

REFRAMING FATNESS: CRITIQUING 'OBESITY'

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Introduction

OVER THE LAST twenty years or so, fatness,¹ pathologised as overweight and obesity, has been a core public health concern around which has grown a lucrative international weight loss industry. Referred to as a 'time bomb' and 'the terror within', analogies of 'war' circulate around obesity, framing fatness as enemy.² Religious imagery and cultural and moral ideologies inform medical, popular and policy language with the 'sins' of 'gluttony' and 'sloth', evoked to frame fat people as immoral at worst and unknowledgeable victims at best,³ and understandings of fatness intersect with gender, class, age, sexuality, disability and race to make some fat bodies more problematically fat than others. As Evans and Colls⁴ argue, drawing on Michel Foucault,⁵ a combination of medical and moral knowledges produces the powerful 'obesity truths' through which fatness is framed as universally abject and pathological. Dominant and medicalised discourses of fatness (as obesity) leave little room for alternative understandings. Yet, informed by a long history of feminist and queer fat activism, there are other, non-medicalised accounts of fatness that offer alternatives to, and/or directly challenge, the 'truths' on which obesity discourse is based.⁶ These critical accounts can be drawn together under the umbrella 'Fat Studies',⁷ an interdisciplinary field spanning the humanities and social sciences, including the nutritional sciences via the Health at Every Size (HAES)⁸ movement.

Fat studies as a research field intersects with fat activism, which has a longer history, often involving art and performance practices to disrupt dominant understandings of fatness and/or create spaces for, and encounters with, fat bodies outside of any pathological framing. Work within fat studies and fat activism intersects with the core interests of the medical humanities in multiple ways and yet there has been surprisingly little engagement between them. In fact, as Atkinson et al. argue, the medical humanities 'have . . . accorded negligible attention to the art, arguments and activities of activist movements' more broadly.⁹ A *critical* medical humanities provides impetus for such engagement. In this chapter, we outline this potential in relation to fat studies and fat activism. In so doing, we are not suggesting the critical medical humanities can provide the means to 'tackle obesity' better; rather, we suggest that engaging these

movements can foreground alternative understandings of fatness beyond pathology and promote more socially just engagements between medicine and fat bodies.

In this chapter we firstly give some background on fat studies and fat activism before, secondly, signposting examples of fat studies scholarship that have synergies with the critical medical humanities. Thirdly, we draw on insights from queer and disability theory and the research justice movement to indicate ways in which the critical medical humanities may develop socially just engagements with fatness. These insights are illustrated through Charlotte's own involvement in art and performance-based activist events.

Background: Fat Studies and Fat Activism

Fat studies is an interdisciplinary and academic field that developed out of a series of gatherings and publications (including a dedicated journal¹⁰ and two readers¹¹) in the West within the past ten years,¹² particularly following the 2000 World Health Organisation report on obesity.¹³ The rhetoric of obesity epidemiology since 2000 has framed fatness as a crisis and implicated it within a post-millennial neoliberal politics of austerity. However, this period also witnessed a coming of age for critical¹⁴ communities, and within fat studies 'obesity' is not framed as a 'natural medical fact' without the use of scare quotes, and significantly for this volume on *critical* medical humanities, being critical is central to fat studies. As Cooper has explained elsewhere:

Fat Studies is different to dominant obesity discourse in that it is critical; it seeks to expand the understanding of fatness beyond the narrow confines of medicalisation or pathology, which is why the term 'obese' is frequently censured; it often incorporates a social model which shifts the focus of interrogation away from the fat body itself and more towards positioning and contingent systems and structures; and it provides a platform for identifying, building and developing fat culture as well as extending alliances between activism and the academy.¹⁵

