View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by UEL Research Repository at University of East London

Anti-Fat Attitudes in Healthcare

Kelly Robinson

A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Professional Doctorate in Clinical Psychology

May 2021

ABSTRACT

Background: Anti-fat attitudes and weight-based discrimination are well documented as pervasive in western society. The dominant medical narrative of weight serves to maintain the assumption that weight is wholly within an individual's control. As such, fat people are discriminated against and blamed for their ill-health. The nation's weight has gained further attention as a result of COVID-19 placing significant strain on our healthcare system. The current pandemic serves as another example of how fat people are discriminated against and seen as lower priority for care in comparison to others.

Aims: To consider the public's awareness and views about these issues, and whether there would be public support for future policies seeking to mitigate weight discrimination in healthcare.

Method: Employing a critical realist approach, this study used qualitative methods of engaging twelve participants in semi-structured interviews. Interviews were analysed using Thematic Analysis.

Results: Two main themes were identified. 'Social Representations of Weight' which considered the way that fat people are spoken about and the dominant narratives in our society that shape public views. The second theme, 'Intersections with Services and Systems' captured the moral and conceptual dilemmas involved in the prioritisation of healthcare and discrimination that fat people face.

Conclusions: Findings highlighted the complex, yet flexible views that people hold in relation to fat people accessing healthcare. There was an awareness of the negative effects of discrimination on access to healthcare, and the inequity of this. Participants held contradictory views simultaneously; oscillating between the consideration that an element of discrimination is unavoidable, and possibly acceptable in some instance, whilst stating that discrimination is unethical, and that healthcare is a human right. The findings offer the hope that perhaps anti-fat attitudes are not as fixed as previous research indicates. Additionally, that there may be public support for policy change and the possibility of weight becoming a protected characteristic.

ACKNOWLEDGEMENTS

Thank you to all the participants who took the time to share their views with me.

A massive thank you to Dr Ken Gannon for your support, knowledge, and calming influence.

Lastly, thank you to my family and friends who have supported me through the challenges and celebrated the successes. To those of you who painstakingly corrected each word and comma, for those who offered encouragement and pep talks, those who brought me snacks, but mostly for your belief in me. I am incredibly grateful for you all.

CONTENTS

1. INTRODUCTION

1.1 Overview

This study explores attitudes of members of the public to people labelled ‘obese’ (PLO) accessing healthcare within the United Kingdom (UK) National Health Service (NHS). The concept of ‘obesity’ and the language used to describe it will be discussed.

Anti-fat attitudes are considered one the few forms of prejudice that are deemed socially acceptable (Puhl & Heuer, 2010a). This research outlines some of the areas in which people experience such prejudicial attitudes, paying particular attention to the NHS healthcare system, considering the current COVID-19 pandemic.

The researcher was interested in gaining public opinions as recent public movements have significantly mobilised legal and government systems. In the United States, public demonstrations have increased pressure on the Government to ensure that the police officer responsible for the death of George Floyd was tried in court (Ankel, 2020). In the UK, public responses have resulted in the launch of a ‘diversity commission’, the suspension of the export of riot gear, and a legal review of home office policies (Otter, 2020). The researcher was intrigued as to whether public opinions related to weight discrimination may have the power to impact policy in a similar way.

As such, members of the public were asked about their views of fat people accessing healthcare, as well as exploring their views on the weight-based discrimination that fat people face in healthcare settings. It is likely that attitudes they hold will be present in policy making as we understand that weight-based stigma is widely upheld in our society. These issues are important to the field of psychology as psychologists can play an influential role in developing and managing equitable services, as well as shaping policy.

1.2 Author's Position to the Research Topic.

As a white, straight sized[1], cis woman, I was aware of the privileges I held before commencing this research. I considered that questions or challenges of anti-fat attitudes may be more 'palatable' coming from me, rather than someone with personal experience of anti-fat attitudes – perhaps my lack of experience of discrimination would allow me some distance from the emotion associated with this topic. I was aware that straight sized participants may find it easier to talk to me as a straight sized person, as they may perceive I share some of their views about fat people. In contrast, I considered that if black or brown people elected to participate in the study, they may feel less able to openly discuss how race and ethnicity intersect with weight and appearance, if they perceived that I was unaware of my own whiteness.

Although I have been passionate about the issue of weight-based discrimination for several years, I was aware that there would be issues that I had not considered due to my own experiences of privilege. I also considered whether I was the best person to be conducting this research, and whether it was my place having had no personal experience or direct understanding of this discrimination. Thus, I would not be aware of some of the details of the lived experience of fat people in society. However, I felt my experience as a woman, being exposed to body shaming and the way the female body is valorised gave me some knowledge and insight into the stereotypes and judgements held by our society.

1.3 Language and Terminology

1.3.1 Fat or Obese?

The term 'fat' is used throughout this research to refer to a person who describes themselves as 'heavier' than 'average', as well as to refer to people who are labelled as "overweight" or "obese" according to medical categories (which change periodically)(NHS, 2018; Rothblum & Solovay, 2009). At present, a Body Mass Index (BMI) calculation takes an individual's height and weight to categorise them as 'underweight', 'healthy weight', 'overweight' or 'obese'. Currently, a BMI over 30 would result in a person being labelled 'obese' (NHS,

---

[1] 'Straight sized' is a term used to describe people/ clothing sizes that are smaller than 'plus size'.

2018).

There were lengthy considerations and consultation about whether using terms such as ‘fat’ and ‘anti-fat attitudes’ would alienate some readers. However, the researcher drew guidance from scholars, writers, and activists with personal experience of such attitudes, and felt it important to support their preference. Activist and writer Aubrey Golden (2020) has written at length about the harmful and derogatory use of the medical term ‘obesity’, and the visceral feelings it conjures for people it is used against. She writes that although ‘straight sized’ (“healthy weight”) people may perceive medical terms such as ‘overweight’ and ‘obese’ as neutral, that this is not the case for fat people. These words encompass decades of judgements from health professionals, failed support, misdiagnoses and denial of care. Further research suggests that calling fat people ‘obese’ medicalises human diversity. By medicalising people in this way, indeed a “cure” to this natural differentiation in human size is deemed appropriate (Puhl & Heuer, 2010b; Rothblum & Solovay, 2009).

The argument is presented that ‘fat’ is merely a word, in the same way that ‘tall’ and ‘brunette’ are descriptors. Of course, most such terms imply a comparison of some sort. People are only tall relative to others that are short. Also, as averages can shift over time, ‘tall’ might mean different things in different places, and at different times. But, similarly to height, fatness can be understood as a form of human diversity.

Activists involved in the fat rights movement reject medical terms and seek to reclaim ‘fat’ as value neutral (Cooper, 1998; Rothblum & Solovay, 2009). Writers argue that persistently avoiding the word ‘fat’ maintains the stigmatisation of fat bodies, upholding the word’s power. Instead, they encourage everyone to use the word fat, as an act of rebellion, with no intended malice, to diminish the power it holds (Golden, 2018, 2020b; Orbach, 1979).

1.3.2 Anti-Fat Attitudes

Goffman, (2009: p3) described stigma as an element that discredits the individual, diminishing the person who possesses the attribute “from a whole and usual person to a tainted, discounted one”. These perceived attributes seek to convey a particular social identity that is devalued in certain social and cultural contexts (Crocker et al., 1998).

The social devaluation and discrimination towards fat individuals is defined as weight stigma, or anti-fat attitudes (Cramer & Steinwert, 1998). Weight stigma is a multilevel construct, associated with ideas of personal responsibility and blame. Weight stigma is recognised to inhibit access to structural, psychological and interpersonal resources, thus promoting health disparities (Hatzenbuehler et al., 2013). In our society this discrimination appears to have become accepted and normalised (Previte & Gurrieri, 2015).

1.4 History of the Fat Body

It is important when discussing body shape and size to consider the capricious nature of body ideals in society. Fat bodies are not aberrations of our current consumer driven era of excess, they have been in existence for tens of thousands of years. The carving of the ‘Venus of Willendorf’ is thought to be the oldest three-dimensional representation of a human being found, dating back to 28,000 – 25,000 BCE. This carving is understood to have been created by the Grimaldis, migrants from Africa who inhabited Europe. It is unclear whether she was a fertility goddess, or a talisman of good health and beauty, but early race scientists pathologised fatness when they saw it on black indigenous people (Cramer & Steinwert, 1998).

Thin has not always been better. Rounded models in Rubens’s paintings reflect the beauty ideal of his era, yet today they would be viewed as ‘overweight’. In the early to mid 1800s food was scarce, as such, people with larger bodies tended to be wealthier as their size indicated they had enough to eat, and they were therefore perceived to be healthier and more prosperous (Previte & Gurrieri, 2015). This changed when transportation and industrialisation made food distribution and production far easier. As food became more readily available, people began to increase in weight. As such, the differentiation between the wealthier, fatter bodies, and poorer, thinner bodies began to lessen. The wealthier classes sought to reclaim their social power over the lower classes by trying to differentiate themselves once again (Strings, 2012, 2019). This was in some part done by idealising thinness. Slender bodies became a sign of style and prosperity. With this shift also came a change in medical advice. Previously, people had been warned from becoming too thin, as this was associated with numerous disorders. However after much persuasion it appeared that doctors changed their ideas about health in order to endorse the thinner body (Baker, 2015; Crawford, 1980; Strings, 2019).

1.4.1 Pathologising the Fat Body

With growing valorisation of the thin body and developments in pharmacology, it became possible to medicalise weight in new ways. Weight loss drugs became widely prescribed in Western society in the early 1900s, as doctors offered thyroid medication as a weight loss aid. This was followed by the prescription of amphetamines, laxatives and diuretics, with side effects ranging from mild to fatal (Brown, 2015). With this medicalisation of body size came a shift in language, and the use of more clinical words such as ‘adipose’, ‘overweight’ and ‘obese’. Both ‘overweight’ and ‘obese’ convey clinical and moral judgement – that a person is over the “correct” weight, and ‘obese’ from the Latin word “obesus” which translates to “wasted away with fat” (Lewis & Short, 2020).

‘Obesity’ was officially established as an ‘epidemic’ in 1994 by the World Health Organization (WHO). Being fatter was associated with metabolic disorders and increased disease risks (Latner et al., 2005). WHO statistics report that levels of ‘obesity’ have tripled since 1975 (Wanniarachchi et al., 2020; WHO, 2018). The use of the term ‘epidemic’ represents a further development of the medicalisation of fatness. It locates ‘obesity’ in the same category as infectious diseases, and in doing so it raises possibilities of infection or contagion (Elliott, 2007).

1.4.2 Current Western Climate

In recent decades, Western cultures have witnessed a marked trend toward particular beauty ideals for women, which favour thinness. Yet looking at average weight statistics, young women have actually become heavier on average (Flegal et al., 2016). Thinness was and continues to be associated with elite, white femininity, implicating the individual as refined, restrained, and delicate (Strings, 2012, 2019). Strings, (2012) also argues that the thin body ideal has always been racialised, as fatness was stigmatised and linked with poor, black and immigrant women, then used to rationalise excluding them from full participation in society.

In the UK we are currently undergoing a period of rapid social change. Members of the public are speaking up about injustices and demanding political change. It is possible that this shift is enabling more marginalised groups to be visible, heard and accepted. However, the anonymity social media provides has also facilitated people to feel less cautious about voicing discriminatory and hateful attitudes, particularly towards people from marginalised groups (Silva, 2016; Wanniarachchi et al., 2020). Fat people are one of the few minority groups who are routinely stigmatised in mainstream media, including body and fat shaming of celebrities.

In other areas however, fatness is not stigmatised in the same way. In some cultures, the fat body indicates that the individual is well cared for (Adams, 2000). Additionally, in areas where undernutrition is a major threat to life, fatness is valued. For example in areas with a high prevalence of HIV and AIDS, being fat can indicate that an individual is healthy and free from disease (Levy-Navarro, 2005; Swinburn et al., 2019). It is crucial to consider the alternative views about fatness across the world, and the way that medical views of fatness are so embedded in western medicine.

1.5 Current Medicalised View of Weight in the Western World

The current approaches to fatness in western society tend to be based on notions of individual behaviour and personal responsibility. The researcher considers who benefits from this narrative other than pharmaceutical companies selling weight loss medication.

1.5.1 Medical Accounts of Fatness

At the heart of many arguments concerning the relationship between weight and health is ‘science’. We are told that being fat is a direct result of consuming more calories than are being burnt through physical activity. We are also told that it can lead to the development of serious conditions, including type II diabetes, cancer and stroke (NHS, 2019). In western medicine, emphasis is placed on diet and an assumption that consumption of cheap, sugary food is to blame. This classist assumption has been longstanding in stories about fat people. As described in section 1.3, wealthy and poor bodies began to be differentiated by size, fatness became stigmatised as being associated with greed, laziness, lack of knowledge and the lower classes (Cooper, 2021; Probyn, 2008).

It has been argued that the focus on individual behaviour is a consequence of a neoliberal emphasis on autonomy and individual responsibility. This leads to a culture of shame and stigmatisation, upheld by ‘scientific’ research. Capitalist culture makes it difficult to be fat, such that many fat people have internalised this stigma and admit a want to lose weight (LeBesco, 2011). When weight and health are viewed as within an individual’s control, those individuals that are perceived to not have control of their weight are stigmatised by society, and at risk of negative character assumptions being made about them (Brewis et al., 2011; DeJong, 1980). LeBesco, (2011) suggests that pathologising fatness (as discussed in section 1.3.1) leads to an increased sense of shame for fat people, an aversion to seeking medical care and the development of unhealthy relationships with food which include dieting, binge eating and dangerous weight cycling. Research indicates that these issues have more detrimental effects on health than a constant but high weight (Berg, 1993; Germov & Williams, 1996).

1.5.2 Health and Weight

It is argued that much of the information about the links between health and weight are exaggerated and ideological. Yet the reports that indicate being fat is unhealthy have great persuasion in our society, which likely contributes to the pervasiveness of weight stigma in healthcare specifically (Campos et al., 2006; Crawford, 1980; Drury, Louis, et al., 2002; LeBesco, 2011; Robison, 2005).

The term ‘healthism’ was devised by Crawford, (1980) as a political ideology that advances a ‘healthy’ lifestyle to a ‘high moral calling’. Further development of this ideology considers healthism to be underpinned by racist and eugenic practises that intended to separate people in to categories of ‘healthy’ and moral versus ‘unhealthy’ and foreign (Skrabanek, 1994).

1.5.3 Classifications and Measurements of Weight

The Body Mass Index (BMI) was developed in the 1830s by Mathematician Adolphe Quetelet. Quetelet was attempting to discover the ‘ideal man’, placing people into categories that had not existed before. These categories were then used as ‘scientific justification’ for the sterilisation of many black and disabled people for existing outside of these new ‘ideal’ parameters (Golden, 2019b; Strings, 2019). The BMI is a widely used tool which uses a person’s weight and height to calculate a BMI number. Numerical ranges and the categories associated with BMI calculations have changed across time and culture. For example, in 1998, BMI cut offs were lowered and people became ‘obese’ overnight (Rothblum & Solovay, 2009). Currently, a BMI of 30 or above would result in a person being labelled as ‘obese’ (NHS, 2018).

There are numerous shortcomings of the BMI further to its eugenicist history. A simple BMI calculation does not take into consideration someone’s body composition, activity level, general wellbeing, or lifestyle. For example, by this rudimentary measure, a short but muscular person could be diagnosed as ‘overweight’ or ‘obese’ purely by their height to weight ratio, and by this categorisation, apparently be at risk of significant health conditions. It has been argued that such categories are unhelpful and damaging. Instead, it is suggested that weight could be more helpfully viewed as a trait that varies across any population in a bell curve, like height (Ogden et al., 2006).

1.5.4 Weight Management Approaches

Having different categories of weight results in a drive for people to want, or be expected, to exist within the “normal” BMI category, potentially as a result of the hegemonic character of healthism. Foucault, (1991) suggested that the public want to be perceived as healthy, partly due to living in a society that profoundly discriminates against, and marginalises, those individuals who are believed to have ‘opted out’ of health. For around 60% of people in the UK, weight loss would be required in order be placed in the ‘normal’ BMI range (Baker, 2021).

Studies report that repeated weight-reduction attempts serve to dysregulate the metabolic system and make attainment of the thin ideal even more unlikely. If achieving thinness were simply a case of eating less and doing more, then we would expect more people to be “successful” in achieving, and more importantly, maintaining this ideal. Yet decreasing one’s caloric intake significantly suppresses metabolism. The human body is extremely resilient in the face of adversity and, to accommodate the decrease in energy intake, the body will become more efficient by slowing down its’ metabolic rate. This change in metabolic rate protects existing fat stores from fast depletion (Bray & Sciences, 1975; Garrow et al., 1978; Welle et al., 1984; Wolpert, 2007). Furthermore, studies report that long-term weight loss is not maintained. Wolpert, (2007) reported that typically up to two-thirds of people who have lost weight will gain back more weight than they lost within four years. Brown, (2015) reported figures of up to 97% of dieters regaining at least everything they lost within three years. They argue that much obesity research fails to reflect the truth about diets, as they are rarely longitudinal and tend not follow people for more than 18 months.

Some research argues that weight-stigma may be justified and necessary to activate individuals to lose weight and sustain weight loss (Latner et al., 2009). This narrative has been embraced by numerous health professionals and policy makers, who promote stigma and shame narratives as a valuable method to motivate people to lose weight (Ogden & Clementi, 2010). The perception of some professionals is that calling their patients ‘fat’ (using the term derogatively) is more likely to encourage them to take personal responsibility in reducing their weight (Betts, 2010; Ramesh, 2010). However, there is very little evidence that this approach is effective, especially considering the ethical implications of perpetuating shame (Lewis et al., 2011; MacLean et al., 2008). More recent diet trends centralise mindful and ‘intuitive eating’, as well as some of the psychological and behavioural factors that may result in a person ‘overeating’. Although these approaches appear to mitigate some of the shaming narratives, they continue to present weight loss as something that is easily attainable and sustainable whilst holding the individual as solely responsible for implementing change (NOOM, 2021). The pervasive message remains, that both the origin and the resolution for obesity lies within the individual. As a result, ideas of “personal responsibility” fuel stigmatisation which continues to be held as an acceptable societal response (Brewis, 2014; Clair et al., 2016a; Lewis et al., 2011; Pearl, 2018).

1.6 Alternative Approaches to Fatness That Emphasise Social Dimensions

Despite the predominant individualistic view of fatness in western medicine, there is a growing body of research that opposes the narrative of fatness resulting from such individualistic assumptions of poor diet and inactivity. Instead, this growing research attempts to explore the nuances of body size, as well as critically reviewing the ‘science’ that makes claims about health and weight relationships.

1.6.1 Social Determinants of Health

Research suggests our individual health is not only determined by our eating habits and behaviours (which are also shaped by context); it is also influenced by social determinants. These social factors are thought to account for up to 75% of our health outcomes. Attempts to address these factors have included concentrating on the development of a public health approach, that goes beyond the prevalent belief of weight denoting health, and indicate a requirement for government intervention (CDC, 2021; Kersh, 2009; Penney & Kirk, 2015; Saguy et al., 2014).

When we think about weight in this way, we find differential consequences for individuals and communities. When we consider the social determinants of health, the blame and stigma associated individual responsibility is significantly reduced. This narrative also highlights the importance of environmental and policy changes that are necessary in order to ensure people have access to resources necessary for a ‘healthy’ life, positioning the population’s weight as a public health issue (Nestle & Jacobson, 2000; Pearl, 2018). Puhl & Heuer, (2010b) take the stance of weight being a public health issue further, claiming that weight stigma can be viewed as a social justice issue. They proposed that weight stigma does not serve to reduce fatness, rather it threatens the health of fat people through health disparities and social inequalities, which calls for this to addressed as a priority for public health policies. There has been a call for public engagement to produce ethical policies that reflect community values, as until recently, weight-based stigma has not been concentrated on as a legitimate concern (Barry et al., 2009; Jebb, 2004; Puhl & Heuer, 2010a). But it is not yet known how exposure to such arguments about the social determinants of health may shape public attitudes about health risks, policy and discrimination (Saguy et al., 2014).

1.6.2 Health at Every Size

Another alternative stance to the view that fatness causes ill health is The Health at Every Size (HAES) paradigm. HAES seeks to contest the concept of linear causality between weight and health, instead drawing attention to the value of a “fulfilling and meaningful lifestyle” over and above body weight or size. The HAES approach is considered to be less stigmatising than conventional medicalised approaches (Bacon, 2010; Bacon & Aphramor, 2014; Flegal et al., 2005; Robison, 2005). HAES holds the position that weight, like height, is a human trait that varies across any population (Ogden et al., 2006). With this considered, it is unrealistic to expect the whole human race to fit within the narrow parameters of what is deemed ‘normal’ weight. What appears to threaten some people’s views is a fat person being happy and confident in themselves, because they may believe that it is not possible for a fat person to be happy if they have not yet achieved or are even trying to achieve the ‘ideal body’ that equals happiness. This confusion can trigger mockery and hostility towards fat people. The HAES seeks to challenge this perception and encourages people to enjoy multiple aspects of life free from guilt or shame, promoting the value of connectedness, joy in movement, and centralising social justice in the maintenance of health and overall wellbeing (Bacon, 2010; Bacon & Aphramor, 2014).

This approach also seeks to remove individual blame by producing an understanding of the numerous elements that contribute to our weight and size. Bray & York (1979) and Grilo & Pogue-Geile (1991) suggest that a person’s genes may be more powerful than environmental factors in determining their weight. Additionally, the level of overeating necessary to gain weight varies dramatically between people (Rose & Williams, 1961). By considering these multiple interacting factors, this research promotes a more holistic approach to overall wellbeing, taking people’s health concerns seriously and not assuming weight as a causal factor. As Primeau et al, (2011) suggest, fat people are not a homogenous group, as some fat people have better metabolic profiles that apparently ‘healthy’ weight individuals. Arguably one of the most striking issues the HAES sets to highlight is that rather than fatness causing ill health, it is the stigma that fat people face which results in stress related illnesses (Bacon & Aphramor, 2014; Ogden & Clementi, 2010; Robison, 2005).

1.6.3 Weight Stigma and Ill Health

Many studies have further supported that weight stigma and discrimination are responsible for stress-induced pathophysiology and psychological disorders, as well as possibly contributing to weight retention and gain (Brewis, 2014; Muennig, 2008; Ogden & Clementi, 2010; Puhl & Heuer, 2010b). These studies consider that it is in fact the stress of judgment and discrimination from others that causes co-morbid health problems for fat patients, rather than carrying 'excess weight'. Research suggests that stigmatization causes fat people chronic stress which affects their allostatic load which results in cumulative and chronic effects on their health (Bacon & Aphramor, 2014; Brondolo et al., 2009; Dressler, 2018). Judgements are made that being fat in unhealthy, as such, access to healthcare is often treated as an incentive, something that a person can achieve if they lose weight, but adequate healthcare is a human right (Bacon & Aphramor, 2014; Baker, 2015; Saguy et al., 2014).

Research from the Centre for Disease and Control and Prevention (CDC, 2021) found the lowest mortality rates in people labelled 'overweight' and 'mildly obese' due to their BMI. This was also found by (Flegal, 2005) who report that fatter people live longer. However, public misconceptions and pervasive assumptions about the causes of fatness continue to impact to expressions of weight stigma due to a complex mixture of moral judgements and 'scientific fact' (Puhl & Heuer, 2010b; Saguy & Riley, 2005).

In addition to the physical health concerns associated with being fat, significant psychological distress can result from being stigmatised. Ratcliffe & Ellison, (2015) considered that exposure to weight-based stigma can result in negative self-perception, mood changes and safety behaviours. These findings further highlight the need for psychologists' involvement with these issues to support with policy to prevent stigma and discrimination.

