in. But most medical programs do little to combat them and may instead reinforce stereotypical assumptions.

“We're taught so early on in a fatphobic manner in medicine,” says Vicky Borgia, a primary care doctor in southern Philadelphia. “It's in the water and you don't know it because you're swimming in the water.”

Borgia's own medical education perpetuated negative stereotypes about heavier folks and reinforced outdated beliefs about weight and weight loss. “We're taught things that we think are benign and well-meaning that actually do harm.”

Although Borgia finished school more than twenty years ago, not a lot has changed. Most curricula today push a simplistic narrative about weight and health, says Heather Brown, a critical obesity researcher at A.T. Still University. “There's not a lot of room in standard curriculum to deal with a topic as complex as weight.” This can perpetuate assumptions that a person is to blame for their weight and that, if they are unable to lose weight, they are lazy, noncompliant, or don't care about their health.

Biases aside, most family doctors want to give their patients quality, personalized care. But an overburdened system can inhibit them from doing so. Doctors' offices in the U.S. have become incentivized by the pay-per-service insurance model to see more patients, and faster. It's not uncommon for a doctor to have a panel of more than a thousand patients and appointment times

under 15 minutes. “The [overwhelming pace] is what leads many well-meaning people who otherwise would practice in a different way, practice in the way they are,” Borgia says. “You don’t have time to see people as human beings.”

Institutions can also influence how doctors approach and treat their patients. Doctors can get paid by insurance providers for talking with heavier patients about their weight. “That’s why you’re pressured to be weighed in the office, because it’s collecting BMI data. And then [the doctor] can get paid...for counseling for obesity,” Borgia explains.

But given short, impersonal appointments, a doctor’s ability to actually counsel a patient is limited. “If the patient is interested and wants to have that conversation, then I think it’s one that is beneficial,” says Phelan, the Mayo Clinic stigma researcher. But too often it manifests as, “‘You’re fat and you need to lose weight and I can’t offer you any help,’ [which] does more harm than good.”

For many patients, this practice is tiresome, frustrating, and stigmatizing. Many point to it as a reason they delay care, because they don’t want to receive yet another lecture about their weight. “Every single time you go to the doctor it’s, ‘You need to lose weight, you need to lose weight,’” Lesley says. “You get to the point where you’re just like, ‘Well, why would I go to the doctor for that, because they’re just going to tell me to lose weight.’”

To combat weight stigma in medicine, education needs to start early and be continually reinforced, Puhl says. Studies of successful interventions addressing weight bias are limited, because many are too short to make lasting change—it takes a long time and repeated education to address internalized biases. However, Puhl says, the interventions that work best address multiple aspects of stigma. These might include education about the factors that contribute to a person’s body size and the complexity of weight loss, as well as hearing directly from heavier patients about their experiences with weight bias. “One thing that’s been particularly effective is really trying to help medical professionals understand that weight stigma legitimately harms the health of their patients,” Puhl adds.

But even the most well-rounded, highest-quality interventions must fight an uphill battle against a culture that perpetuates and even condones weight stigma. “It essentially remains legal almost everywhere in the country to discriminate against people because of their body weight,” Puhl says. “That sends a message that this is a form of stigma that is tolerable.”

Every stigma researcher I spoke with agrees that combatting medical weight bias ultimately requires addressing weight stigma at large, and that changing public policy is critical. As of right now, Michigan is the only state where people are legally protected from weight discrimination the same way people are protected from discrimination for their race, gender, and sexual orientation.

However, there is a growing recognition within healthcare of the dangers posed by weight stigma. In 2020, more than 100 medical and scientific organizations around the world came together to sign a pledge to combat weight bias in healthcare. For the first time, Puhl says, “the

medical community [was] speaking with one voice, identifying that this is a legitimate problem that needs to be addressed.”

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Tucked in among the red brick row houses of southeastern Philadelphia, the Radiance Medical Group hardly seems like a doctor’s office. Daylight streams into the waiting room through tall windows, warming exposed brick walls and a dark wood floor. A leather couch and armless, electric-blue suede chairs wait expectantly, and Borgia’s own desk sits in the corner. A community mini-fridge and Keurig sit next to a corral of colorful mugs emblazoned with phrases like “Ask me about my pronouns” and “Fuck the Patriarchy.”

“It feels like you’re literally walking into your friend’s living room,” says Zhaniah, a Radiance patient. “When I go there, I feel really safe. It’s not an experience I ever had [in healthcare].”

Before Vicky Borgia started Radiance Medical Group, she spent over 20 years working in big medical institutions, including multiple low-income clinics where she would see patients rapid-fire. Despite wanting to give her patients the individual, unbiased care they deserve, she had hardly enough time to learn their names, let alone form personal connections with them. On a particularly busy day, Borgia saw 40 patients before her 1:30 pm lunch break. She recalls thinking, “I could run these people down with my car and I wouldn’t remember that I saw them today.”