Critical scholarship concerning fat pre-dates fat studies, as do fat activism and critical health promotion in relation to fat people. Fat activism has strong historical and cultural roots in a fat feminism underpinned by queer identity and community. The Fat Underground, one of the earliest groups to develop a theory and practice of fat activism, counted many lesbian and bisexual feminists within its sprawling membership.¹⁶ As queer developed and began to be theorised as something connected to and distinct from an expression of sexuality, third-wave fat activists, such as the collective who produced FaT GiRL zine, amplified and solidified queer fat feminist aesthetic praxis.¹⁷ Today, fat and queer are profoundly linked, through organisations such as NOLOSE, in academia, popular culture and fat activism more generally.¹⁸

Being critical in the context of fat studies means being critical of the dominant ways in which fatness is framed as pathology and engaging with other critical movements and theory, including feminist, queer and poststructural theory. Much work in fat studies stands in contradistinction to dominant modes of knowledge production,

particularly in the medical sciences, in its style and its approaches to fat. Work is often written in the first person, avoids the quantification of bodies and any simple classification of bodies as fat (or not) on this basis, and entails reflexive, situated research that acknowledges the role of the researcher's body in the production of knowledge and the partiality of perspectives produced. This is important because, as Wann explains:

If you do fat studies work, you yourself are always already part of the topic. Every person who lives in a fat-hating culture inevitably absorbs anti-fat beliefs, assumptions, and stereotypes, and also inevitably comes to occupy a position in relation to power arrangements that are based on weight.¹⁹

Being critical is not therefore a simple 'paint by numbers' approach to revealing an oppression; rather it entails interrogating the intersecting power relations through which knowledge claims are made about fatness.²⁰ In contrast, in mainstream, medicalised obesity discourse, fat people are almost always absent as active participants and owners of knowledge, even though we are ostensibly at its heart. Fat studies therefore provides a platform where critical perspectives could, theoretically, converge, irrespective of grassroots or professional allegiances. Yet there are tensions and it is important here that we acknowledge these to avoid presenting fat studies as a uniform and unified field.

Firstly, fat studies is predominantly Anglo-American. It is dominated by research and activism in the US;²¹ there is an increasing body of work from the UK but a significant absence of work from the Majority World. As Cooper has argued, whilst this is understandable to some extent (the 'fat American' stereotype; longer fat activist archives in the US), the specificities of politics and healthcare in different national contexts mean that fat stigma and prejudice take different forms in different places. For example, the relationship between fat, class and neoliberal models of responsibility play out differently in the context of a privately funded healthcare system (US) and a publicly funded National Health Service (UK). It is therefore important that geographically heterogenous understandings of fat are developed to avoid the risks of cultural imperialism.²²

Secondly, as with any interdisciplinary field, the breadth of methodological and epistemological approaches means there are internal tensions, particularly regarding the relationship to the more clinically oriented HAES movement. There are also tensions, as Cooper explains, 'between researchers who are somewhat removed from the day-to-day experience of being fat and those who have a closer relationship to it'²³ and between those who are supportive or not of fat liberation. Some authors (for example, Probyn²⁴), whilst rooted in feminist work, continue to accept the core tenets of dominant obesity discourse.²⁵ Drawing simple lines around what is, or is not, fat studies is therefore impossible.

Thirdly, there are tensions surrounding the relationship between activism and the academy. With its emphasis on measurable impact, the neoliberal academy too often gives rise to a form of individualist career-building scholarship where there is little space for activism or genuine community involvement.²⁶ As a result, in some areas

of academic work, we are seeing the concepts that we, as activists, originated being whitewashed and appropriated in spaces that are part of a fat studies genealogy but removed from the everyday realities of living as a fat person. For example, over the past couple of years there have been critical institutional gatherings of academics and health professionals where fat people/activists are absent or treated as an unwelcome presence, or where obesity discourse is present.²⁷ This colonisation of fat experience, particularly around ameliorating ‘harsh’ activist language, could be seen as an inevitable consequence of fat studies’ relevance, popularity and development as an *academic* field. However, losing direct activist input risks also losing relevancy and power through losing track of the roots of fat studies within fat activism. This connection to activism is germane to a discussion of critical medical humanities, as well as the themes of this chapter. Whilst the medical humanities does not have its roots in activism, it is similarly an interdisciplinary field with an interest in engaging non-academics in research. Whilst a critical medical humanities could usefully engage with activism and activists, it is important to avoid a situation where a project’s subjects are treated as walk-on bit-players instead of as equals and collaborators, compared to the ‘real’ work undertaken by project managers.

