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FAT RIGHTS, PUBLIC HEALTH OPPRESSION AND PREJUDICE, AND THE “OBESITY EPIDEMIC”

*Nicholas D. Lawson**

ABSTRACT

The pervasiveness, frequency, and intensity of fat shaming, bullying, and harassment experienced by fat people is well-documented, and three quarters of the American public support antidiscrimination protections for fat people.¹ Yet fat people generally remain unprotected from discrimination under federal and state law in all but two jurisdictions.² This Article traces these problems to the agendas of public health leaders, organizations (the Centers for Disease Control and Prevention and the World Health Organization), and associated industries, which are fighting an “obesity epidemic.” It describes some of their fat-shaming strategies and persistent public-health-crisis framings, as well as sensationalized presentations of

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¹ Rebecca M. Puhl et al., *Legislating for Weight-Based Equality: National Trends in Public Support for Laws to Prohibit Weight Discrimination*, 40 INT’L J. OBESITY 1320, 1322 (2016).

² See *infra* Section III(B)(2).

research to attract news attention, boost visibility, and attract more funding for research and/or support for anti-obesity interventions. These behaviors ensure profits for a \$50 billion diet industry and a market for prescription weight loss drugs.³ Yet almost all medical and environmental interventions for weight loss have little to no evidence of effectiveness.⁴ Environmental interventions are also opposed by the public, fat people, and especially fat rights advocates, who describe these interventions and the rhetoric used to generate support for them as stigmatizing.⁵ In addition, they ignore discrimination against fat people and facilitate inaction on solutions to extend fat people antidiscrimination protections. This inaction in turn facilitates discrimination against individuals who are disproportionately Black, Latinx, poor, women, and persons with disabilities.⁶ This Article argues that politicians and advocacy leaders from marginalized populations will serve their constituents best by extending fat people antidiscrimination protections and placing fat rights advocates and fat people in charge of the policies purported to benefit them.

³ See *infra* note 18 and accompanying text.

⁴ See *infra* Section II.

⁵ See *infra* Section IV.

⁶ See *infra* note 48, Section V(B), and accompanying text.

I. INTRODUCTION

An optimal strategy for anti-obesity⁷ campaigns, according to one public health law professor, should be to “recast overeating and sedentary living as unsexy and uncool”⁸:

Anti-obesity campaigns that portray overeating as uncool, athleticism as chic, and slender (but not too skinny) as sexy are more likely to inspire people. On the other hand, promotional efforts should not shy from judicious use of shame: portraying obesity as a burden to others (medically and financially) and a sign of self-indulgence can lend force to calls for self-restraint.⁹

The younger fat-shaming begins, the better. One 2011 anti-obesity campaign in Georgia featured a TV spot in which “a heavy white boy about 10 years old [sat] opposite his mother in a large, empty space and asks forlornly, ‘Mom, why am I fat?’”¹⁰ Ashamed, his mother bowed her head, suggesting that she was to blame, and a tag line read: “75% of Georgia patients with overweight kids don’t recognize the problem,” followed by: “*Stop sugarcoating it, Georgia.*”¹¹

The campaign featured billboards with sad, fat boys and girls of various races and ethnicities looking out at the camera with the word “WARNING” and the following captions in each: “Fat kids become fat adults”; “Big bones didn’t make me this way. Big meals did”; “He has his father’s eyes, his laugh, and maybe even his diabetes”; “Fat prevention begins at home. And the buffet line”; “Chubby isn’t cute if it leads to type 2 diabetes”; “It’s hard to be a little girl if you’re not”; and “Chubby kids may not outlive their parents.”¹²

⁷ Fat rights advocates prefer the term “fat” to “obese,” and I generally use the former.

⁸ Maxwell Gregg Bloche, *Obesity and the Struggle Within Ourselves*, 93 GEO. L.J. 1335, 1350 (2005).

⁹ *Id.* at 1354.

¹⁰ ABIGAIL C. SAGUY, WHAT’S WRONG WITH FAT? 158 (2013); Kathy Lohr, *Controversy Swirls Around Harsh Anti-Obesity Ads*, NPR (Jan. 9, 2012, 4:02 PM), <https://www.npr.org/2012/01/09/144799538/controversy-swirls-around-harsh-anti-obesity-ads>; Lara Salahi, ‘*Stop Sugarcoating*’ *Child Obesity Ads Draw Controversy*, ABC NEWS (Jan. 2, 2012, 11:09 AM), <https://abcnews.go.com/Health/Wellness/stop-sugarcoating-child-obesity-ads-draw-controversy/story?id=15273638#.TwMgzyPLx1N>.

¹¹ SAGUY, *supra* note 10, at 158 (emphasis added).

¹² *Id.*

The dominant public health agendas and communications about fat people today tend to be less overt. Yet, public health leaders and leading public health organizations, such as the Centers for Disease Control and Prevention (“CDC”) and the World Health Organization (“WHO”),¹³ still refer to obesity as an epidemic¹⁴ and adopt public-health-crisis frames that result in more anti-fat prejudice and public beliefs that discrimination against fat people is justified.¹⁵ Sociology professor Abigail Saguy also explains that “[m]any people assume that if the risks of ‘obesity’ have been exaggerated, it is the fault of the mass media.”¹⁶ “Yet scientists also routinely simplify and sensationalize their own results to attract news media attention, thereby boosting their visibility and attracting funding for their research.”¹⁷ Professor Anna Kirkland observes:

The hype over increasing weights also keeps grants flowing to public health researchers, insures profits for the diet industry (with annual spending valued at \$50 billion), and creates a market for bariatric surgery and prescription weight loss drugs. Journalists have a steady supply of alarming headlines to report to an anxious public.¹⁸

These public-health-crisis frames often translate to the news media, and the public, through sensational invocations of “sloth and

¹³ Abigail C. Saguy, *Representations of Fatness by Experts and the Media and How This Shapes Attitudes*, in THE OXFORD HANDBOOK OF THE SOCIOLOGY OF BODY AND EMBODIMENT 105, 112-13 (Natalie Boero & Katherine Mason eds., 2021). Saguy states that:

The fact that those promoting claims about the dangers of obesity have significant economic power (e.g., Hoffmann-La Roche, Weight Watchers, the International Obesity Task Force) and symbolic authority (e.g., CDC, WHO, doctors) than those challenging these claims (e.g., fat acceptance organizations and associations combatting eating disorders) helps explain why the idea that obesity represents a major public health crisis dominates public discourse.

Id.

¹⁴ SAGUY, *supra* note 10, at 108-14.

¹⁵ Abigail C. Saguy et al., *Reporting Risk, Producing Prejudice: How News Reporting on Obesity Shapes Attitudes About Health Risk, Policy, and Prejudice*, 111 SOC. SCI. & MED. 125, 125 (2014).

¹⁶ SAGUY, *supra* note 10, at 107.

¹⁷ *Id.*

¹⁸ Anna Kirkland, *The Environmental Account of Obesity: A Case for Feminist Skepticism*, 36 J. WOMEN CULTURE & SOC’Y 463, 473 (2011) (citation omitted).

gluttony.”¹⁹ “Americans are gobbling down more calories than ever, resulting in a 50 percent increase in the nation's obesity rate, with young people, the more highly educated and Hispanics leading the way,”²⁰ begins one typical news report on the “obesity epidemic.” Another news article, also drawing loosely on scientific research, reports that “[s]ome 300,000 Americans die each year from eating millions of cookies, hot dogs, potato chips, and other empty calories during increasingly inactive lives, according to another report also published in *JAMA*.”²¹

This Article describes the oppression of fat people by leaders and organizations in the medical and public health fields. It describes their ongoing war with an “obesity epidemic” through weight loss interventions that generally do not work. It also explains their inattention to fat prejudice, and the perspectives and priorities of fat rights advocates, who, above all, want antidiscrimination protections. This Article argues that antidiscrimination laws are badly needed for fat people—a currently unprotected population that is disproportionately Black and Latinx, poor, female, and comprised of persons with disabilities. Additionally, it asserts that we should not trust obesity policies or proposed legislation that ignore the concerns and priorities of fat rights advocates and fat people. Part II describes the ineffectiveness of medical and environmental interventions for weight loss and their contributions to fat stigmatization. Next, Part III provides overwhelming evidence of prejudice and discrimination against fat people and judicial resistance to protecting obese persons from discrimination under the Americans with Disabilities Act (“ADA”). Then, Part IV describes the opinions and priorities of fat rights advocates, fat people, and the public, who generally support extending fat people antidiscrimination protections and generally oppose environmental interventions for weight loss. Part V considers what sustains the status quo “war on obesity” and what ought to be done to spur leaders in government and civil rights advocacy to choose a different approach.

¹⁹ SAGUY, *supra* note 10, at 115.

²⁰ Ulysses Torassa, *Americans Keep Packing on the Pounds*, PLAIN DEALER, Oct. 27, 1999, at 1A.

²¹ Mike Hudson, *America Is Fat, Getting Fatter: Nearly 1 in 5 Obese, Results Can Be Fatal*, TIMES-PICAYUNE, Oct. 27, 1999, at A1.

II. THE INEFFECTIVENESS OF MEDICAL AND ENVIRONMENTAL INTERVENTIONS FOR WEIGHT LOSS AND FAT STIGMATIZATION

A. Medical Interventions

1. *Ineffectiveness of Diet, Exercise, Lifestyle Coaching, Behavioral Therapy, and Pharmacotherapy on Weight Loss*

The public health campaign strategy to fight the “obesity epidemic” described above may seem particularly hard to justify when considered in the following context: Voluntary efforts to lose weight through lifestyle changes, such as diet and exercise, generally do not work.²² Lifestyle coaches, behavioral therapy, and pharmacotherapy generally do not help.²³ Expecting fat people to undergo bariatric surgeries for relatively modest reductions in weight also seems unfair, even if these procedures turn out to be safe and concerns about their short- and long-term complications turn out to be unfounded.

A Cochrane Review found that prescribing exercise for overweight or obese adults appears to result in only a 4.5-pound weight loss after three to twelve months.²⁴ A two-year randomized trial of obesity treatment in primary care practice described in the *New England Journal of Medicine* found minimal improvements with usual care (3.7 pounds), quarterly primary care practitioner visits with monthly sessions with lifestyle coaches (6.4 pounds), and the addition of meal replacements or weight-loss medications (orlistat or sibutramine) (10.1 pounds).²⁵ Another Cochrane Review similarly found only approximately an eleven-pound weight loss with long-term

²² Francesco Rubino et al., *Joint International Consensus Statement for Ending Stigma of Obesity*, 26 *NATURE MED.* 485, 489 (2020) (“There is a widespread assumption, including among many medical professionals, that voluntary lifestyle changes (diet and exercise) can entirely reverse obesity over long periods of time, even when severe.”).

²³ See *infra* notes 24-32 and accompanying text.

²⁴ Kelly A. Shaw et al., *Exercise for Overweight or Obesity (Review)*, *COCHRANE DATABASE SYSTEMATIC REVIEWS* 47 (2006) (analysis 1.1, comparing “[e]xercise versus no treatment control,” found a mean difference of -2.03 kg in favor of exercise, which translates to 4.47 lbs).

²⁵ Thomas A. Wadden et al., *A Two-Year Randomized Trial of Obesity Treatment in Primary Care Practice*, 365 *NEW ENG. J. MED.* 1969, 1969 (2011).

pharmacotherapy.²⁶ A Cochrane Review of bariatric surgery found that it appears to be the most effective intervention for weight loss, resulting in a mean weight reduction of roughly forty-six pounds.²⁷

Two additional Cochrane Reviews performed in 2017 found only an 8.1-pound weight loss (1.18-point reduction in Body Mass Index (“BMI”)) with diet, physical activity, and behavioral interventions for the treatment of overweight or obesity in adolescents aged twelve to seventeen,²⁸ and only a 3.2-pound weight loss (0.53-point reduction in BMI) in children aged six to eleven.²⁹ The review of adolescent studies also looked separately at psychological approaches, which resulted in less than one-point reductions in BMI in adolescents overall.³⁰ With cognitive behavioral approaches, there was a BMI decrease of 0.35,³¹ and with motivational interviewing approaches, there was a BMI decrease of 1.0.³²

²⁶ Raj S. Padwal et al., *Long-Term Pharmacotherapy for Obesity and Overweight*, COCHRANE DATABASE SYSTEMATIC REVIEWS 1, 2 (2003) (“Compared to placebo, all three drugs reduced weight by around five kg [equivalent to around eleven pounds] or less”).

²⁷ Jill L. Colquitt et al., *Surgery for Weight Loss in Adults*, COCHRANE DATABASE SYSTEMATIC REVIEWS 1, 98 (2014) (citing a mean weight reduction of 20.87 kilograms, which converts to 46.01 pounds).

²⁸ Lena Al-Khudairy et al., *Diet, Physical Activity and Behavioural Interventions for the Treatment of Overweight or Obese Adolescents Aged 12 to 17 Years*, COCHRANE DATABASE SYSTEMATIC REVIEWS 2 (2017) (finding that the interventions lowered body weight by 3.67 kilograms, which converts to 8.1 pounds; they lowered BMI by 1.18).

²⁹ Emma Mead et al., *Diet, Physical Activity and Behavioural Interventions for the Treatment of Overweight or Obese Children from the Age of 6 to 11 Years*, COCHRANE DATABASE SYSTEMATIC REVIEWS 4 (2017) (finding that the interventions lowered body weight by 1.45 kilograms, which converts to 3.2 pounds; they lowered BMI by 0.53).

³⁰ Al-Khudairy et al., *supra* note 28, at 215.

³¹ *Id.* at 212-13 (citing some studies which found an increase of 0.9 BMI; meanwhile, the best result found a decrease of 1 BMI).

³² *Id.* at 212-14 (showing that one study found an increase of 1.3 BMI, compared with only a 0.5 BMI increase in controls; meanwhile, the best result found a decrease in BMI by 1.6).

2. *The Treat and Reduce Obesity Act of 2021*

i. **Pharmaceutical and Psychological Therapy Lobbying**

Limited effectiveness has not kept the pharmaceutical, psychological therapy, and diet industries from selling these weight-loss interventions, while demanding compensation and reimbursement. A December 1, 2021 article in *Roll Call* by Lauren Clason described how “medical groups and pharmaceutical companies [are] ramping up pressure on Congress to add coverage of obesity drugs and weight-related behavioral therapy under Medicare.”³³ Through this initiative, lobbyists hope to persuade the Centers for Medicare and Medicaid Services to broaden coverage through regulatory means.³⁴ Alternatively, they either “want[] Congress to tuck its priorities into legislation such as Democrats’ House-passed \$2 trillion budget reconciliation bill in the Senate”³⁵ or to pass the Treat and Reduce Obesity Act of 2021 (“the Act”).³⁶ The Act would also expand coverage to include these drugs and intensive behavioral therapy for obesity.³⁷ Medicare currently covers behavioral therapy through a patient’s primary care provider, but not through other providers, such as dietitians and psychologists. In its current form, the Act has existed virtually unchanged since its 2012 version.³⁸

Pharmaceutical companies invested in anti-obesity drugs would gain access to the \$102 billion Part D drug market if the

³³ Lauren Clason, *Advocacy Blitz Targets Medicare Coverage of Obesity Treatment*, ROLL CALL (Dec. 1, 2021), <https://www.rollcall.com/2021/12/01/advocacy-blitz-targets-medicare-coverage-of-obesity-treatment>.