1.7 Weight Stigma and Discrimination in our Current Society

It is important to give a political and cultural context to this research; as discussed in section 1.3, ideas about shape and weight have varied over time and culture. As such, we must consider the current UK climate of opinion and how this further perpetuates challenges for fat people in our society, which unfortunately appear to conflict with the alternative, less individualised understandings of weight as described above.

1.7.1 Perceived Responsibility and Blame

As highlighted in section 1.4.1. the medicalised view of fatness, and most frequently discussed issues in research, is that a person’s weight is perceived to be a result of elements wholly within their control, for example poor diet and lack of activity (Bell & Morgan, 2000; Crandall & Moriarty, 1995; DeJong, 1980).

Research by Weiner, (1993) explored the relationship between perceived personal responsibility and certain conditions. They found that people with more stigmatising conditions (including drug use and ‘obesity’) were rated high on personal responsibility and were disliked, evoked limited pity, yet high anger (Weiner et al., 1988). More recent studies have found similar patterns. Crandall & Moriarty, (1995) examined attitudes towards 66 different health conditions and diseases and found that the perceived degree of personal responsibility predicted social distance and rejection from others; the higher the degree of perceived responsibility for a person’s condition, the more distance and rejection they received from others.

These views of accountability and blame persist, despite studies reporting that less than 25% of our overall health is influenced by behavioural factors (CDC, 2021) and the noted efforts of activists, as well as a growing body of research outlining the social determinants of health (Brewis, 2014; Hatzenbuehler et al., 2013; Puhl & Heuer, 2010b). It is possible that the public are unaware of such studies, despite information challenging the individualised narratives of fatness being readily available in the public domain. When the dominant societal views are blame and lack of empathy for a stigmatized group, public are unlikely to support social change or policy change to enable fat members of society the same care and protection as thinner peers (Bobo et al., 2012; Loury, 2002).

1.7.2 Human Rights

In the UK, weight is not currently a protected characteristic under the Equality Act (2010). This likely contributes to the prevalence of weight-based stigma and

discrimination as there is currently no law or policy permitting this.
However, the British Psychology Society (BPS) Code of Conduct and Ethics for psychologists (BPS, 2018) is broader in its claim that psychologists should "avoid practices that are unfair or prejudiced" (p.10). This statement can understood to include weight-based prejudice. Furthermore, one of the core values of the NHS constitution is "everyone counts" – ensuring nobody is excluded, discriminated against, or left behind (NHS, 2009). Yet we know that people are still being judged as unhealthy and denied surgery due to their weight. Their value, morality and meaningfulness are seemingly judged by their medical charts (Bacon & Aphramor, 2014; Baker, 2015).

1.7.3 Western Media

The media has a significant impact in shaping public opinion, with laypeople aligning with particular newspapers and narratives about the world. The media plays an crucial role in the public's understandings of health, and has been influential in spreading anti-fat attitudes through misconceptions and oversimplifications of fatness (Ata & Thompson, 2010). Over the past decades there has been an increase in the speed and breadth of how media is shared and consumed. We are able to access millions of images of celebrities with idealised, digitally altered slim bodies, with little variety in their shape and size (Brewis et al., 2011). Systematic reviews have found that using social media for images is correlated with body image concerns (Anderson et al., 2017; Wanniarachchi et al., 2020). It is also understood that public views of fatness and weight-related health risks are mainly formed from access to media sources, (including magazines, newspapers, television, and social media) rather than reputable, evidence based sources (Rich & Evans, 2005; Saguy & Almeling, 2008). Ramasubramanian, (2011) further highlighted how impactful media exposure can be. They reported that exposure to negative stereotypes can increase prejudice, and exposure to counter-stereotypical depictions can decrease prejudice. Saguy et als., (2014) study supported these findings, suggesting that the media positioning 'obesity' as an "epidemic" is increasing anti-fat attitudes in the public.

Despite this, Evans, (2006) and Hilton et al., (2012) researched the escalating coverage of 'obesity' in the UK press over the years. Interestingly they found that there was a shift from 1996 – 2010 to move away from individual focus and blame, towards a reporting on societal solutions and public interest in the matter. Hilton and colleagues (2012) suggested this might be an early indicator to policy makers of a growing public awareness of the need for regulatory change.

1.8 Contexts in Which Weight-Stigma is Displayed and Experienced

There is widespread documentation of the detrimental weight-based stereotypes that fat people are unattractive, lazy, weak and uneducated (Brownell et al., 2005; Puhl & Heuer, 2010b; Puhl & Latner, 2007). For the fat people who experience additional forms of oppression, due to their race, ability, class, sexuality and other protected characteristics, it is important to consider how the multiple aspects of their identity may compound the discrimination they are faced with (Bacon & Aphramor, 2014; Bombak et al., 2016; Burnham, 2012; Golden, 2020a; McPhail & Bombak, 2015)

1.8.1 Institutional and Systemic Discrimination

Not only are fat people stigmatised by other individuals in society, there is research evidencing that fat people are systemically discriminated against and disadvantaged in a range of settings (Canning & Mayer, 1966; Clair et al., 2016a; Pagán & Dávila, 1997; Puhl & Heuer, 2010a). Research has explored medical settings (Schwartz et al., 2003); workplaces (O’Brien et al., 2013); government agencies (Lewis et al., 2010) and education institutions (O’Brien et al., 2007) where fat people are treated less favourably than their thinner peers due to judgements made about them. These prevailing attitudes place fault with individuals for their size, and are commonly understood as justifiable discrimination (Hebl & Heatherton, 1998; Puhl & Brownell, 2001).

1.7.1.1. Education: From an early age, children learn that fat people are to be stigmatised. There are studies that suggest children of any gender develop preferences for lean bodies (Di Pasquale & Celsi, 2017; Latner et al., 2005; Lerner et al., 1973). Additional studies suggest that children are likely to have more negative attitudes towards fat children than towards children with a broad range of disabilities including facial disfigurement and physical difficulties. Children develop an extremely negative stereotype of fat people which included traits of being dirty, lazy and stupid (Goodman et al., 1963; Richardson et al., 1961).

Matthews & Westie, (1966) report that high-school students wished to keep more "social distance" from a fat peer than from a disabled peer. It is possible that the way fat students are discriminated against effects their desire to continue in education. Canning & Mayer (1966) reported that in a sample of high-school graduates, 52% of "nonobese" females went to college whilst only 32% of "obese" females did, despite no difference in objective measures of intelligence and achievement. The authors write that education is a crucial variable in determining social class, and discrimination in the higher education system against fat students may contribute to a downward spiral in social mobility.

1.7.1.2. Financial and Employment: Financial discrimination is another challenge faced by fat people in Western society. In the early 1900s Sweden levied a tax on individuals based on the number of pounds they were overweight (Bray & Sciences, 1975). This resulted in fat people being penalised financially for their weight. The distribution of weight across low, middle and high socioeconomic status was studied by Goldblatt et al., (1965), who found that the percentage of thin women was positively correlated with social class level, suggesting that more of a communities' wealth was held by thin members of society than by fat members.

In relation to employment specifically, it has been documented by Personnel Today, (2005) that 93% of the 2000 Human Resources professionals asked would employ an 'average' weight person over a fat person with the same qualifications. Additionally, 15% of these HR professionals would be less likely to promote a fat employee, thus maintaining thinner people in positions of power and wealth.

1.7.1.3. Gender: For women particularly, weight may be more salient as the body is deemed important in defining a woman's attractiveness. If body type is more central to determining a women's attractiveness, then a body type deemed unattractive will be more damaging in the overall view of a woman. Thus potentially resulting in a lack of care and help, as (Benson et al., 1976) found that people who are deemed ‘physically attractive’ are more likely to receive help than those deemed “unattractive”.

Furthermore, fat transgender people are frequently denied lifesaving gender-affirming care and surgery unless they lose weight. There is significant evidence of the high instances of eating disorders in the trans community. The obligation to lose weight to be eligible for surgery will possibly exacerbate the instances of eating disorders, and negatively affect mental health (Freespirit & Aldebaran, 1979).

1.7.1.4. Ability: The Body Positive Movement has gained significant media attention in the past few years. However, it continues to be apparent that some bodies qualify for preferential treatment over others. (Berne, 2015) wrote that some bodies are valuable, and others are disposable. The argument is raised that bodies are valued for their ability to produce a profit. Those bodies that do not conform with such neo-liberal ideas are frequently isolated and eliminated. Disabled people are frequently left out of conversations about body positivity as it feels that we are encouraged to love our body if it is deemed ‘loveable’ by culturally defined standards. Unfortunately, as more body positive straight sized ‘influencers’ post images of their “imperfect” bodies and circle their “imperfections”, fat and disabled bodies have become marginalised once again within the very movement they created (Fishman, 1998; Osborn, 2021).

1.8.2 Activism

In 1969 the National Association to Advance Fat Americans (NAAFA) was formed when a man was angry about how his wife was being treated, due to her size. NAAFA is currently the world’s longest running fat rights organisation calling for Fat Acceptance. Following NAAFA’s lead, the Fat Underground was formed, they called for Fat Liberation and published their manifesto in 1973 demanding equal rights for fat people in all areas of life (Fishman, 1998; Osborn, 2021).

More recently, in the US, activists have teamed up with disabled and LGBTQ+ activists to resist triage discrimination during the COVID-19 pandemic. Many disabled and fat members of society have raised concerns that they would not be offered care, based on recent US government guidelines about who is eligible or worthy of a ventilator in the current COVID-19 pandemic (Christian et al., 2014; O’Laughlin & Hick, 2008; Truog et al., 2020).

1.9 Ways Stigma Operates in Healthcare Settings and Ways in Which Policy and Practise Can Be Influenced by The Broader Social Discourse.

1.9.1 NHS Context

In the UK we have access to the NHS which offers free healthcare for all, albeit services being chronically underfunded and understaffed (NHS Support Federation, 2020). As discussed in Section 1.4.1, ideas of personal responsibility for one’s weight are found on the NHS website. With this assumption comes a number of attitudes and opinions about who is deserving of care, and who is wasting valuable NHS time and recourses (Campbell, 2020; de Frel et al., 2020; Obesity Empowerment Network, 2021). The discrimination towards fat people that is evident in wider western society is also found within healthcare systems. These attitudes make accessing healthcare far more challenging for fat patients when compared to ‘average sized’ patients. Previous studies suggest that support for ‘obesity’ policies vary based on perceptions of whether a person’s weight is a result of genetic disability, personal behaviour, or a problematic food environment (Barry et al., 2009; Saguy et al., 2014).

1.9.2 Anti-Fat Attitudes of Staff

There are a vast number of articles and personal accounts documenting people’s experiences of accessing healthcare as a fat person. Research studies outlining staff attitudes towards their fat patients are widely available, yet overt discrimination appears to be continuing unchallenged.

A variety of different healthcare professionals have been found to exhibit anti-fat attitudes. Foster et al., (2003) published in Obesity Research that 50% of doctors described fat patients as awkward, unattractive, ugly and noncompliant. Huizinga et al., (2009) report that higher patient BMI was correlated with lower physician respect. Additionally, 74% of medical students were found to exhibit a level of anti-fat bias (Phelan et al., 2015). Nurses have also been found to exhibit this bias (Mulherin et al., 2013). The majority of nurses involved in Poon & Tarrant's (2009) research reported negative attitudes towards fat patients, thinking of them as “shapeless, slow and unattractive”. Anti-fat bias has also been found to be prevalent amongst obesity clinicians and researchers (Forhan & Salas, 2013) as well as dieticians (Stone et al., 1992) and exercise scientists (Chambliss et al., 2004).

It is important to acknowledge how embedded anti-fat bias and stigma are. Decades of cultural ideals and narratives of causality and blame will take time and effort to acknowledge and challenge. Individuals working in healthcare may not be aware of the potency of their biases, as well as being misinformed about the physical health issues that supposedly come with being fatter. (Donkers, 2017; Golden, 2017, 2019a; Kolata, 2016). These studies have implicated the importance of addressing these attitudes in training programmes and continuing professional development for healthcare professionals.

1.9.3 Quality of Care for Fat Patients

In relation to accessing healthcare, it is suggested that the attitudes of healthcare professionals translate to observable differences in the quality of care that a fat patient may receive in comparison to a straight sized patient. Studies suggest that doctors develop less rapport with their fat patients as they spend less time with them, often failing to refer them for diagnostic tests (Gudzune et al., 2013; Hebl & Xu, 2001; Phelan et al., 2015). Fat people's experiences of healthcare are mostly described as negative, humiliating, and oppressive. This leaves them understandably reluctant to return to healthcare settings, cancelling appointments and avoiding preventative care. In extreme cases this can lead to misdiagnosis or serious problems left untreated with life threatening consequences (Doolan-Noble et al., 2019; Drury et al., 2002; Golden, 2019a; Setchell et al., 2015).

Worryingly, these experiences persist within the context of guidance from the National Institute for Health and Care Excellence (NICE) to offer regular, non-discriminatory healthcare, as well as managing comorbidities when identified and not delaying until a person has lost weight (NICE, 2014). It is possible, that the harm done by health care providers is not necessarily intentional, as they too have been raised in a culture that denigrates fatness. Yet it remains uncommon in most training programmes for people identify and challenge this lifelong socialised bias (Golden, 2019c, 2020a).

1.9.4 Weight as Risk Factor for the Development of Serious Illnesses

Prior to the outbreak of COVID-19, being fat had been associated with poor prognosis of various other diseases. Notably, in cancer treatment, fat patients are reported to have worse outcomes and increased risk of death than average size patients. It has been suggested that being fat may exacerbate all types of cancer. However, there has been an acknowledgement that medical care for this client group is compromised. Medication doses are most frequently based on standard body sizes. These standard sizes are out of date, as they were often defined many years ago when the average person was thinner than today (Ligibel et al., 2014; Ni et al., 2017; Yang et al., 2020).

Being fat has also been associated with chronic inflammation and decreased immune system, which is considered to increase a person’s susceptibility to infections (de Frel et al., 2020; Ryan & Caplice, 2020; Tamara & Tahapary, 2020). Hence, this evidence suggests that being fat might be a risk factor for increased severity of COVID-19 symptoms. Moreover, a study by Campos et al., (2018) had previously highlighted the impact of ‘obesity’ to reduce lung function in sedentary patients. Hence, fat patients tend to be more vulnerable to COVID- 19 infection and more significant disease progression due to reduced baseline lung functional capacity. With regards to fat people needing to be ventilated if they become severely unwell, previous research found they were more likely to have substantial complications, but there were no evidence of increased mortality (Anzueto et al., 2011).
In contrast, a meta- analysis by Ni et al., (2017) reported the protective influence of ‘obesity’ in Acute Respiratory Distress Syndrome (ARDS) patients. This contradicting view raises doubts concerning the impact of a person’s weight in the disease severity and prognosis of COVID-19. In relation to disease severity, it is also suggested that due to a lifetime of weight-stigma, fat people may be reluctant to seek medical care resulting in a delay in seeking essential treatment increasing the chances of them becoming more significantly unwell (Obesity Empowerment Network, 2021).

1.9.5 Prioritisation of Care

In the past year, the nation's weight has gained further media attention as a result of the COVID-19 pandemic. It is widely recognised that the pandemic has placed significant strain on an already stretched healthcare system. When demand for resources (such as intensive care beds and ventilators) exceeds supply, healthcare professionals are left to make extremely challenging moral decisions of which patients to prioritise.

1.8.5.1.COVID Triage Policy: Prioritisation and triage for treatment of this virus is gaining a significant amount of media coverage and focus on social media. Articles have reported that triage care plans are disadvantaging those with pre-existing conditions and disabilities (Christian et al., 2014; Obesity Empowerment Network, 2021; Truog et al., 2020).

In the absence of government guidelines, hospitals have developed triage committees in order to guide their decision making. 'Survivability' is considered as the most widely accepted measure, this is still subjective and not without criticism (Glenza, 2020). Such triage committees have been denounced as 'death panels', yet their purpose is to save as many lives as possible in this time of crisis. The most recommended approach to allocate limited ventilators is to prioritise those critically ill patients who are more likely to survive to hospital discharge with treatment. The use of these committees may help to mitigate the tremendous emotional burden of staff coming face to face with these dilemmas (Truog et al., 2020).

1.9.6 Fat People Being Further Disadvantaged

The current mechanistic understanding of the relationship between fatness and COVID-19 (as outlined in section 1.8.4) has led to the suggestion of interventions (e.g. weight loss drugs and low-calorie diets) to potentially lessen the risk of developing severe COVID-19 symptoms (Sattar et al., 2020). The UK government urged the public to make attempts to reduce their weight in order to reduce the strain on the NHS (Department of Health & Social Care, 2020b). This recent emphasis on weight, with the addition of a moral emphasis on helping the NHS, adds further shame and stigma to being fat (Boseley, 2020). The current pandemic serves as another example of how fat people are discriminated against in healthcare systems and seen as lower priority for accessing care in comparison to others. There is a poignant fear expressed by a number of disabled and fat people that they will not be saved if they fall ill with the virus (Baker, 2020; Hill et al., 2005).

1.10 Scoping Review: Obesity Stigma in Healthcare – Public Opinions

As discussed above, fat people are stigmatised in many ways, and in various areas of their lives. This stigmatisation occurs in a context in which being slim is valorised and being fat is viewed as a sign of personal moral failure. Because being fat is understood to carry additional health risks, fat people are perceived as being responsible for their condition and may receive lower priority for access to services and care.

The researcher was interested in what is known about the views of the public in relation to personal responsibility for health issues that are perceived as related to their weight. The research was also interested whether the public believe that fat people should be denied access, or at least have to makes changes to behaviour and weight, before being allowed access.

A scoping review of the literature related to public opinions of 'obesity' stigma in healthcare was conducted using Science Direct, PSYCHINFO and EBSCO, (See Appendix A and B for the scoping review strategy and outcome).
The following search terms were used: (public opinions) AND (obesity) AND (healthcare).
Limiters included:
- English language
- Title, abstract and keyword only
- Adult only (>18yrs)
- Published between 2000 – 2021

Initially the researcher limited the search to include only research from the UK. However, this was too limiting, producing only three papers which were not considered to be substantial in addressing the purpose of the scoping review. As such, articles from Europe, USA, Canada, Australia and New Zealand were also included. 15 articles were considered relevant for this research.

The articles covered a number of topics, including public perceptions of the causes of fatness, including the role of social media in shaping public perceptions, attitudes towards fat patients, and the implications for public health policies.

1.10.1 Public Perceptions

The articles identified in the scoping review continue to confirm that public attitudes towards fatness are mainly negative and assume that weight is a direct result of lifestyle choices. Ambwani et al., (2014) found that 92.5% of their 811 young adult participants held at least one stigmatising view of fat people. Participants completed self-report questionnaires assessing obesity stigma and eating disorder features. The researchers reported to be surprised that participants were willing to disclose such significant stigmatising attitudes toward fat people. They also noted that negative attitudes towards fat people were held by fat and non-fat participants, suggesting that fat people internalise the negative stigma they experience. The attitudes were explored further and found to be multidimensional – some attitudes indicating feelings of concern for a fat person’s wellbeing based on assumptions that they experience shame and low self-esteem in relation to their weight, and other attitudes indicating of perception of fat people being inferior to ‘normal’ weight people. However, it was unclear whether these attitudes were held at different times by the same individual. They suggest that further research would benefit from exploring the multidimensional nature of attitudes of fatness. Additionally, they suggest a mixed-method design would gather more understanding of these issues, instead of focussing on self-report measures.

This stigma has been observed to be widespread and cause profound emotional suffering to the individuals discriminated against (Brewis, 2014). Brewis’ study also supported Ambwani et al's., (2014) finding that fat people can internalise weight stigma which may result in powerful self-reinforcing cycles that may increase emotional suffering and weight gain. Additionally, in relation to public attitudes, Farrell et al., (2016) used semi-structured focus groups to explore view about preventive ‘obesity’ regulations amongst distinct social groups – one of majority high-income, high levels of home ownership and education, the other of majority low-income, high levels of unemployment and government housing. They found that views differed between the social classes. Ignorance was perceived as the dominant explanation for ‘obesity’ in areas of greater wealth, which reinforces social divisions and continues to marginalise those people who are already marginalised. In contrast, people from disadvantaged areas that took part in the study considered the necessity to improve material and environmental circumstances that limit people’s access to health resources, whilst also recognising that they have different priorities not linked to improving their health status. This research highlights that public perceptions about obesity are not fixed and differ between groups. The impact of neoliberal attitudes privileging rationality and autonomy was considered to influence the views of socio-economically privileged groups, who had access to social capital to make life choices associated with health.

1.9.1.1.Subsequent treatment from the public: Linked with public attitudes towards fat people is the behaviour that results from these attitudes. Randall et al., (2017) developed online and field experiments to explore to what extent weight-discrimination may impact help received from a stranger. They found that fat individuals were less likely to be offered help, and were exposed to more impolite and impersonal treatment. The researchers also manipulated cues in the field experiment to include the fat subject wearing a t-shirt indicating they had completed a 5k race. They found that people were more polite towards them, suggesting that when fat people display evidence that they do not conform to common stereotypes of fatness, they are perceived and treated more favourably. These findings support DeJong's, (1980) study that suggest when fat individuals display “stereotype-inconsistent cues” they are more likely to elicit help from a stranger and benefit from reduced discrimination.

1.9.1.2.The role of the (social) media in shaping public opinions: The literature review identified that that media (news articles, social media and political news) play a crucial role in public opinions towards fatness as well as influencing the language they use.

De Brún et al., (2013) explored the representation of fatness in the Irish media by conducting a thematic analysis of 346 news articles. They found that the media centralised women as responsible for men’s and children’s health, as engagement in preventative health behaviours were viewed as a woman’s domain.

An exploration of stigmatising metaphors used by the media to describe a United States politician were explored by Anderson et al., (2017). They coded 240 news articles referring to the politician's weight and found that numerous metaphors were used to shame this individual about their weight. They discuss that metaphors are used by journalists as they have the power to persuade readers to adopt new attitudes, as well as serving to reinforce societally held attitudes. Their research highlights the prevalence of the use of metaphors to stigmatise weight and how this strengthens weight stigma in society.

Cotter et al., (2021) were also concerned with the use of metaphors to reinforce weight stigma. They reviewed newspapers, policy documents and conducted 15 semi-structured interviews with people who self-identified as 'obese'. They found that metaphors of war were commonly used across these three areas, positioning fatness as the opponent to be targeted. The epidemic metaphor was frequently found in new articles. This metaphor positions fatness as a disease, implying contagion and a lessened individual responsibility to manage it. They conclude that metaphors place responsibility on the individual as well as the social system, whilst perpetuating moral judgment and stigma. Their interview data highlighted that people had internalised messages about their weight being their fault, suggesting the media's conceptualisation of fatness as something that can be controlled was particularly persuasive.

Wanniarachchi et al., (2020) conducted a systemic literature search of weight-stigma in social media. They found that the anonymity of social media has resulted in widespread weight stigmatisation, with people claiming that fatness is a result of personal irresponsibility that is complex and cannot be treated with standard medical interventions. Thy consider that the negative impact of social media on the perpetuation of weight stigma calls for improved regulatory policies to manage discriminatory content.

1.10.2 'Obesity' as a Public Health Issue

Lewis et al., (2011) considered the different types of weight stigma that a person may encounter. They suggest that more indirect forms of stigma appeared to have the most impact on health and wellbeing, leaving people exposed to this stigma vulnerable of social isolation and withdrawal from daily activities. They also found that people felt more disempowered by environmental forms of stigma due to it feeling impossible to do anything about them. Morain & Mello, (2013) discussed the importance of understanding the public's values, ensuring the pubic are involved in decision making regarding new policies that reflect their values. Gostin et al., (2019) argued that every person has the right to affordable, high quality healthcare. They argue that law affects public health globally, by structuring and perpetuating social determinants of health, and that any laws that undermine an individual's right to equitable healthcare must be opposed.