Recognising these tensions, and in the spirit of feminist scholarship,²⁸ we first contend that one element in the development of a critical medical humanities must be greater transparency and reflection on the modes of knowledge production within the field itself. This requires acknowledging the forms of privilege and the positions from which we write.²⁹ Thus, we first situate the knowledge that we produce here within our own lived and embodied biographies:

Charlotte Cooper: I am a middle-aged, working-class queer from East London. I tend to orientate myself around punk, feminism and postmodernism. I am fat. My contributions to fat activism over nearly 30 years have included publications, event organising, public life, academic work and thousands of complicated conversations and ideas. My fat politics bleed into other forms of activism, as well as into my cultural work. I make zines (small, homemade publications), films, performance and digital artefacts, amongst other cultural objects and moments. I currently make my living as a psychotherapist and have my own practice. I am not someone who can be easily placed into the discrete categories – academic, service user, health professional, artist – that seem to emerge through medical humanities. As a somewhat unruly presence I destabilise some of the taken-for-granted positioning of the field, which I relish and regard as an important part of what I bring to this edited collection.

Bethan Evans: I am a white, middle-class academic geographer (whose work is interdisciplinary), scholar-activist and fat body. I have written elsewhere about some of the challenges I face negotiating these multiple positions whilst undertaking research.³⁰ I am fat, though my body size has changed over the course of my life, sometimes being thin, sometimes fat. At the size I am now, I have had uncomfortable encounters with clinical professionals but I am not disabled by the built environment and have not

suffered abuse in public places. In contrast to the dominant ways in which 'impact' and 'knowledge exchange' are framed in academia, I do not see knowledge moving from academia to activism; rather my academic work is informed by engagement with activists and my aim is for activist understandings of fatness to disrupt and inform academic approaches. Working with scholar-activists like Charlotte is one way in which I aim to do this. My position as a middle-class, white academic places me in a privileged position in writing this chapter and, in doing so, I acknowledge that the account we produce here is necessarily partial.

Fat Studies and Medical Humanities

In this section we draw on the three Es, which Whitehead and Woods use to frame the critical medical humanities³¹ in order to outline the potential for engagement with fat studies:

Ethics

According to Downie and MacNaughton, a critical perspective is essential to understanding the role of the medical humanities (and, more specifically, philosophy within medical humanities) in relation to bioethics.³² In particular, the humanities draw direct attention to the assumptions that underpin medical knowledges and practices. This, in combination with more expansive questions in bioethics, has led to a concern in the medical humanities with the attitudes and perceptions that inform medical knowledge production, interventions and clinical encounters. Within fat activism and fat studies, these questions of ethics are mirrored in work that questions taken-for-granted assumptions about fatness in the production of medical knowledge and the ethics of health interventions. Solovay argues that:

There are three fundamental beliefs about fat held by the medical establishment all of which have profound implications not only for the health and well-being of fat people, but also for the law. These rarely challenged assumptions are: that weight is mutable, that weight loss is a benign procedure and that fat is unhealthy. Medicine's failure to examine these basic assumptions critically has resulted in the development of a field riddled by bias.³³

These assumptions are so powerful that they can override important ethical questions about the potential harm of interventions aiming to reduce weight. For example, Evans and Colls question the ethics of a body mass index (BMI) measurement programme, which went ahead despite evaluation by the National Screening Committee that it was unable to 'do more good than harm'.³⁴ Fat studies and HAES scholarship challenges these assumptions, demonstrating that there is no simple relationship between weight and health, that weight loss is not benign and in fact may be worse for health than remaining at a consistently higher weight, and that weight loss is not sustainable.³⁵ Fat studies also challenges claims to 'objectivity' in the production of knowledge on

fat. In the medical humanities, one of the few papers written directly on fat addresses the combination of medical and cultural knowledges about fat through analysis of the discursive constructions of obesity in an episode of the US TV show about a plastic surgery clinic, *Nip/Tuck*. Classed stereotypes about fat as a result of laziness are addressed here, as is the objectification of fat bodies within clinical examinations and the disciplinary role of medicine in relation to fat. Within fat studies there are many analyses of the ways in which fat is represented across a range of media. These include analyses of cultural discourses in public health policy³⁶ and *The Fat Studies Reader* has a whole section on size-ism in popular culture and literature.³⁷