³⁴ *Id.*

³⁵ *Id.*

³⁶ Treat and Reduce Obesity Act of 2021, S. 596, 117th Cong. (2021); Treat and Reduce Obesity Act of 2021, H.R. 1577, 117th Cong. (2021).

³⁷ *See id.* at § 3-4 (Section 3 is called “Authority to Expand Health Care Providers Qualified to Furnish Intensive Behavioral Therapy” and Section 4 is called “Medicare Part D Coverage of Obesity Medication”).

³⁸ *See, e.g.*, Treat and Reduce Obesity Act of 2012, S. 3699, 112th Cong. (2012) (“To amend title XVIII of the Social Security Act to include information on the coverage of intensive behavioral therapy for obesity in the Medicare and You Handbook, to provide written notification to beneficiaries and providers regarding new Medicare coverage of intensive behavioral therapy for obesity.”).

Medicare ban is lifted.³⁹ Insulin and weight loss drug manufacturers, such as Novo Nordisk and Eli Lilly, donate cash to many advocacy groups, medical research projects associated with obesity treatments, and politicians.⁴⁰ These politicians include Representative Ron Kind (Democrat from Wisconsin), the chief sponsor of the bill in the House since 2019, and Senator Tom Carper (Democrat from Delaware), who has been its chief sponsor in the Senate since 2012.⁴¹

The Obesity Care Now campaign pushing for coverage derives from a consortium of industry and medical groups comprising the Obesity Care Advocacy Network (“OCAN”).⁴² The group has recently “churned out news releases, sponsored newsletters, and participated in webinars featuring lawmakers.”⁴³ Novo Nordisk is the top industry donor to OCAN’s parent organization, the Obesity Action Coalition, and pays the messaging firm Precision Strategies to carry out the campaign.⁴⁴ Joe Nadglowski, who is OCAN’s co-chairperson as well as president and Chief Executive Officer of the Obesity Action Coalition, reports that the recent campaign was motivated by “the heightened focus on the risk of obesity and racial disparities during the COVID-19 pandemic.”⁴⁵ High-profile organizations, like the NAACP and the National Urban League, have endorsed the campaign.⁴⁶

OCAN’s messaging appears to have resonated with Representative Nanette Diaz Barragan (Democrat from California), who spoke on the House floor on December 13, 2021, in support of the

³⁹ Clason, *supra* note 33.

⁴⁰ *Clients Lobbying on H.R. 1530: Treat and Reduce Obesity Act of 2019*, OPEN SECRETS, <https://www.opensecrets.org/federal-lobbying/bills/summary?id=hr1530-116> (stating that Novo Nordisk leads the lobbying list with twenty-two reports and specific issues in 2019 and twenty in 2020, which was followed by the next-highest lobbyist—the American Academy of Nutrition and Dietetics—which had four reports in 2020). Other lobbyists included in the report were: the American Association of Clinical Endocrinologists which had four reports in 2019; the American Psychological Association which had four reports in 2019 and three reports in 2020; the Healthcare Leadership Council which had three reports in 2019; and the Academy of Nutrition and Dietetics, CrossFit, Inc., and Eisai Co., Ltd. which each had two reports in 2019. *Id.*

⁴¹ Clason, *supra* note 33; Treat and Reduce Obesity Act of 2019, H.R. 1530, 116th Cong. (2019); Treat and Reduce Obesity Act of 2012, S. 3699, 112th Cong. (2012).

⁴² Clason, *supra* note 33.

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ *Id.*

Treat and Reduce Obesity Act, and referred to research conducted by OCAN’s Precision Strategies.⁴⁷ In her remarks, Representative Barragan highlighted the fact that “[o]besity [] disproportionately impacts communities of color, particularly Black and Latino adults. Nearly half (49.6 percent) of Black Americans and 44.8 percent of Latino Americans are living with obesity, compared to 42.2 percent of their white counterparts.”⁴⁸ She further stated:

Despite a 2013 decision by the American Medical Association [AMA] recognizing obesity as a treatable disease, Medicare still stigmatizes obesity as a choice and denies access to the full continuum of care. . . . The Treat and Reduce Obesity Act [would change that and] would modernize Medicare by providing access to anti-obesity medications and intensive behavioral therapy⁴⁹

But although Representative Barragan claimed that “outdated Medicare rules deny access to *effective* obesity care,”⁵⁰ the empirical evidence described above calls into question the effectiveness of that care. Although Representative Barragan criticized Medicare for “stigmatizing” obesity, she referred to obesity several sentences later as an “epidemic.”⁵¹ Neither Representative Barragan nor any other Members of Congress have proposed any bills to address stigma, prejudice, and discrimination against persons with obesity. The Reducing Obesity in Youth Act of 2021 similarly referred to the problems of “increases in bullying by classmates,” but it offered nothing by way of anti-bullying protections for fat students and youth.⁵² Instead, it proposed various strategies to make fat youths thin

⁴⁷ 117 CONG. REC. E1357 (daily ed. Dec. 13, 2021) (statement of Rep. Barragan).

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.* (emphasis added).

⁵¹ *Id.*

⁵² Reducing Obesity in Youth Act of 2021, S. 2741, 117th Cong. § 2(a)(9) (2021). The Safe Schools Improvement Act of 2021, S. 2410, 117th Cong. (2021) requires “a prohibition of bullying or harassment conduct based on [] a student’s actual or perceived race, color, national origin, sex (including sexual orientation and gender identity), disability, or religion,” *id.* at § 3(a), and does not include fat people explicitly. In contrast, New York City requires reporting on “the number of such material incidents” involving student-to-student bullying, harassment, intimidation, or discrimination “that [a]re related to each of the following categories: (i) race, (ii)

by using intervention tactics such as “linking early care and education and health care providers”⁵³ and “engaging families.”⁵⁴

ii. Implications and Fat Stigmatization

The problems of pharmaceutical and diet industry marketing to older adults were explored vividly in the well-known 2000 film, *Requiem for a Dream*, in which Ellen Burstyn received an Academy Award nomination for her performance as a lonely elderly widow named Sara Goldfarb.⁵⁵ In the movie, Sara receives a call that she has been invited to her favorite television show. It is a show which centers on weight loss, and its host at one point declares, “I am a living testament! Sixty-five pounds thinner!”⁵⁶ She begins a restrictive crash diet in an attempt to fit into a red dress for the show.⁵⁷ Then one of her friends tells her, “My Louise, she lost fifty pounds just like that. . . . Poof! . . . She went to a doctor, and he gave her pills. You don’t want to eat.”⁵⁸ Sara decides to visit the doctor, where the following interaction occurs:

DOCTOR PILL: I see you’re a little overweight.

SARA: A little? I have fifty pounds I’m willing to donate.

DOCTOR PILL: We can take care of that. No problem.

The medications make her lose twenty-five pounds but also distort her sense of reality.⁵⁹ She begins to hallucinate that she is mocked by the host and crowd from the television show about her appearance, and that she is attacked by her refrigerator. Her doctor appears unconcerned:

DOCTOR PILL: What seems to be the problem? The weight is doing fine.

ethnicity or national origin or both, (iii) religion, (iv) gender, (v) *weight*, (vi) gender identity, gender expression or sexual orientation, or any combination thereof and (vii) disability.” NEW YORK CITY, N.Y. CODE § 21-980(2)(b) (emphasis added).

⁵³ Reducing Obesity in Youth Act of 2021, S. 2741, 117th Cong. § 3(c)(1)(C) (2021).

⁵⁴ *Id.* at § 3(b)(4).

⁵⁵ REQUIEM FOR A DREAM (Thousand Words 2000).

⁵⁶ *Id.*

⁵⁷ *Id.* (“The one your father liked so much. I remember how he looked at me in the red dress.”).

⁵⁸ *Id.*

⁵⁹ *Id.*

SARA: The weight is fine. I'm not so good. The refrigerator--

DOCTOR PILL: Something wrong?

SARA: Things are all mixed up. Confused like--

DOCTOR PILL: Well, that's nothing to worry about. Just give this to the nurse and make an appointment for a week.⁶⁰

Sara flees her apartment and goes to the casting agency office in Manhattan to confirm when she will be on television.⁶¹ Sara's disturbed state causes her to be admitted to a psychiatric ward, where a doctor makes her unwittingly "consent" to undergo electroconvulsive therapy without anesthesia.⁶² Sara's treatment leaves her in a dissociated, catatonic, and near-vegetative state, to the horror of her friends.⁶³

Should the Sara Goldfarb story in *Requiem for a Dream* raise any concerns about the Treat and Reduce Obesity Act and the problem of pharmaceutical and diet industry marketing to older adults? Absolutely. However, the movie does overdramatize the potential side effects of stimulant weight-loss medications. Ironically, it also appears to have overestimated their effectiveness at reducing weight—ten pounds rather than twenty-five pounds in the film.⁶⁴ The weight loss medications being pushed by Novo Nordisk (semaglutide (Wegovy))—"priced around \$1,300 for a one-month supply"⁶⁵—and Eli Lilly (tirzepatide)—"between \$5,500 and \$5,700 a year"⁶⁶—are also not stimulants; therefore, they are unlikely to cause the psychosis and addiction depicted in the movie. Clinical trials suggest these new medications may potentially reduce weight by 27.6 pounds, for example, from 221 pounds to 193.4 pounds, and reduce BMI from 38

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ See Wadden et al., *supra* note 25, at 1969 and accompanying text; see also Padwal et al., *supra* note 26, at 2 and accompanying text.

⁶⁵ Clason, *supra* note 33.

⁶⁶ INST. FOR CLINICAL & ECON. REVIEW, *ICER Publishes Final Evidence Report and Policy Recommendations on Tirzepatide for Type 2 Diabetes* (Feb. 15, 2022), <https://icer.org/news-insights/press-releases/icer-publishes-final-evidence-report-and-policy-recommendations-on-tirzepatide-for-type-2-diabetes>.

(obese) to 33 (obese),⁶⁷ roughly the same as Sara’s 25-pound weight loss.

My concerns with the Treat and Reduce Obesity Act and similar legislation are not with medication side effects. They are also not, at least not primarily, about wasteful spending on drugs and behavioral therapies of limited effectiveness with taxpayer funds that could be spent on things like affordable housing or home and community-based services for people with disabilities. My chief concerns are that OCAN, Novo Nordisk, Eli Lilly, Amgen, Boehringer Ingelheim, Pfizer,⁶⁸ and the American Psychological Association⁶⁹ will exacerbate fat prejudice and stigmatize persons with obesity in order to sell their products to Members of Congress, doctors, and the American public. To entice people like Sara Goldfarb to “ask her doctor” about weight loss medications and therapies, the diet industry needs friends, family members, the media, and doctors to make fat people feel bad about their weight and themselves.

OCAN’s Obesity Care Now campaign, while focused for the moment on Medicare, is also about more than just seniors. Novo Nordisk Executive Vice President Doug Langa said that “as a company, we certainly think that seniors in the U.S. should have access to anti-obesity medications.”⁷⁰ Nadglowski, however, said he expects private insurers to follow Medicare’s example if Congress broadens coverage, which would expand the marketing pool for these drugs well beyond the elderly population.⁷¹

B. Environmental Interventions

Environmental interventions for weight loss appear no more likely than medical interventions to be effective.⁷² Public health efforts to control calorific foods are unlikely to succeed. Professor Richard Epstein explains that with tobacco, “[t]here is a single product

⁶⁷ See Donna H. Ryan, *Next Generation Antiobesity Medications: Setmelanotide, Semaglutide, Tirzepatide and Bimagrumb: What Do They Mean for Clinical Practice?*, 30 *J. OBESITY & METABOLIC SYNDROME* 196, 200, 204 (2021).

⁶⁸ Clason, *supra* note 33.

⁶⁹ See *Clients Lobbying on H.R. 1530: Treat and Reduce Obesity Act of 2019*, *supra* note 40.

⁷⁰ Clason, *supra* note 33.

⁷¹ *Id.*

⁷² See *infra* Sections II(B)(1)-(4).

from a single source that looks as though it will explain many of the cases. . . . Tobacco is a discrete product that produces a characteristic set of illnesses. Fat comes from all sorts of food, many of which are unexceptionable.”⁷³ Accordingly, results from studies on the effectiveness of environmental interventions to facilitate weight loss in populations are not encouraging.

1. Soda Taxes

Taxes on soda, also known as sugar-sweetened beverages (“SSBs”), have been championed by many public health leaders as an effective strategy to combat the “obesity epidemic,” despite soda’s generally small contribution to average daily caloric intake.⁷⁴ Taxes on SSBs have been studied in Mexico; Berkeley, California; and Philadelphia, Pennsylvania. After implementation of Mexico’s SSB excise tax, “which represent[ed] an approximate 11% increase in the price of carbonated sweetened beverages,”⁷⁵ it was found that “[o]ver a [two]-year span, following the implementation of the tax, purchas[es] of taxed beverages decreased by 9.7%.”⁷⁶

In Berkeley, California, a year after another excise SSB tax of 1 cent per fluid ounce—resulting in about a 8% total increase in price,⁷⁷

⁷³ Richard A. Epstein, *What (Not) to Do About Obesity: A Moderate Aristotelian Answer*, 93 GEO. L.J. 1361, 1381-82 (2005) (“The success of the tobacco litigation lay in its ability to overcome the simple paradigm of the Second Restatement. Part of that attack comes from the view that the industry was guilty of massive fraud in the way in which it marketed cigarettes, especially, but not exclusively, to minors. Once the fraud argument is accepted, then the assumption of risk defense disappears, leaving only the question of causation in the line of defense, which for many tobacco-related illnesses is relatively easy to overcome.”).

⁷⁴ See generally Asher Rosinger et al., *Sugar-Sweetened Beverage Consumption Among U.S. Youth, 2011–2014*, NAT’L CTR. FOR HEALTH STAT. (2017), <https://www.cdc.gov/nchs/data/databriefs/db271.pdf> (“Boys consumed an average 164 kilocalories (kcal) from sugar-sweetened beverages, which contributed 7.3% of total daily caloric intake. Girls consumed an average 121 kcal from sugar-sweetened beverages, which contributed 7.2% of total daily caloric intake.”).