Katz, (2014) highlighted the issues in defining 'obesity' as a disease, and argues that doing so contradicts our bodies' functionality, and implied personal blame. Further considerations regarding the language of the 'obesity epidemic' have been criticised by Nolan & Eshleman, (2016).They argue that this language is stigmatising and there is insufficient evidence that fatness has risen at an exponential rate. They cite Hermiston, (2010) and Campos et al., (2006) to argue that the term "epidemic" (implying an infectious disease that spreads rapidly, resulting in widespread death) is inaccurate, and rather "moral panic" may be more appropriate as this suggests an exaggeration of the risks and the projection of fears onto a stigmatised group. As highlighted previously, 'epidemic' implies contagion, so fat people can be seen to somehow infect or contaminate others.

1.9.2.1.Suggested interventions related to public opinions: Greener et al., (2010) suggest that public support for policy interventions is necessary for lasting change. However, they discus that whilst 'obesity' continues to be perceived as caused by individual failure which can be conquered by willpower alone, that public support is unlikely. As such, they propose system level intervention to re-frame public opinions, raising awareness of the multiple social, environmental, physical and political factors that influence a person's weight. Structural-level interventions to target health disparities have also been suggested by Cook et al., (2014).

1.11 Critique of the Literature and Rationale for Research

The scoping review confirmed many of the general attitudes and judgements that are made about fat people, by the public and by healthcare staff, but little discussion of the public's view of fat people accessing healthcare nor of how the public understand fat people's experience of healthcare.

1.11.1 Context of Public Funded Healthcare

As highlighted, there was limited data from the UK exploring public perceptions of fat people's access to healthcare. Most of the research produced by the literature search was based in the USA, where healthcare is funded very differently to the UK. As such, the researcher considers that public attitudes to fat people accessing healthcare may be different when healthcare is publicly funded. When the dominant view of the public is that fat people are to blame for their health issues, this may result in the judgement they have a lesser claim on scarse healthcare resources than 'innocent victims' of illness. Public support can be a powerful catalyst for change and the researcher was curious about whether weight-based discrimination in healthcare settings was something that the public had particular views about.

1.11.2 Something That Needs to Be 'Cured'

The majority of articles perceive weight loss as the desired outcome for optimal health. Arguments continue to be based in science, be that the oversimplified "eat less, move more" equation, the increase in allostatic load or the neurobiological explanations of variation in weight amongst the population. It appears science seemly legitimises arguments that fatness is a medical issue, which again frames it as something that needs to be 'cured' (Saguy, 2012).

The literature tends to focus on consulting fat people about the best way to tackle anti-fat attitudes. Whilst stigmatised groups will undoubtedly be able to highlight people's blind spots, that work has the potential to be extremely triggering. As such, responsibility should also be placed on 'straight sized' people and healthcare staff to consider their biases, through self-reflection and training, in order to hold a more balanced perspective and awareness of how stigma perpetuates the challenges for fat people in our society.

1.11.3 Authors Position to Research Area

During my 10 years working in the NHS, as a Healthcare Support Worker, Assistant Psychologist and currently as a Trainee Clinical Psychology I have witnessed much of what is discussed in the literature. Particularly when working in physical health settings, I have been aware that fat patients were often spoken about with less compassion than ‘average’ sized patients. I was struck by how readily staff, and patients, would make causal links between their weight and ill-health. There were limited opportunities to explore alternative ways of thinking about health and weight, despite the wealth of literature discussing the harm caused by weight-stigma and discrimination. It felt important to me to explore these attitudes in relation to access to healthcare to consider whether there was any space for flexibility in people’s attitudes and a desire to make healthcare more equitable.

1.12 Aim of Study and Research Questions

As outlined, anecdotally people have voiced their personal experiences of being judged and discriminated against as a result of their size (Golden, 2018, 2020a, 2020b; Kolata, 2016). Much research corroborates these experiences and has consistently reported weight-judgements and biases are present at multiple levels of society. Yet there is little research focusing on public opinions of this discrimination, particularly in healthcare settings.

In light of the recent COVID-19 pandemic and the messages of limited healthcare resources in the UK, it felt important to also explore public attitudes of this. Whether the public were aware of these issues and whether they felt triaging was justified, based on perceived ideas of responsibility and blame.

The scoping review highlighted the importance of public engagement with policy making to ensure that policies reflected community values. As such, it felt necessary to consider the public’s attitudes about these issues, to consider whether there would be public support for future policies seeking to mitigate weight discrimination in healthcare.

1.12.1 Research Questions

The aim of this study was to begin to generate more exploratory data of the public's views of fat people accessing care in the NHS, particularly in light of the current COVID-19 pandemic.
To address this, the two primary research questions are:

- What are public opinions of 'obese' people accessing healthcare?
- Are the public aware of anti-fat attitudes that 'obese' people are exposed to when accessing healthcare?

2. METHODOLOGY

2.1 Rationale for Methodology

This research employed a semi-structured qualitative interview method which sought to generate rich accounts of individual's views concerning fat patients accessing healthcare in the UK. A qualitative method was thought to be the most appropriate as it aims to enrich understanding of a person's experiences and processes (Harper & Thompson, 2011).

2.1.1 Epistemological Considerations

The research questions and rationale outlined above require a Critical Realist position. This position is ontologically realist, meaning that there is an assumption of an external reality independent from human minds, and epistemologically relativist, in that using different methods will produce different perspectives of reality. This approach assumes that data can inform us of reality, but it does not mirror it (Willig, 2012). Critical realism is critical then, as efforts to describe and explain the world are bound to be imperfect. As such, any descriptions cannot be justified in any absolute sense, and are always open to critique (Zachariadis et al., 2010).

For example, for the purposes of this study we are proposing that body weight (strictly mass) is a material reality, but concepts of 'obesity' and 'fatness' are social concepts that are constructed in particular ways. We recognise that attitudes about fatness are culturally determined; fat is a relative judgement and ‘obesity’ is established on the basis of normative criteria. Therefore, though the body is materially real, judgements about particular bodily attributes (weight, appearance etc.) are socially grounded and, in addition, beliefs about entitlements to healthcare are grounded in socially informed moral beliefs and values. The interview data reflects individual’s perspectives, and the subsequent analysis is an interpretation of the researcher, who constructs the findings based on their own understanding, knowledge, and experience, thus the analysis is constructed through the lens of the researcher.

2.1.2 Rationale for Critical Realist Thematic Analysis

The method of qualitative analysis needs to be compatible with the epistemological position (Willig, 2012). Thematic Analysis (TA) was selected for this research. TA is a method of identifying, analysing, organising, describing, and reporting patterns identified within a data set. It can also be conducted from different epistemological positions including realist and social constructionist (Braun & Clarke, 2006).

There are limited studies exploring public opinions of fat people accessing healthcare, as such this research is exploratory. One of the benefits of TA is its flexibility and independence of particular theory or epistemology. Thematic analysis is not linked to a particular epistemological position, but this is not to say epistemology is not irrelevant. As such, TA can potentially provide a rich and detailed, yet complex interpretation of data (Braun & Clarke, 2006; Clarke & Braun, 2013; Willig, 2013). TA is useful in enabling the researcher to examine and interpret individuals’ perspectives, highlighting similarities and differences (Braun & Clarke, 2006; King, 2004).

An inductive approach was used to identify patterns within the data, in order for themes to be led by, and clearly linked to, the data (Braun & Clarke, 2006; Patton, 2005). However, the research cannot claim to be purely inductive as the identified themes do not directly represent participant’s language (Banister, 2011), but are interpreted and actively constructed by the researcher, informed by the literature and the researcher’s experiences and beliefs (Taylor & Ussher, 2001).

2.1 Ethical Considerations

2.1.1 Ethical Approval

Ethical approval was sought and gained from the School of Psychology Ethics Committee at University or East London (UEL) (Appendix C). The study was carried out in line with guidelines from the British Psychological Society's (BPS) Code of Ethics and Conduct (BPS, 2018).

2.1.2 Informed Consent

After seeing the research advert online (Appendix D) and contacting the researcher, an Invitation Letter (Appendix E) was sent to all potential participants. Participants provided signed consent (Appendix F) before commencing the interview, at this point they were reminded of their right to terminate the interview at any point. Participants were informed that if they wished to withdraw from the study their contribution (e.g. any audio recordings and interview transcripts) would be removed and confidentially destroyed, up until a given date where data will have been transcribed and analysis started. Data management and the recording of the interviews were also explained: In order to identify participant data each audio file was named with an interview number. Each participant was allocated a participant number, in chronological interview order. Audio and transcription files were named e.g "Participant 1"and "Interview 1" respectively.

2.1.3 Anonymity

Minimal identifying information was obtained, consent forms were the only documentation with participant names on, these forms were stored in a password protected OneDrive accessible through a password protected computer.

Only the researcher, supervisors and examiners had access to the transcripts. Participant's names or other identifying features were omitted from the transcripts and steps were taken to ensure that quotes used in the research could not be traced to individuals. Careful selection of quotations also minimised any identifiable contributions in resulting publications in order to protect anonymity.

2.1.4 Data Management and Storage

Transcription was undertaken only by the sole researcher to further protect confidentiality of participants. Audio recordings were deleted once each interview was transcribed. Following examination of the doctoral thesis and acceptance, (approximately August 2021) consent forms will be destroyed. Anonymised transcripts will be kept for up to three years after the research has been completed and then deleted.

2.1.5 Risk to Participants

The researcher monitored the emotional state of interviewees and offered breaks if necessary. Participants were also informed that they could terminate the interview at any point, and that the researcher may terminate the interview if they felt the participant was distressed. Each participant was debriefed (Appendix G) after their interview and given details of sources of information and support services if they felt affected by anything in the interview.

The interview questions were not intended to cause emotional distress, however, if someone knew of someone, or had personal experience of stigma or discrimination due to their weight it is possible that the content of the research could have been upsetting. As such, support services were highlighted on both the invitation letter and debrief forms. Participants were also given the researchers email address should they have had any questions or concerns about the research after their interview.

2.1.6 Risk to Researcher

As part of the risk assessment, potential risks to the interviewer were considered. Due to interviews taking place over Microsoft Teams due to COVID-19 restrictions, the risk to the interviewer was significantly reduced. There was the possibility that participants may have assumed the interviewer was aligned to a particular view and perceived this negatively. There was also the possibility of the interviewer becoming distressed by things that participants said during their interview. The interviewer ensured that their supervisor was aware of when interviews were taking place, as well as being able to contact their supervisor by email or phone if they needed support following an interview. All interviews were completed on allocated study days to ensure that the interviewer had time to process the discussion after if necessary.

2.2 Design

2.2.1 Development of Interview Schedule

Semi-structured interviews permit participants to speak freely and allow them space to develop their thoughts (Smith, 1996), whilst still remaining within a focused area to ensure all participants are covering similar material but flexible enough that the interviewee is not constrained (Crowe et al., 2015).
It is possible that this method of collecting data can create bias in participant responses. The researcher was aware that societal conventions may be particularly pertinent, as the nature of the topic of this research could be viewed as sensitive, and participants may filter their responses to be viewed more favourably by the researcher (Hammersley & Gomm, 2008).

The first draft of the interview schedule was produced and trialled after an initial literature review (Appendix H). Care was taken to ensure that the language and tone were considered, in line with the writings and recommendations of scholars, writers and activists with personal experience of discrimination as a result of their body size or appearance. A pilot interview was conducted with an initial participant to see whether the proposed schedule allowed for a natural flow of conversation around the topic. Adjustments were made to the wording of some questions and a further question was added to invite participant's views in relation to issues arising from the current COVID-19 pandemic (Appendix I).

2.2.2 Research Setting

Due to restrictions of face to face working and social distancing measures at the time of data collection, all interviews were conducted via Microsoft Teams by the sole researcher.

2.2.3 Resources

The research required audio-recording and transcribing equipment as well as a password protected computer. Interviews were recorded using the record feature in Microsoft Teams and the linked transcription.

2.2.4 Recruitment

Participants were selected via opportunity sampling. They were all members of the public who responded to a research advertisement that was shared on Instagram and Facebook (Appendix D). In total, 15 people responded to request more information about the study after seeing the advert. As previously outlined, they were all sent the Participant Invitation Letter (Appendix E) and given the opportunity to ask any further questions about the study. Of the 15 potential participants who received the Participant Information Letter, 12 people responded to say they wanted to participate in an interview. No participants requested for their data to be withdrawn from the study following interview.
As the research was interested in public attitudes the inclusion criteria were broad. Participants were all residing in the United Kingdom and were over 18. No potential participants were excluded from the study as all who responded to the advert fit the inclusion criteria.

2.3 Data Collection and Analysis

12 interviews were held. This sample number is deemed appropriate for qualitative analysis, as Guest et al's., (2006) study of data saturation and variability suggests that data saturation occurs within the first 12 interviews. The interviews took place from October 2020 – December 2020.

2.3.1 *Data Collection:*

The interviews lasted between 45-60 minutes. The trial of the initial interview schedule lasted approximately 45 minutes. At the beginning of each interview the interviewer confirmed participants had had the opportunity to read the Participant Invitation Letter (Appendix E) that was sent to them prior to interview. There was an opportunity for participants to ask any questions they had about the research before giving their consent to participant in the study (Appendix F). The interviewer ensured that participants knew that the interview could be terminated by them at any point. The interviewer then proceeded with the interview schedule (Appendix I), which was audio recorded.

After completing the interview, the Debrief Information Sheet (Appendix G) was discussed with participants and a copy was sent to them via email. Participants were also offered the opportunity to ask further questions.

2.3.2 Demographics:

All participants lived in the UK and were over 18 years old. Of the 12 participants that were interviewed 8 of these identified as female and 4 as male. It is possible that the social media channels that were used for advertisement leant towards a female audience which likely skewed the sample. The sample included 3 healthcare workers who disclosed their occupation during the interview, they were not asked directly by the researcher. Due to the nature of the study the interviewer wanted participants to feel confident that their participation remained anonymous. Additionally, as the participants were not being compared, it was not necessary for the group to be homogenous, as such, no further identifying personal data was collected by the researcher.

2.3.3 Transcription

A semantic level of transcription was employed by the by the researcher helping familiarise the researcher with the data. This method of transcribing was used as TA does not require a detailed transcribing convention (Banister, 2011; Braun & Clarke, 2006)

2.3.4 Phases of Thematic Analysis

The process of TA has been described by (Braun & Clarke, 2006) as a theoretically flexible method that organises, describes and interprets qualitative data. Interviews were analysed as follows:

- Familiarisation with the data: the researcher immersed themselves in the data, by reading and re-reading interview transcripts.
- Generating initial codes: codes were developed at the semantic level of analysis (Appendix J: Coded Transcript), ensuring the research questions were held in

mind ((Braun & Clarke, 2006). An initial coding framework was produced linking codes with extracts of transcripts (Appendix K).

- Searching for themes: codes were integrated into broader themes. All data relevant to each theme needed to be extracted and first associated with individual codes, then initial themes (Appendix L).

- Reviewing themes: themes were then reviewed and refined. A thematic map was developed to illustrate connections between the themes (Appendix M).

- Defining themes: themes were then defined and named to ensure overall meaning was captured

- Once each theme was clearly defined, they were supplemented with extracted quotations from interviews that capture the essence of the theme. In presenting these quotations I have followed the most recent APA 7th edition guidance (American Psychological Association, 2019)

2.3.5 Use of Thematic Network

The final phase involves exploring the relationship between to themes and to their context. At this stage the presentation of findings shifts from a description of the transcript data to the meanings that have emerged and what Braun and Clarke (2006) describe as making an argument in relation to the research question.

The analytic categories utilised are as follows and examples are drawn from (Paley, 2019) to illustrate:

- A ‘Global Theme’ is a super-ordinate theme that embraces the principal metaphors in the data. Global Themes group the lower-order themes. For example, ‘Social Representations of Weight’ and ‘Intersection with Services’.
- Where necessary, an ‘Organising Theme’ is middle-order theme that organises the ‘Basic Themes’. For example, ‘Language’, ‘(Un)Deserving’ and ‘Experiences of Healthcare Staff and Systems’.
- A ‘Basic Theme’ is the lowest-order theme. For example, the organising theme of ‘(Un)Deserving” had three basic themes of ‘moral and conceptual dilemmas’, ‘dehumanising care’ and ‘something to fix’.

3. ANALYSIS

The themes and sub-themes found within the data are summarised in Table 1.

Table 1: Summary of themes and sub-themes

Global Theme	**Organising Themes**	**Basic Themes**
Social Representations of Weight	- Language	- *Labels and Categorisation*
	- Scientific Legitimacy	
	- Media Exposure	
Intersections with Services	- (Un)Deserving	- *Moral complexities of resource allocation and prioritisation*
	- Something to Fix	
	- Dehumanised and Dismissed	
	- Engaging with Healthcare staff and Systems	- *Compounding Disadvantage*
		- *Considerations for Change*

3.1 Introduction to Themes

3.1.1 Global Theme 1: Social Representations of Weight

This theme captures the more abstract social representations of weight, including the language used to talk about weight, the medical narratives that are privileged through trust in science and how this is perpetuated by the media.

3.1.2 Global Theme 2: Intersections with Services and Systems

This theme captures how care and services are experienced as a result of the above social representations of weight. There is a consideration of the moral and conceptual dilemmas involved in the prioritisation of healthcare, and the way that fat patients are frequently discriminated against.

3.2 Social Representations of Weight

This theme captured participants' overarching description of the more abstract ways that ideas about weight are constructed within society.

3.2.1 Language

Participants' accounts suggest that the language and views about language used to talk about fatness are complex and changeable.

3.2.1.1. *Labels & Categorisation*: Labels and categories were discussed as societally constructed descriptors that have since become associated with "obese" diagnoses. Some participants felt that "it's our human nature to categorise", although others perceived this categorisation to be unnecessary.

There was great variation in the language people perceived to be acceptable or offensive. Some considered words to be "*triggering*" or "*offensive*" and others refered to stigma. Participants were asked what the term 'obesity' means to them, and how it differed from other terms such as fat, plus-size, large, or any others words they may use. Most participants perceived 'fat' to be a "*loaded*" and "*offensive*" term and felt that 'overweight' or 'obese' were less emotive as they are "*medical classifications*":

> *Obesity to me feels like a health term…something that implies a person's weight has a negative impact on their health…specifically cardiovascular.*

> *It feels more technical than fat, large or plus size and more like a term you'd hear from a doctor versus a person on the street.*
>
> *Participant 6*

'Obese' was perceived by some as "*just a medical term*" and "*more professional*". However, although most participants recognised 'obesity' as a medical term, they referenced some of the damaging associations that are made:

> *Obesity as a medical term used by professionals, but I think it's quite a harsh word, like when someone is called obese it seems loaded, like they are lazy, maybe because that's the kind of things we get told about in the media, like it's a disease or something.*
>
> *Participant 8*

Additionally, some participants with personal experience of weight-based discrimination, shared that the word 'obesity' reminds them of medical trauma they have experienced:

> *For some reason, I'm not 100% sure why, obese feels the worst of all those other descriptors. Possibly because it carries the weight of science behind it to an extent… anyone can call a person fat, but it doesn't matter as much as when an authority figure or a medical professional calls someone obese. Obese to me feels like the last stop, you're a complete failure, there's no way around it.*
>
> *Participant 2*

The way that language about weight is used was also discussed by some participants. It appeared that most descriptors of weight ('obese', 'overweight' or fat) are rarely used simply as descriptors and carry judgements and stigma. As such, being labelled in this way was considered problematic and unhelpful:

> *Obese is always said in a medical context it's never said just as a descriptor, it doesn't really feel like a description of a human being, it's so medical and scientific, like it's a disease but one that it's your fault you caught.*
>
> *Participant 1*

There was an acknowledgement that medical language of ‘obesity’ feels disconnected and dehumanising:

> *The way it is used always feels so accusatory as well, like obese people are not people, they're just OBESE.*
>
> *Participant 2*

A consideration was made that the extent to which these descriptors are “*social terms*” and loaded in certain ways has change over time and “*vary under individual perspective*":

> *Like some of the clinical terms used to describe someone with learning difficulties have been turned in to an insult and used in a flippant way, the school yard effect, and unfortunately has become a negative term. I think the same has happened with the word fat.*
>
> *Participant 9*

Interestingly, it appeared that there was the idea that there might be an “*appropriate*” way to speak. Participants appeared conscious of using particular words that they perceived to be offensive. There appeared a dilemma that using medical language felt safer and clearer, despite it also feeling uncomfortable to describe people in such a way:

> *Obese just sounds so dramatic and there is such a connotation to it, overweight is one that I would feel more comfortable using I suppose, overweight it's very clear, you know what it is you're over weight, so it also gives you a solution, to stop being overweight, to lose weight. Obesity is just a bit of a random medical term.*
>
> *Participant 10*

This dilemma was also noted in relation to other terms, displaying an uncertainty about which words were appropriate or comfortable to use. Some participants considered ‘fat’ to be a “*triggering*” or “*offensive*” word, whilst recognising that this may not be the case for others:

> *I sometimes feel bad saying "fat" but then I know that some people actually prefer to be called fat. In my opinion large or larger are a bit problematic, because it implies like a comparison, larger than who or what?*
>
> *Participant 8*

> *I know some people who prefer to be called fat, where others would find this insulting, so I guess it's based on individual preference on how they would like to be described. But then I don't really know why we would have to say anything about someone's weight on a day to day basis any way. Unless they wanted to talk about it and brought it up I guess.*
>
> *Participant 7*

It is possible that the uncertainty of knowing how to talk about these issues resulted in people distancing themselves from engaging in these conversations. Many participants expressed that this was the first time they had explored this topic in much detail. Whilst the majority of participants distanced themselves from these attitudes and appeared concerned with the more "*appropriate"* way to speak, some participants were able to reflect on their own prejudicial attitudes stating that they know they have "*a fat prejudice*" and that they "*judge*" fat people. The researcher noted that participants held multiple, possibly competing, views simultaneously. Additionally, their position on the language used to talk about weight shifted as they reflected on it throughout the course of the interview.

3.2.2.1. *Disease Language***:** Notions of disease and warfare were frequently used when discussing medical labels that are given to people based on their weight. The "obesity epidemic" was *referenced as implying fault and contagion*:

> *(Obesity epidemic) is so medical and scientific, like it's a disease, but one that it's your fault you caught.*
>
> *Participant 1*

Such language serves to further exclude fat people from society as they are perceived as people to be avoided, as if 'obesity' was a disease that could be caught though carelessness and irresponsibility. Images and terms derived from warfare are frequently used in the context of disease (e.g. fight against COVID, battling cancer). The metaphors of war we hear and use in relation to weight conjure a sense of fatness or fat people being the opponent or enemy, where fat people are *“targeted*” and *“attacked for living”* their lives. One participant described a need for fat people to *“arm themselves*” going to a GP appointment. This brought about an image of people having to fight for their right to healthcare or perhaps their life, as well as arming themselves against pejorative language they may encounter in the appointment.

3.2.2 Scientific Legitimacy:

Throughout the interviews was a sense of participants reporting to “*know*” certain things to be true due to science. There are appeals to commonly known "*facts*" about obesity, risk factors and consequences. The ability to accurately measure certain parameters gives substance and credibility to these claims. Appeals are made that we “*cannot ignore the science*” as a domain of facts and value-free judgements. This certainty of particular narratives about weight and health appears to centralise science as true knowledge:

> S*cience has proven time and time again that some conditions are inherently linked to size, lifestyle and fat content in your diet.*
>
> *Participant 6*

Scientific knowledge was held in high esteem, particularly in relation to informing us of the medical conditions frequently associated with being fat, of which all participants identified at least one. Participants spoke of what we know in definite terms about the importance of weight and health; that “*high BMI can cause health issues*”, including “*joint and heart problems*” with little space for alternative truths:

> *I think that weight is hugely important in determining someone's health and there are conditions like diabetes and joint pain and things that are evidently commonly linked to higher weight.*
>
> *Participant 6*

At the same time there was a recognition that BMI lies on a continuum of body weight and that somewhat arbitrary cut-offs form “boundaries” associated with certain labels. There was a sense unfairness that such arbitrary cut-offs result in significant judgements about a person’s health:

> *Rationing (of healthcare) based on obesity, as measured by a BMI number, must be inherently unfair. Additionally, who sets the line as to which BMI number is obese?*
>
> *Participant 12*

> *BMI isn't a fair indicator of someone's health alone. Currently a BMI over 25 is considered obese and it feels like a very serious inference on someone's health…perhaps too serious given someone may in fact be larger but healthy.*
>
> *Participant 7*

The continuum idea is somewhat at odds with that of disease, because most people tend to see health and disease as distinct categories. Some participants recognised the contradictory nature of this. Yet most still felt that a scientific measure of a "*baseline*" was necessary to aid the measurement of weight and subsequent categorisation.