This discourse matters for medical ethics because it contributes to a situation in which the dominant understanding of fat bodies is abject, irresponsible and stigmatised, and this, in turn, has an impact on the health of fat bodies. Within fat activist communities, bad experiences of medical care, in which the patient's fatness obscures the purpose of the consultation and/or leads to a dehumanising encounter with medical professionals, are common – and, in fact, both of us have experienced this first-hand. Ernsberger reviews previous studies on social class, weight and health, demonstrating that social stigma, stress and prejudicial medical care are important factors in this relationship.³⁸ In particular, he cites work that demonstrates how doctors are less likely to perform screening and preventative health checks on fat patients and how fat people are less likely to seek medical care because of bad experiences with medical professionals. Bovey reports that 'Llewellyn Louderback remarked that advising a fat person to see his [sic] physician is like telling a mouse to go see a cat,'³⁹ and cites numerous examples from a survey of two hundred fat women, who report shocking experiences of hatred encountered from medical professionals. Similar attitudes are perhaps evident within Medical Humanities research by Weisberg and Duffin, in which an interdisciplinary class of medical, nursing and law students read 'Fat Lady' by Irvin Yalom to discuss 'treating patients/clients one hates'.⁴⁰

Education

Bovey, in discussing the prejudice faced by fat people in encounters with medical professionals, suggests that the dislike that doctors have for fat patients 'comes from their middle-class values rather than from their training or from any scientific basis'.⁴¹ Writing more recently, Boero argues that 'pre-existing, yet largely unexamined cultural understandings of fatness form the plinth of representations of scientific debate or agreement about weight.'⁴² Thus, considering the role of medical education in the production of fat stigma requires attending to the ways in which 'common-sense' knowledges intersect with simplistic 'scientific' understandings to produce fat as abject.

Given that the dominant medico-scientific approach to fat is one of pathology, it is interesting to consider whether it would be possible to deliver a critical medical humanities approach in alignment with fat studies within medical education, which otherwise presents fat as undesirable. Within fat studies research, two key issues relating to education are evident. Firstly, a focus on fat inevitably draws attention to the

bodies present within the classroom. Both Guthman⁴³ and Escalera⁴⁴ identify potential problems faced by fat teachers in delivering critical courses in which their bodies may become a factor in evaluation of the content of the course. Watkins et al. also suggest that fat studies classes require students to think about their own bodies and the ways in which they evaluate their own self-worth.⁴⁵ This has the potential to challenge students' negative perceptions of fat, but also, as Guthman documents, discomfits some students by challenging the frameworks within which they understand themselves to be a 'good' subject.⁴⁶ Secondly, Koppelman, following a review of courses that teach fat literature, concludes that the stories used present a limited interpretation of fat experience. She suggests that such courses need to engage with stories told from the perspective of fat activists in order to develop alternative understandings of fatness beyond the dominant approach.⁴⁷ Such activist literatures would be essential for the incorporation of critical approaches to fat within medical humanities education.

