



“Fat broken arm syndrome”: Negotiating risk, stigma, and weight bias in LGBTQ healthcare

Emily Allen Paine

HIV Center for Clinical and Behavioral Studies, Division of Gender, Sexuality, and Health, Columbia University and New York State Psychiatric Institute, 722 W 168th Street, Office R342, New York, NY, 10032, USA

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ABSTRACT

In the U.S., the weight of LGBTQ people—and sexual minority women in particular—is a key focus for those addressing sexual and gender minority health disparities. Sociomedical stigma related to both fat and sexuality, however, complicates patient-provider perceptions and discussions about weight and health. I analyzed data from interviews with LGBTQ patients, healthcare employees, and observations at a LGBTQ healthcare organization to reveal how weight bias becomes a barrier to care for LBQ cisgender women, transgender men, and nonbinary people assigned female. Understood by patients as similar to “trans broken arm syndrome,”—wherein providers attribute health concerns of trans people to minority gender identities and gender affirming care—patients report “fat broken arm syndrome,” wherein providers are perceived to attribute patient health concerns to weight. Patients interpret weight bias as intersectional stigma—related to multiple marginalized identities and embodiments—that puts their health at risk. Healthcare professionals make sense of risk, however, through competing fat frames. Although patient narratives suggest the promise of utilizing stigma-reduction approaches, many providers—typically those who do not share patient standpoints—emphasize the importance of framing fat as an urgent health risk in order to “do no harm.” This case advances knowledge by demonstrating the relational process through which interventions designed to ameliorate health disparities may inadvertently discourage marginalized, “at-risk” patients from healthcare access and adherence.

Over the past two decades, amid alarm raised by scientific and media actors about the obesity epidemic in the U.S., measuring the body mass indexes (BMIs) of individuals within and across populations has become increasingly commonplace within public health research. During this same period, research on LGBTQ health has boomed; the National Institutes of Health designated sexual and gender minorities (those who do not identify as straight and/or cisgender) a health disparity population in 2016, introducing new research funding opportunities. These trends converge in studies of the weight of LGBTQ people. A commonly cited component of the lesbian health disadvantage, for example, is that lesbian and bisexual cisgender (non-transgender, hereafter cis) women have higher BMIs compared to straight cis women (Eliason et al., 2015; McPhail and Bombak 2015).

Simultaneously, the 2010 passage of the Patient Protection and Affordable Care Act (ACA) transformed the institution of healthcare in the U.S. Above and beyond providing health insurance coverage to millions, the ACA sought to address inefficiencies in the U.S. healthcare system. Although capitalist ideologies suggested that the dominant fee-for-service healthcare delivery model would result in competitive prices

for consumers, the U.S. pays far more for healthcare than other wealthy nations—and yet Americans remain in worse health (Avendano and Kawachi 2014). Proponents of value-based delivery models argue that population health will improve and healthcare costs will decline only after the provision of efficient, high-quality—not quantity—care has been financially incentivized, for example, through the creation of accountable care models that offer monetary rewards to organizations that meet established quality goals (DeVore and Champion, 2011; Porter and Teisberg 2006; for more on the ACA, see Blumenthal et al., 2015).

Reforming healthcare delivery has required significant changes to allow “health” to be measured and compared, including: the delineation of populations; quantifiable measures of health that can be compared across groups; and innovative health information technology systems capable of capturing such measures (Cruz, 2017; Epstein 2007; Majmudar et al., 2015). As key components of the larger shift toward quantifying and standardizing health and medicine, policy interventions have also redefined the roles of patients, providers, and other healthcare actors (Franz et al., 2016; Timmermans and Epstein 2010). Some of these changes have fomented perceived divisions between medical

E-mail address: ep2982@columbia.edu.

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practitioners and administrators and meet resistance from practitioners when, for example, quantifiable quality goals—such as routine smoking cessation and BMI counseling—are interpreted to be irrelevant external factors encroaching upon provider discretion in healthcare (Cain 2019; Mechanic and McAlpine 2010). Efforts toward digitally standardizing care quality may also conflict with parallel movements constructing patients as consumers and promoting patient-centered practices (Franz et al., 2016; Timmermans and Oh 2010).