3.2.3 Media Exposure

Many participants identified the media as perpetuating the way that fat people are positioned in our society. Participants referenced *"sensationalised documentaries"* and the way the media quote science to report on 'obesity epidemic':

> *I think media has gone a great job in vilifying the overweight, according to their benchmark population. A heavy…pardon the pun…burden on society costing healthcare X number of pounds.*
>
> *Participant 5*

There were also discussions about the way the media has portrayed fat people in relation to the COVID-19 pandemic and the reporting of challenges within the NHS services in relation to underfunding and understaffing. There were comments made about the way that fat people are currently being blamed for services being overrun due to the associated risks of high BMI and severity of COVID-19 symptoms. Some participants felt that this was unfair and unnecessary, whilst others accepted that fat people were partly responsible, and should be doing more to reduce their own risks – such as losing weight or shielding. Those participants who felt this focus on weight was unfair, referenced long-standing issues with limited resources which they felt was linked to NHS funding and management rather than a particular group of people in society:

> *I think it's awful to scapegoat the group of people who are classed as obese and essentially blame them for the hospitals being overrun, it's pretty fucked up to be honest and just makes me think that the government were backed in to a corner because people were questioning their ridiculous lack of management and maybe it felt easy to point the finger at that group of people because generally they seem to easy targets.*
>
> *Participant 8*

Participants felt that it was "*easy"* for the Government *"to blame fat people*" and "*vet patients against each other*". However, there were references made to some positive effects of the media influencing alternative narratives of what heathy looks like:

> *It brings up all that in the media about body confidence and what does a healthy body look like, because it isn't all on numbers and how you look, it's how you feel as well, I think that's what's missing from the BMI measurement.*
>
> *Participant 10*

It appeared that some participants felt it was important that social media was offering opportunities for the dissemination of different views and experiences. Some people were made aware of discrimination in healthcare after seeing people talk about it on social media:

> *I have heard many times, in real life and online, that people have been judged by healthcare professionals for their weight.*
>
> *Participant 6*

Participants were not asked directly about their views of the media's perpetuation of stigma, yet nearly all participants mentioned how influential they felt the media was in shaping and maintaining people's attitudes:

> *It's challenging that some narratives are fixed on that idea that it's about laziness.*
>
> *Researcher*
>
> *I think it's really stuck, yeah it's very stuck and reinforced with media and government scheme…you can't ban fat people.*
>
> *Participant 1*

3.3 **Intersection with Services**

This theme considers the way participants viewed the issues concerning access and entitlement to healthcare. On one hand, participants considered that if people don't take care of themselves and take responsiblity for their problems they are less deserving than others. On the other hand, they recognise the complexities at play and they can also empathise with the ways in which fat people may be framed when they seek health care (even when the issue is not directly weight-related).

Participants spoke of the judgements that are made about fat people which in turn lead to views about whether they are deserving or undeserving of care. All participants were able to cite a number of "*quick decisions and assumptions*" that are made about people as a result of their weight, including *"bad health", "poor mobility", "self-inflicted", "not helping themselves", "poor families eating crisps and chocolate", "lazy", "high risk", "greedy*" and *"uneducated".* The majority of participants appeared to distance themselves from these societal attitudes towards weight and intellectualised the morality of their judgements. When they spoke about the ways in which fat people are judged they used distancing statements such as "*they are often perceived as…*" or "*society views them as*…". This distancing seemingly enabled participants to state that they felt discrimination towards fat people was unfair, but they understood why it occurred. It was explored how these judgements may impact a fat person's access to care.

3.3.1 (Un)Deserving

There was a variation in opinion about fat people accessing healthcare, particularly in light of the reports of limited resources. Some participants spoke to a dilemma of rationally, holding the belief that everyone is entitle to healthcare, yet when resources are stretched, people should be required to demonstrate commitment and effort to reduce their own risks. If a person was "*not appropriately defending themselves*" by trying to reduce their weight, then they were perceived to be less deserving of NHS care as they would be more responsible, more to blame, for becoming ill:

> *It may not be fair, but I understand it, if they are not willing to look after themselves in terms of diet and exercise why should the NHS spend time and money on them that is wasted.*
>
> *Participant 11*

> *I think, in the UK anyway, people's stereotypical views and assumptions all have that factor in that they feel "well this is a free to use health system people shouldn't abuse it", if you can help yourself you should. So I think that has a lot to do with things.*
>
> *Participant 10*

There were further competing views noted by the researcher, including a call for more "*compassionate holistic care*", yet if a fat person is not helping themselves that it would be hard for healthcare professionals to help them. Despite an acknowledgment that perhaps this view was unfair, there was an expectation of shared responsibility and proven commitment which does not appear to be required for non-fat patients:

> *But not it isn't fair that people aren't getting the care or time they might need, but then if they aren't doing anything themselves then it's hard for other people to help them. Some surgeries required people to lose X amount of weight before, maybe this is demonstrating commitment, a strange way to vet potential patients against each other?*
>
> *Participant 5*

Some participants felt more strongly about this and perceived it to be a "*small injustice that an obese person who may not care for their body receiving treatment over another".* These judgements appeared to assume that anyone could dramatically reduce their weight if they tried hard enough. It is plausible that these attitudes about fat people being deserving of care have become internalised for many people. A particularly poignant consequence of this is the feelings of fear and shame that fat people experience when accessing healthcare services. The recent pandemic has highlighted the moral complexities surrounding resource allocation. For those participants who had experience of weight-based discrimination, there was a real sense of fear about "*who would fight*" for them if they were to become ill with COVID-19 given the messages we are receiving about high BMI and increased severity of COVID symptoms, including a more negative prognosis, particularly if they were perceived to have not been "*helping themselves*".

3.3.1.1. *Moral complexities of resource allocation and prioritisation*: Prioritisation of treatment was raised as a moral dilemma by all participants. Participants spoke of the challenges faced by healthcare staff and the "*horrific*" and "*awful*" position they are put in when there is "*no alternative but to prioritise*" some patients over others. There was a great deal of empathy displayed towards the healthcare staff having to make such difficult decisions, and a consideration of the wider system issue of inadequate funding:

> *Who gets to decide whose life is more valuable? I appreciate that they are in a very difficult position if they just don't have enough resources, but it just feels like it's easier to blame fat people.*
>
> *Participant 2*

Some participants engaged in their own imagined prioritisation dilemmas, considering who they felt may be more deserving of intensive care. Some felt that prioritisation by age was most appropriate. Yet they continued to highlight the challenges of choosing who is more or less deserving based on a number of factors:

> *If it was between an obese adult and a healthy teenager - I'd choose the healthy teenager. But that has less to do with weight and more to do with age as who's to say the teenager doesn't beat up their body with drugs and alcohol every weekend? does that make them less worthy of higher care? I think not.*
>
> *Participant 8*

Some participants acknowledged other groups of people who have been named has high risk of becoming seriously ill with COVID-19. When intersecting identities were included in their decision making, it appeared that protected characteristics that people cannot change – race, ethnicity or age were deemed more important in terms of prioritisation than a person's weight, as the narrative that a person can change their weight persists:

> *I can see obesity has an element of self-control, whereas the race that you were born with, the age that you are you have no control over.*
>
> *Participant 10*

Despite how easily participants were able to cite several common negative assumptions about fat people, there was some flexibility in participants' judgements about a person's weight. The was an acknowledgment that perhaps there may be people for whom the stereotypes are not correct. It appears that they recognise the complexities and can empathise with the ways in which fat people may be framed when they seek healthcare:

> *You mentioned health and weight just then. Can you tell me a bit more about how you feel they are and aren't related?*
>
> *Researcher*

> *Well I guess it's believed that being healthy means being an 'average', there's that word again, weight, like as someone gets over a certain weight for their height or whatever that they become more unhealthy. I think there are a lot of issues with this, someone might be super lean but eat a really shitty diet in order to stay that small, or they might literally just drink coffee. Then another person who is deemed overweight might exercise, walking, the gym, whatever and eat a really balanced diet, but they are just naturally bigger.*
>
> *Participant 8*

Flexibility in judgements was also discussed in relation to culture, time, and geography:

> *My Grandma used to be like god forbid any of her children looked hungry…in different areas of the world it is actually better to be fat, it shows you aren't ill.*
>
> *Participant 1*

3.3.2 Something to Fix

These judgements appear to uphold the narrative that being fat is something to be changed or fixed. Many participants were of the assumption that "*no one would choose*" to be fat. There was a sense of people not being able to reach their full potential if they were fat, as well as assumptions about a poor quality of life as a result of "*limited mobility*" and functioning:

> *Doesn't sound like a nice life to me, I don't know why people would want to live like that and not try feel better… it seems such a waste of potential. Living inside a heavy, and maybe unhealthy body.*
>
> *Participant 5*

Losing weight was positioned as something to be praised as it was perceived to be indicative of leading a healthier lifestyle and improved quality of life. The label 'overweight' was considered by one participant to be a clear instruction of an action to be taken by the individual:

> *Overweight it's very clear, you know what it is you're over weight, so it also gives you a solution, to stop being overweight, to lose weight.*
>
> *Participant 10*

Participants shared experiences of "*targets*" given by them by doctors to reduce their BMI, as well as having more positive experiences of healthcare when their weight had been seen to reduce:

> *I know you said that you have fluctuated between different weights and I wondered if you experienced people responded to you differently in healthcare at different weights?*
>
> *Researcher*

> *Yeah it's way more positive experience when you weight is smaller, or if on record your weight is reduced, they speak to you like a child, like "WELL DONE" which is extremely patronising.*
>
> *Participant 1*

Despite many participants feeling that being fat was something for an individual to fix, there was an awareness of how challenging change may be for people due to a number of factors. Some participants cited motivation and physical challenges relating to exercise:

> *Physically it might be harder for them to move if they are carrying more weight or if they are bigger and can't do certain exercises. Maybe they would be nervous to go to a gym or something, you don't really see that many overweight people at the gyms do you. So yeah I don't know how they would start the process.*
>
> *Participant 5*

Other participants considered the multiple social and economic factors associated with a person's health (as previously discussed) that may make change significantly harder for some people:

> *It's so hard, to actually make a conscious change to do something about it is so difficult because at the other side of it life is so busy, and so demanding…some people who are fearful of keeping a roof over their heads, there is so much else going on.*
>
> *Participant 10*

3.3.3 Dehumanised and Dismissed

Participants discussed the ways that fat people are treated once they are judged as undeserving of care and that their weight is something they need to fix. Some spoke anecdotally of their own experience of being "*dismissed*" despite them "*begging for help*". Others spoke of experiences of people they knew:

> *She was dismissed immediately and sent elsewhere without a second thought. And I remember how terrible she felt, how upset she was. She wasn't treated like a person, she was just too fat to deal with and ushered out of the office*
>
> *Participant 2*

Part of the interview schedule involved informing participants about Phelan et al's., (2014) study exploring medical student's negative attitudes towards their fat patients. Many participants were surprised to learn about the research that reported medical staff spend less time with fat patients, they raised that if there are multiple factors to consider in relation to someone's health, that more time should be spent with them, not less. A number of participants that identified feeling "*upset*" and that it was "*unfair*", "*unethical*" and "*inhumane*" for fat people to be dismissed and denied care. Some questioned whether this went against their professional codes of practise.:

> *It's potentially more difficult to do surgery on someone who has a lot of fat, I guess in terms of cutting someone open and accessing whatever needs to be fixed. But then surely they should be spending more time with people to discuss risks, not less time. It feels dismissive, which is totally unethical, and surely goes against their oath or codes of practise or whatever.*
>
> *Participant 8*

These experiences were thought to leave fat people feeling unseen and unheard by medical professionals and services. There was an awareness of how frustrating and tiring it may be to be constantly spoken to about your weight, despite this potentially not being the reason for seeking medical support. There was a sense from both personal and perceived experiences of the health professionals dictating the appointments as they make judgements about what it best for the patient. It appeared that in order to get access to the care they need, patients were having to make a scene:

> *"if you have to get a bit lary, do it, it's your health, you are suffering".*
>
> *Participant 1*

This experience appeared to be further exacerbated by issues previously raised regarding lack of resources for services, which results in medical professionals being too stretched to make time to get to know their patients in the same way they were able to many years ago:

> *They (GPs) have to be able to cultivate relationships with patients that they can't do anymore, it used to be local, now the system is full of locums who want to get down the list. So many new names, in and out.*
>
> *Participant 1*

This linked with comments about the importance of needing to spend time considering someone's context in order to *"see the person behind the problem".*

When participants spoke about the discrimination faced by fat people accessing care they appeared to hold conflicting views simultaneously. Stating that discrimination “is *entirely unethical”* and *“like any prejudice it is inherently unfair”,* however something they *“can totally understand”* and is *“unavoidable”.* For some, these views were particularly strong, considering whether such discrimination was even legal:

> *I’m pretty sure it’s like illegal to discriminate against someone based on weight but would a doctor say it’s in their best interest or whatever to be healthier and lose weight?*
>
> *Participant 8*

3.3.4 Engaging with Healthcare Staff and Systems

Additional issues concerning access and entitlement involved the way in which fat patients engaged with services, and the way services engaged with them. Some participants spoke to the way judgements about fatness flow into healthcare services and staff attitudes. They referenced the personality and value assumptions that may be made if staff also hold stigmatised views of fat people, perhaps that they are “*wasting their time*”. Participants considered that it would be likely that medical staff would focus on a person’s weight, even if the reason for their appointment was not weight related:

> *I imagine it would be frustrating and probably make them feel shit if it (weight) was brought up all the time by doctors, if they feel like they are being told off or something.*
>
> *Participant 9*
>
> *Friends have told me about their experiences of going to the doctor with something that’s bothering them and then the doctor has almost always connected it to their weight.*
>
> *Participant 8*

One participant described feeling “*lambasted*” by their GP during appointments and felt that no efforts were made to consider their context and “*why*” they might be fat. With the consideration of how the constant focus on weight may affect fat patients, questions arose as to whether it was necessary to bring up a person’s weight, particularly if it was not something they were seeking support for:

> *But then I don't really know why we would have to say anything about someone's weight on a day to day basis any way. Unless they wanted to talk about it and brought it up I guess.*
>
> *Participant 7*

As well as the experiences of individual patients and professional, participants also considered the hierarchy of staff and the narratives of health held at each level by individuals in power, which are subsequently woven into policy and service planning. There was an awareness of multiple level "*societal bias which trickles down to our services*" and will filter down to individuals, affecting how they perceive others, and subsequently how they may treat them. Some participants felt it was understandable that fat people would want to "*avoid healthcare altogether*" if they are at risk of being shamed about their size. Additionally there was an awareness that those individuals who do continue to engage with healthcare services people may choose to hide elements of their lifestyle from health professionals in order to protect themselves from harsher judgements and the risk of being dismissed and further shamed. In relation to this, one participant shared that "*it's appalling that we live in a world where someone's health and level of health service is affected because of conscious of unconscious bias".*

3.3.4.1. *Compounding Disadvantage*: In addition to discussions about discrimination and disadvantage fat people face in healthcare settings, there were also discussions about how this discrimination is part of a broader issue of access to health, including considerations of environmental and social determinants of health.

Some participants referenced inequity of services across geographical locations. In particular that inner city services are likely to be far busier generally, particularly at present as a result of COVID-19 complications and the increased number of cases in cities compared to more rural areas:

> *You just hope you live in an area that isn't as overrun as other people and if you're in inner city London that's so tough.*
>
> *Participant 1*

A number of participants referenced systemic level inequities that they perceived to contribute towards the cause and maintenance of fatness, as well as further disadvantaging fat people. Issues of income and work hours arose. Participants identified that eating healthily can be expensive and for a number of people, particularly in inner cities, affordable and available food is not always the ‘healthiest’ option, resulting in people “*relying on convenience foods*” or “*what they can afford*”. In addition to this was the awareness that for some people their shift work may further limit the food choices available to them during unsociable hours. There did appear to be assumptions made that fat people tended to be in lower paid and more unsociable jobs. It was unclear whether this was a result of stereotypical judgements of fat people being uneducated or perceived to be as result of barriers faced by fat people in society. Nevertheless, references were made to people “*grabbing something between shifts*” and commuters having additional challenges to incorporate health eating into their days:

> *People have long work hours then long commutes home, what are they going to eat, they aren’t going to start making full on gourmet food.*
>
> *Participant 1*

Class was also referenced in multiple interviews in relation to education and a person’s ability to advocate from themselves. This appeared to link with some of the societal level perceptions of fat people being uneducated, if a fat person was able to articulate themselves, or prove social capitol in other areas, for example being middle class, they were perceived to be more “*sensible*” and perhaps judged less harshly:

> *There is the intersection of people who don’t know how to advoke for themselves. So I think class comes in to play massively, as it does with everything in this country…it’s assumed if you are obese that you are more working class or struggling, but if you’re able to walk in and speak then they might be like “oh well they are a sensible person” it comes back to class again, which is horrible.*
>
> *Participant 1*

Some participants considered that ta person may be exposed to multiple disadvantages which interact to impact a person’s health more generally:

> *If one area of your life, whether it be diet, exercise, work, money, your general wellbeing and physical health, if one of those areas starts to deteriorate it is going to impact on all the others…social deprivation in terms of the idea that obesity is something that is gradual, and can build up overtime and that social deprivation may increase that or speed up the process.*
>
> *Participant 10*

One participant considered the compounding disadvantage of the concept of jogging being particularly dangerous for black people, as well as being an activity most commonly being associated with middle class people:

And the whole concept of jogging is very middle class, some black people go jogging and they get killed.[2]

Participant 1

Participants spoke to the complexity and conceptual dilemmas that arose when considering the marginalisation of certain groups and how they may be further disadvantaged in relation to treatment prioritisation. They considered "healthcare as a universal right", whilst referring to complexities of these decisions, again highlighting that they were holding disparate views at any one time. It appeared that participants at times triangulated between rational and emotional mind tensions:

> *It's a complex question whether I think that it's fair to treat people different as a healthcare professional because of their weight. On the one hand I believe firmly that everyone should be listened to and their concerns over their body taken seriously without undermining their experience as something that is immediately suspected as being weight related. However, science has proven time and time again that some conditions are inherently linked to size/lifestyle/fat content. Everyone should be able to have access to the care they need and shouldn't be palmed off from receiving treatment simply because they are obese - however if their problems are proven weight related then they have a duty of care to themselves to work on the doctors guidance to lose weight and get healthier in the hopes it'll improve*

---

[2] On February 23, 2020, Ahmaud Arbery, an unarmed 25-year-old black man, was pursued and fatally shot by three white men whilst jogging near Brunswick, Georgia.

> *how they feel.*
>
> *Participant 6*

When a person was able to prove social capitol in other areas, for example being well-educated, middle-class or able to advocate for themselves, this appeared to mitigate some of the negative judgements they were exposed to. In contrast, if you are disadvantaged in multiple ways it is likely that this further diminishes the understanding or care you are granted:

> *If you are deprived are privileged in some way or don't have access to social resources or social capital you will then not be treated as though (weight) is a symptom of that. And then I think its get in to a real kind of difficult stance then in which you're kind of penalising people for something that (systems) have done.*
>
> *Participant 4*

3.3.4.2. *Considerations for change*: Participants freely gave suggestions as to how healthcare services could improve the treatment of fat patients. Suggestions for change were positioned as bigger than an individual making a considered effort to address their own biases and judgements. Instead, participants identified collective, structural level changes to increase equity in services. This included more emphasis placed on contextual factors and holistic care for individuals.

Participants felt that "*early intervention"* was particularly important, and the support that was offered needed to "*equip*" people with "*tools*" and be "*solution orientated*". The relational aspects of care were also discussed as a means to cultivate compassionate and non-judgemental relationships, where people were offered kindness regardless of fault or responsibility for their condition.

4. DISCUSSION

This chapter considers the research findings in relation to existing literature and the research questions. Implications and recommendations are suggested within the context of a critical review of this research. Final reflections from the researcher and a conclusion are also shared.

4.1 Summary of Key Findings

Throughout this research participants offered varied and changeable views in relation to their opinions of fat people accessing healthcare. Their views are reflected throughout all the themes, particularly in relation to the language they used to talk about fat people and whether they viewed them as deserving of care based on whether they were deemed responsible for their ill health. As detailed throughout the analysis, the themes encapsulate the dynamic weighing up of dilemmas that are part of the formation of their opinions.

There were variations in the language that participants used and a perception that there was an “appropriate” way to talk about these issues. ‘Fat’ was considered by most participants to be a triggering and insulting word. As such, the majority of participants felt more comfortable using ‘overweight’ and ‘obese’ to describe people than they did using the word ‘fat’. A comment was made about the word ‘fat’ having been through a shift in meaning, in the same way that words used to describe people with learning disabilities have become derogatory and insulting. The researcher considered that ‘fat’ is often used by people to describe how they feel, when in fact words such as ‘tired’, ‘bloated’ or even ‘unhappy’ may be more appropriate descriptors for what they are feeling. The researcher was interested in how ‘fat’ had developed over the years to encompass a range of feelings and how it had come to be perceived and used as an insult.

Participants also displayed a degree of flexibility in their views in relation to the discrimination fat people face, at times holding contradictory views simultaneously. Participants spoke of a number of moral and conceptual dilemmas that arose when they considered the challenges of whether someone was deserving of being granted access to care. Participants spoke of what we know about the relationship between weight and health in definite terms, citing science as adding credibility to this knowledge. They were then able to reflect on the injustice and ethical issues associated with dismissal and discriminated of fat people. There was an overall sense of judgements about weight being concerned with a fat person’s health. It appeared that the importance people placed on the relationship between weight and health permitted stigma and discrimination to continue. Despite this, participants showed an awareness of the compounding disadvantage that fat people may be faced with which may serve to maintain their weight through increased stress, lack of access to resources, or the need to prioritise security and safety over ‘health’.

During the analysis, power plays appeared to run throughout most if not all of the identified themes. The researcher considered power as a superordinate theme, however it felt more fitting as a broader organising principle that encompassed everything discussed throughout the research. It felt important to recognise the presence and nature of power at the multiple levels discussed throughout this research. Firstly, at the societal level, which narratives are indorsed by those in positions of power, resulting in particular groups of people being perceived in different ways, and the language used to talk about them. Secondly, considering how services are structured around this and how people are disadvantaged or privileged. Some participants referenced power directing, asking who made decisions about the BMI cut-offs to assign labels and diagnoses, who had the right to choose whose life is worth saving and considering who controls the messages we receive via the media.

4.2 Findings in Relation to the Literature and Research Questions

Previous research indicated that attitudes about fat people are mostly negative and laden with stigmatising stereotypes and assumptions. The study’s findings highlight the complexities of people’s views, thus offering hope that there is a possibility to shift from a culture of blame and stigma towards fat people, as the way in which people held multiple views implies a degree of flexibility in their thinking.

4.2.1 Concepts and Terminology Used to Describe Fat People

As discussed in chapter 1, there is an online movement where a number of activists are encouraging people to use the word ‘fat’ instead of ‘obese’. It appeared that the majority of participants were unaware of this movement, suggesting that the language they use continues to be influenced by medical narratives in the media. A person would have to actively search for alternative narratives about being fat as well as accessing information related to fat-activism. In contrast, the messages the public receive about weight from mainstream media are pervasive and predominantly negative (Anderson et al., 2017; Ata & Thompson, 2010; Saguy et al., 2014).