Experience

As we were researching this chapter, we both read Heidi Lyth's account of a fat woman in her care (2003),⁴⁸ and Brian Briggs's poem, 'Elizabeth' (2013).⁴⁹ Though published ten years apart, these strike us as examples of one common form of work within the medical humanities, in which health professionals use imaginative prose and poetry to explore their roles as nurse and doctor. As fat studies scholars, we were both struck by the authors' use of abjection in their depictions of anonymous fat women. Briggs's is: 'Not attractive. Fat. Lardy even,' and Lyth's fills the bed from which she 'waddles' to the toilet and back. The language used here reveals a tendency to dehumanise the fat patient, reducing them to matter (fat, lard) and commenting in negative terms on their attractiveness and the way they move. As a psychotherapist, Charlotte is drawn to the writers' lack of empathy for their fat subjects in accounts that, presumably, are offered as examples of understanding gendered fat subjectivities. But these stories make us, as fat activists, groan and roll our eyes; they present fatphobia dressed up as progressive and humanising narratives through the humanities. They drip with condescension and unquestioned prejudice projected on to the nameless and voiceless fat women central to the pieces. These stand in contrast to the ways in which narrative, autoethnography and creative forms of representation have been used in fat studies that foreground the experience of fat people themselves rather than health professionals. For example, Jason Elvis Baker's cartoon, 'Transfatty', explores gendered embodiment from a trans perspective; and Kim Taylor's image, 'Drowned and Deserted', inspired by the poem 'Learning to Breathe', explores the experience of breathlessness and 'drowning on dry land' that comes from encountering the obvious discomfort that the artist's difference invokes in others.⁵⁰ Elsewhere, Cooper and Murray explore their experiences of fat activism through a conversation piece;⁵¹ Longhurst uses autoethnography to document her experiences of weight loss;⁵² White uses autoethnography to explore flat-chestedness in the context of fat/trans embodied experiences;⁵³ and Samantha Murray discusses the tension in coming out as fat and accepting her body in the context of

dominant fatphobia⁵⁴ using her own experiences of gastric band surgery to explore the construction of fat as deviant and pathological, and raising important questions that contrast with the increasing presentation of obesity surgery as a ‘quick-fix’ solution to the so-called ‘obesity epidemic’.⁵⁵ There are also multiple examples of work within fat studies that engages with literary and other creative accounts of fatness – see, for example, Huff, who presents a reading of two poems in order to ‘fatten’ literary history,⁵⁶ and Shaw, who considers fatness in relation to Jamaican dancehall music.⁵⁷

Queer and Disability Theory

We now present some suggestions of how medical humanities might develop a more *critical* approach to fat. The examples from medical humanities research that we discussed above – notably Lyth’s account of a fat woman in her care, and Briggs’s poem, ‘Elizabeth’ – demonstrate that simply making art out of experience is inadequate; practitioners and cultural workers must also engage with marginal perspectives and activist praxis if they are to develop socially conscious work. As we mentioned in the introduction, fat studies currently presents tensions around professionalisation and grassroots experience. Even within this critical field, it is common to find work ‘about’ or ‘for’ (rather than ‘by’) fat people. But it is our belief that medical humanities should also strive to develop an integrated discourse and that, ideally, work should be ‘with’ and ‘by’ user groups and lay people. This entails developing a critical approach to power that recognises and honours activist histories and contributions without professionalising them out of existence, or colonising or gentrifying them. In the remainder of this chapter, we draw on three influences to suggest conceptual and epistemological routes to doing this: Queer Theory, Disability Theory and Research Justice.

There has been some engagement with Queer Theory within the medical humanities recently, through work exploring the experiences of Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) patients,⁵⁸ and which uses Queer Theory to ‘queer’ normative clinical ideals.⁵⁹ Here, we are interested in queering medical humanities in order to facilitate a progressive approach to fat within the field. Common definitions of queer include concepts such as odd, unconventional, deviant, disruptive and sickly. Queering comes from a body of work known as Queer Theory, which has roots in postmodernism, poststructuralism, feminism, civil rights movements and psychoanalysis. Queer Theory is largely associated with sexual identity, particularly a broad range of non-normative sexualities and non-binary expressions of gender, and is frequently mistaken as a synonym for (male) homosexual. Here, we use queer to mean all of these things, and join Noreen Giffney in noting the benefits of the term’s slipperiness:

There is an unremitting emphasis in queer theoretical work on fluidity, über-inclusivity, indeterminacy, indefinability, unknowability, the preposterous, impossibility, unthinkability, unintelligibility, meaninglessness and that which is unrepresentable and uncommunicable.⁶⁰