The tensions characterizing broader shifts in healthcare delivery crystallize in the case of fat, or obesity. While some social scientists work to determine population rates and the risks associated with fat, others examine the construction of fatness as a social problem in the U.S. (Greenhalgh 2015; Kwan and Graves 2013; Saguy 2013). Studies reveal how media actors in particular have translated and amplified medical research by constructing a moral framework in which individual-level choices are blamed for the society-level pattern of increasing BMIs, and fat is conflated with disease (Kwan 2009; Saguy and Almeling, 2008). Belief that rampant moral depravity—rather than systemic factors—is the cause of the “obesity epidemic” fuels the widespread belief that it is one’s civic duty, as “virtuous biocitizens” (Greenhalgh 2015), to shame fat people into making better, “healthier” choices (Bombak 2014; Kwan and Trautner 2011; Puhl and Heuer, 2010; Rail et al., 2010). Fat people are stigmatized (Goffman [1963] [1963] 1986), or discredited and conceptualized as deviant, and non-fat people are framed to be morally superior.

In addition to advancing knowledge on LGBTQ health and healthcare, research on how weight stigma is shaping the experiences of minorities speaks to the interests of both camps of scholars: those interested in the social construction and consequences of the obesity epidemic, and those working to determine how people who are categorized as overweight or obese face barriers to health and well-being. We now know that weight stigma experienced across social settings disadvantages the health of fat people through a variety of pathways, including perceptions of weight bias in health settings (Phelan et al., 2015; Puhl and Heuer, 2010; Tomiyama et al., 2018). Discrimination resulting from weight bias is linked to increased stress within, avoidance of, and poorer quality healthcare (Mensing et al., 2018; Tomiyama et al., 2018). In short, moral panic about weight—underpinned by medical discourse about the risks associated with high BMI, filtered through the clinical gaze as well as popular media—is argued to undermine the health of fat people (Bombak et al., 2016; Foucault, 1973; Murray 2007; Rail et al., 2010).

A growing body of research takes an intersectional approach to examining how anti-fat stigma is constructed and experienced in relation with other spheres of systematic oppression (Pausé et al., 2016; Smith 2019). Strings, for example, frames obesity-related discourse about black women as a continuation of the long, racialized colonial practice of stigmatizing black women (2019). Analyses of public health discourse about “lesbian obesity” argue that groups marginalized along multiple axes experience a form of weight stigma specific to and rooted in additional stigmatized identities (McPhail and Bombak, 2015). Although some studies find that alternative ideal body images in queer subcultures can help buffer stress from weight stigma (Edmonds and Zieff, 2015; Taylor 2018), other studies find that weight may be more stigmatized for sexual minorities compared to their straight counterparts, particularly among older cohorts (Ingraham, 2019; Paine et al. 2019). These studies share a common goal of contextualizing the impact of fat discourses in light of one’s position in relation to multiple systems of oppression (Cho et al. 2013). Their goals overlap with those of public health scholars in that they seek to understand and therefore learn how to best disrupt the reproduction of inequality through social processes.

This study advances these conversations by revealing how different fat frames, deployed in a post-ACA care delivery landscape, are shaping the healthcare experiences of diverse LGBTQ people. By analyzing data from interviews with patients, their providers, and observations at a LGBTQ healthcare organization collected from 2014 through 2017,

findings also offer insight into how healthcare employees frame weight, risk, and stigma amid the larger shift toward quality-driven care in medicine. In doing so, this study bridges and extends literature and theory about fat frames and intersectional stigma, suggesting that medical-moral approaches commonly adopted by providers have become a form of minority stress that diminishes the health and well-being of LGBTQ people (Lick et al., 2013; McPhail and Bombak 2015)—and that to improve sexual and gender minority health, interventions must be foundationally informed by community health knowledge.

1. Methods

The theme of weight bias emerged from early inductive coding of interviews in a larger study of the healthcare experiences of multiply-marginalized LGBTQ people least likely to seek healthcare: lesbian, bisexual and queer cis (non-transgender) women (Everett and Mollborn 2014); transgender men (Grant et al., 2011); and nonbinary people assigned female at birth (those who identify as neither male nor female) (Cruz, 2014). With approval from the IRB at the University of Texas at Austin, I collected data from 2014 to 2017. The larger study was designed to investigate what happens within health settings to compel patients to continue or avoid seeking care. To do so, I interviewed 50 patients about their experiences across care contexts in a progressive urban area and conducted observation at a health center specialized for LGBTQ people (hereafter the Center) as well as interviews with 11 providers and 12 staff members (total study N = 73). Out of the 50 patient participants, 11 identified Black or African American, 5 as Black and multiracial or mixed race (3 white and 2 Native American), 3 as Latina/x/o and white, 2 as Latino, 2 as South Asian, 2 as South Asian and white, one as Latina and Asian, one as Asian and white, one as Native American and white, one as multiracial and 21 as white. All patients were ages 21 to 46. In order to protect the confidentiality of the Center and employees, I withhold details about the organization and demographic data about providers and staff, referring to employees using the pronoun “they.”