In addition to the views about the most appropriate and least offensive language to use was the overwhelming sense that being fat was somehow wrong, and something that needed fixing or curing. The focus on medical disease language implies a need to cure obesity, positioning it as an illness. This association with medicine and science appears to legitimise the discrimination fat people face, it is often implied that people criticise fat people as they are concerned about that person's health (LeBesco, 2011). Furthermore, propagating the disease and war language of an 'obesity epidemic' is within certain group's political and economic interest, whilst causing extreme distress to those in society who are stigmatised and discriminated against as a result (Campos et al., 2006). Nolan & Eshleman, (2016) also considered such disease based language to be stigmatising and result in exaggeration of perceived risks (P. Campos et al., 2006; Hermiston, 2010).

4.2.2 Arbitrary Measures of Weight Resulting in Diagnosis

A dilemma that participants spoke of was the BMI measurement that continues to be used throughout health services in the UK to diagnose people as 'obese'. Participants considered some of the shortcomings of the BMI to categorise people, whilst commenting that they felt some kind of baseline measurement was necessary. Those that questioned the legitimacy of the BMI with more scrutiny shared experience of being placed in the 'outgroup' and labelled as 'overweight', particularly when they view themselves as leading a relatively healthy and balanced life. Some participants reflected on how easy it was to be placed in the overweight category.

Those individuals who spoke of personal experience of being labelled and diagnosed as 'overweight' or 'obese' perceived this to have had no positive influence, nor did it enable them to access support or services. Participants recognised that a diagnosis of 'obesity' would result in barriers to accessing care. This was interesting considering the way healthcare is structured in the UK, whereby in many cases a diagnosis is necessary in order to access services and support.

4.2.3 Perceptions of Self-Control and Responsibility

Weight-based discrimination has been compared to other forms of discrimination such as sexism and racism and the perceived differences between various types of discrimination. It has been discussed that anti-fat attitudes are deemed more acceptable than racist attitudes due to the perceived controllability of weight (Crandall & Moriarty, 1995; Puhl & Brownell, 2001). As such, being fat is frequently perceived as a choice, whereby fat people have brought discrimination upon themselves. These studies emphasise how acceptable weight-based stigma is in our society. Obesity stigma was pervasive throughout the interviews in this research, however there appeared to be a level of tentativeness from participants to voice strong negative attitudes towards obese people. Participants tended to intellectualise strong negative attitudes towards fat people rather than claim any particular attitudes of their own. It is possible that intellectualising the issues provided further distance from any challenging feelings that may arise in relation to the dilemmas discussed. It perhaps also enables participants to legitimise any anti-fat attitudes they may hold, as these views are societally programmed and not the views of a few immoral people.

The way that participants spoke of ‘functionality’ of the fat body and the importance of self-management of health and weight to preserve NHS resources forced the researcher to consider how neoliberal philosophy may be contributing to such attitudes in society. Active, working bodies in society have been considered contributors to democracy, whilst the opposite types of body are perceived as drains on resources (Elliott, 2007). Foucault, (2007) described the shift to an information economy, where physical strength and activity are not essential, the fat body is reframed as an unnecessary demand on healthcare due to fat people making bad personal choices regarding food consumption. This shift is concomitant with the shift to a neoliberal form of governmentality. The “perfect citizen” is one who is now able to maintain control over their body weight in today’s context of excess (LeBesco, 2011). Furthermore, the concept of Body Currency refers to the notion that societally we are taught that if we are able to achieve the ‘ideal body’ of the ‘perfect citizen’ (through hard work and determination) that we will be rewarded with success and happiness. This does not simply apply to weight, as the same can be said for other body ‘ideals’ including appearance or being able-bodied. This ideal is flawed as it fraudulently depicts that anyone can physiologically gain the ‘ideal body’, which as we discussed earlier is not scientifically possible for the majority of society (Weiner, 1993).

Petersen, (2003) suggests that people are increasingly demanded, as a condition of access to healthcare, to play their role in the minimisation of their contribution to healthcare costs by becoming more conscientious consumers of services. Health as an obligation not a right repositions people as at fault if they are deemed unhealthy, particularly if they have been granted access to information about health (LeBesco, 2011). This research supported this notion as there was an overwhelming sense of being unable to help a fat person if they were not willing to help themselves. It appeared that when a person being fat may impact another person’s care, that participants felt it was the fat person’s responsibility to lose weight to minimise the chance of them become sick and thus using care and resources that could be given to someone else. LeBesco's, (2011) study suggested that society appears to recognise that condemning someone just because they are fat is rude and immoral, by positioning fat as unhealthy and exhorting them to change we are on safer moral ground – helping, striving for a better society, less burden on NHS. But the policing of fatness on health grounds threatens the well-being of fat people.

The compounding disadvantages experienced by some members of society were understood by participants to make leading a healthy lifestyle more challenging for some. The effect of an obesogenic environment on enabling people to make “good choices” has been discussed by LeBesco, (2011), who concluded that this is impossible for more marginalised groups in our society. Further stigmatisation and discrimination are elicited due to the inevitable ‘failure’ of marginalised groups, who, due to lack of access to environmental support are unable to make “good choices” and are subsequently judged in line with societal and cultural expectations of personal accountability. This study highlighted that although participants were aware of environmental factors that would make things more difficult for fat people, they still perceived that they should be actively pursuing a ‘healthier’ lifestyle. Similarly, to research identified in the Scoping Review (Section 1.9), it appeared that the majority of participants felt that whether a person was deserving of support was dependant on effort they were putting in themselves. There was an emphasis on ‘trying’, and if a person was deemed to not be trying then they were unable to be helped by others and ultimately less deserving of care. Being of ‘normal’ weight appears to bestow cultural capital (De Brún et al., 2014). This suggests that a person’s status and worth in society may be jeopardised due to being fat. In support of Randall et al's (2017) this study found that when fat people displayed characteristics that were at odds with society stereotypes that they were perceived as more likely to be able to access care. For example, if they were able to display cultural capital, such as being articulate, educated, sensible and engaging in ‘healthy behaviours’ they were taken more seriously and not dismissed as readily. This further supports the findings of (Monaghan, 2010b, 2010a; Saguy & Riley, 2005) who previously suggested that a person’s trustworthiness and integrity was negatively affected by being fat. This research further highlighted the protective factor of being middle class on fat people’s exposure to anti-fat attitudes. When a person is perceived to be of middle or upper class, there is often an assumption that this person is educated, and sensible, therefore their weight is considered to be the result of factors outside of their control.

Saguy, (2012) reported that there was a perception that fat people were incapable of holding an objective view about weight. The findings of this study dispute this assumption as those participants with personal experience of weight-based discrimination held reflective and balanced attitudes. They, similarly to other participants, reported that the discrimination and stigma was harmful and unfair, yet recognised that a joint effort between the individual, services and policies was necessary.

4.2.4 Debates and Dilemmas

Debates about access to care are certainly not specific to COVID-19. Certain health conditions might be viewed more heavily as resulting from personal choice and responsibility, for example alcohol and smoking related illnesses (Weiner, 1993). Age is not our fault, ability is not our fault, yet judgements are still made. It appears there is an extra level of heat to discussions in recent years as people have access to more information online, more access to connect with other people to share experiences and more access to share their judgements of others with limited consequence online.

The notion of such discrimination being justifiable was also raised in relation to denial of certain surgical procedures. Participants voiced that they understood denial of care to be due to the risk being too high to operate on a fat person. Whilst it is plausible that certain operations may be more complicated or take longer if the patient is fat (Sudlow et al., 2020). In this study, the notion of ‘risk’ was used to add clinical and scientific backing to a discriminatory act, as weight loss pre-surgery was in part considered as ‘proof’ that a fat person was committed to the surgery being successful. Additionally, it is important to consider whether denial of medical intervention due to risk could indeed increase risk in other areas of a person’s life, for example negatively affecting their mental health, or become physically dangerous if people go to extreme lengths to lose the weight needed to progress with surgery. Participants continuously reflected that they felt healthcare services needed to take a more holistic view of a person’s health and offer more tailored support, so the researcher was interested that weight loss continued to be positioned as the most important aspect for health.

Those individuals who spoke of personal experience of being labelled and diagnosed perceived this to have had no positive influence, nor did it enable them to access support or services. This was noteworthy considering the way healthcare is structured in the UK whereby in many cases a diagnosis is necessary in order to access services and support. It was also interesting to the researcher that the lack of NHS resources was not questioned further by participants. Instead of considering the government’s role in NHS underfunding, there was a sense of individual responsibility to not use NHS care in order for the vulnerable (through no fault of their own) to have access to what they need. Although some participants discussed that they were aware that many media forums are controlled by the same people in power, and thus the information the public are provided is coming from a particular point of view or agenda, connections were not raised that those same people in positions of power are the ones deciding on policy and funding for services.

4.2.5 Q1 – What are Public Opinions of ‘Obese’ People Accessing Healthcare?

As discussed, people’s opinions appeared to be changeable and open to persuasion in light of new information and given the time to weigh up the complexities of the topic. This research found that participants viewed health to be primarily a personal responsibility, that a person should be making every attempt to reduce their weight in order to reduce their risk of becoming seriously unwell. Particularly in relation to the recent pandemic, participants’ opinions leaned towards fat people being less deserving of care than ‘average’ sized people. There was reference to the media influencing such views due to the reporting of stories highlighting weight as a risk factor in the development of more serious COVID symptoms.

However, there was also an acknowledgement that health is a shared responsibility and services may benefit from taking a more holistic stance to care to ensure people have the resources they need in order to maintain their overall health.

4.2.6 Q2 - Are the Public Aware of Anti-Fat Attitudes That ‘Obese’ People are Exposed to When Accessing Healthcare?

Participants all displayed an awareness of the barriers fat people face when accessing healthcare. They referenced societal judgements that filter into staff attitudes and subsequently affect the care that fat people receive. Although participants voiced that they did not think it was fair people faced such discrimination, there was a sense of this discrimination being understandable and justifiable. This appeared to be linked with the perception that a person’s weight is something that they can control, if they try. This was particularly interesting as although participants cited numerous social determinants of health, there was still a consideration of personal responsibility, particularly in relation to minimising their use of the NHS given the scarcity of health resources.

It is important to consider why the NHS is this way, after years of underfunding appear to have taken its toll, participants did not appear to place anyone in particular at fault for this.

4.3 Implications and Recommendations

As discussed, stigma and weight-based discrimination are longstanding issues within society. Yet an awareness of these issues has not led to significant change to prevent the discrimination that fat people are faced with in healthcare settings. Given how pervasive weight-based discrimination is in our society and services, it has been suggested that policy level implications are necessary (Barry et al., 2009; MacLean et al., 2008; Puhl & Heuer, 2010). This research suggests that the public are, to some extent, aware of the ways fat people are discriminated against when accessing healthcare, an insight which was not clear in previous literature. There was an overwhelming sense that participants perceived such discrimination to be unfair, unethical, and possibly illegal. Despite this, they still tended to believe that there may be situations in which a degree of discrimination was acceptable or unavoidable. This could suggest that they are open to persuasion, as they oscillated between different positions in relation to the research questions throughout their interviews.

4.3.1 Investment in Weight as a Public Health Issue

Participants spoke of the difficulties in separating the multiple disadvantages that fat people face. That class, race and health were linked so closely supports MacLean et al's. (2008) study arguing for public health planning in the management of obesity. From a public health perspective, it is important to consider the implications of normalising weight-based discrimination (Saguy, 2012). Stigma can be considered as a barrier to access and engagement (Puhl & Brownell, 2001; Puhl & Heuer, 2009) therefore an environment that facilitates weight-based discrimination is damaging to physical and psychological health of fat patients.

In support of this, the UK Government have developed a number of policies targeted at promoting healthier food choices through work with planning teams to develop healthier food environments (Department of Health & Social Care, 2020a, 2020b). There is an acknowledgement of a person's environment having an effect on the food choices they are able to make. The intention is to ensure shops that sell diverse food options are available to people and easy to reach by walking or public transport. Additionally, they aim to avoid overconcentration of takeaways in close proximity to schools and other facilities for young people. The policies highlight campaigns focused on encouraging fat people to take steps to reduce their weight, ensuring companies provide food labels, ending the promotion of foods high in fat, sugar and salt (HFSS) in stores and in the media. Whilst this approach is potentially less stigmatising and individualistic, it still positions obesity as something to be fixed. It feels unfair to remove people’s choice, but if they are being replaced with alternative options then this still gives people autonomy over what they chose to eat. Whilst the researcher appreciates policy that is aimed towards supporting people to feel healthier, problems arise when health continues to be directly linked to body size (Evans, 2006). Associating health and body size leads to bodies being medicalised in a way which polarises bodies in to being fat and unhealthy or thin and healthy (Evans, 2004). Focusing on science and medicine in this way positions this knowledge as fact, thus reducing the body to an object of science. This positioning limits our view of fat bodies, seeing them as ill, at risk and dangerous (Parr, 2002). Another critique of the Government’s ‘obesity’ policy is that it’s is on educating the public about how calorific food is, not educating the public about the harmful physical and psychological effects of weight-based stigma

More helpful considerations of health could allow for the non-medicalising of fat bodies, with the focus instead on feeling healthy which is not bound to any measurement or diagnosis. This enables us to hold a more flexible view of health and the understanding that bodies change over time (Evans, 2006; Robison, 2005)

4.3.2 Public Investment in Policy

Studies have highlighted the importance of public involvement in the development and implementation of new policies (Barry et al., 2009; Nestle & Jacobson, 2000). As argued by MacLean et al., (2008) awareness of weight-discrimination in healthcare is not enough. A consideration at the level of commissioning could be how services quantify and monitor the effectiveness of healthcare services. This research suggests that the public may be more accepting of policies aimed to increase equity of healthcare as those involved with this study were empathetic to multiple challenges faced by fat people accessing healthcare. Additionally, as attitudes of this sample of participants were less firmly set than previous research suggested, this research implies that education about the social determinants of weight may have more success than previously considered. However, further research would be needed to gain a wider and more representative sample.

Previous research has considered it to be necessary to introduce legislation prohibiting weight-based discrimination. In the UK, the Equality Act (2010) protects us from discrimination against a number of protected characteristics including age, race, sex and disability. Weight is not currently a protected characteristic, and thus, stigmatising or discriminating against someone based on their weight is not currently illegal (Randall et al., 2017). The researcher considered whether the public may be sympathetic to weight becoming a protected characteristic, as some of them believed that it was already illegal to discriminate based on weight.

4.3.2.1. *Stakeholders/ involvement:* This research highlighted that the public perceive it to be important to listen to the patient's voice and see the person in their context. This supports previous research stating the importance of representation of fat people at all levels of policy and service development in order to contribute to policy and service level change. Although it should not be the role of the marginalised to continue to raise issues of discrimination, stakeholder involvement has been shown to be important in maintaining conversations about stigma reduction (Saguy & Riley, 2005).

4.3.3 Wider System Considerations

This study highlighted the public's views that more holistic support is necessary and how broadening the focus to well-being rather than focusing solely on weight, is less stigmatising and potentially more helpful. Building on this, clients may benefit from more connections between services to ensure collaborative working and that their needs are being met. This may also provide more patients alternative choices of intervention or support, if wanted, as opposed to the current drive in referrals to calorie counting weight loss programmes.
As suggested by MacLean et al (2009) this research further highlights the need for provisions enabling healthcare professionals to gain more knowledge about

the causes of weight variation as well as highlighting the harmful effects of weight-based discrimination.

4.3.4 Media

As discussed in Chapters 1 and 3, the media plays an important role in the dissemination of messages about weight and health that are available to the public. This study highlighted the public's awareness of the skewed messages we receive from the media and how these messages serve to maintain weight-based stigma. There appeared to be an openness from participants to consider alternative narratives about fatness, with some participants speaking of social media influencers and online articles exploring body positivity and enjoying life as a fat person. This suggests that there is room for the media to present these alternative, more balanced narratives and that they would be accepted by the public (Pearl, 2018). The acceptance of multiple views of weight and health may serve to open conversations, reduce bias and enact change by lessening the imparity between fat and non-fat people in society.

The government's policy paper on 'tackling obesity' (Department of Health & Social Care, 2020a), considers the advertisement of HFSS on television and online, and how this effects children in teaching them about what constitutes a healthy diet. They intend to ban HFSS products being shown before 9pm, as well as restricting HFSS online advertising by the end of 2022.

4.3.5 Research Considerations

What was striking about this research was that participants made strong claims about prioritisation and resource allocation, then on considering the dilemmas in more depth reflected that everyone should be entitle to healthcare. Which as discussed, suggests an openness in thinking, and scope for more nuanced public health messages.

The researcher suggests further attempts are made to capture the public's views of current 'obesity' policies in more detail. Some participants referenced that the focus on fat people to reduce their weight and save the NHS was harmful, yet they also held in mind that certain aspects of the Government's recent policy to tackle environmental factors associated with “unhealthy” food choices were helpful.

Broadly speaking, it would be beneficial for any further research on this topic to consider building on the literature that considers the UK’s unique position in relation to public attitudes to fat people accessing the NHS. As discussed, the majority of research from the Scoping Review (Section 1.9) explored healthcare in the USA and Australasia, whose healthcare systems are not funded in the same way.

Additionally, as Farrell et al., (2016) explored public views in two differing areas of Australia, it may be helpful to extend the study to a larger population in order to be able to explore public attitudes across various areas in the UK. Doing so may offer insight into local public attitudes which may influence more targeted community-driven interventions and public health campaigns. For example, offering community education groups, social spaces, food vouchers or support groups depending on a communities’ needs. Additionally, as the views of participants in this study were flexible, it may be helpful to consider in more detail the areas where people hold less judgemental views. Public health and education campaigns could build on the areas where the public have shown flexibility in their views. It is also possible that future research using representative samples could explore correlates and predictors of openness and flexibility.

It would also be interesting for further research to explore the degree of awareness of anti-fat attitudes in healthcare with NHS senior management, commissioners and policy makers. The researcher considers whether people in positions of power are also aware of how discrimination is affecting fat people’s access to care within their services. Exploring staff’s awareness and attitudes in a similar way to this research may highlight biases and stigma at a managerial level of the system, potentially indicating a need for structural and policy changes and where this change is needed. It is possible that different members of staff may have differences in their views on this issue as a result of their professional training and experiences. If this was the case, education and training could be tailored specifically to staff groups.

Following this research it could be beneficial to examine particular tensions in more detail. A tension that arose across multiple interviews was that of inequity and moral decision making in services. There was an awareness that people already disadvantaged are further disadvantaged as a result of inadequate care received due to their weight.

4.4 Critical Review

Yardley's (2015) principles were considered for the critical evaluation of this research. Limitations of the research are also considered.

4.4.1 Sensitivity to Context

The researcher spent time considering the appropriate language to use throughout the research, as discussed in chapter one. The researcher continued to reflect on their position as a cis-gender, white, straight sized woman when engaging with the literature and during interactions with participants.

Some participants offered further considerations for the research, which the researcher believed was due to them feeling that their voice was being heard and their opinions were respected.

4.4.2 Commitment and Rigor

The researcher was committed to gaining people's perspectives on complex issues and therefore completed in-depth interviews with twelve participants in order to gain a deep understanding of their views. Advertising the research across social media platforms attempted to capture a broad representation of views from people from various social contexts.

The researcher engaged with relevant literature throughout the process of this research and ensured that important research, articles and blogs were incorporated to develop a considered insight into the current context and discussions around these issues.

The data as analysed following Braun & Clarke's, (2006) Thematic Analysis guidelines.

The researcher used direct quotes from participant's interviews to initiate codes and support the themes in order to represent the breadth of participant's views.

4.4.3 Coherence and Transparency

Clear documentation of the research processes demonstrate the researcher's commitment to ensuring coherence and transparency. In particular, the interpretation of the data is outlined in Section 3, with the addition of extracts from transcripts (Appendix J) showing initial codes (Appendix K) and the development of themes (Appendix L) included in the appendices.
The researcher kept a reflective journal to consider their own views and influences towards the study. Throughout the process of this study, the researcher's own views have been challenged and open to change in a similar way that was observed for participants.

4.4.4 Impact and Importance

The study achieved its aim of exploring public's views of fat people accessing healthcare. The research findings offer insights into understanding people's views on complex moral dilemmas of access to healthcare based on perceived responsibility and blame. It offers insight into the dynamic changeable nature of people's views, and considers means by which people's views are shaped, for example by the media, policies, and context. The degree of flexibility of people's views has not been fully explored in previous research, this finding indicates possibility and hope for change as the participants in this study appeared sensitive to the unethical treatment of fat people in healthcare and made a number of suggestions as to how this could be addressed.

4.4.5 Limitations

Although the inclusion criteria were wide and interviews were conducted remotely due to COVID-19 restrictions, making engagement in the research more accessible for many, it is possible that those individuals who had particularly strong views were the ones who elected to participate in the research. On saying this however, some participants who elected to participate had lived experience of facing weight-based discrimination and maintained a thoughtful, balanced stance on the issues being discussed in the interviews. It is likely that a large proportion of the general public perceive that issues of health inequality are not something they need to engage in discussion about, as they may not believe it affects them directly. Some participants reflected that the interview was the first time they had considered these issues in detail.

The participants of this study were not a homogenous group. This was a conscious choice made by the researcher to ensure that inclusion criteria were broad to enable the opportunity for different perspectives to be brought into the data set. Additionally, even a homogenous group of people are unlikely to hold a single position on an issue, they triangulate between different views as rational and emotional mind tensions are at play. Participants in this study were not engaged in policy and as such are considered lay people on this topic, thus the hope was that they would represent the different debates that are currently at play.

Although the study sample did include a range of ethnicities, it is unlikely to be truly reflective of the general population (ONS, 2011). However, the interviews do provide insight into what and how people think about these issues. Additionally, only 4 of the 12 participants were male. An explanation for this is the platforms on which the advertising poster was posted, in groups and on social media platforms more commonly used by women. Another possibility is that women have more experience of weight-based stigma and thus felt more able to speak to this in interview. Although these factors may limit the generalisability of the findings, it is important to note that generalisability is not the aim of qualitative date (Willig, 2008).

By not collecting further demographic information I was unable to make suggestions about whether certain groups of people tended to hold particular views. It would have been interesting to explore whether different groups of people, perhaps from certain socio-economic backgrounds, geographical locations or ethnic backgrounds expressed differing views. By exploring particular groups in more depth, it would be possible to tailor interventions to specific communities, as discussed previously in section 4.3.5. Research Implications.

4.5 Research Reflections

At times I considered whether my use of language to talk about fat people may appear pejorative to some readers. A great deal of consideration was taken when exploring the literature around this. The decision was made to align with the fat-rights frame (Cooper, 1998; Rothblum & Solovay, 2009; Saguy et al., 2014), that rejects the medical terms ‘overweight’ and ‘obese’. However, as much of the research uses such terms, it was challenging to exclude them completely from this research. I began interviews by defining ‘obese’ and explained that it was a medical term. The participants were then asked which language they felt most comfortable using, I then used their language throughout the rest of the interview. In order to be fully aligned with the fat-rights frame, I could have ensured that ‘fat’ was used throughout interviews. However, as discussed, the majority of the public are exposed to the media using medical descriptions of weight and thus the researcher considered that using the term ‘fat’ may alienate some participants from applying to take part and make them feel less able to voice their own opinions which they may have perceived of being in contrast to my own.

I noted that many of the participants appeared unsure and concerned about the ‘right’ or politically correct thing to say was. Most participants spoke with caution, particularly around the language they used to speak about fat people, appearing to prefer words such as “overweight” or “obese” as they viewed them as clinical labels which were more professional. It is possible that participants felt more comfortable using medical language rather than more colloquial terms to talk about fat people due to a fear of appearing insensitive or ‘getting it wrong’. It is possible that I was also being positioned as a health professional which may have limited what participants felt able to share. Additionally, as interviews were conducted over Microsoft Teams, it may be that participants felt less able to speak as candidly as they may have been able to had data collection been completely anonymous, for example using online questionnaires. However, I did not believe that online data collection would have elicited such rich information about people’s views.