Queer supports disruptive, fragmented and marginal subjectivities, and, given its foundation in postmodernism, refuses authoritarian universal narratives.⁶¹ This makes

space for multiple perspectives and intersections rather than seeking one universal understanding of fat. Queer formulates the subaltern's voice as one that disrupts dominant discourse. 'Queers Read This', a pamphlet circulated at a Pride march in New York in 1990, is one of the earliest invocations of queer, and is loaded with rage and hatred of authority; it positions queers as a threat to the social order.⁶² Queering also means applying a particular lens towards a subject, and here we particularly evoke Sara Ahmed's figure of the killjoy, a queered, racialised, gendered subject, a critic who pipes up and disrupts from the margins, a figure who understands that the mainstream is overrated.⁶³ The figure of the killjoy provides a counter to any attempt to reduce fat activism to celebration, as nothing more consequential than a moment of fun compared to the real work of tackling the global 'obesity' epidemic. This minimises the work that takes place when marginal populations claim ownership of knowledge; it is, as film curator and activist Derica Shields explains, akin to a liberal 'pat on the head'.⁶⁴ In contrast, the racialised, gendered and queered subject of the killjoy forces recognition that the struggle for self-actualisation and social transformation involves:

causing unhappiness even if that is not the point of our action. So much happiness is premised on, and promised by, the concealment of suffering, the freedom to look away from what compromises one's happiness. To revolt can hurt not only because you are proximate to hurt but also because you cause unhappiness by revealing the causes of unhappiness.⁶⁵

These processes are revealing; they expose those whose happiness is established on others' oppression, silence and complicity. Thus, queering the medical humanities requires being a killjoy, questioning the perspectives that are privileged within the field and in ways that may be uncomfortable and disruptive. It may also open up the field to engagements with forms of creative practice that are deliberately disruptive. For example, Charlotte is a founding member of Homosexual Death Drive, a fat queercore (queer and punk) art band. She uses the band to develop a queer antisocial sensibility with the aim of disrupting audience expectations and expanding possibilities for fat, middle-aged women like herself, and anybody else who is interested. Audiences typically expect Homosexual Death Drive to be funny, cosy comedienness, like Dawn French or Victoria Wood. There is humour, but we are threatening presences too; our songs are obnoxious and our behaviour is challenging. It is common for people to walk out of our shows in disgust, and we wave them away and give them the finger.

Homosexual Death Drive is not a medical humanities project, but it is a concrete example of how queer might expand a critical medical humanities approach to fat. In Homosexual Death Drive, 'the obese' are vivid creators, owners and operators of knowledge about fat, gendered and queered bodies.⁶⁶ Our fatness in the band is intersectional: we are more than one-note beings and we use our embodiment ambiguously, through the delightful pain of the queer antisocial, and expertly, such that anyone can participate. Through performing, we have discovered new knowledge that could never arise from the practices in a clinic, or from the restricted poetry and prose quoted earlier, both of which are premised on the medicalised abjection of fat people.

The social model of disability offers a means of understanding fat people in relation to marginalisation, medicalisation and social transformation. This model was promoted in the UK in the 1990s by a movement of disabled scholars and activists⁶⁷ with great success and is now the dominant approach in practice and research, including the medical humanities. The movement initially used a Marxist framework to historicise disability and problematise medicalisation, advocating a distinction between impairment as physical difference and disability as social construction. This distinction is a powerful one that has been important for disabled people's rights by emphasising the need for social transformation through, for example, building policies for equal access and anti-discrimination policies rather than medical interventions designed to normalise their bodies. Garden has suggested that the social model of disability may provide a way for the medical humanities to engage more fully with the social context and social determinants of disability.⁶⁸ Couser has similarly proposed that Disability Studies has much to offer medical humanities in relation to medical education through providing a means to recognise the harms that medical treatment has caused people with disabilities, as well as its benefits.⁶⁹ Here, we suggest that the social model of disability has the potential to support a critical medical humanities approach to fat, particularly through de-centring medicalised definitions and practitioner perspectives.