In total, one quarter of patient participants discussed how perceived discrimination, judgment, and other forms of stigma related to body size became barriers to care during interactions with a variety of healthcare providers (defined by participants), including medical doctors, psychiatrists, acupuncturists, and nurses. Instead of asking direct questions about perceived discrimination in health settings, I asked patients to describe positive, negative, memorable and recent healthcare interactions. If patients brought up the subject of weight, I asked probing questions to gain further insight into perceptions of weight stigma and how bias was understood to relate to patients’ conceptualizations of health, embodiment, and additional social identities. I took efforts to address how my embodied positionality as a white, visibly queer, gender nonconforming academic who does not identify as fat and has not been medically categorized as overweight shaped my conversations with participants (see Paine, 2018).

At the Center from 2016 to 2017, I generated field notes during and after observing waiting rooms, meetings, and work areas (I did not observe patient-provider interactions). During this period, I observed interdepartmental meetings in which conversations about addressing “sizeism,” including organizational approaches to measuring and discussing patient body size and weight, were debated and contested. This topic also commonly arose during informal conversations as well as in-depth interviews with employees; in other cases, I solicited employee thoughts about these discussions.

I coded and analyzed transcribed interviews and field notes in the qualitative coding program MAXQDA, but no program codes were used. Instead, I used the program to assist in organization of data and the process of constructing themes and subthemes emerging from data. I took an abductive analytic approach, which emphasizes the importance of analyzing emergent themes and phenomena against a backdrop of

extant literature and theory in order to best assess how new findings can build off of, relate and contribute to urgent gaps in knowledge (Timmermans and Tavory 2012).

2. Findings

2.1. “Fat broken arm syndrome”

The problem is, you’re overweight While relaying detailed accounts of healthcare encounters, patients described how providers confronted their weight during appointments for preventative primary care check-ups, holistic healthcare, counseling sessions with therapists and psychiatrists, and care for acute illness or injuries. Patients, who typically preferred the term “fat” over “overweight” or “obese” (which were overwhelmingly deemed stigmatizing), relayed signals and cues they interpreted to indicate provider bias against fatness, typically referred to as sizeism or fatphobia. Patients encountering these cues questioned providers’ abilities and investment in supporting their health. When discerning practitioner beliefs and intentions, patients were not only concerned with avoiding stress associated with confronting weight stigma; patients emphasized fear of misdiagnoses, and spoke of incidents wherein they believed their or their friends’ health concerns were ignored because providers could not see past the “problem” of weight. Therefore, patients understood their ability to ascertain a provider’s attitude toward fat as necessary to diminish health risks resulting from potential medical negligence.

For example, Amelia (white cis queer femme) went to see an acupuncturist covered by her insurance for knee pain. They were “maybe 3 or 4 min into intake, and she just told me, ‘You just need to lose weight.’ And I was like, well what am I seeing you for then? ... You know, it was just so bizarre and dismissive.” Patients interpret such interactions to indicate a provider’s belief that weight is more important than patient health concerns or “goals,” that patients do not understand their bodies, and that patients have not heard popular ideas about fatness and health. Patients framed the outlandishness of the latter assumption—that, during an era characterized by the obesity epidemic, anyone could be unaware of this basic social fact—to lead to them to believe providers wished to *shame* patients into weight loss. Amelia continued:

I do realize if I lost weight, I’d have less knee pain. I’m not oblivious to what’s going on with my body, but ... certain things are not directly related to being a fat person. And those health concerns should also be valid. For me as a fat person being in a doctor’s office, seeing at what point that gets brought up and to what extent and how far it gets pushed makes you wonder, sort of gauge the quality of care you might anticipate ... I have patellofemoral syndrome, is what I later found out ... which I can rectify with stretches ... So if it’s an immediate thing or someone’s pushing it a lot, you think ok, well then this person’s not going to see the larger picture of my health ... luckily I haven’t had any really misdiagnosed serious thing ... there’s stories of people, fat patients of course, who had cancer and they were told to lose weight but turns out something was really terribly wrong.

Here, Amelia emphasizes that her evaluation of whether or not a provider can support her health is informed by her knowledge that weight-distraction puts fat people at risk of misdiagnosis (Chrisler and Barney 2017; Phelan et al., 2015). That she feels lucky only her pain is deemed unimportant, rather than a more consequential health problem, points to broader community knowledge through which patients make sense of their health risks.