⁷⁵ Melissa A. Fernandez & Kim D. Raine, *Insights on the Influence of Sugar Taxes on Obesity Prevention Efforts*, 8 CURRENT NUTRITION REP. 333, 335 (2019).

⁷⁶ *Id.*

⁷⁷ *Id.* at 336 (citing Lynn D. Silver et al., *Changes in Prices, Sales, Consumer Spending, and Beverage Consumption One Year After a Tax on Sugar-Sweetened Beverages in Berkeley, California, US: A Before-And-After Study*, 14 PLOS MED.

“[s]ales of SSBs declined by 9.6% in Berkeley, whereas they increased by 6.9% in non-Berkeley stores. . . . [However], [t]here were no significant reductions in SSB intake or per capita SSB caloric intake.”⁷⁸

A more recent excise SSB tax in Philadelphia, Pennsylvania of 1.5 cents per fluid ounce—equaling approximately 8.6-17.6% of the total price,⁷⁹ resulted in a 51.0% decrease in volume sales one year after tax implementation; however, this was partially offset by a corresponding 24.4% increase of volume sales in Pennsylvania border zip codes.⁸⁰

In general, soda tax studies have found that “[t]he equivalent of a 10% SSB tax was associated with an average decline in beverage purchases and dietary intake of 10.0%.”⁸¹ However, it is less clear whether these declines are also accompanied by decreases in BMI or obesity prevalence.⁸²

2. *Fast Food Taxes and Zoning Regulations*

There is also scant evidence to support taxes on fatty foods, fast-food taxes, or zoning regulations on fast-food restaurants. Samantha Roberts and her colleagues found one review suggesting that:

e1002283 (2017); Jennifer Falbe et al., *Impact of the Berkeley Excise Tax on Sugar-Sweetened Beverage Consumption*, 106 AM. J. PUB. HEALTH 1865, 1869 (2016)).

⁷⁸ *Id.*

⁷⁹ Christina A. Roberto et al., *Association of a Beverage Tax on Sugar-Sweetened and Artificially Sweetened Beverages with Changes in Beverage Prices and Sales at Chain Retailers in a Large Urban Setting*, 321 JAMA 1799, 1804 (2019) (depicting an 8.6% increase in price at supermarkets, 14.2% increase in price at mass merchandise stores, and 17.6% increase in price at pharmacies).

⁸⁰ *Id.* at 1799.

⁸¹ Andrea M. Teng et al., *Impact of Sugar-Sweetened Beverage Taxes on Purchases and Dietary Intake: Systematic Review and Meta-Analysis*, 20 OBESITY REVS. 1187, 1187 (2019).

⁸² See Samantha Roberts et al., *Efficacy of Population-Wide Diabetes and Obesity Prevention Programs: An Overview of Systematic Reviews on Proximal, Intermediate, and Distal Outcomes and a Meta-Analysis of Impact on BMI*, 20 OBESITY REVS. 947, 950 (2019) (reporting that “[m]eta-analysis of four primary studies included in reviews that reported association between a 1% increase in SSB price and BMI found an association of borderline significance [with the following] [mean difference in BMI associated with 1% increase in SSB price: -0.02”).

[O]verall, a 1% increase in the price of fast food was associated with a 0.3% absolute decrease in consumption but not with statistically significant changes in BMI. Similar small but positive effects on proximal and intermediate outcomes but nonsignificant effect on distal outcomes were found across the full dataset of five reviews addressing this question.⁸³

Accordingly, it is unlikely that fast-food taxes will result in statistically significant, let alone meaningful, reductions in population weight or obesity prevalence.

Roland Sturm and Aiko Hattori studied the impact of a zoning regulation that restricted the opening and remodeling of standalone fast-food restaurants in South Los Angeles since 2008, but they found “no evidence that [the regulation] resulted in improving the diet of residents or reduc[ing] obesity rates.”⁸⁴

3. *School Vending Machine Restrictions and Farm to School Programs*

School vending machine restrictions and farm to school programs also appear to be of limited effectiveness. A 2010 analysis of policies restricting access to school vending machines that used two nationally representative data sets “strongly suggest[ed] that limiting access to soft drinks at school might not reduce children’s soft drink consumption because of the many alternative outlets where they can obtain soft drinks, including homes, convenience stores, and other school outlets such as afterschool events.”⁸⁵ Furthermore, a 2019 analysis of interventions also found only “low-certainty evidence that reduc[ing] availability of SSBs in schools is associated with decreased SSB consumption.”⁸⁶

⁸³ *Id.* at 952.

⁸⁴ Roland Sturm & Aiko Hattori, *Diet and Obesity in Los Angeles County 2007-2012: Is There a Measurable Effect of the 2008 “Fast-Food Ban”?*, 133 SOC. SCI. & MED. 205, 210 (2015).

⁸⁵ Jason M. Fletcher et al., *Taxing Soft Drinks and Restricting Access to Vending Machines to Curb Child Obesity*, 29 HEALTH AFF. 1059, 1062 (2010).

⁸⁶ Peter von Philipsborn et al., *Environmental Interventions to Reduce the Consumption of Sugar-Sweetened Beverages and Their Effects on Health*, COCHRANE DATABASE SYSTEMATIC REVIEWS. 1, 2 (2019).

The Healthy, Hunger-Free Kids Act created a “farm to school program” to increase “access to local foods,”⁸⁷ though there is only “very low-certainty evidence that . . . school fruit programmes are associated with decreased SSB consumption.”⁸⁸ While there may be other reasons to support farm to school programs, they do not appear to show promise as an effective means of reducing population weight.

4. Restrictions on Food Advertising to Children

Opposition from the food, advertising, and television industries ultimately led Congress to withdraw the Federal Trade Commission’s authority to regulate unfair advertising to children⁸⁹ and derailed “proposed nutrition criteria for food products marketed to children drafted by a working group of federal agencies.”⁹⁰ Though some commentators have recommended “[m]obilization of parents as a political force to improve standards for food marketed to children,”⁹¹ this may have the unintended consequence of increased weight stigmatization.

III. OVERWHELMING EVIDENCE OF PREJUDICE AND DISCRIMINATION AGAINST FAT PEOPLE

A. Pervasiveness and Intensity

The scant evidence to support public health leaders’ weight loss interventions described earlier in this article begs the question of whether they are focusing on the right things, making the right investments, and using public resources in the most socially responsible ways. These efforts seem especially indefensible in light of overwhelming evidence of prejudice and discrimination against fat people, problems that these leaders rarely try to do anything about.⁹² Public health communications about the “obesity epidemic” probably make them much worse.⁹³

⁸⁷ Act of Dec. 13, 2010, Pub. L. No. 111-296, § 243, 124 Stat. 3183, 3236-38.

⁸⁸ See Philipsborn et al., *supra* note 86, at 2.

⁸⁹ *Id.* at 24.

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² See, e.g., *supra* note 52 and *infra* note 174 and accompanying text.

⁹³ See Saguy et al., *supra* note 15, at 132.

1. *Frequency, Locations, and Sources*

Research suggests that being the target of weight stigmatization, harassment, or discrimination is a near-universal experience for fat people, with about half experiencing some form of weight stigma at least once per week.⁹⁴ The most frequent setting where weight bias occurs is at home,⁹⁵ and the most frequently reported source of weight stigma is family members.⁹⁶

Table 1. Percent (%) Experiencing Weight Stigma from Select Sources and Frequency in a Sample of U.S. Adults with Mean BMI of 32⁹⁷

	Ever	Multiple Times
Family members	72	62
Doctors	69	52
Classmates	64	56
Sales clerks at stores	60	47
Friends	60	42
Co-workers or colleagues	54	38
Servers at restaurants	47	35
Employers, supervisors	43	26
Teachers, professors	32	21

Table 1 summarizes sources of weight stigmatization, as reported by one sample of fat U.S. adults.

⁹⁴ Lenny R. Vartanian & Sarah A. Novak, *Internalized Societal Attitudes Moderate the Impact of Weight Stigma on Avoidance of Exercise*, 19 *OBSIDITY* 757, 759 (2011) (In a sample of 111 adults (mean BMI 32), 97% “reported experiencing some form of weight stigma at least once in their lives, and 48% reported experiencing some form of weight stigma at least once per week.”).

⁹⁵ Rebecca M. Puhl et al., *Weight Stigmatization and Bias Reduction: Perspectives of Overweight and Obese Adults*, 23 *HEALTH EDUC. RSCH.* 347, 352 (2008) (The most frequent setting where weight bias occurred was the home (34.5%), and the most frequently reported sources of stigma were peers/friends, parents, spouses, other family members.).

⁹⁶ Rebecca M. Puhl & Kelly D. Brownell, *Confronting and Coping with Weight Stigma: An Investigation of Overweight and Obese Adults*, 14 *OBSIDITY* 1802, 1808 tbl.4 (2006).

⁹⁷ *Id.*

2. *School*

Experiences of fat shaming, bullying, and harassment begin at an early age. In one study conducted at a Connecticut high school, most students reported that they “observed verbal threats and physical harassment toward overweight and obese students.”⁹⁸ Specifically, “65% to 77% of students observed overweight and obese peers being ignored, avoided, excluded from social activities, having negative rumors spread about them, and being teased in the cafeteria,” and “[a]t least 84% of participants observed overweight students being teased in a mean way and teased during physical activities.”⁹⁹

3. *Employment and Healthcare*

Other studies have explored the impact of weight stigma on employment and healthcare. One study examining the impact of weight stigma in the workplace found that “an increase in weight of 2 [standard deviations above the mean] results in a predicted earnings increment of \$14,889 for men and a predicted earnings decrement of \$18,902 for women.”¹⁰⁰

Another study explored the impact of weight stigma on receipt of routine gynecological cancer screenings.¹⁰¹ Of the 498 overweight or obese women surveyed, 41% responded affirmatively when asked, “Have you ever delayed seeking health care or cancer-screening tests because of your weight?”¹⁰² In addition, 73% reported that they experienced one or more of these barriers: disrespectful treatment (36%); embarrassment about being weighed (35%); negative attitudes of providers (36%); advice to lose weight, even if unrelated to their medical condition (46%); and small gowns, exam tables, and

⁹⁸ Rebecca M. Puhl et al., *Weight-Based Victimization Toward Overweight Adolescents: Observations and Reactions of Peers*, 81 J. SCH. HEALTH 696, 696 (2011).

⁹⁹ *Id.*

¹⁰⁰ Timothy A. Judge & Daniel M. Cable, *When It Comes to Pay, Do the Thin Win? The Effect of Weight on Pay for Men and Women*, 96 J. APPLIED PSYCH. 95, 108 (2010).

¹⁰¹ Nancy K. Amy et al., *Barriers to Routine Gynecological Cancer Screening for White and African-American Obese Women*, 30 INT’L J. OBESITY 147 (2006).

¹⁰² *Id.* at 149.

equipment (46%).¹⁰³ These problems disproportionately impact women.

B. Fat People Are Generally Not Protected by Antidiscrimination Laws

Despite the intensity and pervasiveness of prejudice and discrimination against fat people, they remain generally unprotected by federal, state, and local antidiscrimination laws.

I. Federal Laws

There are no federal laws explicitly prohibiting weight discrimination. Neither obese nor morbidly obese persons are protected under the Civil Rights Act.¹⁰⁴ On one hand, courts have generally recognized obesity as a physical impairment protected under the ADA only if caused by an underlying physiological disorder.¹⁰⁵

¹⁰³ *Id.* at 151.

¹⁰⁴ *Cf.* 42 U.S.C. § 2000-e(a) (which protects only against discrimination based on race, color, religion, sex, or national origin); *Taylor v. Small*, 350 F.3d 1286, 1292 (D.C. Cir. 2003) (“Title VII [of the Civil Rights Act] does not proscribe discrimination based upon an employee’s excessive weight.”).

¹⁰⁵ *See* *Cook v. State of R.I., Dep’t. of Mental Health, Retardation, & Hosps.*, 10 F.3d 17, 24 (1st Cir. 1993); *Francis v. City Meriden*, 129 F.3d 281, 286 (2d Cir. 1997); *Michaels v. Cont’l Realty Corp.*, No. RDB–10–1998, 2011 WL 4479697, at *4 (D. Md. 2011), *summarily aff’d*, 469 Fed. App’x. 209, 210 (4th Cir. 2012); *E.E.O.C. v. Watkins Motor Lines, Inc.*, 463 F.3d 436, 443 (6th Cir. 2006); *Richardson v. Chi. Transit Auth.*, 926 F.3d 881, 888 (7th Cir. 2019); *Morriss v. BNSF Ry. Co.*, 817 F.3d 1104, 1108–13 (8th Cir. 2016). For district courts so holding, see, for example, *Sturgill v. Norfolk S. Ry. Co.*, No. 18-cv-566, 2019 WL 1063374, at *4–5 (E.D. Va. Mar. 6, 2019); *Shell v. Burlington N. Santa Fe Ry. Co.*, No. 15-cv-11040, 2018 WL 1156249, at *3 (N.D. Ill. Mar. 5, 2018); *Brownwood v. Wells Trucking, LLC*, No. 16-cv-01264, 2017 WL 9289453, at *6 (D. Colo. Nov. 9, 2017); *Silva v. Bd. Cty. Comm’rs Cty. of Roosevelt*, No. 15-cv-1046, 2017 WL 4325769, at *7–8 (D.N.M. Sept. 26, 2017); *Valtierra v. Medtronic Inc.*, 232 F. Supp. 3d 1117, 1123–25 (D. Ariz. 2017); *Revolinski v. Amtrak*, No. 08-cv-1098, 2011 WL 2037015, at *11 (E.D. Wis. May 24, 2011); *Hayes v. Wal-Mart Stores, Inc.*, 781 F. Supp. 2d 1080, 1091 (D. Or. 2011); *Ni v. Rite Aid of N.J.*, No. 10-cv-1522, 2010 WL 2557523, at *3 (D.N.J. June 22, 2010); *Hill v. Verizon Md., Inc.*, No. 07-cv-3123, 2009 WL 2060088, at *6 (D. Md. July 13, 2009). For district courts holding that obesity, in particular morbid obesity, is an impairment whether or not caused by an underlying physiological disorder, see, for example, *Velez v. Cloghan Concepts, LLC*, 387 F. Supp. 3d 1072, 1076 (S.D. Cal., 2019); *Velez v. II Fornanio (Am.) Corp.*, No. 18-cv-1840, 2018 WL

On the other hand, interpretive guidance from the U.S. Equal Employment Opportunity Commission (“EEOC”) has clarified that “severe [aka morbid or gross] obesity, which has been defined as body weight more than 100% over the norm ... is clearly an impairment,”¹⁰⁶ and “[w]hether severe obesity rises to the level of a disability will turn on whether the obesity substantially limits, has substantially limited, or is regarded as substantially limiting, a major life activity.”¹⁰⁷ “Morbid obesity” is also considered a disability for the purposes of disability affirmative action in federal employment under Section 501 of the Rehabilitation Act.¹⁰⁸ Advocates have proposed a Weight Discrimination in Employment Act, modeled on the Age Discrimination in Employment Act, which appears to have popular support.¹⁰⁹

2. *State and Local Laws*

Weight discrimination is prohibited in only one state—Michigan, which prohibits discrimination based on height and weight.¹¹⁰ However, proposed bills are pending in New York, which aims to prohibit discrimination based on weight,¹¹¹ and in Massachusetts, which targets discrimination based on height and

6446169, at *2–4 (S.D. Cal. Dec. 10, 2018) ; *McCullum v. Livingston*, No. 14-cv-3253, 2017 WL 608665, at *35 (S.D. Tex. Feb. 3, 2017); *Whittaker v. America’s Car-Mart, Inc.*, No. 1:13CV108 SNLJ, 2014 WL 1648816, at *2-3 (E.D. Mo. Apr. 24, 2014); *EEOC v. Res. for Human Dev., Inc.*, 827 F. Supp. 2d 688, 693-95 (E.D. La. 2011); *Lowe v. American Eurocopter, LLC*, No. 1:10-cv-24, 2010 WL 5232523, at *7–8 (N.D. Miss. Dec. 16, 2010); *Bryant v. Troy Auto Parts Warehouse, Inc.*, No. IP 95–1654–C–D/F, 1997 WL 441288, at *3 (S.D. Ind. Apr. 25, 1997).