Although the interview specifically asked for participant’s personal views of fat people accessing healthcare, a number of participants distanced themselves from societal judgements, instead speaking in a way that acknowledged societal and staff attitudes, but not whether they shared these attitudes. I wondered whether the growing increase in awareness of microaggressions, and some people being exposed in the media resulted in participants being cautious to align with particular attitudes. Another factor to consider is the inherent power imbalance of interviewer and interviewee; despite participants being assured that interviews remain anonymous; participants may have felt unable to express certain views as their own due to fear of being perceived to be discriminatory or judgemental.

As mentioned, for many participants this was the first time they had discussed some of the issues brought up in the interview. Participants shared that they valued taking part in the research and found the topic interesting and thought provoking. Some participants acknowledged that it was the first time they had really thought about how fat people were so disadvantaged in healthcare as a result of weight-stigma. Additionally, in relation to my own awareness building, as I became more involved in my research I began noticing more ways in which fat people are marginalised by society. For example, the sizes of seats in restaurants and public transport, lack of parking spaces offering the space to fully open car doors. I also began to feel more comfortable having important consciousness raising conversations as I spoke to my friends and family about my research.

Personally, I was surprised by how many of the people I spoke to held such balanced views. On reflection, during my time researching for the literature review I felt deflated at times reading how intrenched anti-fat attitudes are in so many of our systems and wider society. Whilst analysing my data I began to feel more hopeful as I noticed that people’s views were not as fixed as I had anticipated. This left me feeling hopeful that things could change in relation to how fat people are treated, and that the public would likely support policies to address such issues. I regularly reflected on this issue and those mentioned above in reflective spaces with my peers as well as in my reflective journal (Appendix N). I considered the parallels with covid-19 vaccinations, and the polarising positions people appear to have been drawn into. If people who have chosen to have the vaccine perceive opponents as irrational, prejudice anti-vaxers then there is little hope for persuasion, but flexibility and openness offers possibilities for change.

4.6 Conclusion

This research contributed to the literature by offering an exploration of public opinions of fat people accessing healthcare in the light of the current COVID-19 pandemic.

The research suggested that the embedded cultural narrative of weight being an individual's responsibility shapes the public's views on whether a person is deserving of healthcare. There appeared a moral dilemma of recognising that healthcare is a universal human right, yet a widely held sense of personal responsibility to decrease our own health risks (including losing weight). This research also suggests the flexibility of the publics views and that there is perhaps more sensitivity and empathy towards fat people than previous research has suggested. As such it appeared that there could be public support in making weight a protected characteristic.

The research suggests that more could be done at a policy and service level to support the awareness and dissemination of alternative narratives about weight to healthcare staff, in the hope of reducing stigma and subsequent weight-based discrimination.

It is plausible that by moving away from a culture of blame and discrimination regarding weight, that a fat person's access to and experience of healthcare services would be improved, thus supporting their physical and mental health.

5. References

Adams, M. (Ed.). (2000). *Readings for diversity and social justice*. Routledge.

American Psychological Association. (2019, September). *APA Style: Quotations From Research Participants*. https://apastyle.apa.org/style-grammar guidelines/citations/quoting-participants.

Ambwani, S., Thomas, K. M., Hopwood, C. J., Moss, S. A., & Grilo, C. M. (2014). Obesity stigmatization as the status quo: Structural considerations and prevalence among young adults in the US. *Eating Behaviors*, *15*(3), 366–370.

Anderson, J., Zhu, Y., Zhuang, J., Nelson, J. C., Bresnahan, M. J., & Yan, X. (2017). Metaphors that communicate weight-based stigma in political news: A case study of New Jersey Governor Chris Christie. *Weight-Based Stigmatization: A Special Issue on Determinants, Mediating Mechanisms, and Intervention Programs*, *67*(3), 139–146. https://doi.org/10.1016/j.erap.2016.12.007

Ankel, S. (2020, June 24). *30 days that shook America: Since the death of George Floyd, the Black Lives Matter movement has already changed the country*. Business Insider. https://www.businessinsider.com/13-concrete-changes-sparked-by-george-floyd-protests-so-far-2020-6?r=US&IR=T

Anzueto, A., Frutos-Vivar, F., Esteban, A., Bensalami, N., Marks, D., Raymondos, K., Apezteguia, C., Arabi, Y., Hurtado, J., Gonzalez, M., Tomicic, V., Abroug, F., Elizalde, J., Cakar, N., Pelosi, P., Ferguson, N. D., & for the Ventila group. (2011). Influence of body mass index on outcome of the mechanically ventilated patients. *Thorax*, *66*(1), 66–73. https://doi.org/10.1136/thx.2010.145086

Ata, R. N., & Thompson, J. K. (2010). Weight bias in the media: A review of recent research. *Obesity Facts*, *3*(1), 41–46.

Bacon, L. (2010). *Health at every size: The surprising truth about your weight*. BenBella Books, Inc.

Bacon, L., & Aphramor, L. (2014). *Body respect: What conventional health books get wrong, leave out, and just plain fail to understand about weight*. BenBella Books.

Baker, C. (2021). *Obestiy Statistics* (Briefing Paper No. 3336). House of Commons Library. https://commonslibrary.parliament.uk/research-briefings/sn03336/

Baker, J. (2015). *Things no one will tell fat girls: A handbook of unapologetic living*. Seal Press.

Baker, M. (2020, March 23). *Whose Life is Worth Saving? In Washington State, People With Disabilities Are Afraid They Won't Make the Cut*. The New York Times. https://www.google.co.uk/amp/s/www.nytimes.com/2020/03/23/us/coronavirus-washington-triage-disabled-handicapped.amp.html%3f0p19G=0232

Banister, P. (2011). *Qualitative methods in psychology: A research guide*. McGraw-Hill Education (UK).

Barry, C. L., Brescol, V. L., Brownell, K. D., & Schlesinger, M. (2009). Obesity Metaphors: How Beliefs about the Causes of Obesity Affect Support for Public Policy. *The Milbank Quarterly*, *87*(1), 7–47.

Bell, S. K., & Morgan, S. B. (2000). Children's Attitudes and Behavioral Intentions Toward a Peer Presented as Obese: Does a Medical Explanation for the Obesity Make a Difference? *Journal of Pediatric Psychology*, *25*(3), 137–145. https://doi.org/10.1093/jpepsy/25.3.137

Benson, P. L., Karabenick, S. A., & Lerner, R. M. (1976). Pretty pleases: The effects of physical attractiveness, race, and sex on receiving help. *Journal of Experimental Social Psychology*, *12*(5), 409–415. https://doi.org/10.1016/0022-1031(76)90073-1

Berg, F. M. (1993). *Health Risks of Obesity: 1993 Special Report*. Obesity & Health, Healthy Living Institute. https://books.google.co.uk/books?id=aD4UAQAAMAAJ

Berne, P. (2015, June 9). Disibility Justice—A working draft. *Sins Invalid*. https://www.sinsinvalid.org/blog/disability-justice-a-working-draft-by-patty-berne

Betts, M. (2010, July 30). Doctors ‘should tell overweight patients that they are fat’. *Herald Sun*. http://heraldsun.com.au/news/national/doctors-should-tell-overweight-patients-that-they-are-fat/story-e6rf716-1225898699043

Bobo, L. D., Charles, C. Z., Krysan, M., & Simmons, A. D. (2012). 3. The Real Record on Racial Attitudes. In *Social trends in American life* (pp. 38–83). Princeton University Press.

Bombak, A. E., McPhail, D., & Ward, P. (2016). Reproducing stigma: Interpreting “overweight” and “obese” women’s experiences of weight-based discrimination in reproductive healthcare. *Social Science & Medicine*, *166*, 94–101.

Boseley, S. (2020, June 3). *Obesity and coronavirus: How can a higher BMI increase your risk?* The Guardian. https://www.theguardian.com/world/2020/jun/03/obesity-and-coronavirus-how-can-a-higher-bmi-increase-your-risk

BPS. (2018, April 18). *Code of Ethics and Conduct (2018)*. The British Psychological Society. https://www.bps.org.uk/news-and-policy/bps-code-ethics-and-conduct

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Bray, G. A., & Sciences, J. E. F. I. C. for A. S. in the H. (1975). *Obesity in Perspective: Part 1*. [U.S. Department of Health, Education, and Welfare, Public Health Service], National Institutes of Health, John E. Fogarty International Center for Advanced Study in the Health Sciences. https://books.google.co.uk/books?id=wAmMIoe-El4C

Bray, G. A., & York, D. A. (1979). Hypothalamic and genetic obesity in experimental animals: An autonomic and endocrine hypothesis. *Physiological Reviews*, *59*(3), 719–809. https://doi.org/10.1152/physrev.1979.59.3.719

Brewis, A. A. (2014). Stigma and the perpetuation of obesity. *Social Science & Medicine*, *118*, 152–158. https://doi.org/10.1016/j.socscimed.2014.08.003

Brewis, A. A., Wutich, A., Falletta-Cowden, A., & Rodriguez-Soto, I. (2011). Body norms and fat stigma in global perspective. *Current Anthropology*, *52*(2), 269–276.

Brondolo, E., Gallo, L. C., & Myers, H. F. (2009). Race, racism and health: Disparities, mechanisms, and interventions. *Journal of Behavioral Medicine*, *32*(1), 1.

Brown, H. (2015, March 24). *The Weight of the Evidence: It’s time to stop telling fat people to become thin.* Slate.

https://slate.com/technology/2015/03/diets-do-not-work-the-thin-evidence-that-losing-weight-makes-you-healthier.html

Brownell, K. D., Puhl, R. M., Schwartz, M. B., & Rudd, L. E. (2005). *Weight bias: Nature, consequences, and remedies.* Guilford Publications.

Burnham, J. (2012). Developments in Social GRRRAAACCEEESSS: Visible-invisible and voiced-unvoiced. *Culture and Reflexivity in Systemic Psychotherapy: Mutual Perspectives*, 139–160.

Campbell, D. (2020, November 22). *NHS patients at risk as ICUs routinely understaffed, doctors warn.* The Guardian. https://www.theguardian.com/society/2020/nov/22/nhs-patients-at-risk-as-icus-routinely-understaffed-doctors-warn

Campos, E. C. de, Peixoto-Souza, F. S., Alves, V. C., Basso-Vanelli, R., Barbalho-Moulim, M., Laurino-Neto, R. M., & Costa, D. (2018). Improvement in lung function and functional capacity in morbidly obese women subjected to bariatric surgery. *Clinics (Sao Paulo, Brazil)*, *73*, e20–e20. PubMed. https://doi.org/10.6061/clinics/2018/e20

Campos, P., Saguy, A., Ernsberger, P., Oliver, E., & Gaesser, G. (2006). The epidemiology of overweight and obesity: Public health crisis or moral panic? *International Journal of Epidemiology*, *35*(1), 55–60.

Canning, H., & Mayer, J. (1966). Obesity—Its Possible Effect on College Acceptance. *New England Journal of Medicine*, *275*(21), 1172–1174. https://doi.org/10.1056/NEJM196611242752107

CDC. (2021, March 9). *Sources for Data on Social Determinants of Health*. Centre for Disease Control and Preventio. https://www.cdc.gov/socialdeterminants/data/index.htm

Chambliss, H. O., Finley, C. E., & Blair, S. N. (2004). Attitudes toward obese individuals among exercise science students. *Medicine & Science in Sports & Exercise*.

Christian, M. D., Sprung, C. L., King, M. A., Dichter, J. R., Kissoon, N., Devereaux, A. V., & Gomersall, C. D. (2014). Triage: Care of the Critically Ill and Injured During Pandemics and Disasters: CHEST Consensus Statement. *Chest*, *146*(4), e61S-e74S. https://doi.org/10.1378/chest.14-0736

Clair, M., Daniel, C., & Lamont, M. (2016). Destigmatization and health: Cultural constructions and the long-term reduction of stigma. *Social Science & Medicine*, *165*, 223–232. https://doi.org/10.1016/j.socscimed.2016.03.021

Clarke, V., & Braun, V. (2013). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist*, *26*(2).

Cook, J. E., Purdie-Vaughns, V., Meyer, I. H., & Busch, J. T. A. (2014). Intervening within and across levels: A multilevel approach to stigma and public health. *Structural Stigma and Population Health*, *103*, 101–109. https://doi.org/10.1016/j.socscimed.2013.09.023

Cooper, C. (1998). *Fat and proud: The politics of size*. Womens PressLtd.

Cooper, C. (2021). *Fat activism: A radical social movement*. Intellect Books.

Cotter, C., Samos, D., & Swinglehurst, D. (2021). Framing obesity in public discourse: Representation through metaphor across text type. *Journal of Pragmatics*, *174*, 14–27. https://doi.org/10.1016/j.pragma.2020.12.015

Cramer, P., & Steinwert, T. (1998). Thin is good, fat is bad: How early does it begin? *Journal of Applied Developmental Psychology*, *19*(3), 429–451. https://doi.org/10.1016/S0193-3973(99)80049-5

Crandall, C., & Moriarty, D. (1995). Physical illness stigma and social rejection. *The British Journal of Social Psychology*, *34 (Pt 1)*, 67—83. https://doi.org/10.1111/j.2044-8309.1995.tb01049.x

Crawford, R. (1980). Healthism and the Medicalization of Everyday Life. *International Journal of Health Services*, *10*(3), 365–388. https://doi.org/10.2190/3H2H-3XJN-3KAY-G9NY

Crocker, J., Major, B., & Steele, C. (1998). Social Stigma. In: Gilbert, D.T., Fiske, S.T. and Lindzey, G., Eds.,. In *The Handbook of Social Psychology* (4th ed., Vol. 2, pp. 504–553). Academic Press.

Crowe, M., Inder, M., & Porter, R. (2015). Conducting qualitative research in mental health: Thematic and content analyses. *Australian & New Zealand Journal of Psychiatry*, *49*(7), 616–623.

De Brún, A., McCarthy, M., McKenzie, K., & McGloin, A. (2013). “Fat is your fault”. Gatekeepers to health, attributions of responsibility and the portrayal of gender in the Irish media representation of obesity. *Marketing to Children - Implications for Eating Behaviour and Obesity: A Special Issue with the UK Association for the Study of Obesity (ASO)*, *62*, 17–26. https://doi.org/10.1016/j.appet.2012.11.005

De Brún, A., McCarthy, M., McKenzie, K., & McGloin, A. (2014). Weight stigma and narrative resistance evident in online discussions of obesity. *Appetite*, *72*, 73–81. https://doi.org/10.1016/j.appet.2013.09.022

de Frel, D. L., Atsma, D. E., Pijl, H., Seidell, J. C., Leenen, P. J. M., Dik, W. A., & van Rossum, E. F. C. (2020). The Impact of Obesity and Lifestyle on the Immune System and Susceptibility to Infections Such as COVID-19. *Frontiers in Nutrition*, *7*, 279. https://doi.org/10.3389/fnut.2020.597600

DeJong, W. (1980). The Stigma of Obesity: The Consequences of Naive Assumptions Concerning the Causes of Physical Deviance. *Journal of Health and Social Behavior*, *21*(1), 75–87. JSTOR. https://doi.org/10.2307/2136696

Department of Health & Social Care. (2020a). *Policy paper Tackling obesity: Empowering adults and children to live healthier lives*. Department of Health & Social Care.

Department of Health & Social Care. (2020b). *Press release: New obesity strategy unveiled as country urged to lose weight to beat coronavirus (COVID-19) and protect the NHS*. Department of Health & Social Care. https://www.gov.uk/government/news/new-obesity-strategy-unveiled-as-country-urged-to-lose-weight-to-beat-coronavirus-covid-19-and-protect-the-nhs

Di Pasquale, R., & Celsi, L. (2017). Stigmatization of Overweight and Obese Peers among Children. *Frontiers in Psychology*, *8*, 524–524. PubMed. https://doi.org/10.3389/fpsyg.2017.00524

Donkers, M. (2017, March 7). *'It's Because You're Fat'—And Other Lies My Doctors Told Me*. The Establishment. https://theestablishment.co/just-lose-weight-and-other-lies-my-doctors-told-me-16e71dddb836/

Doolan-Noble, F., Pullon, S., Dowell, T., Fuller, D., & Love, T. (2019). Men living with obesity in New Zealand: What does this mean for health care in general practice? *Obesity Research & Clinical Practice*, *13*(3), 233–239. https://doi.org/10.1016/j.orcp.2019.02.005

Dressler, W. W. (2018). Stress. *The International Encyclopedia of Anthropology*, 1–11.

Drury, A., Louis, M., & Aramburu, C. (2002). Exploring the association between body weight, stigma of obesity, and health care avoidance. *Journal of the American Academy of Nurse Practitioners*, *14*(12), 554–561.

Elliott, C. D. (2007). Big Persons, Small Voices: On Governance, Obesity, and the Narrative of the Failed Citizen. *Journal of Canadian Studies*, *41*(3), 134–149. https://doi.org/10.3138/jcs.41.3.134

Evans, B. (2004). *'Be Fit Not Fat': Broadening the Childhood Obesity debate beyond dualisms'*.

Evans, B. (2006). 'Gluttony or sloth': Critical geographies of bodies and morality in (anti) obesity policy. *Area*, *38*(3), 259–267.

Farrell, L. C., Warin, M. J., Moore, V. M., & Street, J. M. (2016). Socio-economic divergence in public opinions about preventive obesity regulations: Is the purpose to 'make some things cheaper, more affordable' or to 'help them get over their own ignorance'? *Social Science & Medicine*, *154*, 1–8. https://doi.org/10.1016/j.socscimed.2016.02.028

Fishman, S. (1998). *Life in the Fat Underground*. Radiance Magazine. http://www.radiancemagazine.com/issues/1998/winter_98/fat_underground.html

Flegal, K. M. (2005). Excess Deaths Associated With Underweight, Overweight, and Obesity. *JAMA*, *293*(15), 1861. https://doi.org/10.1001/jama.293.15.1861

Flegal, K. M., Graubard, B. I., Williamson, D. F., & Gail, M. H. (2005). Excess Deaths Associated With Underweight, Overweight, and Obesity. *JAMA*, *293*(15), 1861–1867. https://doi.org/10.1001/jama.293.15.1861

Flegal, K. M., Kruszon-Moran, D., Carroll, M. D., Fryar, C. D., & Ogden, C. L. (2016). Trends in obesity among adults in the United States, 2005 to 2014. *Jama*, *315*(21), 2284–2291.

Forhan, M., & Salas, X. R. (2013). Inequities in Healthcare: A Review of Bias and Discrimination in Obesity Treatment. *Canadian Journal of Diabetes*, *37*(3), 205–209. https://doi.org/10.1016/j.jcjd.2013.03.362

Foster, G. D., Wadden, T. A., Makris, A. P., Davidson, D., Sanderson, R. S., Allison, D. B., & Kessler, A. (2003). Primary Care Physicians' Attitudes about Obesity and Its Treatment. *Obesity Research*, *11*(10), 1168–1177. https://doi.org/10.1038/oby.2003.161

Foucault, M. (1991). *The Foucault effect: Studies in governmentality*. University of Chicago Press.

Foucault, M. (2007). *Discipline and Punish: The Birth of the Prison* (B. B. Lawrence & A. Karim, Eds.; pp. 445–471). Duke University Press. https://doi.org/10.1515/9780822390169-058

Freespirit, J. & Aldebaran. (1979). Fat liberation manifesto. *Off Our Backs*, *9*(4), 18–18. JSTOR.

Garrow, J. S., Durrant, M. L., Mann, S., Stalley, S. F., & Warwick, P. M. (1978). Factors determining weight loss in obese patients in a metabolic ward. *International Journal of Obesity*, *2*(4), 441–447.

Germov, J., & Williams, L. (1996). The Epidemic of Dieting Women: The Need for a Sociological Approach to Food and Nutrition. *Appetite*, *27*(2), 97–108. https://doi.org/10.1006/appe.1996.0038

Glenza, J. (2020, April 9). *Who gets a ventilator? The 'gut-wrenching' choices facing US health workers*. The Guardian.

https://www.theguardian.com/world/2020/apr/09/us-healthcare-workers-make-gut-wrenching-decisions-coronavirus

Goffman, E. (2009). *Stigma: Notes on the management of spoiled identity*. Simon and Schuster.

Goldblatt, P. B., Moore, M. E., & Stunkard, A. J. (1965). Social Factors in Obesity. *JAMA: The Journal of the American Medical Association*, *192*(12), 1039. https://doi.org/10.1001/jama.1965.03080250017004

Golden, A. (2017, May 2). What Happens When One Fat Patient Sees A Doctor. *Your Fat Friend*. https://medium.com/the-establishment/what-happens-when-one-fat-patient-sees-a-doctor-eddd6cd4a252

Golden, A. (2018, October 29). Please, just call me fat. *Your Fat Friend*.

Golden, A. (2019a, January 17). How Health Care Bias Harms Fat Patients. *Your Fat Friend*. https://medium.com/s/story/the-bias-epidemic-8f27e79bd21c

Golden, A. (2019b, October 15). The Bizarre and Racist History of the BMI. *Your Fat Friend*. https://elemental.medium.com/the-bizarre-and-racist-history-of-the-bmi-7d8dc2aa33bb

Golden, A. (2019c, December 16). Weight Stigma is a Dangerous Threat to Health. *Your Fat Friend*. https://elemental.medium.com/weight-stigma-is-a-dangerous-threat-to-health-8b8f524873fa

Golden, A. (2020a, February 11). Dear Doctor, Here’s What Fat Patients Need From You. *Your Fat Friend*. https://elemental.medium.com/10-things-health-care-providers-can-do-to-better-treat-their-fat-patients-6ac7131eb20c

Golden, A. (2020b, July 27). Just Say Fat: Please, let fat people describe our own bodies. *Your Fat Friend*. https://humanparts.medium.com/just-say-fat-c2c28e3bb00

Goodman, N., Dornbusch, S. M., Richardson, S. A., & Hastorf, A. H. (1963). Variant Reactions to Physical Disabilities. *American Sociological Review*, *28*(3), 429. https://doi.org/10.2307/2090353

Gostin, L. O., Monahan, J. T., Kaldor, J., DeBartolo, M., Friedman, E. A., Gottschalk, K., Kim, S. C., Alwan, A., Binagwaho, A., Burci, G. L., Cabal, L., DeLand, K., Evans, T. G., Goosby, E., Hossain, S., Koh, H., Ooms, G., Roses Periago, M., Uprimny, R., & Yamin, A. E. (2019). The legal determinants of health: Harnessing the power of law for global health and sustainable development. *The Lancet*, *393*(10183), 1857–1910. https://doi.org/10.1016/S0140-6736(19)30233-8

Greener, J., Douglas, F., & van Teijlingen, E. (2010). More of the same? Conflicting perspectives of obesity causation and intervention amongst overweight people, health professionals and policy makers. *Social Science & Medicine*, *70*(7), 1042–1049. https://doi.org/10.1016/j.socscimed.2009.11.017

Grilo, C. M., & Pogue-Geile, M. F. (1991). The nature of environmental influences on weight and obesity: A behavior genetic analysis. *Psychological Bulletin*, *110*(3), 520–537. https://doi.org/10.1037/0033-2909.110.3.520

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, *18*(1), 59–82.

Hammersley, M., & Gomm, R. (2008). Assessing the radical critique of interviews. *Questioning Qualitative Inquiry: Critical Essays*, 89–100.

Harper, D., & Thompson, A. R. (2011). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. John Wiley & Sons.

Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health*, *103*(5), 813–821.

Hebl, M. R., & Heatherton, T. F. (1998). The stigma of obesity in women: The difference is black and white. *Personality and Social Psychology Bulletin*, *24*(4), 417–426.