Dominant obesity discourse positions the health practitioner, as well as lay practitioners such as leaders of commercial weight loss groups or personal trainers, as benevolent and concerned helpers. As discussed above, this contrasts greatly with fat people's own accounts of clinical and para-clinical encounters, which are loaded with prejudice, callousness, obstructiveness and negative feeling.⁷⁰ The social model of disability offers a useful critique of the clinical encounter that is congruent with fat people's narratives. Here, the interaction between health professional and disabled and/or fat patients features a normalising imperative that is weighted with moral assumptions.⁷¹ Such an interaction refuses the value of embodied difference. This is not a neutral or scientific refusal but a political one, which denies people's right to exist as they are and obstructs social change in their favour.⁷² Disability activists use art, as well as more traditional forms of protest, to critique their social marginalisation, and imagine a more just and crip-/disability-friendly society.⁷³

For example, QUILTBAGG is a fat, queer and disabled arts initiative that is informed by the social model of disability. This is an occasional gathering of fat and disabled queers who have an art practice of some kind, organised by Charlotte and her friend, the performer Liz Carr. There is usually a silly theme, such as outer space or Halloween, which we customise to reflect our own identities as 'aliens' or 'monsters', bringing treats to share and dressing up. We meet in a public area that is accessible to wheelchair users and we are mindful of people's hidden access needs arising from, for example, autism, little money or fatigue. The gathering is free-form, but with two important activities: firstly, we do a go-around where people talk about who they are and what they make or are currently working on; secondly, we order and eat pizza together. In this way we get to know each other and develop epistemologies

from sharing our art practice. There are clear parallels here between this group and arts-in-health work that intersects with the medical humanities. Although everybody who comes to QUILTBAGG has an abundance of experience as a medical subject, we do not meet as clinical beings but as cultural workers. Thus, this could not be conceptualised as an arts-in-health intervention. Our conversations are supportive, and it is common for collaborations to arise from the space. The social model, our queerness and cultural practice, connects us, but we are a diverse group of people making use of each other's histories and cultures to develop a community-based discourse that recognises us as autonomous beings rather than subjects of health or clinical practices.

The social model has important ramifications for fat people regardless of whether fat people or the broader disability community recognise this. Carol Schmidt's essay described how fat people become disabled through medicalisation.⁷⁴ Cooper's 1997 paper, titled 'Can a Fat Woman Call Herself Disabled?', uses the social model of disability to theorise fat people's social positioning and to frame medical interventions for 'normalising' fat people, such as weight loss, as problematic.⁷⁵ Others have built on this work, or developed connections between disability and fat:⁷⁶ recently, Colls and Evans have used the social model to challenge ideas about the 'obesogenic environment', suggesting that this model would shift attention away from a concern with identifying environmental factors that might make bodies fat to one that is concerned with questioning the social (e.g. stigma) and physical (e.g. inaccessible built design) elements of environments that might disable fat bodies.⁷⁷ A social model of fat proposes that it is not fat people who should be made to lose weight, an action that is largely unsustainable and has health risks, but that social change must happen in order for people of all sizes to live good lives. This shift would lead to a fundamentally different approach to fat within clinical settings.

The last body of work that we will discuss here, which has the potential to transform medical humanities, involves a mixture of methodology and social justice.⁷⁸ Research Justice is a term that is emerging from social justice communities, particularly in the US, and their interests in deconstructing knowledge production.⁷⁹ As with Queer Theory and Disability Activism, Research Justice asks pertinent questions about power and knowledge: who gets to know? How is research used to uphold power? How can research be used to benefit the communities on which it is based? Research Justice is a practical means of working with these questions.