¹⁰⁶ EEOC COMPL. MAN. § 902.2(c)(5)(ii) n.15 (2009) (citing THE MERCK MANUAL OF DIAGNOSIS AND THERAPY 981 (Robert Berkow ed., 16th ed. 1992)) (“[M]edical experts sometimes use the term ‘morbid obesity’ or ‘gross obesity’ to mean the same thing as ‘severe obesity,’ i.e., body weight more than 100% over the norm. The term ‘obesity’ has been defined as ‘[t]he excessive accumulation of body fat. Except for heavily muscled persons, a body weight 20% over that in standard height-weight tables is arbitrarily considered obesity.’”).

¹⁰⁷ *Id.* at n.16.

¹⁰⁸ *SF-256 Self-Identification of Disability*, U.S. OFF. PERS. MGMT. (Oct. 2016), https://www.opm.gov/forms/pdf_fill/sf256.pdf.

¹⁰⁹ Jennifer L. Pomeranz & Rebecca M. Puhl, *New Developments in the Law for Obesity Discrimination Protection*, 21 *OBESITY* 469, 469 (2013).

¹¹⁰ Elliot-Larsen Civil Rights Act of 1976, MICH. COMP. LAWS § 37.2202(1)(1).

¹¹¹ Assemb. 1851, 2021-2022 Leg., Reg. Sess. (N.Y. 2021).

weight.¹¹² This form of discrimination is also prohibited in several municipalities including: San Francisco, CA,¹¹³ Binghamton, NY¹¹⁴ Santa Cruz, CA,¹¹⁵ Madison, WI,¹¹⁶ Urbana, IL,¹¹⁷ and Washington, DC.¹¹⁸

C. Judicial Resistance to Protecting Fat People from Discrimination Under the Americans with Disabilities Act

In general, fat rights advocates would prefer fat antidiscrimination protections through an amendment to the Civil Rights Act or by some other legislation that gives fat people standalone protections akin to the Age Discrimination in Employment Act.¹¹⁹ While fat rights advocates understandably would prefer to avoid the stigma associated with the disability label, they still support extending antidiscrimination coverage to obesity as a disability under the ADA.¹²⁰ They may also have the best chance to acquire antidiscrimination protections through the ADA, and coverage

¹¹² H.B. 1683, 191st Gen. Court (Mass. 2019).

¹¹³ SAN FRANCISCO, CAL., ADMIN. CODE ch. 12A (2021) (prohibiting discrimination based on height and weight).

¹¹⁴ BINGHAMTON, N.Y., CITY CODE § 45-2 (2021) (prohibiting discrimination based on height and weight).

¹¹⁵ SANTA CRUZ, CAL., MUN. CODE § 9.83.020 (2021) (prohibiting discrimination based on physical characteristic, defined as “a bodily condition or bodily characteristic of any person which is from birth, accident, or disease, or from any natural physical development, or any other event outside the control of that person including height, weight, and individual physical mannerisms.”).

¹¹⁶ MADISON, WIS., GEN. ORDINANCES § 39.03(2) (2021) (prohibiting discrimination based on physical appearance, defined as “outward appearance of any person, irrespective of sex, with regard to hairstyle, beards, manner of dress, weight, height, facial features, or other aspects of appearance.”).

¹¹⁷ URBANA, ILL., CODE OF ORDINANCES § 12.39 (2021) (prohibiting discrimination based on personal appearance, defined as “outward appearance of any person, irrespective of sex, with regard to bodily condition or characteristics, such as weight, height, facial features, or other aspects of appearance.”).

¹¹⁸ WASHINGTON, D.C., CODE § 2-1402.11(a) (2021) (prohibiting discrimination based on personal appearance).

¹¹⁹ Telephone Interview with Tigress Osborn, Chair, Darlene Howell, Sec’y, & Elaine K. Lee, Nat’l Ass’n to Advance Fat Acceptance, and with Brandie Sendziak & Sondra Solovay, Fat Legal Advoc., Rts., & Educ. Project (Apr. 7, 2021) [hereinafter Telephone Interview with NAAFA and FLARE].

¹²⁰ *Id.*

through the ADA could afford fat people relatively more comprehensive protections, including the right to accommodations.

To appreciate some of the barriers fat people face, it is worth reviewing several fat discrimination cases and considering how judicial ADA analysis typically proceeds. These cases, which overwhelmingly pertain to employment discrimination, also illustrate what the oppression of fat people looks and feels like. Several distinct themes emerge.

I. Review of Employment Discrimination Cases

i. Obesity/Obese Physique as an Inherent Disqualification

Cases reveal beliefs on the part of many employers, managers, and supervisors that obesity and an obese physique or personal appearance is an inherent disqualification for certain positions and inconsistent with the preferences of clients and consumers.

In *Frank v. Lawrence Union Free School District*,¹²¹ an Assistant Superintendent of Curriculum and Instruction told a teacher his “obesity was not conducive to learning and would somehow prevent him from being able to perform the essential functions of a seventh grade math teacher.”¹²² The teacher had received otherwise positive evaluations but was denied tenure based on her recommendations and was discharged.

In *Lescoe v. Pennsylvania Department of Corrections*,¹²³ a correctional officer (“CO”) with morbid obesity was constantly harassed about his weight. “Look at you,” said one Lieutenant, “You don’t even appear to be a CO.”¹²⁴ In 2011, Citizen’s Medical Center in Texas instituted a policy that “requires potential employees to have a body mass index of less than 35. . . . It state[d] that an employee’s physique ‘should fit with a representational image or specific mental

¹²¹ 688 F. Supp. 2d 160 (E.D.N.Y. 2010).

¹²² *Id.* at 171.

¹²³ SCI Frackville, No. 11-2123 (3d Cir. July 18, 2011).

¹²⁴ Brief of Petitioner-Appellant at 3, *Lescoe v. Pa. Dep’t Corr.– SCI Frackville*, 464 Fed. Appx. 50 (3d Cir. 2012); *id.* at 5 (“Although his boots were shined, his uniform pressed and hair cut and everything was in order, [the remark] obviously was about his weight.”) (internal citations omitted).

projection of the job of a health-care professional,' including an appearance 'free from distraction' for hospital patients."¹²⁵

ii. Paternalistic, Safety-Based Justifications for Excluding Fat People

As is typical in other types of disability discrimination, cases reveal employers disingenuously using paternalistic, safety-based justifications for excluding fat applicants and employees. In *Cook v. Rhode Island Department of Mental Health, Retardation, and Hospitals* ("MHRH"),¹²⁶ an applicant for the position of institutional attendant for persons with intellectual disabilities passed her physical examination.¹²⁷ But the MHRH "claimed that [her] morbid obesity compromised her ability to evacuate patients in case of an emergency and put her at greater risk of developing serious ailments (a 'fact' that MHRH's hierarchs speculated would promote absenteeism and increase the likelihood of workers' compensation claims)."¹²⁸

In *EEOC v. Resources for Human Development, Inc.*,¹²⁹ an employee with morbid obesity overseeing a day care program was terminated because of "concerns about [her] mobility and whether she would be able to react quickly, if the need arose, to protect the safety of the children under her care."¹³⁰ She recounted that her employer

stated that I would have difficulty administering CPR
but I have a CPR card and have had one for the 8 years
I worked. . . . [A]t no time during my employment has

¹²⁵ Emily Ramshaw, *At Victoria Hospital, Obese Job Candidates Need Not Apply*, TEXAS TRIB. (Mar. 26, 2012), <https://www.texastribune.org/2012/03/26/victoria-hospital-wont-hire-very-obese-workers> ("The majority of our patients are over 65, and they have expectations that cannot be ignored in terms of personal appearance,' hospital chief executive David Brown said in an interview. 'We have the ability as an employer to characterize our process and to have a policy that says what's best for our business and for our patients.'").

¹²⁶ 10 F.3d 17 (1st Cir. 1993).

¹²⁷ *Id.* at 21.

¹²⁸ *Id.*

¹²⁹ No. CIV. A. 10-3322, 2011 WL 3841066 (E.D. La. Aug. 31, 2011).

¹³⁰ EEOC's Opposition to Defendant's Motion for Summary Judgment at 24, U.S. Equal Emp't Opportunity Comm'n v. Resources for Human Dev., Inc., No. CIV. A. 10-3322, 2011 WL 3841066.

my weight caused me difficulty nor stopped me from performing my job. I have never had a write-up or supervision concerning this matter.¹³¹

She was fired nevertheless.

iii. “Goodyear Blimp,” “Buddha,” and “Butterball”

Derogatory name calling appears to be another theme. In *Motto v. Union City*,¹³² the immediate supervisor of a truck driver with morbid obesity “for over ten years, continuously called him ‘Shamu’ and Goodyear Blimp.”¹³³ In *Bryant v. Troy Auto Parts Warehouse, Inc.*,¹³⁴ an employee was repeatedly harassed throughout his employment by his store manager and co-workers, who “gave him the nickname ‘Buddha,’ and they called him various derogatory names related to his girth. . . . [The co-owner told him] that he would just have to get used to it.”¹³⁵ In *Butterfield v. New York*,¹³⁶ a correctional employee was nicknamed “‘butterball’ in the workplace on the basis of his morbid obesity.”¹³⁷

iv. “I Bet You Can’t Even See Your Dick”; “Get Off Your Fat, Fucking Ass”

Perhaps most striking in these cases is the intensity of disgust and anger directed towards fat employees. In *Butterfield*, the plaintiff was targeted through “inappropriate caricatures depicting an overweight cartoon character [that] were posted throughout the facility.”¹³⁸ One day after he received surgery for morbid obesity, “his soda [was] apparently tainted with a substance that caused nausea and burning in his stomach, which resulted in a visit to the facility’s

¹³¹ *Id.* at 2.

¹³² No. CIV. A. 95-5678, 1997 WL 816509 (D.N.J. Aug. 27, 1997).

¹³³ *Id.* at *5.

¹³⁴ No. IP 95-1654-C-D/F, 1997 WL 441288 (S.D. Ind. Apr. 25, 1997).

¹³⁵ *Id.* at *1 (“All along, [the employee] made it clear that he did not like these names, and that he preferred to be called ‘Rick.’ [He] also complained to [the co-owner].”)

¹³⁶ No. 96CIV.5144(BDP)LMS, 1998 WL 401533 (S.D.N.Y. July 15, 1998).

¹³⁷ *Id.* at *6.

¹³⁸ *Id.* at *4.

Registered Nurse and a trip to the emergency room.”¹³⁹ He later “received, while on duty, a series of harassing phone calls in which the caller either hung up, pretended to be vomiting, yelled over the phone or banged the receiver against a hard object. He also received similar calls at his home during that same period” from the Correctional Facility.¹⁴⁰ Later, “his locker at work was sprayed with cheese.”¹⁴¹

In *Lescoe*, the plaintiff was targeted with remarks about “not being able to see his groin area because his belly was in the way and comments about his sex life with his wife.”¹⁴² Lescoe was asked by a supervisor if “he was in the military and when he replied in the affirmative, [the supervisor told him] that he was a disrespect to the military being as big as he was and that if he had been in Iraq with him, [he] would have killed him.”¹⁴³ In another incident, a supervisor stated: “‘Look at you Lescoe. I bet you can't even see your dick. . . .’ [Then, the supervisor] took a meter stick, bent down on one knee and attempted to place it against [Lescoe's] groin to measure the distance.”¹⁴⁴ At one point, a different supervisor “called him on the phone and said, ‘get off your fat, fucking ass, you don't get a 45 minute lunch.’ In actuality, he had already been relieved from him post and had taken a 20 minute lunch, not 40.”¹⁴⁵

In *Hayes v. Wal-Mart Stores, Inc.*,¹⁴⁶ a manager “deliberately withheld [a morbidly obese employee's] licensing and training, deliberately assigned [him] trailers that required power equipment to unload, even though [the employee] did not have power equipment licenses, and stated that he did so because he wanted [the employee] to ‘sweat some off his fat ass.’”¹⁴⁷

¹³⁹ *Id.*

¹⁴⁰ *Id.* at *5.

¹⁴¹ *Id.*

¹⁴² Brief of Petitioner-Appellant at 4, *Lescoe v. Pa. Dep't Corr. – SCI Frackville*, 464 Fed. Appx. 50 (3d Cir. 2012).

¹⁴³ *Id.* at 5-6.

¹⁴⁴ *Id.* at 6 (internal citation omitted).

¹⁴⁵ *Id.* at 7 (internal citation omitted).

¹⁴⁶ 781 F. Supp. 2d 1080 (D. Or. 2011).

¹⁴⁷ *Id.* at 1088.