Hebl, M., & Xu, J. (2001). Weighing the care: Physicians' reactions to the size of a patient. *International Journal of Obesity*, *25*(8), 1246–1252. https://doi.org/10.1038/sj.ijo.0801681

Hermiston, A. J. (2010). "Who are you calling 'fat'?": The social construction of the obesity epidemic. In *Understanding Emerging Epidemics: Social and Political Approaches*. Emerald Group Publishing Limited.

Hill, J. O., Catenacci, V., & Wyatt, H. R. (2005). Obesity: Overview of an epidemic. *The Psychiatric Clinics of North America*, *28*(1), 1–23, vii. https://doi.org/10.1016/j.psc.2004.09.010

Hilton, S., Patterson, C., & Teyhan, A. (2012). Escalating coverage of obesity in UK newspapers: The evolution and framing of the 'obesity epidemic' from 1996 to 2010. *Obesity (Silver Spring, Md.)*, *20*(8), 1688–1695. https://doi.org/10.1038/oby.2012.27

Huizinga, M. M., Cooper, L. A., Bleich, S. N., Clark, J. M., & Beach, M. C. (2009). Physician respect for patients with obesity. *Journal of General Internal Medicine*, *24*(11), 1236.

Jebb, S. (2004). Obesity: Causes and consequences. *Women's Health Medicine*, *1*(1), 38–41. https://doi.org/10.1383/wohm.1.1.38.55418

Katz, D. (2014). Perspective: Obesity is not a disease. *Nature*, *508*(7496), S57–S57.

Kersh, R. (2009). The Politics of Obesity: A Current Assessment and Look Ahead. *The Milbank Quarterly*, *87*(1), 295–316. JSTOR.

King, N. (2004). 21——Using Templates in the Thematic Analysis ofText——. *Essential Guide to Qualitative Methods in Organizational Research*, 256.

Kolata, G. (2016, September 25). Why Do Obese Patients Get Worse Care? Many Doctors Don't See Past the Fat. *The New York Times*. https://www.nytimes.com/2016/09/26/health/obese-patients-health-care.html

Latner, J. D., Stunkard, A. J., & Wilson, G. T. (2005). Stigmatized students: Age, sex, and ethnicity effects in the stigmatization of obesity. *Obesity Research*, *13*(7), 1226–1231.

Latner, J., Wilson, G., Jackson, M., & Stunkard, A. (2009). Greater History of Weight-related Stigmatizing Experience is Associated with Greater Weight Loss in Obesity Treatment. *Journal of Health Psychology*, *14*, 190–199. https://doi.org/10.1177/1359105308100203

LeBesco, K. (2011). Neoliberalism, public health, and the moral perils of fatness. *Critical Public Health*, *21*(2), 153–164. https://doi.org/10.1080/09581596.2010.529422

Lerner, R. M., Karabenick, S. A., & Stuart, J. L. (1973). Relations among Physical Attractiveness, Body Attitudes, and Self-Concept in Male and Female College Students. *The Journal of Psychology*, *85*(1), 119–129. https://doi.org/10.1080/00223980.1973.9923870

Levy-Navarro, E. (2005). “So Much Meat”: Gloria Anzaldúa, the Mind/Body Split, and Exerting Control over My Fat Body. In A. Keating (Ed.), *EntreMundos/AmongWorlds* (pp. 163–169). Palgrave Macmillan US. https://doi.org/10.1057/9781403977137_16

Lewis, C., & Short, C. (2020). *A Latin Dictionary*. Nigel Gourlay.

Lewis, S., Thomas, S. L., Blood, R. W., Castle, D. J., Hyde, J., & Komesaroff, P. A. (2011). How do obese individuals perceive and respond to the different types of obesity stigma that they encounter in their daily lives? A qualitative study. *Social Science & Medicine*, *73*(9), 1349–1356.

Lewis, S., Thomas, S. L., Hyde, J., Castle, D., Blood, R. W., & Komesaroff, P. A. (2010). ‘ I don’t eat a hamburger and large chips every day!’ A qualitative study of the impact of public health messages about obesity on obese adults. *BMC Public Health*, *10*(1), 1–9.

Ligibel, J. A., Alfano, C. M., Courneya, K. S., Demark-Wahnefried, W., Burger, R. A., Chlebowski, R. T., Fabian, C. J., Gucalp, A., Hershman, D. L., Hudson, M. M., Jones, L. W., Kakarala, M., Ness, K. K., Merrill, J. K., Wollins, D. S., & Hudis, C. A. (2014). American Society of Clinical Oncology position statement on obesity and cancer. *Journal of Clinical Oncology : Official Journal of the American Society of Clinical Oncology*, *32*(31), 3568–3574. PubMed. https://doi.org/10.1200/JCO.2014.58.4680

Loury, G. C. (2002). When Color Should Count. *The New York Times*, *28*.

MacLean, L., Edwards, N., Garrard, M., Sims-Jones, N., Clinton, K., & Ashley, L. (2008). Obesity, stigma and public health planning. *Health Promotion International*, *24*(1), 88–93. https://doi.org/10.1093/heapro/dan041

Matthews, V., & Westie, C. (1966). A Preferred Method for Obtaining Rankings: Reactions to Physical Handicaps. *American Sociological Review*, *31*(6), 851. https://doi.org/10.2307/2091664

McPhail, D., & Bombak, A. E. (2015). Fat, queer and sick? A critical analysis of ‘lesbian obesity’in public health discourse. *Critical Public Health*, *25*(5), 539–553.

Monaghan, L. F. (2010a). ‘Physician Heal Thyself’, Part 1: A qualitative analysis of an online debate about clinicians’ bodyweight. *Social Theory & Health*, *8*(1), 1–27. https://doi.org/10.1057/sth.2008.21

Monaghan, L. F. (2010b). ‘Physician Heal Thyself’, Part 2: Debating clinicians’ bodyweight. *Social Theory & Health*, *8*(1), 28–50. https://doi.org/10.1057/sth.2008.20

Morain, S., & Mello, M. M. (2013). Survey finds public support for legal interventions directed at health behavior to fight noncommunicable disease. *Health Affairs*, *32*(3), 486–496.

Muennig, P. (2008). The body politic: The relationship between stigma and obesity-associated disease. *BMC Public Health*, *8*(1), 128. https://doi.org/10.1186/1471-2458-8-128

Mulherin, K., Miller, Y. D., Barlow, F. K., Diedrichs, P. C., & Thompson, R. (2013). Weight stigma in maternity care: Women’s experiences and care providers’ attitudes. *BMC Pregnancy and Childbirth*, *13*(1), 1–13.

Nestle, M., & Jacobson, M. F. (2000). Halting the obesity epidemic: A public health policy approach. *Public Health Reports (Washington, D.C.: 1974)*, *115*(1), 12–24. https://doi.org/10.1093/phr/115.1.12

NHS. (2009). *The NHS Constitution*. Department of Health. https://www.ruh.nhs.uk/about/trustboard/Archive/2010_february/documents/04.3_Appendix_1.pdf

NHS. (2018, November 5). *BMI healthy weight calculator*. NHS. https://www.nhs.uk/live-well/healthy-weight/bmi-calculator/

NHS. (2019). *Obesity*. NHS. https://www.nhs.uk/conditions/obesity/

NHS Support Federation. (2020). *Staff Shortages*. NHS Support Federation. https://nhsfunding.info/symptoms/10-effects-of-underfunding/staff-shortages/

Ni, Y.-N., Luo, J., Yu, H., Wang, Y.-W., Hu, Y.-H., Liu, D., Liang, B.-M., & Liang, Z.-A. (2017). Can body mass index predict clinical outcomes for patients with acute lung injury/acute respiratory distress syndrome? A meta-analysis. *Critical Care (London, England)*, *21*(1), 36–36. PubMed. https://doi.org/10.1186/s13054-017-1615-3

NICE. (2014). *Weight management: Lifestyle services for overweight or obese adults* [Pubic Health Guideline]. National Institute for Health and Care Excellence. https://www.nice.org.uk/guidance/ph53/resources/weight-management-lifestyle-services-for-overweight-or-obese-adults-pdf-1996416726469

Nolan, L. J., & Eshleman, A. (2016). Paved with good intentions: Paradoxical eating responses to weight stigma. *Weight Stigma and Eating Behaviours*, *102*, 15–24. https://doi.org/10.1016/j.appet.2016.01.027

NOOM. (2021). *Learn to eat mindfully. Psychology is the key to lasting change.* NOOM. https://www.noom.com/#/

Obesity Empowerment Network. (2021). *Covid-19 Risk & Obesity*. https://oen.org.uk/covid-19-risk-obesity/

O’Brien, K., Hunter, J., & Banks, M. (2007). Implicit anti-fat bias in physical educators: Physical attributes, ideology and socialization. *International Journal of Obesity (2005)*, *31*, 308–314. https://doi.org/10.1038/sj.ijo.0803398

O’Brien, K. S., Latner, J. D., Ebneter, D., & Hunter, J. A. (2013). Obesity discrimination: The role of physical appearance, personal ideology, and anti-fat prejudice. *International Journal of Obesity*, *37*(3), 455–460.

Ogden, C. L., Carroll, M. D., Curtin, L. R., McDowell, M. A., Tabak, C. J., & Flegal, K. M. (2006). Prevalence of Overweight and Obesity in the United States, 1999-2004. *JAMA*, *295*(13), 1549. https://doi.org/10.1001/jama.295.13.1549

Ogden, J., & Clementi, C. (2010). The Experience of Being Obese and the Many Consequences of Stigma. *Journal of Obesity*, *2010*, 429098. https://doi.org/10.1155/2010/429098

O’Laughlin, D. T., & Hick, J. L. (2008). Ethical Issues in Resource Triage. *Respiratory Care*, *53*(2), 11.

ONS. (2011). *2011 Census*. Office for National Statistics. https://www.ons.gov.uk/census/2011census

Orbach, S. (1979). *Fat is a feminist issue: A self-help guide for compulsive eaters*. http://catalog.hathitrust.org/api/volumes/oclc/4952315.html

Osborn, T. (2021). *From New York to Instagram: The history of the body positivity movement*. BBC Bitesize. https://www.bbc.co.uk/bitesize/articles/z2w7dp3

Otter, S. (2020, September 2). *100 days since the death of George Floyd. What has changed?* Manchestr Evening News. https://www.manchestereveningnews.co.uk/news/uk-news/100-days-death-george-floyd-18614625

Pagán, J. A., & Dávila, A. (1997). Obesity, Occupational Attainment, and Earnings. *Social Science Quarterly*, *78*(3), 756–770. JSTOR.

Paley, J. (2019). *Phenomenology as qualitative research: A critical analysis of meaning attribution*. Routledge.

Parr, H. (2002). Medical geography: Diagnosing the body in medical and health geography, 1999–2000. *Progress in Human Geography*, *26*(2), 240–251. https://doi.org/10.1191/0309132502ph367pr

Patton, L. (2005). Methodology of the Sciences. *Science*, *72*(5), 826–838.

Pearl, R. L. (2018). Weight Bias and Stigma: Public Health Implications and Structural Solutions: Weight Stigma. *Social Issues and Policy Review*, *12*(1), 146–182. https://doi.org/10.1111/sipr.12043

Penney, T. L., & Kirk, S. F. L. (2015). The Health at Every Size Paradigm and Obesity: Missing Empirical Evidence May Help Push the Reframing Obesity Debate Forward. *American Journal of Public Health*, *105*(5), e38–e42. https://doi.org/10.2105/AJPH.2015.302552

Personnel Today. (2005, October 25). *Fattism rife in business*. Personnel Today. https://www.personneltoday.com/hr/fattism-rife-in-business/

Petersen, A. (2003). Governmentality, Critical Scholarship, and the Medical Humanities. *Journal of Medical Humanities*, *24*(3), 187–201. https://doi.org/10.1023/A:1026002202396

Phelan, S. M., Burgess, D. J., Puhl, R., Dyrbye, L. N., Dovidio, J. F., Yeazel, M., Ridgeway, J. L., Nelson, D., Perry, S., Przedworski, J. M., Burke, S. E., Hardeman, R. R., & van Ryn, M. (2015). The Adverse Effect of Weight Stigma on the Well-Being of Medical Students with Overweight or Obesity: Findings from a National Survey. *Journal of General Internal Medicine*, *30*(9), 1251–1258. https://doi.org/10.1007/s11606-015-3266-x

Phelan, S. M., Dovidio, J. F., Puhl, R. M., Burgess, D. J., Nelson, D. B., Yeazel, M. W., Hardeman, R., Perry, S., & van Ryn, M. (2014). Implicit and explicit weight bias in a national sample of 4,732 medical students: The medical student CHANGES study: Medical Student Weight Bias. *Obesity*, *22*(4), 1201–1208. https://doi.org/10.1002/oby.20687

Poon, M.-Y., & Tarrant, M. (2009). Obesity: Attitudes of undergraduate student nurses and registered nurses: *Attitudes towards obesity*. *Journal of Clinical Nursing*, *18*(16), 2355–2365. https://doi.org/10.1111/j.1365-2702.2008.02709.x

Previte, J., & Gurrieri, L. (2015). Who is the biggest loser? Fat news coverage is a barrier to healthy lifestyle promotion. *Health Marketing Quarterly*, *32*(4), 330–349.

Primeau, V., Coderre, L., Karelis, A., Brochu, M., Lavoie, M., Messier, V., Sladek, R., & Rabasa-Lhoret, R. (2011). Characterizing the profile of obese patients who are metabolically healthy. *International Journal of Obesity*, *35*(7), 971–981.

Probyn, E. (2008). IV. Silences behind the mantra: Critiquing feminist fat. *Feminism & Psychology*, *18*(3), 401–404.

Puhl, R., & Brownell, K. D. (2001). Bias, Discrimination, and Obesity. *Obesity Research*, *9*(12), 788–805. https://doi.org/10.1038/oby.2001.108

Puhl, R. M., & Heuer, C. A. (2009). The Stigma of Obesity: A Review and Update. *Obesity*, *v. 17*(5), 941–964. PubAg. https://doi.org/10.1038/oby.2008.636

Puhl, R. M., & Heuer, C. A. (2010a). Obesity stigma: Important considerations for public health. *American Journal of Public Health*, *100*(6), 1019–1028. https://doi.org/10.2105/AJPH.2009.159491

Puhl, R. M., & Heuer, C. A. (2010b). Obesity Stigma: Important Considerations for Public Health. *American Journal of Public Health*, *100*(6), 1019–1028. https://doi.org/10.2105/AJPH.2009.159491

Puhl, R. M., & Latner, J. D. (2007). Stigma, obesity, and the health of the nation's children. *Psychological Bulletin*, *133*(4), 557.

Ramasubramanian, S. (2011). The impact of stereotypical versus counterstereotypical media exemplars on racial attitudes, causal attributions, and support for affirmative action. *Communication Research*, *38*(4), 497–516. https://doi.org/10.1177/0093650210384854

Ramesh, R. (2010, July 28). Doctors should tell people they are fat, not obese, minister says. *The Guardian*. https://www.theguardian.com/lifeandstyle/2010/jul/28/doctors-feat-obese-warnings-health

Randall, J. G., Zimmer, C. U., O'Brien, K. R., Trump-Steele, R. C. E., Villado, A. J., & Hebl, M. R. (2017). Weight discrimination in helping behavior. *Weight-Based Stigmatization: A Special Issue on Determinants,* *Mediating Mechanisms, and Intervention Programs*, *67*(3), 125–137. https://doi.org/10.1016/j.erap.2017.02.002

Ratcliffe, D., & Ellison, N. (2015). Obesity and internalized weight stigma: A formulation model for an emerging psychological problem. *Behavioural and Cognitive Psychotherapy*, *43*(2), 239.

Rich, E., & Evans, J. (2005). 'Fat ethics'–the obesity discourse and body politics. *Social Theory & Health*, *3*(4), 341–358.

Richardson, S. A., Goodman, N., Hastorf, A. H., & Dornbusch, S. M. (1961). Cultural Uniformity in Reaction to Physical Disabilities. *American Sociological Review*, *26*(2), 241. https://doi.org/10.2307/2089861

Robison, J. (2005). Health at every size: Toward a new paradigm of weight and health. *MedGenMed : Medscape General Medicine*, *7*(3), 13–13. PubMed.

Rose, G. A., & Williams, R. T. (1961). Metabolic studies on large and small eaters. *British Journal of Nutrition*, *15*(1), 1–9. https://doi.org/10.1079/BJN19610003

Rothblum, E. D., & Solovay, S. (Eds.). (2009). *The fat studies reader*. New York Unviersity Press.

Ryan, P., & Caplice, N. (2020). Is Adipose Tissue a Reservoir for Viral Spread, Immune Activation and Cytokine Amplification in COVID-19. *Obesity*, *28*. https://doi.org/10.1002/oby.22843

Saguy, A. C. (2012). *What's wrong with fat?* Oxford University Press.

Saguy, A. C., & Almeling, R. (2008). *Fat in the fire? Science, the news media, and the "obesity epidemic" 2*. *23*(1), 53–83.

Saguy, A. C., Frederick, D., & Gruys, K. (2014). Reporting risk, producing prejudice: How news reporting on obesity shapes attitudes about health risk, policy, and prejudice. *Social Science & Medicine*, *111*, 125–133. https://doi.org/10.1016/j.socscimed.2014.03.026

Saguy, A. C., & Riley, K. W. (2005). Weighing Both Sides: Morality, Mortality, and Framing Contests over Obesity. *Journal of Health Politics, Policy and Law*, *30*(5), 869–923. https://doi.org/10.1215/03616878-30-5-869

Sattar, N., McInnes, I. B., & McMurray, J. J. V. (2020). Obesity a Risk Factor for Severe COVID-19 Infection: Multiple Potential Mechanisms. *Circulation*, CIRCULATIONAHA.120.047659. https://doi.org/10.1161/CIRCULATIONAHA.120.047659

Schwartz, M. B., Chambliss, H. O., Brownell, K. D., Blair, S. N., & Billington, C. (2003). Weight bias among health professionals specializing in obesity. *Obesity Research*, *11*(9), 1033–1039.

Setchell, J., Watson, B., Jones, L., & Gard, M. (2015). Weight stigma in physiotherapy practice: Patient perceptions of interactions with physiotherapists. *Manual Therapy*, *20*(6), 835–841. https://doi.org/10.1016/j.math.2015.04.001

Silva, J. M. (2016). High hopes and hidden inequalities: How social class shapes pathways to adulthood. *Emerging Adulthood*, *4*(4), 239–241.

Skrabanek, P. (1994). *The death of humane medicine and the rise of coercive healthism*.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health*, *11*(2), 261–271.

Stone, E. F., Stone, D. L., & Dipboye, R. L. (1992). Chapter 12 Stigmas in Organizations: Race, Handicaps, and Physical Unattractiveness. In K.

Kelley (Ed.), *Advances in Psychology* (Vol. 82, pp. 385–457). North-Holland. https://doi.org/10.1016/S0166-4115(08)62608-4

Strings, S. (2012). Thin, white, and saved: Fat stigma and the fear of the big black body. *UC San Diego*. https://escholarship.org/uc/item/55p6h2xt#author

Strings, S. (2019). *Fearing the black body: The racial origins of fat phobia*. New York University Press.

Sudlow, A., Pournaras, D. J., & Osborne, A. (2020). Bariatric surgery. *Surgery (Oxford)*, *38*(11), 738–744. https://doi.org/10.1016/j.mpsur.2020.08.002

Swinburn, B. A., Kraak, V. I., Allender, S., Atkins, V. J., Baker, P. I., Bogard, J. R., Brinsden, H., Calvillo, A., De Schutter, O., Devarajan, R., Ezzati, M., Friel, S., Goenka, S., Hammond, R. A., Hastings, G., Hawkes, C., Herrero, M., Hovmand, P. S., Howden, M., … Dietz, W. H. (2019). The Global Syndemic of Obesity, Undernutrition, and Climate Change: The Lancet Commission report. *The Lancet*, *393*(10173), 791–846. https://doi.org/10.1016/S0140-6736(18)32822-8

Tamara, A., & Tahapary, D. L. (2020). Obesity as a predictor for a poor prognosis of COVID-19: A systematic review. *Diabetes & Metabolic Syndrome: Clinical Research & Reviews*, *14*(4), 655–659. https://doi.org/10.1016/j.dsx.2020.05.020

Taylor, G. W., & Ussher, J. M. (2001). Making sense of S&M: A discourse analytic account. *Sexualities*, *4*(3), 293–314.

Truog, R. D., Mitchell, C., & Daley, G. Q. (2020). The Toughest Triage—Allocating Ventilators in a Pandemic. *New England Journal of Medicine*, *382*(21), 1973–1975. https://doi.org/10.1056/NEJMp2005689

Wanniarachchi, V. U., Mathrani, A., Susnjak, T., & Scogings, C. (2020). A systematic literature review: What is the current stance towards weight stigmatization in social media platforms? *International Journal of Human-Computer Studies*, *135*, 102371. https://doi.org/10.1016/j.ijhcs.2019.102371

Weiner, B., Perry, R., & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology*, *55 5*, 738–748.

Weiner, Bernard. (1993). On sin versus sickness: A theory of perceived responsibility and social motivation. *American Psychologist*, *48*(9), 957–965. https://doi.org/10.1037/0003-066X.48.9.957

Welle, S. L., Amatruda, J. M., Forbes, G. B., & Lockwood, D. H. (1984). Resting Metabolic Rates of Obese Women after Rapid Weight Loss*. *The Journal of Clinical Endocrinology & Metabolism*, *59*(1), 41–44. https://doi.org/10.1210/jcem-59-1-41

WHO. (2018). *Obesity and overweight*. WHO. https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight.

Willig, C. (2012). *Qualitative interpretation and analysis in psychology*. McGraw-Hill Education (UK).

Willig, C. (2013). *Introducing qualitative research in psychology*. McGraw-hill education (UK).

Wolpert, S. (2007, April 3). *Dieting does not work, UCLA researchers report*. Newsroom. https://newsroom.ucla.edu/releases/Dieting-Does-Not-Work-UCLA-Researchers-7832

Yang, X., Yu, Y., Xu, J., Shu, H., Xia, J., Liu, H., Wu, Y., Zhang, L., Yu, Z., Fang, M., Yu, T., Wang, Y., Pan, S., Zou, X., Yuan, S., & Shang, Y.

(2020). Clinical course and outcomes of critically ill patients with SARS-CoV-2 pneumonia in Wuhan, China: A single-centered, retrospective, observational study. *The Lancet Respiratory Medicine*, *8*(5), 475–481. https://doi.org/10.1016/S2213-2600(20)30079-5

Zachariadis, M., Scott, S., & Barrett, M. (2010). *Designing mixed-method research inspired by a critical realism philosophy: A tale from the field of IS innovation*.