At the moment there is an emphasis on participatory, community-based action research methodologies within Research Justice.⁸⁰ Organisations such as DataCenter, based in Oakland, offer training to enable grassroots organisations, often based in trade union activism, to design and develop their own research projects. People who are often the objects of research, including migrant and undocumented workers in the US, become its owners. Research Justice has not yet developed into working with experimental methodologies or cultural work; moreover, published studies tend to be solidly located in quantitative methodology with some qualitative work beginning to creep in. But the Research Justice values of community ownership and epistemological autonomy could be applied to medical humanities projects with exciting results.

Research Justice also fits very well with a recent pedagogic turn known by various names, including the Para-Academy.⁸¹ This refers to scholarship that takes place beyond the neoliberal university through open-access learning and teaching, especially by academics who have found themselves pushed out of traditional career pathways. Charlotte's report, 'No More Stitch-Ups! Media Literacy for Fat Activists', is an example of one such initiative.⁸² This study adopts Research Justice values, emerging from and serving the fat activist community, and has been developed and distributed through Para-Academic channels using a Creative Commons licence that allows both free access and sharing. Our collaboration on this chapter could also be regarded as a form of Para-Academic practice, working with our identities as scholars and activists within and outside the university. Medical humanities typically entails similar interdisciplinary collaboration and we see Research Justice and the Para-Academy as media through which to reflect on power within such collaborations in order to open up accounts of fatness to those produced beyond the academy or clinical practice.

Conclusion

In this chapter, we have outlined the key elements of fat studies research and its connections to the medical humanities. We have suggested that an engagement between fat studies and medical humanities has the potential to challenge dominant medicalised accounts of fatness and raise important questions about medical encounters with fat bodies in the fields of ethics, education and experience. To do so, we have presented Queer Theory, the social model of disability and Research Justice as fields with potential for enabling a more critical approach to fat within the medical humanities. This involves new forms of knowledge production, dissemination and aesthetics that are accessible to socially marginalised people.

At present, there is a clear divide between medical and lay and activist understandings of fatness and there has, to date, been limited engagement between activist communities and the medical humanities. It is clear to many fat people that many health professionals in the West are fatphobic, so we have chosen to disengage with them and talk to our communities in our own ways. Our experiences as medically positioned subjects are often so dismal that we need the resources that cultural activism affords fat activists to engage with medical power without self-destructing or burning out. A more critical medical humanities approach to fatness has the potential to address the roots of these dismal experiences. This will not necessarily be easy and, as with the figure of the killjoy, will necessitate disruption of taken-for-granted approaches to fat within medical and some humanities fields. The three approaches we suggest here will enable this more critical engagement in terms of a scepticism of authoritarianism, a belief in the power of the margins and creation of spaces that are not necessarily professionalised, institutionalised or even funded. These three fields illustrate how activism and cultural work are closely tied together, and how culture could be the medium that brings together a closer and more critically aligned relationship between activism and medicine through the critical medical humanities.

Further Reading

- Fat Studies: An Interdisciplinary Journal of Body Weight and Society*.
 Shelley Bovey, *The Forbidden Body: Why Being Fat is Not a Sin* (London: HarperCollins, 1994).
 Paul Campos, *The Obesity Myth: Why America’s Obsession with Weight is Hazardous to your Health* (New York: Gotham Books, 2004).
 Charlotte Cooper, *Fat and Proud: The Politics of Size* (London: Women’s Press, 1998).
 Kathleen LeBesco, *Revolting Bodies: The Struggle to Redefine Fat Identity* (Amherst: University of Massachusetts Press, 2004).
 Esther D. Rothblum and Sondra Solovay (eds), *The Fat Studies Reader* (New York: New York University Press, 2009).
 Sondra Solovay, *Tipping the Scales of Justice: Fighting Weight-Based Discrimination* (Amherst: Prometheus Books, 2000).
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Notes

1. In this paper we use the word ‘fat’ and ‘fatness’ rather than ‘obese’ and ‘obesity’ in line with fat activism, which uses these terms as a means of self-definition and in order deliberately to avoid terms that pathologise fatness; see Charlotte Cooper, ‘Fat Studies: Mapping the Field’, *Sociology Compass* 4.12 (2010), pp. 1020–34.
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