2. *Judicial Analysis and Justifications for Excluding Obese Persons from ADA Coverage*

Today, however, the outcome of cases such as those described above would probably hinge on the following analysis: Can the plaintiff prove that his or her obesity has been caused by a rare secondary condition like hypothyroidism, Cushing's disease, or polycystic ovary syndrome?¹⁴⁸ In the very unlikely event that he or

¹⁴⁸ See *Cook v. State of R.I., Dep't. of Mental Health, Retardation, & Hosps.*, 10 F.3d 17, 24 (1st Cir. 1993); *Francis v. City of Meriden*, 129 F.3d 281, 286 (2d Cir. 1997); *Michaels v. Cont'l Realty Corp.*, No. RDB-10-1998, 2011 WL 4479697, at *4 (D. Md. 2011), *summarily aff'd*, 469 Fed. App'x 209, 210 (4th Cir. 2012); *E.E.O.C. v. Watkins Motor Lines, Inc.*, 463 F.3d 436, 443 (6th Cir. 2006); *Richardson v. Chi. Transit Auth.*, 926 F.3d 881, 888 (7th Cir. 2019); *Morriss v. BNSF Ry. Co.*, 817 F.3d 1104, 1108-13 (8th Cir. 2016).

For district courts so holding, see, e.g., *Sturgill v. Norfolk S. Ry. Co.*, No. 18-cv-566, 2019 WL 1063374, at *4-5 (E.D. Va. Mar. 6, 2019); *Shell v. Burlington N. Santa Fe Ry. Co.*, No. 15-cv-11040, 2018 WL 1156249, at *3 (N.D. Ill. Mar. 5, 2018); *Brownwood v. Wells Trucking, LLC*, No. 16-cv-01264, 2017 WL 9289453, at *6 (D. Colo. Nov. 9, 2017); *Silva v. Bd. Cty. Comm'rs Cty. Roosevelt*, No. 15-cv-1046, 2017 WL 4325769, at *7-8 (D.N.M. Sept. 26, 2017); *Valtierra v. Medtronic Inc.*, 232 F. Supp. 3d 1117, 1123-25 (D. Ariz. 2017); *Revolinski v. Amtrak*, No. 08-cv-1098, 2011 WL 2037015, at *11 (E.D. Wis. May 24, 2011); *Hayes v. Wal-Mart Stores, Inc.*, 781 F. Supp. 2d 1080, 1091 (D. Or. 2011); *Ni v. Rite Aid of N.J.*, No. 10-cv-1522, 2010 WL 2557523, at *3 (D.N.J. June 22, 2010); *Hill v. Verizon Md., Inc.*, No. 07-cv-3123, 2009 WL 2060088, at *6 (D. Md. July 13, 2009).

For district courts holding that obesity, in particular morbid obesity, is an impairment whether or not caused by an underlying physiological disorder, see, e.g., *Velez v. Cloghan Concepts, LLC*, No. 18-cv-1901, 2019 WL 2423145, at *4 (S.D. Cal. June 10, 2019); *Velez v. II Fornanio (Am.) Corp.*, No. 18-cv-1840, 2018 WL 6446169, at *2-4 (S.D. Cal. Dec. 10, 2018); *McCollum v. Livingston*, No. 14-cv-3253, 2017 WL 608665, at *35 (S.D. Tex. Feb. 3, 2017); *Whittaker v. America's Car-Mart, Inc.*, No. 1:13CV108 SNLJ, 2014 WL 1648816, at *2-3 (E.D. Mo. Apr. 24, 2014); *EEOC v. Res. Human Dev., Inc.*, 827 F. Supp. 2d 688, 693 (E.D. La. 2011); *Lowe v. Am. Eurocopter, LLC*, No. 10-cv-24, 2010 WL 5232523, at *7-8 (N.D. Miss. Dec. 16, 2010); *Bryant v. Troy Auto Parts Warehouse, Inc.*, No. IP 95-1654-C-D/F, 1997 WL 441288, at *3 (S.D. Ind. Apr. 25, 1997). See also, THOMAS REINEHR ET AL., *DEFINABLE SOMATIC DISORDERS IN OVERWEIGHT CHILDREN AND ADOLESCENTS* 618 (Mosby Inc. 2007) ("assessed prospectively 1405 children aged 4 to 16 years who were overweight and came to our specialized clinic for endocrinology and obesity endocrinology and obesity with a standardized diagnostic procedure

she can, the employee may attempt to establish other elements of her claim under the ADA. If not, the employee loses. It does not matter how good he or she is at her job or how badly she is treated in the workplace. What matters is whether the employee can prove that his or her obesity is secondary to a rare condition like hypothyroidism, Cushing's disease, or polycystic ovary syndrome.

Professor Samuel Bagenstos has discussed the unfairness and illogic of such judicial analyses in the context of *Richardson v. Chicago Transit Authority*,¹⁴⁹ a

decision [that] seems to call for an inquiry into whether a condition has an *identifiable* organic etiology, but it is not clear why that should matter. Given the evolving state of medical knowledge, doctors still do not know the precise etiology of any number of conditions that they diagnose and treat. What normative theory would exclude people with those conditions from the protection of the ADA?¹⁵⁰

Endocrine or syndromal disorders were diagnosed in 13 children (<1%; 4 with hypothyroidism, 1 with Cushing's syndrome, 1 with growth hormone deficiency, 2 with pseudohypoparathyroidism, 1 with pseudopseudohypoparathyroidism, 2 with Prader-Willi syndrome, 1 with Bardet-Biedl syndrome, 1 with Klinefelter syndrome).")

¹⁴⁹ 926 F.3d 881 (7th Cir. 2019).

¹⁵⁰ *Id.* at 890-92; SAMUEL R. BAGENSTOS, *DISABILITY RIGHTS LAW: CASES AND MATERIALS* 43 (3rd ed. 2020) (emphasis in original). Bagenstos explains that the court in *Richardson*

seemed to hold that obesity could not be an impairment [and therefore could not be protected as a disability under the ADA] unless it stemmed from an "underlying physiological disorder or condition." But what does that mean? All of our behavior stems from some "underlying physiological . . . condition," if only from hormones and brain chemistry. Brain proteins that alter appetite and activity levels, not to mention genetics, are substantial contributors to morbid obesity. More broadly, every fact about our body is by definition physiological. And morbid obesity, being a condition of one's physiology, is by definition a "physiological condition"—one that the medical profession has defined as a "disorder."

Id. See also *supra* notes 49 and 106 and accompanying text. Bagenstos also discusses *Bragdon v. Abbott*, 524 U.S. 624, 631 (1998), in which the Court held that HIV was "an impairment from the moment of infection"—even if it had not yet caused any outward symptoms. He then asks, "What made asymptomatic HIV an 'impairment'?"

Given that most psychiatric disabilities, such as bipolar disorder and major depressive disorder, have no identifiable organic etiology yet are included within the ADA's coverage,¹⁵¹ these justifications for excluding obesity seem thin.

i. Voluntariness

These decisions seem to demonstrate an assumption that obesity reflects a voluntary lifestyle choice, whereas true disabilities result from circumstances and conditions beyond the control of such individuals. Yet, “the Act indisputably applies to numerous conditions that may be caused or exacerbated by voluntary conduct, such as alcoholism, AIDS, diabetes, cancer resulting from cigarette smoking, heart disease resulting from excesses of various types”¹⁵² While the original ADA once described disability discrimination as being “based on characteristics that are beyond the control of such

The mental or physical effect of the condition? The presence of a discrete, identifiable, physiological cause? Or the blessing of organized medicine (the fact that the medical profession has recognized a particular diagnosis of “HIV disease”)? This question is important in cases involving conditions that do not have a discrete, identifiable physiological cause, like some cases of morbid obesity, chronic fatigue syndrome, or psychiatric disability. In most of these cases, the medical or psychological professions have recognized diagnoses that are defined by a set of symptoms. But those diagnostic categories inevitably reflect not just the underlying scientific facts but the professional community's normative views about what ought to be considered abnormal.

BAGENSTOS, *supra* note 150, at 42.

¹⁵¹ 29 C.F.R. § 1630.2(j)(3) clarifies that “major depressive disorder, bipolar disorder, post-traumatic stress disorder, obsessive compulsive disorder, and schizophrenia substantially limit brain function,” and that “[g]iven their inherent nature, these types of impairments will, as a factual matter, virtually always be found to impose a substantial limitation on a major life activity.”

¹⁵² *Cook*, 10 F.3d at 24 (emphasis added); *see also* EEOC COMPL. MAN. § 902.2(e) (2009) (“Voluntariness is irrelevant when determining whether a condition constitutes an impairment. For example, an individual who develops lung cancer as a result of smoking has an impairment, notwithstanding the fact that some apparently volitional act of the individual may have caused the impairment. The cause of a condition has no effect on whether that condition is an impairment.”) (referencing H. Judiciary Rep. No. 29, 101st Cong., 2d Sess. (1990) (noting that “[t]he cause of a disability is always irrelevant to the determination of disability”)).

individuals,”¹⁵³ that language was removed from the statute under the ADA Amendments Act (“ADAAA”) of 2008.¹⁵⁴

ii. Stigmatization

It is also argued that courts should “not recognize obesity as an impairment because it will have a stigmatizing effect on obese individuals.... [But i]t is difficult to see how protection under [the ADA] will produce more psychological harm than is caused by companies freely and openly refusing to hire people because of their obesity.”¹⁵⁵ Those who argue that the disability label will cause obese persons stigmatic harm may misconstrue the ADA’s definition of disability. Under the amended statute, individuals have a disability if they have any physiological disorder or condition that substantially limits a major bodily function, even if it has no effect on their ability to work or go about daily life.¹⁵⁶ A disability label says nothing at all about an individual’s ability to work and should not be construed as stigmatizing when viewed in this light.

¹⁵³ M. Neil Browne et al., *Obesity as a Protected Category: The Complexity of Personal Responsibility for Physical Attributes*, 14 MICH. ST. UNIV. J. MED. & L. 1, 24 (2010) (citing as reason to exclude obese persons from ADA coverage, the statute’s original § 12101(a)(7), which stated that “individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society” (emphasis in original)).

¹⁵⁴ ADA Amendments Act of 2008, Pub. L. No. 110-325, sec. 4, § 12102(3), 122 Stat. 3553, 3554-55.

¹⁵⁵ Taylor v. Burlington N.R.R. Holdings, Inc., 444 P.3d 606, 616 (Wash. 2019).

¹⁵⁶ 42 U.S.C. § 12102(1) (2009) (“The term ‘disability’ means, with respect to an individual (A) a physical or mental impairment that substantially limits one or more major life activities of such individual.”); 29 C.F.R. § 1630.2(h) (“*Physical or mental impairment* means (1) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems ... or (2) Any mental or psychological disorder”) (emphasis in original); 42 U.S.C. § 12102(2)(B) (2009) (“major life activity also includes the operation of a major bodily function”); 29 C.F.R. § 1630.2(i)(2) (“Whether an activity is a ‘major life activity’ is not determined by reference to whether it is of ‘central importance to daily life.’”); 29 C.F.R. § 1630.2(j)(1)(ii) (“An impairment need not prevent, or significantly or severely restrict, the individual from performing a major life activity in order to be considered substantially limiting.”).

iii. Antagonism Towards Disability Rights

Judges' attempts to limit the ADA's coverage of obesity to rare secondary etiologies also reflect a pattern of judicial antagonism toward broad definitions of disability in general.¹⁵⁷ Meanwhile, other statutes confer broader coverage for other protected categories. Title VII of the Civil Rights Act, for example, protects everyone—black or white,¹⁵⁸ male or female,¹⁵⁹ Muslim, Jewish, or Christian.¹⁶⁰ Setting judges straight may require an act of Congress that includes obesity or morbid obesity in the ADA regardless of etiology or at least an EEOC regulation doing the same.

¹⁵⁷ See Michelle A. Travis, *Impairment as a Protected Status: A New Universality for Disability Rights*, 46 GA. L. REV. 937, 959 (2012); Nicole Buonocore Porter, *Explaining "Not Disabled" Cases Ten Years After the ADAAA: A Story of Ignorance, Incompetence, and Possibly Animus*, 26 GEO. J. ON POVERTY L. & POL'Y 383, 385 (2019) (reviewing 976 cases between January 1, 2014 and December 31, 2018, that addressed the "disability" issue and finding that "the court erroneously held that the plaintiff was not disabled on 210 of them."). She offers three explanations: "a little bit of ignorance (courts and parties that were apparently unaware that the ADAAA was passed); a little bit of incompetence (plaintiffs who did not adequately plead their claims and did not use all of the interpretive tools available under the ADAAA); and possibly, a little bit of animus." *Id.*

¹⁵⁸ *Race/Color Discrimination – FAQs*, U.S. EQUAL EMP. OPPORTUNITY COMM'N, <https://www.eeoc.gov/youth/racecolor-discrimination-faqs#Q6> (last visited Apr. 15, 2022) (Question 6: "Are White employees protected from race discrimination even though they are not a minority?"; Answer: "Yes. You are protected from different treatment at work on the basis of your race, whether you are White, Black, or some other race.").

¹⁵⁹ *Sex Discrimination*, U.S. EQUAL EMP. OPPORTUNITY COMM'N, <https://www.eeoc.gov/youth/sex-discrimination> (last visited Apr. 15, 2022) ("Everyone, regardless of gender, is protected from sex discrimination under Title VII.").

¹⁶⁰ *Religious Discrimination*, U.S. EQUAL EMP. OPPORTUNITY COMM'N, <https://www.eeoc.gov/youth/religious-discrimination> (last visited Apr. 15, 2022) ("The laws enforced by EEOC protect all sincerely-held religious beliefs. It does not matter if you hold the beliefs of a traditional organized religion, such as Buddhism, Christianity, or Judaism, or if you hold what others consider nontraditional beliefs, such as Wicca and Rastafarianism. Non-believers also are protected from religious discrimination.").

IV. OPINIONS ABOUT FAT ANTIDISCRIMINATION LAWS AND MEDICAL/ENVIRONMENTAL INTERVENTIONS

A. Opinions of Fat Rights Advocates

Leaders from the two main fat rights organizations, the National Association to Advance Fat Acceptance (“NAAFA”) and the Fat Legal Advocacy, Rights, and Education (“FLARE”) Project, make clear that their overwhelming top policy priority is the enactment of antidiscrimination protections for fat people.¹⁶¹ According to its founder, Sondra Solovay, FLARE’s preference would be to include protections for fat people under the Civil Rights Act of 1964, including Title II, which pertains to private entities that affect commerce, and Title VII, which addresses employment.¹⁶² NAAFA’s and FLARE’s priorities for obesity research are “[t]hat obesity researchers study cultural bias against fat people and ways to reduce that bias,”¹⁶³ and they are not interested in containing the “obesity epidemic.”