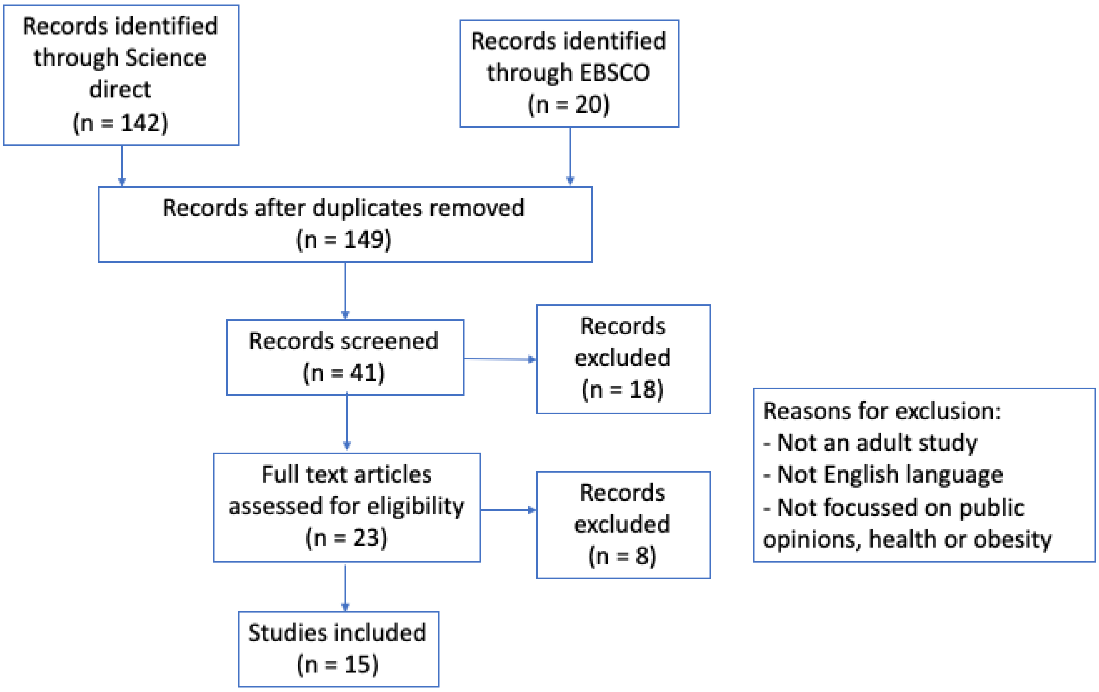
6. APPENDICIES

6.1 Appendix A: Literature Search

Date conducted Dec 2020 - Jan 2021

Key Term search in Title, Abstract and Key Word: (public opinions) AND (obesity stigma) AND (healthcare)
Databases searched: EBSCO: PsychInfo, Academic Search Complete, = 20 Science Direct= 470 when duplicates were removed Scopus= 142 when duplicates were removed (Limits applied: English language, 2000-2021.)
Inclusion criteria - The review is concerned with public opinions of obese people accessing healthcare, as such papers including these issues were featured. - The research should focus on public opinions, not healthcare professionals. - Reviews including any systematic or meta-analysis, to cross reference with current review. - Published between 2000 -2021 - Full text available
Exclusion criteria - Paediatric healthcare - Views of healthcare professionals - *initially limiters had been set to only include research from the UK but this was too limiting .
Bidirectional citation searching (checking references and citations) was used on the final 15 articles and appropriateness for inclusion was based on: title i.e. public opinions/ attitudes AND obesity AND healthcare. However, no further appropriate literature was discovered.

6.2 Appendix B: Literature Review



6.3 Appendix C: Ethics Approval

C1: Ethics Approval

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: John Turner

SUPERVISOR: **Kenneth Gannon**

STUDENT: Kelly Robinson

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: AntiFat Attitudes in Healthcare Settings

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

APPROVED

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer):*

C2: Request for Title Change to an Ethics Application

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. Using your UEL email address, email the completed request form along with associated documents to: Psychology.Ethics@uel.ac.uk
4. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

REQUIRED DOCUMENTS

1. A copy of the approval of your initial ethics application.

Name of applicant: Kelly Robinson

Programme of study: Professional Doctorate in Clinical Psychology

Name of supervisor: Dr Ken Gannon

6.4 Appendix D: Research Advertisement

University of
East London

Participants Needed!

Public opinions on healthcare allocation

Are you interested in talking about the allocation of healthcare resources?
As part of my Doctorate in Clinical Psychology I am conducting research into healthcare allocation in the context of the COVID-19 pandemic, including how people are prioritised in terms of access to resources. I would love to hear your views!

If you are interested in taking part in this study, or would like some more information, please contact:
Kellie Robinson

6.5 Appendix E: Participant Invitation Letter

PARTICIPANT INVITATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a postgraduate student in the School of Psychology at the University of East London and am studying for a Professional Doctorate in Clinical Psychology. As part of my studies I am conducting the research you are being invited to participate in.

What is the research?

I am conducting research into public attitudes to overweight and obese people accessing healthcare and views on barriers they face.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate in my research as I am looking to involve members of the public from around the UK.

I emphasise that I am not looking for 'experts' on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect.

You are free to decide whether or not to participate, there is no obligation to do so.

What will your participation involve?

If you agree to participate you will be asked to:

Complete a brief online questionnaire about your views of overweight and obese people accessing healthcare. This will take around 15minutes. Your views will be anonymous as you will not be asked to enter any identifying information.

Following completion of the online questionnaire you will be invited to participate in a follow up interview explore your views further. There is no obligation to do so, but if you agree to be interviewed you will be invited to leave contact details of your choice (phone number, email or address) in order for the researcher to contact you. Interviews will be expected to take around 45minutes. Interview location can be flexible. They can take place using Microsoft TEAMS webchat, over the phone or face to face at the UEL Stratford campus. The interview will be audio recorded in order for the researcher to transcribe the discussion.

Unfortunately, I will not be able to pay you for participating in my research, but your participation would be very valuable in helping to develop knowledge in this area and may contribute to the development of services for overweight people.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times.

Your responses to the online questionnaires will be anonymous as no identifying data will be requested.

If you choose to participate in a follow up interview you will not be identified in this data collection or any written material resulting from the data collected, or in any write-up or dissemination of the research.

During the interview you do not have to answer any questions that you don’t wish to, and can stop your participation at any time.

What will happen to the information that you provide?

All data collected will be stored securely on a password protected drive only accessible through a password protected computer to ensure that it can only be accessed by the researcher.

All interview data will be anonymised, names will not be used in the write up of the research.

Interview recordings will be deleted as soon as they are transcribed by the researcher.

Once the study has been completed the data will remain securely stored and will be deleted 3 years following completion in line with NHS data protection regulations.

If you chose to withdraw your data it will all be deleted, as long as data analysis has not started. This is explained further below.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. Separately, you may also request to withdraw your data even after you have participated data, provided that this request is made by 1st November 2020 (after which point the data analysis will begin, and withdrawal will not be possible).

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Kelly Robinson

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr Kenneth Gannon. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: K.N.Gannon@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.lomas@uel.ac.uk)

6.6 Appendix F: Consent Form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study:

AntiFat Attitudes in Healthcare Settings

I have the read the information letter relating to this research study and have a copy to keep. What the research involves and why it is being done have been explained to me, and I have had the chance to talk about it and ask questions. I understand what is going to happen and what I am being asked to do.

I understand that my involvement in this study, and the things I say in the interview, will remain strictly confidential. In the write-up of the study all identifying personal information will be removed and the researcher will ensure that quotes used are not traceable to individuals. Only the researcher will have access to information that could identify me. It has been explained to me what will happen once the research study has been completed.

I am happy to agree to participate in the study. Having agreed to do this, I understand that I can pull out of the study at any time before 1st November 2020 and I don't have to say why. After this date the data will have been analysed and it will not be possible to withdraw my data from the study.

Participant's Name (BLOCK CAPITALS)

....

Participant's Signature

....

Researcher's Name (BLOCK CAPITALS)

....

Researcher's Signature

....

Date: ....

6.7 Appendix G: Debrief Form

University of
East London

PARTICIPANT DEBRIEF LETTER

Thank you for participating in my research study on public views on obese people accessing healthcare. This letter offers information that may be relevant in light of you having now taken part.

What will happen to the information that you have provided?

The following steps will be taken to ensure the confidentiality and integrity of the data you have provided.

- All questionnaire data is anonymous as you were not invited to include any identifiable information.
- All interview data will be anonymised. Your name will not appear in the write up of the research, and steps will be taken to ensure that quotes used in the research cannot be traced to individuals.
- The anonymised data will be seen by the researcher's supervisor and examiners at their request. The researcher intends to publish in academic journals.
- Interview recordings will be deleted as soon as the researcher has transcribed the recording. These transcripts will be deleted after three years of completion of the write up.
- You can pull out of the study at any time before X date and you do not have to say why. After X date the data will have been analysed and it will not be possible to withdraw your data from the study.

What if you have been adversely affected by taking part?

I hope that you have not been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways you may find the following resources/services helpful in relation to obtaining information and support:

The Samaritans:

Call: 116 123
Email: jo@samaritans.org (response time: 24 hours)

Give us a shout:
Anonymous text support in personal crisis: 85258

Beat:
Eating Disorder support: 0808 801 0677

You are also very welcome to contact me or my supervisor if you have specific questions or concerns.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Kelly Robinson

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr Kenneth Gannon School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: K.N.Gannon@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.lomas@uel.ac.uk)

6.8 Appendix H: Initial Draft Interview Schedule

“Overweight/ obese/ fat people report to experience numerous barriers to accessing healthcare”.
- what are you views on this statement? Talk through your thinking.

What do you think some of these barriers may be?

“Overweight/ obese/ fat people report to feel humiliated and dehumanised when accessing healthcare”.
- What are your views on this statement? Talk through your thinking.

Where do you think these attitudes may have originated?

6.9 Appendix I: Interview Schedule

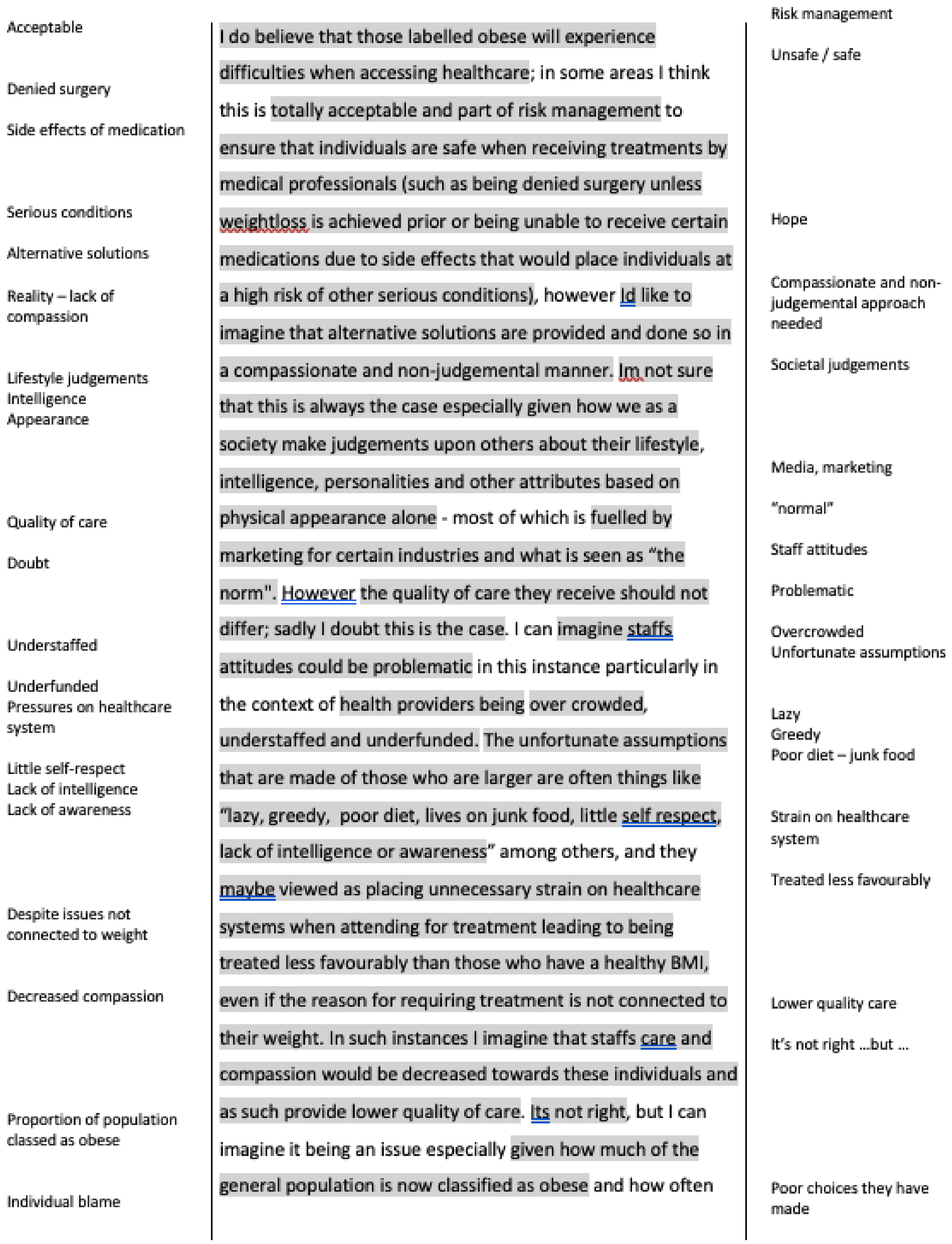
Over the past few years there has been talk in the news and media of an obesity epidemic and the demands this places on our national health service. More recently, the government have released incentives to try and reduce the instances of COVID by targeting obesity as a causal issue.

- Most medical/ government documents use the clinical term ‘obesity’ to describe people whose BMI is over a certain number, I wonder what the term “obesity” means to you, and how it may differ from other descriptors such as fat/ large/ plus size/ any others you may identify with?

- What do you think about the possibility that people labelled as ‘obese’ may experience difficulties and challenges when accessing healthcare?
  What might the challenges be? Do you think its fair that they might experience challenges? Are there any areas of healthcare where challenges may be more likely in your view?

- There is extensive research and literature exploring negative attitudes that medical staff have towards patients viewed as ‘obese’ - admitting that they spend less time with them which arguably can lead to inappropriate/ inaccurate diagnoses and lack of adequate investigation offered to ‘straight size’ people. What are your initial thoughts about this? Does it seem fair to you?
- In relation to COVID-19, we are being informed that ‘obese’ people along with other groups (including people of colour and the elderly) are at increased risk and are particularly vulnerable to be become more seriously ill if they were to contract COVID, and more likely to need intensive care that may include ventilators. Due to the high demand, healthcare professionals are having to make decisions about who to prioritise.
  What do you think about this? What do you think about the focus on BMI as a risk factor for COVID-19?
- Is there anything else from your own experience or views about ‘obese’ people’s experience of accessing healthcare that you would like to share?

6.10 Appendix J: Coded Transcript Example



I do believe that those labelled obese will experience difficulties when accessing healthcare; in some areas I think this is totally acceptable and part of risk management to ensure that individuals are safe when receiving treatments by medical professionals (such as being denied surgery unless weightloss is achieved prior or being unable to receive certain medications due to side effects that would place individuals at a high risk of other serious conditions), however Id like to imagine that alternative solutions are provided and done so in a compassionate and non-judgemental manner. Im not sure that this is always the case especially given how we as a society make judgements upon others about their lifestyle, intelligence, personalities and other attributes based on physical appearance alone - most of which is fuelled by marketing for certain industries and what is seen as “the norm". However the quality of care they receive should not differ; sadly I doubt this is the case. I can imagine staffs attitudes could be problematic in this instance particularly in the context of health providers being over crowded, understaffed and underfunded. The unfortunate assumptions that are made of those who are larger are often things like “lazy, greedy, poor diet, lives on junk food, little self respect, lack of intelligence or awareness” among others, and they maybe viewed as placing unnecessary strain on healthcare systems when attending for treatment leading to being treated less favourably than those who have a healthy BMI, even if the reason for requiring treatment is not connected to their weight. In such instances I imagine that staffs care and compassion would be decreased towards these individuals and as such provide lower quality of care. Its not right, but I can imagine it being an issue especially given how much of the general population is now classified as obese and how often

Acceptable

Denied surgery

Side effects of medication

Serious conditions

Alternative solutions

Reality – lack of compassion

Lifestyle judgements
Intelligence
Appearance

Quality of care

Doubt

Understaffed

Underfunded
Pressures on healthcare system

Little self-respect
Lack of intelligence
Lack of awareness

Despite issues not connected to weight

Decreased compassion

Proportion of population classed as obese

Individual blame

Risk management

Unsafe / safe

Hope

Compassionate and non-judgemental approach needed

Societal judgements

Media, marketing

“normal”

Staff attitudes

Problematic

Overcrowded
Unfortunate assumptions

Lazy
Greedy
Poor diet – junk food

Strain on healthcare system

Treated less favourably

Lower quality care

It’s not right …but …

Poor choices they have made

6.11 Appendix K: Initial Codes

Barriers

Blame

Causation

COVID

Demand exceeds supply

Descriptor

Disadvantage

Discrimination

Elective care

Emergency care

Expected and accepted barriers

Fairness

Fat prejudice

Government incentives

Heath

Holistic picture

Illness

It’s complex

Judgements

Legal issues

Measure of weight

Media

Medical context

Moral judgements

NHS

No effort

Not their fault

Obesity epidemic

Payback

Positive effort

Poverty

Power

Prejudice

Quality of Life

Right thing to say

Risk

Self-inflicted/ self-control

Social deprivation

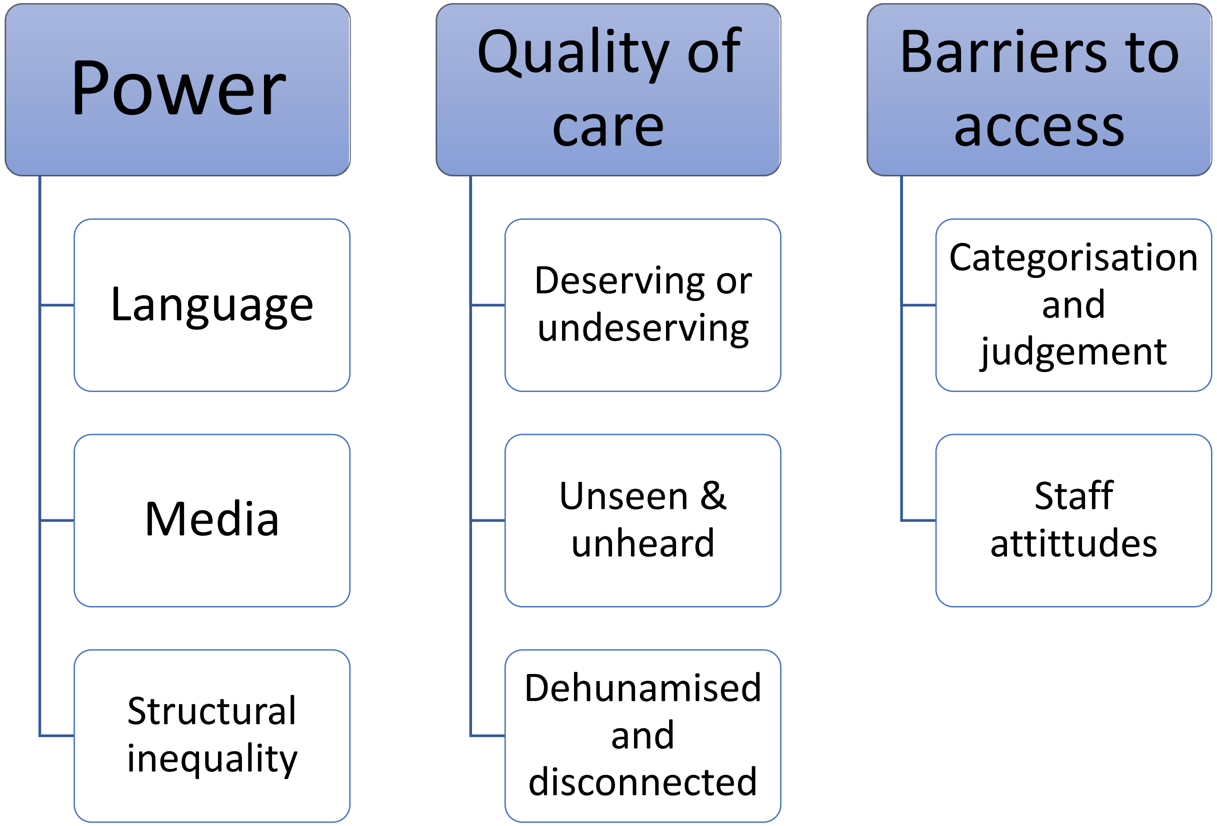
Stigma

Treatment compromised

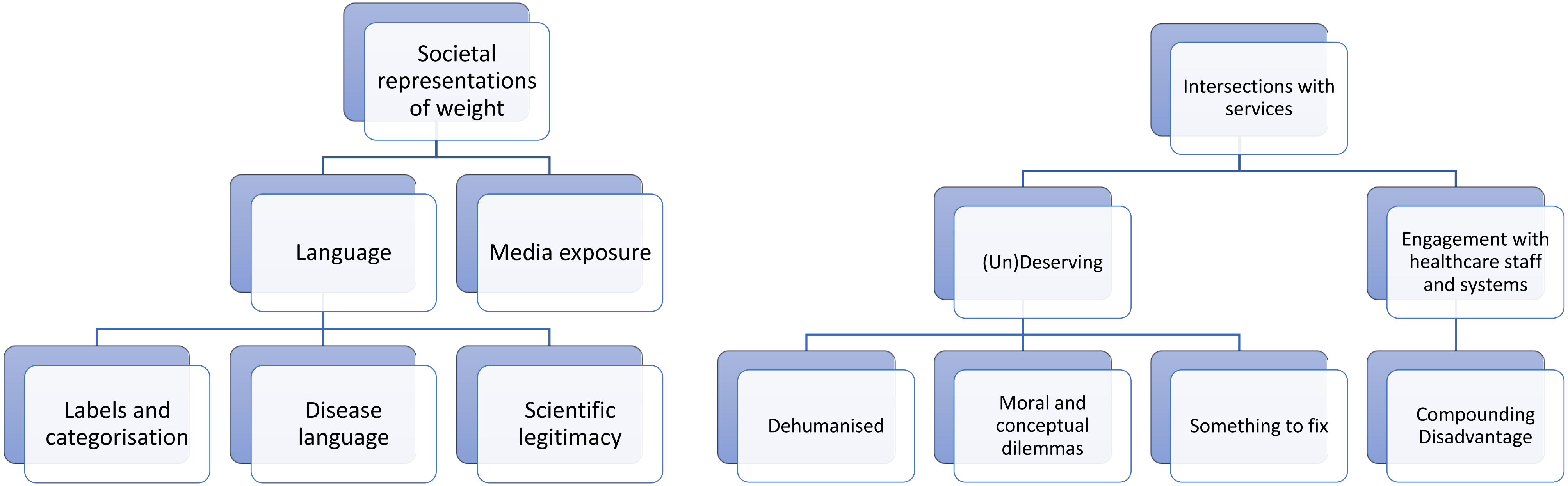
Unfit

Withholding treatment

6.12 Appendix L: Initial Theme Map



6.13 Appendix M: Final Theme Map



6.14 Appendix N: Reflective Journal Excerpts

Thesis Personal Reflections

3rd August 2020

A few people with first-hand experience of judgemental attitudes have come forward to offer their time to be interviewed. As a result I felt like I may have to slightly change my interview questions to ensure that they work for both fat and straight sized participants.

I did my first interview today with someone I did not know, they were very informed about the literature and experiences, including their own.
They discussed intersections of their experience and made reference to class – and the way that it can be easier for fat people to navigate healthcare systems if they are able to advocate for themselves. This was something I had not really thought about in much detail, and hadn't really come up in the literature that I've read. It feels like something that will be really important for me to think about in the discussion.

14th August 2020

I have been lucky so far that the people I have interviewed have not had particularly opposing views to my own. However I am sure this will happen at some point and it will be really important to remember my role as the researcher and not impart my views on the participant. I have spoken about this with some of my peers as we are all researching topics that we have our own personal views about.
After having people approach me who have their own personal experiences of anti-fat attitudes I have been wondering about what it might have been like to speak to me about these things as a straight-sized person. The research does not feel like the place to explore that, but I wondered whether people had been able to speak as openly as they would if they perceived that I too had personally experienced anti-fat attitudes.

12th October 20200

I had quite a tough interview today with a person who held very different views to me. I hope that I managed to remain curious about their position and did not impart my views on them. Having listened to the recording I noticed that I did not sound as comfortable as I did when I had been speaking to people with more “balanced views”. I did wonder whether there are gender and generational differences that affect people’s views. Although I did not collect much in the way of demographics, as the interviews were conducted over Microsoft Teams I could (rightly or wrongly) make some assumptions about the participants’ age and gender based on their appearance and what they said in the interview.

Despite this interview, I think generally I have been feeling more hopeful that people’s views were not at judgemental or fixed as I had previously assumed