She also felt constrained by insurance incentives and the BMI-centric agenda of these larger institutions. Borgia tried to encourage a more holistic, weight-neutral approach, but she found it challenging, and the fast-paced, impersonal system wore on her mental health. And so, in 2019, Borgia began her own private practice.

While open to everyone, Radiance particularly serves marginalized folks who may have experienced trauma in more traditional medical spaces. Borgia wanted to ensure her that practice looks and feels welcoming to everyone.

This wasn’t an easy task, however. “It took me months and months and months to find a space,” Borgia says, because many locations lacked bathrooms that could accommodate people with larger bodies or disabilities. She also spent nearly \$4,000 dollars on a refurbished exam table that can raise and lower and has a 450-pound weight capacity. It cost about three times more than a brand-new, more typical exam that lacks mobility and a higher-weight capacity.

To her patients, Borgia’s work has paid off. “I don’t have to worry about, ‘Am I going to break something, or am I going to feel uncomfortable squeezing into this chair?’” says Cathy, another of Borgia’s patients. Cathy, who worked as a registered nurse for two decades, also appreciates that Vicky only weighs her patients for specific reasons, like when determining medication dosage or before a patient’s surgery. “There’s nothing like being at the doctor’s office and the first thing they do is have a medical assistant call you down the hall...and you have to stand there on the scale with everybody else milling around.”

But it's more than just her physical space that makes Borgia's practice unique and welcoming. It's the relationships she forms with her patients. Borgia is a direct primary care provider, so her patients pay a monthly flat rate to have near unlimited contact with her through appointments, texts, and calls. This format allows her to build strong connections with her patients and give more personalized care. She makes a point to schedule a 90-minute intake appointment for everyone.

"It gives people space and time to cry," Borgia says. "I acknowledge people's trauma, medical and otherwise... There's just so much trauma in the world, you know."

Borgia's approach has had a big impact on her patients. Zhaniah, who is Black, has experienced a lot of medical racism, sexism, and fatphobia and so developed significant anxiety in healthcare settings. But she says that Borgia's practice has helped her immensely, and that both her mental and physical health have improved since joining the practice nearly two years ago. "It's made medical care accessible for me," she says. "This is what it feels like for a [doctor] to actually see me as a person."

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Back in Tulsa, Elizabeth Riley was left deciding her fate—and her daughter's—in the face of a grave cancer diagnosis. Ultimately, she chose to keep the pregnancy and slow her cancer treatments, accepting additional risk to her own life for a chance to give her child one. She endured months of chemotherapy and pregnancy while breathing with just half her typical lung capacity. Finally, on July 13, 2015, Karinae Riley was born.

Karinae was delivered two months early and went straight to the hospital's intensive care unit. Twelve long hours later, Elizabeth held her daughter for the first time. "[Karinae] and I both had all these wires and tubes and stuff hanging off of us, and the nurses were just trying to be careful not to get them tangled up," Elizabeth says. "They just wanted me to be able to finally hold my baby." Karinae weighed only four pounds, but Elizabeth was too weak to lift her. "All they could really do was lay her on my chest, and I just wrapped my arms around her," Elizabeth says, tearing up. "It was a big moment."

Today, Elizabeth lives with her husband and daughter beside a lake in the woods outside of Sand Springs, Oklahoma. The effects of her ordeal linger. Because Elizabeth's cancer wasn't caught before she became pregnant, she had to undergo a different set of cancer treatments to protect her daughter. This involved large doses of the steroid dexamethasone, which has caused her joints to deteriorate. "Both of my hips are now rotting out from underneath me," Elizabeth says.

Despite everything she has been through, Elizabeth says there are still doctors who tell her she wouldn't be in so much pain if she lost weight. "And I'm like, well, okay. I literally can't walk, but okay."

Today, Elizabeth weighs just a bit more than when she was going on 15-mile hikes and singing opera. "I was an extraordinarily healthy human back then," Elizabeth says, "And one thing happened, and now I'm disabled. And everybody looks at my fat and assumes that that's why

I'm disabled. And it's not. Being fat didn't make me disabled, and not being fat won't fix anything for me."

Over the years, Elizabeth has finally found a primary care provider and gynecologist that she trusts, and that has made all the difference in the world. "They actually listen to me, and they don't judge just based on whether or not the scale has moved up," Elizabeth says. Her family doctor takes her seriously; when Elizabeth came in with concerns about a hot, painful leg, he called urgent care to get her seen right away. "He didn't tell me you just need to walk more to make your legs hurt less or something," Elizabeth says. "[It] was really impressive given how much I've been blown off by some other doctors in the past."

Things are finally looking up for Elizabeth. Now five years in remission, she is officially cancer free. And after her second hip replacement in June, Elizabeth will be able to walk, hike, and dance again. Karinae, now six, loves playing outside as much as possible and can't wait to go on bike rides with her mom. But the thing Elizabeth is most looking forward to is teaching her daughter how to grow a garden.



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