I surveyed NAAFA and FLARE leaders for their opinions about environmental interventions for population weight loss and received the following response in May 2021:

FLARE fundamentally opposes interventions targeting weight loss on a population level. Fat people have

¹⁶¹ *About Us*, NAT’L ASS’N TO ADVANCE FAT ACCEPTANCE (2020), <https://naafa.org/about-us>. (“Our Mission: To eliminate discrimination based on body size and provide fat people with the tools for self-empowerment through public education, advocacy and support.”); *What We Do*, THE FAT LEGAL ADVOC., RTS., & EDUC. PROJECT (2021), <https://www.flareproject.org/home/what-we-do> (“FLARE is dedicated to the fundamental belief that fat people deserve equal rights under the law.”)

¹⁶² Email from Sondra Solovay, Fat Legal Advocacy, Rts., & Educ. Project, to author (May 5, 2021) (Title II, 42 U.S.C. § 2000a, would read “because of such individual’s race, color, religion, sex, national origin, height, weight, or appearance.” “NOTE: We would separately define height and weight to include body size, shape, proportions, all ratios of body measurements, and presence or absence of muscle tone.”; Title VII, 42 U.S.C. § 2000e-2, would read “because of such individual’s race, color, religion, sex, national origin, height, weight, or appearance.” “NOTE: We would separately define height and weight to include body size, shape, proportions, all ratios of body measurements, and presence or absence of muscle tone.”).

¹⁶³ *Obesity Research*, NAT’L ASS’N TO ADVANCE FAT ACCEPTANCE, <https://static1.squarespace.com/static/5e7be2c55ceb261b71eadde2/t/5ed710c0c8932671840d1b8a/1591152832495/Obesity+Research%5B2015%5D.pdf>.

always existed and will continue to exist. This is biodiversity in action. Targeting fat people as a population is no different than targeting any other population based on a single characteristic. Targeting fat people as a whole for weight loss intervention is unacceptable and misinformed. The only population-level intervention related to weight that we support is the passage of clear civil rights laws that cover ALL aspects of a fat person's life, from accommodations to employment to medical equity.¹⁶⁴

A full table containing their opinions with respect to 16 specific interventions appears in the appendix of this Article.

B. Opinions of Fat People in General

1. Antidiscrimination

There appears to be strong support for fat antidiscrimination and anti-bullying protections for fat people. Surveys gauging public support for weight antidiscrimination laws in the U.S. have found that those favoring their enactment are more likely to be persons with BMIs greater than 30, to have experienced weight-based teasing and weight-discrimination in the workplace, and to have family members who have experienced weight-based victimization.¹⁶⁵ Another study surveyed women members of a national organization of more than 54,000 adults, including respondents who “self-identified as being personally affected by obesity or struggling with weight,” 91.5% of whom reported a past history of experiencing weight-based stigmatization (Table 2).¹⁶⁶

¹⁶⁴ Email from Sondra Solovay, *supra* note 162.

¹⁶⁵ Rebecca M. Puhl & Chelsea A. Heuer, *Public Opinion About Laws to Prohibit Weight Discrimination in the United States*, 19 *OBESITY* 74, 78-80 (2011). With regard to proposed weight antidiscrimination Law 6, for example, those more likely to endorse support had BMI 30+ (80%) versus 18-24.9 (70%); history of weight-based teasing (78%) versus no such history (70%); history of weight discrimination in the workplace (86%) versus no such history (72%); family members experienced weight-based victimization (81%) versus no such history (69%). *Id.*

¹⁶⁶ Rebecca M. Puhl et al., *Missing the Target: Including Perspectives of Women with Overweight and Obesity to Inform Stigma-Reduction Strategies*, 3 *OBESITY SCI. & PRAC.* 25, 26-30 (2017).

Table 2. Percent (%) Endorsing High Importance of Strategies to Address Weight Stigma Among a Sample of Overweight and Obese U.S. Women

At Home	
Spouses/partners need education about weight stigma, including ways to avoid blaming or shaming their partner about weight	85.5
Anti-stigma initiatives should include a focus on reducing weight stigma by family members	82.6
In Schools	
School-based curriculum should include content aimed at reducing weight-related bullying	83.7
School staff should receive training on how to address weight-related bullying at school	95.7
In Healthcare and Medical Settings	
Obesity treatment and intervention programs should avoid using approaches that stigmatize or blame people affected by obesity	90.0
In the Media	
Children's television programs should be required to positively portray children of diverse body sizes and avoid stigmatizing youth with obesity	86.5
The news and entertainment media should include portrayals of people with obesity that challenge and defy common weight-based stereotypes	84.1
The news and entertainment media should show more accurate examples of what it's like to have obesity, including the harmful stigma that people experience because of their weight	82.0
Television, radio and social media campaigns that address obesity should avoid content that stigmatizes people affected by obesity	83.1
Other	
More advocacy groups are needed to fight discrimination and defend the rights of people who have obesity	73.3

These results strongly suggest that fat people consider efforts to fight discrimination and reduce societal prejudice against fat people as top priorities.

2. *Environmental Interventions*

Some fat people in the U.S. might support the dominant public health approaches to fighting the “obesity epidemic” currently advanced by medical experts and public health leaders. In general, BMI or weight status has not been found to be a significant predictor of support or lack of support for environmental interventions to reduce obesity,¹⁶⁷ although one study of the U.S. and Australian public found that “[o]bese participants were less supportive of imposing a tax on foods than normal and overweight participants.”¹⁶⁸ Some obese persons do appear to support food taxes. It is possible, however, that they support these taxes because they have been told, incorrectly, that they are effective.¹⁶⁹

C. *Opinions Among the U.S. Public*

Research suggests that about three quarters of the American public support the enactment of antidiscrimination protections for fat people.¹⁷⁰ Studies also suggest that Americans tend not to

¹⁶⁷ Brenda Robles & Tony Kuo, *Predictors of Public Support for Nutrition-Focused Policy, Systems and Environmental Change Strategies in Los Angeles County, 2013*, 7 *BMJ OPEN* 1,1 (2017) (stating that weight status was not a significant predictor of support for type of policy, systems, and environmental change policies/practices).

¹⁶⁸ Natalia M. Lee et al., *Public Views on Food Addiction and Obesity: Implications for Policy and Treatment*, 8 *PLOS ONE* 1, 5 (2013); see also Emma Sainsbury et al., *Public Support for Government Regulatory Interventions for Overweight and Obesity in Australia*, 18 *BMC PUB. HEALTH* 513 (2018).

¹⁶⁹ See Lee et al., *supra* note 168, at 6-7 (reporting in Table S6(a), that 29% of obese respondents were of the opinion that a food tax is helpful, and 24% of obese respondents believed that a food tax would decrease obesity).

¹⁷⁰ Puhl et al., *supra* note 1, at 1322 (The percent of respondents agreeing with each statement in 2011-2013 and 2014-2015: “Obese persons should be subject to the same legal protection and benefits offered to people with physical disabilities” (63.8; 72.2); “My state should include body weight in their civil rights law to protect people from discrimination based on their body weight, similar to laws that protect against discrimination due to race, religion and sex” (72.2; 78.9); “It should be illegal for an employer to do all of the following: (a) Refuse to hire a qualified person because of his/her body weight; (b) Fire a qualified employee because of his/her body weight; (c) Deny a promotion or appropriate compensation to a qualified employee because of his/her body weight” (78.1; 78.8)).

approve of most environmental interventions to combat obesity (Table 3).¹⁷¹

Table 3. Percent (%) of Respondents Supporting Policies to Promote Healthy Diets in U.S. General Population Sample¹⁷²

Calorie amounts on menus of chain restaurants	62.6
Subsidies to reduce the price of fresh fruit and vegetables	59.3
A maximum limit on salt levels in pre-packaged foods	48.5
Requiring water or milk as the default drink in children's fast-food meal deals	46.4
A ban on marketing unhealthy food and beverages to children	43.5
Taxes on sugary drinks IF the money was spent on subsidising healthy food	37.2
Restrictions on maximum size (e.g., max of 375 mL) of single serve soft drink	31.0
Taxes on sugary drinks	30.0
Zoning to restrict the number of fast food restaurants near schools	28.3
Taxes on foods with high sugar	27.9
A ban on marketing all food and beverages to children	24.0

In sum, the dominant policy approaches to obesity adopted by leaders in government, medicine, and public health appear to lack support from the persons purported to benefit and from the population at large.

D. Whose Opinions Should Matter?

It is worth considering which initiatives related to fat people deserve greater prioritization. Should our focus be on environmental interventions to reduce the prevalence of obesity, or on efforts to reduce fat prejudice and protect fat people from discrimination under

¹⁷¹ Janelle Kwon et al., *A Multi-Country Survey of Public Support for Food Policies to Promote Healthy Diets: Findings from the International Food Policy Study*, 19 BMC PUB. HEALTH 1205, 5 (2019).

¹⁷² *Id.*

the law? While some might dismiss the question and propose we do both, the reality is that a distinct policy choice is regularly made between the two. Moreover, these policy choices are overwhelmingly made in favor of population weight loss interventions, rather than antidiscrimination protections, as the absence of proposed antidiscrimination legislation plainly indicates. Since these choices might be made inadvertently, policymakers and public health leaders should be pressed to make their choices explicit. More might choose to reduce fat prejudice and protect fat people from discrimination under these circumstances.

The bigger question is why thin public health leaders should lead policy related to fat people. In principle, health policies should reflect the priorities of those purported to benefit. Yet, fat rights advocates have been categorically excluded and denied any input or veto on these policies that substantially affect them.¹⁷³

V. WHAT DRIVES THE STATUS QUO “WAR ON OBESITY”?

It is worth carefully considering why fat rights advocates and fat people have not been put in charge of the public health agendas with respect to obesity and why their voices have not been heard. NAAFA and FLARE leaders report that no medical or health policy leaders have ever contacted them to ask for their opinions in the past.¹⁷⁴ An April 11, 2021 search for “National Association to Advance Fat Acceptance” revealed no hits on the CDC website, and only two articles on PubMed. The reality is that the medical and public health fields have always been hostile to disability perspectives. In 2018, persons with disabilities, despite comprising more than 30% of the adult U.S. population,¹⁷⁵ were substantially underrepresented in the permanent workforce at the U.S. Department of Health and Human Services (“HHS”).¹⁷⁶ The prevalence of persons with disabilities—

¹⁷³ Telephone Interview with NAAFA and FLARE, *supra* note 119.

¹⁷⁴ *See id.*

¹⁷⁵ Danielle M. Taylor, *Americans with Disabilities: 2014, Household Economic Studies*, U.S. CENSUS BUREAU, CURRENT POPULATION REP. P70-152, 4 (Nov. 2018), <https://www.census.gov/content/dam/Census/library/publications/2018/demo/p70-152.pdf>.

¹⁷⁶ *See generally* Nicholas D. Lawson, *Disability Affirmative Action Requirements for the U.S. HHS and Academic Medical Centers*, 52 HASTINGS CTR. REP. 21, 22 (2022).

including morbid obesity, which had a prevalence of 9.2% in the U.S. population at this time¹⁷⁷—was 6% at the U.S. HHS overall, 6.7% at the National Institutes of Health (“NIH”), and 12% at the CDC.¹⁷⁸ Disability is not recognized as a health disparities category¹⁷⁹ and is not included in health professional training curricula.¹⁸⁰ And “[w]hile the COVID-19 pandemic has wreaked disproportionate havoc in marginalized racial/ethnic communities, little attention has been given to people with disabilities in the press, public health surveillance, and research.”¹⁸¹ This inattention is especially remarkable given that the overwhelming majority of COVID-19 deaths—over 95% according to some sources—have occurred among people with disabilities.¹⁸²

¹⁷⁷ Craig M. Hales et al., *Prevalence of Obesity and Severe Obesity Among Adults: United States, 2017–2018*, NAT’L. CTR. FOR HEALTH STAT., CTR. FOR DISEASE CONTROL & PREVENTION 3 (Feb. 2020), <https://www.cdc.gov/chs/data/databriefs/db360-h.pdf>.

¹⁷⁸ U.S. EQUAL EMP. OPPORTUNITY COMM’N, ANN. REP. ON THE FED. WORK FORCE FISCAL YEAR 2018, https://www.eeoc.gov/sites/default/files/2020-06/2018_workforce_tables.zip (Table A-3b).

¹⁷⁹ See, e.g., Gloria L. Krahn et al., *Persons with Disabilities as an Unrecognized Health Disparity Population*, 105 AM. J. PUB. HEALTH S198 (2015); Matthew L. Goldman et al., *The Case for Severe Mental Illness as a Disparities Category*, 69 PSYCHIATRIC SERV. 726, 726-27 (2018).

¹⁸⁰ Letter from Nat’l Council on Disability to Liaison Comm. on Med. Educ. Regarding Integration of Disability Curriculum Requirement (May 30, 2019), <https://ncd.gov/publications/2019/ncd-response-letter-lcme>; Letter from Nat’l Council on Disability to Liaison Comm. on Med. Educ. (Dec. 12, 2019), <https://ncd.gov/publications/2019/ncd-lcme-2nd-response-letter> (criticizing the LCME for including curricula on reducing gender and cultural biases, but not disability biases to reduce health disparities); NAT’L ACAD. OF SCIENCES, ENG’G, & MED., *PEOPLE LIVING WITH DISABILITIES: HEALTH EQUITY, HEALTH DISPARITIES, AND HEALTH LITERACY* 7-8 (2018) (observing that “there is no requirement to include disability in the training of future physicians or other health providers in the United States. Similarly, most public health and human service training programs do not include a curriculum on disabilities . . .”; “the NIH Revitalization Act ensured the inclusion of women and diverse racial groups . . .,” but not disability.).

¹⁸¹ Maya Sabatello et al., *People with Disabilities in COVID-19: Fixing Our Priorities*, 20 AM. J. BIOETHICS 187, 187 (2020).

¹⁸² See Sarah Ruiz-Grossman, *Disability Advocates Demand Public Apology from CDC Director After ‘Hurtful’ Comments*, HUFFINGTON POST (Jan. 14, 2022 8:21 PM EST), https://www.huffpost.com/entry/disability-cdc-director-walensky-coronavirus-deaths_n_61e217b0e4b05645a6e74707 (describing remarks from the CDC Director citing a study that said only 0.003% of vaccinated people had died of COVID-19: “The overwhelming number of deaths — over 75 percent — occurred in people who had at least four comorbidities, so really these are people who were

Medical and public health antagonism toward fat perspectives reflects a pattern on the part of these fields toward dismissing persons with physical and mental disabilities, which also include eating disorders. One public health professor, anticipating that “[s]ome might object to [his fat-shaming] strategy on the ground that it is insensitive to the shame many people, especially young women, feel about their own bodies,”¹⁸³ nevertheless seemed to dismiss these concerns on the grounds that “[t]he mental dynamic of perfectionism, shame, and struggle with authority figures (often parents) that commonly plays out in [anorexia nervosa and related disorders] is unlikely to be much-influenced”¹⁸⁴

A. Bullying, Harassment, and Discrimination Against Fat People Continues to Be Relevant Only Insofar as It Supports a Need for Interventions to Lose Weight

When the topic of bullying, harassment, or discrimination against fat persons actually does come up in government discussions of obesity, it is invariably invoked as a reason to support medical and public health strategies to make fat people thin. The conversation typically goes something like this:

Mr. JEFFRIES. Is it fair to say that childhood obesity increases the likelihood of bullying in school?

Secretary Vilsack. In my personal experience, I would say that is probably true.

Mr. JEFFRIES. Does it increase the likelihood of social isolation?

Secretary Vilsack. Yes.

unwell to begin with — and, yes, really encouraging news in the context of Omicron.”); Letter from Am. Assoc. of People with Disabilities et al. to Rochelle Walensky, Dir., Ctr. for Disease Control & Prevention 1 (Jan. 13, 2022), https://www.aapd.com/wp-content/uploads/2022/01/CDC-Letter_FINAL.pdf (“People with four or more comorbidities are people with disabilities.”); *Characteristics of Covid-19 Deaths*, ALA. DEP’T PUB. HEALTH (Oct. 20, 2020), <https://www.alabamapublichealth.gov/covid19/assets/cov-al-cases-102020.pdf> (finding that over 95% of COVID-19 deaths occurred in persons with disabilities).

¹⁸³ Bloche, *supra* note 8, at 1350.

¹⁸⁴ *Id.*

Mr. JEFFRIES. Is it fair to say that childhood obesity increases the likelihood of severe emotional distress?

Secretary Vilsack. I wouldn't be surprised if that weren't true.

Mr. JEFFRIES. Okay. Now, the health care costs of obesity per year in the United States....¹⁸⁵

Are there Members of Congress with obesity, particularly from communities of color, who have been the targets of fat shaming and who might support legislation to reduce bullying, harassment, and discrimination against fat people? I do not know. I recently contacted my representative, Donald Payne, Jr. (Democrat from New Jersey), after I received an email from him in which he disclosed being a diabetic.¹⁸⁶ I contacted his office to see if he might be willing to add his name to a list of individuals with disabilities holding public office¹⁸⁷ and later found out that he had recently been the target of public fat shaming.¹⁸⁸

I do not know if Representative Payne would be interested in sponsoring antidiscrimination protections for obese persons, though I

¹⁸⁵ *Child Nutrition Assistance: Are Federal Rules and Regulations Serving the Best Interests of Schools and Families?: Hearing Before the H. Comm. on Educ. & the Workforce*, 114th Cong. (2015) (statements of Rep. Hakeem Jeffries and Tom Vilsack, Sec'y of Agriculture).

¹⁸⁶ Email from Rep. Donald Payne, Jr., to author, providing congressional update (Dec. 17, 2021) (on file with author) ("As a diabetic, I am proud to see that insulin payments will be capped at \$35 dollars per month with similar reductions to dozens of other life-saving medications.").

¹⁸⁷ At the moment, only 10 of 435 (2.3%) current U.S. Representatives self-identify as persons with disabilities: three wheelchair users, two amputees, one with a spinal cord injury, one visually impaired, one stroke, one with alopecia, and one with post-traumatic stress disorder. See *Current Elected Officials with Disabilities Database*, NAT'L COUNCIL ON INDEPENDENT LIVING (June 21, 2021), <https://secureservercdn.net/198.71.233.129/bzd.3bc.myftpupload.com/wp-content/uploads/2021/12/12-14-2021-Elected-Officials-with-Disabilities.xlsx>.

¹⁸⁸ See Steven Nelson, *Belly Busted: House Democrat Gets Too Comfortable in Homeland Hearing*, N.Y. POST (June 17, 2021, 2:34 PM), <https://nypost.com/2021/06/17/house-democrat-flashes-stomach-during-virtual-hearing> ("House Homeland Security Committee members were stunned Thursday as one of their colleagues became overexposed during a virtual hearing, revealing his bare belly jutting out... A Payne staffer came to his defense on Twitter, saying the Newark and Orange, NJ, representative was being unfairly fat-shamed. 'It's no secret that as a diabetic the Congressman has his weight struggles. But we try to stick to policy here in Congress.'").

think his constituents would support and reward him for doing so. He is, however, a cosponsor of the Treat and Reduce Obesity Act,¹⁸⁹ the Medical Nutrition Therapy Act of 2021,¹⁹⁰ and various measures supporting environmental interventions to reduce childhood obesity. These include the Reducing Obesity in Youth Act of 2020,¹⁹¹ the Food and Nutrition Education in Schools Act of 2021,¹⁹² the Fit for Life Act of 2014,¹⁹³ and a house resolution expressing support for designation of September as National Childhood Obesity Awareness Month.¹⁹⁴ The Reducing Obesity in Youth Act rightfully refers to the problems of “increases in bullying by classmates”¹⁹⁵ and the resolution correctly states that “some consequences of childhood and adolescent obesity are psychosocial and can hinder academic and social functioning and persist into adulthood.”¹⁹⁶ Yet, these bills and resolutions do not tackle the problems of fat bullying and their negative psychosocial sequelae head on. They take aim not at the bullies, but at the victims. They do not attempt to get the bullies to stop bullying fat people; rather, they attempt to get the fat victims of bullying to stop being fat. What is missing is any discussion, let alone proposal, to reduce bullying,

¹⁸⁹ Treat and Reduce Obesity Act of 2021, H.R. 1577, 117th Cong. (2021).

¹⁹⁰ *See generally* Medical Nutrition Therapy Act of 2021, H.R. 3108, 117th Cong. (2021) (“To amend title XVIII of the Social Security Act to expand the availability of medical nutrition therapy services under the Medicare program.”).

¹⁹¹ *See generally* Reducing Obesity in Youth Act of 2020, H.R. 8918, 116th Cong. (2020) (“To amend the Public Health Service Act to promote healthy eating and physical activity among children.”). These policies are to be administered by the CDC Director. *Id.*

¹⁹² *See generally* Food and Nutrition Education in Schools Act of 2021, H.R. 4282, 117th Cong. (2021) (“To amend the Richard B. Russell National School Lunch Act to establish the Food and Nutrition Education in Schools Pilot Program, and for other purposes.”). These policies are to be administered by the Secretary of Agriculture. *Id.*

¹⁹³ *See generally* Fit for Life Act of 2014, H.R. 4765, 113th Cong. (2014) (“To address childhood obesity, and for other purposes,” including § 101 on “Nutritious Food Access through mobility and Innovation Program,” § 102 on “Expansion of the Fresh Fruit and Vegetable Program,” and § 201 on “connecting America’s health professionals with our schools.”). These initiatives are to be administered by the Secretaries of HHS, Agriculture, and Education. *Id.*

¹⁹⁴ H.R. Res. 341, 113th Cong. (2013) (“Whereas 31.8 percent or 24,000,000 children and teenagers ages 2 to 19 are obese or overweight, a statistic that health and medical experts consider an epidemic.”).

¹⁹⁵ Reducing Obesity in Youth Act of 2020, H.R. 8918, 116th Cong. § 2(a)(9) (2020).

¹⁹⁶ H.R. Res. 341, 113th Cong. (2013).

harassment, and discrimination against fat people other than getting fat people to become thin.

B. Leaving Fat Persons Without Antidiscrimination Protections May Serve to Justify Inequalities Based on Class, Disability, Gender, and Race

Supporters of the Treat and Reduce Obesity Act¹⁹⁷ and the House resolution are also right to recognize that significant disparities exist in obesity rates “based on race and poverty.”¹⁹⁸ But, they ought to recognize as well that obese members of racial or ethnic minorities will also be disproportionately affected by fat discrimination and that this percentage of the obese population currently remains unprotected from such discrimination under the Civil Rights Act, the ADA, and other antidiscrimination laws. Leaving fat persons unprotected may be one other way of “blaming fat people for their weight [and] may serve to justify and reinforce social inequalities” based on class, race, or ethnicity.¹⁹⁹

Thin, affluent individuals, especially those in positions of power in government, medicine, and public health, need to check in with themselves and reflect on “why the obesity epidemic as a social concern has gained such traction among those apparently not afflicted by it”²⁰⁰ and why “healthism speaks to those who are already reasonably healthy.”²⁰¹ For some thin elites, a belief in their control over their personal lifestyles and in the power of their lifestyle

¹⁹⁷ 117 CONG. REC. E1357 (daily ed. Dec. 13, 2021) (statement of Rep. Barragan).

¹⁹⁸ H.R. Res. 341, 113th Cong. (2013) (“significant disparities exist among the obesity rates of children based on race and poverty”).

¹⁹⁹ Abigail C. Saguy & Kevin W. Riley, *Weighing Both Sides: Morality, Mortality, and Framing Contests over Obesity*, 30 J. HEALTH POL. POL’Y & L. 869, 871 (2005); see also JULIE GUTHMAN, *WEIGHING IN: OBESITY, FOOD JUSTICE, AND THE LIMITS OF CAPITALISM* 62 (2011), providing the following student reflection:

Let’s face it, a big portion of this country is lazy and needs some guidance. But, I do believe that if you take someone who is overweight and given them guidelines to be healthy, they can do it.... Since they are poor and may come from different countries, they don’t have the education to help them make the right choices when it comes to food/health.

²⁰⁰ GUTHMAN, *supra* note 199, at 47.

²⁰¹ *Id.* at 60.

practices to determine their success²⁰² may serve to justify their place in the hierarchy, and confirm their belief that they “are thriving because of their lifestyles while the poor are miserable because they are fat.”²⁰³

²⁰² *Lawyers as Leaders – Professor Lawrence Gostin on the Critical Lessons of the COVID-19 Pandemic*, GEORGETOWN LAW (Oct. 6, 2020), <https://www.law.georgetown.edu/150/event/lawyers-as-leaders-lawrence-gostin>.

Do I eat well and exercise and be physically active? Do I do it to live longer? And my answer is no. Emphatically not, no. Emphatically no. I do it to live better. [...] It will make you, you know, do your job a lot better. You’ll be a lot more focused mentally. You’ll feel better about yourself. And so I think that, that you do it to make a better you.

But it does take work, you know, and I’ve often said, you need to do three or four things, and it’s not easy. One is to eat well. [...] Plant based. It has healthy oils like mono or polysaturated oil, but not things like butter or lard or animal fat. You want to have lean protein and vegetables. You know, I am a little bit freaky and so you know. Some people count sheep at night when they go to bed. I actually go back and then I think of what I ate during the day, and then I score myself on vegetables, fruit, protein, and anything bad I put in my body. [...] And then physical activity. Aerobic exercise as well as, um, strength training. Flexibility training is very important. Yoga. And then, um, things like Tai-Chi, or things for your mind like meditation. Um, I know it sounds really corny to a young student, but if you got, if you just did 10 minutes a day of meditation, there’s absolutely solid science that it does good for your physical and mental health. [...] If I’m hungry, and I want, and there are chips or candy or fast-foods around, I’ll actually just put some popcorn. Not. You can’t buy the popcorn in the packet because they’re really unhealthy. But just get plain popcorn, put a little bit in the bottom of a paper bag. Put it in the microwave for three minutes and a half or three, depending on how much. And then, just, it’s so satisfying. And the other thing I do a lot is that I drink a lot of tea and coffee because it fills you up. And then I eat a lot of fruit. I eat a ton of carbs.

I try to make sure that the people around me are living and eating well. I know that at Georgetown Law, you know I, with the people that work with me, I mentor them. And sometimes, I’ll come in and ask them, what have you had for breakfast? And they hide their donuts under the table.

²⁰³ Kirkland, *supra* note 18, at 474, asks “what if it is the case that many elites find the terms of the environmental account to be simply a more palatable way to express their disgust at fat people, the tacky, low-class foods they eat, and the indolent ways they spend their time?” “The pretense that the elites are thriving because of their lifestyles while the poor are miserable because they are fat lets elites pretend we can control our bodies like well-oiled machines if we just try hard enough.” *Id.* at 480.

Civil rights advocacy for fat people and civil rights advocacy for women, communities of color,²⁰⁴ persons with disabilities,²⁰⁵ poor persons and immigrants,²⁰⁶ and LGBTQ+ individuals²⁰⁷ will depend

²⁰⁴ See Jasmine E. Harris, *Reckoning with Race and Disability*, 130 YALE L.J.F. 916, 949-50 (2021):

State institutions and actors policed the line between whiteness and blackness through rhetorical and legal declarations of the biological differences and inferiority of Black people that made them unable to manage participation in democratic governance and civic duties. Medical and scientific ‘proof’ then became the means of marking people. Scientists and thought leaders at some of the nation’s top universities went to great lengths to make blackness a concrete, identifiable, and thus, biological category including dissecting black bodies and announcing such biological markers as cranial measurements proved Black people had smaller skulls and, thus, lower intellect, poor moral barometers, and were ‘not of the same blood’ as white people. ‘Whiteness,’ therefore, became synonymous with health, ‘physical fitness, mental rigor, and genetic superiority.

See also Jess Waggoner, “My Most Humiliating Jim Crow Experience:” *Afro-Modernist Critiques of Eugenics and Medical Segregation*, 24 MODERNISM/MODERNITY 507, 510 (2017) (“The most common disability argument for slavery was simply that African-Americans lacked sufficient intelligence to participate or compete on an equal basis with white Americans.”) (internal citation omitted).

²⁰⁵ See Rabia Belt & Doron Dorfman, *Reweighing Medical Civil Rights*, 72 STAN. L. REV. ONLINE 176, 184 (2020) (“[m]edicalizing civil rights thus means taking the expertise and decision[-]making capacity away from patients and disabled individuals and handing it over to other experts to make decisions for them.”)

²⁰⁶ Controlling the CDC, for example, may depend in part on public outrage over the political misuse of the agency to justify turning away migrants at the nation’s borders during a pandemic on emergency public health grounds, see Opinion, *It’s Time to End the Pandemic Emergency at the Border*, N.Y. TIMES (Nov. 13, 2021), or on the basis of “health-related grounds” under an immigration rule dating back to the eugenics era. See Medha D. Makhlof, *Destigmatizing Disability in the Law of Immigration Admissions*, in DISABILITY, HEALTH, LAW, AND BIOETHICS 187, 187 (I. Glenn Cohen et al. eds., 2020):

In the early twentieth century, the US Public Health Service instructed medical inspectors to search for evidence of conditions such as bunions, flat feet, hernia, hysteria, poor eyesight, psychoses of various kinds, spinal curvature, and varicose veins. It is not an overstatement to say that the exclusion of people with disabilities was a pillar of early immigration policy. The motivations behind such laws at the turn of the century were clear: first, fear of disability itself was pervasive; and second, there were concerns about increasing hereditary disability within the population.

²⁰⁷ *Commission on Sexual Orientation and Gender Identity*, AM. BAR ASS’N, https://www.americanbar.org/groups/diversity/sexual_orientation (last visited Feb. 21, 2022) (listing “Banning Conversion Therapy” on the website’s first page).

on their ability to coalesce and take charge of these medicalized processes, health agencies, and their leaders. These advocates need to remember how “public health campaigns were inseparable from the social agendas of dominant social groups,”²⁰⁸ and how “[m]edicalization [can] have considerable costs.”²⁰⁹ They must ensure that they are all being included and are not being further marginalized by medicalization.

**C. Do Not Trust Obesity Agendas That Do Not
Prioritize the Concerns and Perspectives of Fat
Rights Advocates and Fat People First**

I would not trust any obesity “authorities” or obesity policies that did not fully involve NAAFA and FLARE in all aspects of the process. Given that NAAFA and FLARE leaders report that they have never been contacted by any medical or public health leaders on obesity policy, I would not trust any of the obesity bills currently being proposed before Congress. To many medical and public health anti-obesity leaders, their objections to the environmental interventions for weight loss described in the appendix may seem incomprehensible. Yet, these are individuals who arguably have the most at stake in these policies and are most familiar with the ways in which they involve stigmatizing rhetoric. That stigmatizing rhetoric may be a part of the policies themselves or a part of the process of building support for these policies. One cannot fully evaluate any policy without taking into account all of the communications associated with it.

To illustrate the dangers of pursuing policies related to fat people without involving fat people and fat rights advocates, it is worth considering an example of how disregard for fat persons’ perspectives may be facilitated by a “belittling view of poor fat people’s agency.”²¹⁰ A sustaining refrain appears to be that fat people are *suffering*. In replying to critics of the dominant public health response to obesity,

²⁰⁸ GUTHMAN, *supra* note 199, at 64.

²⁰⁹ Belt & Dorfman, *supra* note 205, at 183-84 (What patient “movements have been fighting for [in general] is to get a seat at the table and to include activist and patient perspectives at different stages in the scientific/medical enterprise. They seek to emphasize the benefits of participatory knowledge over the exclusive regime of medical experts.”)

²¹⁰ Kirkland, *supra* note 18, at 477 (referring to the environmental account of obesity).

Professor Lawrence Gostin often refers to “the crushing burdens of disease, *suffering*, and early death” associated with obesity.²¹¹ “To ignore the burdens of *suffering* from ill health, and fail to take known effective action, is far more morally culpable,” he says.²¹² “The real tragedy, of course, is the disability, *suffering*, and early death that devastates families and communities,”²¹³ and “[g]overnment’s *failure* to act to reduce the *suffering* and early death visited mostly in poor neighborhoods is the far greater injustice.”²¹⁴

But fat rights advocate Ragen Chastain sees things differently. “I see people talk a lot about how we need to ‘do something’ because so many people are ‘suffering from obesity,’” she says.²¹⁵ “[W]hile I sometimes do suffer because I’m obese, I’ve never suffered from obesity.”²¹⁶ What she suffers from, she writes, is “living in a society where [she is] shamed, stigmatized and humiliated because of the way [she] look[s],” being “oppressed by people who choose to believe that [she] could be thin if [she] tried (even though there’s no evidence for that)” and by social pressures to conform to a standard of slenderness.²¹⁷ She writes that she is “suffering from living in a society that tells [her] that the cure for social stigma, shame, humiliation and incompetent healthcare is for [her] to lose weight, when the truth is that the cure for social stigma is ending social stigma.”²¹⁸

That public health leaders have ignored fat rights advocates, pursued obesity agendas they oppose, and have not pursued antidiscrimination protections for fat people probably reflects some level of implicit bias, if not outright animus. Their anti-obesity

²¹¹ Lawrence O. Gostin, *Trans Fat Bans and the Human Freedom: A Refutation*, 10 AM. J. BIOETHICS 33, 34 (2010) (emphasis added).

²¹² *Id.* (emphasis added).

²¹³ Lawrence O. Gostin, *Tackling Obesity and Disease: The Culprit Is Sugar; the Response Is Legal Regulation*, 48 HASTINGS CTR. REP. 5, 5 (2018) (emphasis added).

²¹⁴ Lawrence O. Gostin, *Bloomberg’s Health Legacy: Urban Innovator or Meddling Nanny?*, 43 HASTINGS CTR. REP. 19, 24 (2013) (emphasis added).

²¹⁵ Ragen Chastain, *I’m Not Suffering from Obesity*, DANCES WITH FAT (Mar. 1, 2012), <https://danceswithfat.org/2012/03/01/im-not-suffering-from-obesity/> (she also reports doctors “giving me a treatment plan of weight loss (which is using a completely unreliable diagnostic and then prescribing a treatment that has the opposite result 95% of the time) ... [and] telling me that my strep throat was due to my weight.”).

²¹⁶ *Id.*

²¹⁷ *Id.*

²¹⁸ *Id.*

agendas might reflect an implicit belief that some level of discrimination against fat people is justified because of the cost fat people impose on society or themselves, and they may believe that discrimination will “help” fat people become thin. In fact, some commentators have explicitly opposed antidiscrimination protections for fat people on the grounds that “[t]he conferral of protected status for obesity . . . raises a serious possibility that people will see obesity as ‘okay’ and thus engage in unhealthy behaviors.”²¹⁹ They support discrimination against obese people in order to inflict on them, a “‘cost’ of obesity”²²⁰ that will spur them to take the necessary steps to become thin.²²¹ These justifications, however, seem thin, with feelings of outrage and disgust more likely at the core of these beliefs: “I have trouble accepting that I shouldn’t discriminate against someone who is knowingly fucking up their health.”²²²

VI. FAT RIGHTS GOING FORWARD

The take home message is that antidiscrimination protections for fat people are badly needed and that we should not trust any obesity policies or proposed legislation that ignore the concerns and priorities of fat rights advocates. At a minimum, we should not support any proposed obesity legislation until they are included in the conversation. Many medical and environmental weight-loss interventions might initially seem benign and non-stigmatizing, but they are not, and they typically depend in various ways on stigmatizing rhetoric about fat people. We should pause before pursuing further obesity legislation without significant input from fat rights advocates and fat people in

²¹⁹ Adam R. Pulver, *An Imperfect Fit: Obesity, Public Health, and Disability Antidiscrimination Law*, 41 COLUM. J.L. & SOC. PROBS. 365, 405 (2008) (generally arguing that “anti-discrimination protection would have a negative effect on the public health goal of reducing the prevalence of obesity in America.”)

²²⁰ *Id.* at 405.

²²¹ Obesity prevalence has steadily increased, however, in spite of the dearth of antidiscrimination protections for fat people. This suggests that discrimination against obese people does *not* effectively spur them to become thin.

²²² GUTHMAN, *supra* note 199, at 50, 62 (reflections of a student in Guthman’s course on obesity politics, which also included, “I don’t understand why [one would be] surprised at obese children being taken from their parents by CPS—those parents are slowly *killing* their kids! . . . And what makes [her] think she should be able to have health insurance when she is going to give herself a heart attack if she doesn’t fix her health?”)

general—especially given the limited effectiveness of expensive new anti-obesity drugs and the absence of evidence demonstrating meaningful effects of behavioral therapies, exercise, lifestyle coaching, or environmental interventions on weight loss. Not only are public health leaders’ environmental interventions to control obesity prevalence unlikely to succeed, “because the animating problem is that poor people are fat, the focus on weight loss becomes the metric of success.”²²³ These environmental approaches are less overtly punitive and represent an improvement over traditional fat-shaming. Yet, media framings, while “increasingly emphasizing environmental causation of ‘obesity,’ nonetheless persist in stressing personal responsibility[.]”²²⁴

Civil rights organizations like the NAACP, National Urban League, and leaders in government like Donald Payne, Jr., Nanette Diaz Barragan, and Cory Booker, should become more aware of the prejudices underlying the dominant obesity agenda, how “[c]ontemporary ideas about fatness are ... often cloaked in the language of health,”²²⁵ and how many poor obese members of communities of color remain unprotected by antidiscrimination laws. Regardless of whether fat discrimination reflects racial or ethnic animus, gender, disability, or socioeconomic bias, fat people don’t deserve to be called “Goodyear Blimp,”²²⁶ “Buddha,”²²⁷ or “Butterball.”²²⁸ Whatever the etiology of workers’ obesity or morbid obesity, they do not deserve to be excluded through disingenuous, paternalistic, safety-based justifications.²²⁹ They do not deserve to be

²²³ Kirkland, *supra* note 18, at 467.

²²⁴ Saguy, *supra* note 13, at 106 (citations omitted).

²²⁵ GUTHMAN, *supra* note 199, at 47:

[H]ealth has come to have such a positive value that it is simply unthinkable not to choose it. Some have argued that it is precisely the amorphous character of health that allows degrees of admonishment, surveillance, and control that would likely be considered utterly intrusive in other spheres of life.

Id. at 56-57.

²²⁶ *Motto v. Union City*, No. CIV. A. 95-5678, 1997 WL 816509, at *5 (D.N.J. Aug. 27, 1997).

²²⁷ *Bryant v. Troy Auto Parts Warehouse, Inc.*, No. IP 95-1654-C-D/F, 1997 WL 441288, at *1 (S.D. Ind. Apr. 25, 1997).

²²⁸ *Butterfield v. New York*, No. 96CIV.5144(BDP)LMS, 1998 WL 401533, at *6 (S.D.N.Y. July 15, 1998).

²²⁹ *See supra* Section (III)(C)(1)(ii).

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told to “get off your fat, fucking ass”²³⁰ or that their obese physique is an inherent disqualification.²³¹ Fat people need antidiscrimination protections now, with legislative advocacy and public campaigns to promote fat acceptance led by fat rights advocates. Then we can talk about the desirability or undesirability of environmental interventions and other public health leaders’ priorities.

²³⁰ Brief of Petitioner-Appellant at 7, *Lescoe v. Pa. Dep’t Corr.– SCI Frackville*, 464 Fed. Appx. 50 (3d Cir. 2012).

²³¹ *See supra* Section (III)(C)(1)(i).

APPENDIX

Table 4. Fat Legal Advocacy, Rights, and Education Project (FLARE) Opposition or Support for Environmental Interventions for Population Weight Loss

Environmental Intervention	Score²³²	Explanation (If Any)
Taxes on sugary drinks	0	Oppose because the way this is discussed stigmatizes fat people and may have a disproportionate impact on marginalized communities. FLARE supports positive campaigns about the non-weight-related benefits (health, environmental, etc.) of less processed foods.
Taxes on fatty/fast foods	0	Oppose because the way this is discussed stigmatizes fat people
A ban on advertising/marketing sugary drinks, fatty/fast food	0	Oppose because the way this is discussed stigmatizes fat people. FLARE supports positive campaigns about the non-weight-related benefits (health,

²³² The score ranges from 0 to 10. 0 being strongly opposed and 10 being strongly supported.

		environmental, etc.) of less processed foods.
A ban on advertising/marketing sugary drinks, fatty/fast food to children	0	Oppose because the way this is discussed stigmatizes fat people. FLARE supports positive campaigns about the non-weight-related benefits (health, environmental, etc.) of less processed foods.
Vending machine restrictions in school	0	Oppose because the way this is discussed stigmatizes fat children and exerts counter-productive control. We want to provide children with options. We would support an intervention that requires vending machines providers to also provide access to whole, fresh foods at comparable prices and quality. This enables students to freely choose whether they want a candy bar or an apple.
Nutrition education in school	0	Oppose because the way this is discussed tends to stigmatize fat people. Would

		support a HAES-based education program that is designed to be inclusive, anti-racist, and non-stigmatizing.
Increasing access to local, healthy foods through farm to school programs	10	Yes, support as long as the programs are designed to be inclusive, anti-racist, and non-stigmatizing.
Requiring water or milk as the default drink in children's fast-food meal deals	0	Oppose because the way this is discussed tends to stigmatize fat people. Also oppose because more people of certain racial/ethnic minority backgrounds are unable to digest milk (and may not even realize that), therefore it is a very poor choice for a required or default beverage.
Traffic light labelling (e.g., red for unhealthy food)	0	How are you defining unhealthy food? Sounds like this would be another totally stigmatizing approach, however FLARE has HUGE concern here that the question itself as worded is stigmatizing and

		unclear. Different foods are unhealthy for different people based on individual characteristics - peanut butter is unhealthy for someone with a peanut allergy. High salt foods are unhealthy for people with salt sensitivity.
Calorie amounts on menus of chain restaurants	5	FLARE is neutral on this provided other nutritional information is also provided including all ingredients.
A maximum limit on salt levels in pre-packaged foods	5	Would need more information about this.
Zoning to restrict the number and location of fast-food restaurants	0	Oppose because the way this is discussed stigmatizes fat people and because fast-food restaurants may be the only food options in some communities. We would support a zoning intervention that balances the number of fast-food restaurants with whole, fresh food establishments at equivalent prices. This prevents the development of racist “food deserts”

		and helps marginalized communities maintain access to fresh, affordable, convenient food.
Zoning to restrict the number of fast-food restaurants near schools	0	Oppose because the way this is discussed stigmatizes fat children and because fast-food restaurants may be the only food options for some students. We would support a zoning intervention that balances the number of fast-food restaurants with whole, fresh food establishments at equivalent prices. This prevents the development of racist “food deserts” and helps marginalized communities maintain access to fresh, affordable, convenient food.
Subsidies to reduce the price of fresh fruit and vegetables	10	Yes!
Improving food quality (e.g., less sugar)	Can't Answer	We are fully in favor of improving food quality, however it seems that you are making assumptions about “good” and “bad” food quality

		<p>that relate to stereotypes about fat people and/or weight gain/loss. If by “improving quality” you are talking about fresh ingredients rather than processed, we would support. If you are talking about sugar because you think sugar is inherently bad and makes people fat, we do not share your assumptions.</p>
<p>Promoting regional and seasonal foods</p>	<p>10</p>	<p>Yes, we support access to local foods, as long as this is accomplished in a way that promotes racial and socioeconomic equity. If only affluent neighborhoods receive regional foods of one quality, whereas poorer neighborhoods receive a lesser selection, we would oppose that. It is very easy for environmental racism to become embedded in these kinds of programs. Trucking may be</p>

		needed to counteract the effects of existing environmental racism.
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