Patients therefore questioned the medical knowledge of providers who prioritized addressing weight over patients’ expressed health concerns, or who connected fat to health issues patients believed to be unrelated. Ray (white queer and genderqueer) sought care in a typical

health setting for lethargy and malaise that they suspected to result from hypothyroidism:

It was a straight male doctor ... and he said stuff that really made me upset. At that point I weighed 20 pounds less than I do now. I’ve been quote unquote overweight my whole life. Even when I’m like, thin, because like my body weighs a lot? I don’t know. So then I was seven pounds overweight and he said, “So it looks like you’re overweight and that might be causing ...” ... and he said “So the way you can lose weight is by exercising more and eating less.” And that’s what he wanted to talk about instead of this actual concern I had. It made me so upset I didn’t go back. Like dude, does this matter? ... At that point I was a pretty normal weight. Like why are you making this the issue? Plus I probably exercise more and eat less than you. You don’t even know my habits.

Ray explains that they were upset not only by the discordance between their own and the provider’s appraisals of their body and size, but because—as they detailed—their diet and exercise routine aligned with dominant, popular ideas of good health behaviors. Ray interpreted the doctor’s failure to assess health behaviors before deciding the “problem” was Ray’s weight as evidence that his clinical gaze was driven by a morally-informed, anti-fat bias (Foucault, 1973; Greenhalgh 2015; Murray, 2007; Rail et al., 2010)—which, in turn, precluded discussion of what may be impacting Ray’s health. They added, “after that experience I never went back for an actual check up,” and at the time of interview—years after this encounter—Ray had not received a diagnosis for their ongoing symptoms.

Similarly, Milo (South Asian American queer trans man) shared a medical experience of pre-diabetes he believed was treated “too aggressively when I was still on the borderline,” a medical decision he attributed to fatphobia. This occurred at a different LGBTQ health center, where he formerly worked:

I got prescribed Metformin when my labs came back and the nurse practitioner was basically like “Well, you know, you’re pretty borderline, you know, pre-diabetic so why don’t we just call it and start treating it.” I said, “Ok,” but then started to get really low blood sugars for the first time. I would get faint or dizzy, and since I had never experienced that before and we had never talked about it, I didn’t really know what was happening. So I kept on taking the meds and then by the time I’d brought that up, my body had already gotten used to it, I guess? ... I ended up having to be on an even higher dose ... Something didn’t feel quite right about the way that went down.

When I asked him to say more about what did not feel right, he referred to how, as an employee, he had witnessed the provider making “fat shame-y” comments “in the lunchroom about what people were eating.” He perceived her discussion about the health consequences of his weight to be alarmist, which generated further distrust. He continued:

It didn’t make me want to engage with that particular diagnosis very much. I remember her telling me when she prescribed me the Metformin, “Oh you know, your blood sugar will be great, and you might actually lose weight, it’s a great drug, it’s a miracle drug,” and I was like, ok. Yeah. I didn’t lose weight, I fainted a bunch instead. And the thing is that with the exception of my blood glucose stuff, the rest of my labs were fine, perfectly fine. I didn’t have high cholesterol, I didn’t have anything like that. My blood pressure was good, but [my blood sugar levels were the] thing she like, really harped on ... like, “You’re obese,” you know, with that sense of urgency in her voice, like she thought it was going to kill me tomorrow.

Milo’s narrative reveals the lingering ill-feeling that his provider’s orientation toward fat (or medical fat frame) led her to overestimate the risk that weight—and underestimate the risk that medical intervention—posed to Milo’s health, which negatively (and permanently)

influenced his care and health. His perception of his practitioner suggests she may have been driven by what Greenhalgh (2015) terms “biomyths—myths because they are part of cultural common sense and persist despite their contested status in the scientific community” such as the idea that high BMI is a disease warranting urgent medical intervention (p. 29). His experience further illustrates why participants believe provider weight bias puts their health at risk.

Darrel (Black nonbinary trans man) likened this phenomenon to “trans broken arm syndrome,” which is shorthand for incidents wherein trans people seek care for a health concern unrelated to gender, but providers dismiss the concern as a consequence of being trans. The name suggests a sardonically extreme scenario in which a trans person seeks care for a broken arm, and a provider evaluates the injury to result from being trans (or more specifically, assumed reception of gender affirming medication or surgery). After telling a story about having gastrointestinal bypass surgery suggested to him by his primary care provider “out of the blue,” Darrel said:

Everything is about being fat. I never got diagnosed with diabetes, because people always just chalked it up to me being fat. They were like, “Well, have you tried not being fat?” And so, you know, there are probably articles out there about trans broken arm syndrome as they call it—fat people have the same experience, if not amplified, depending on their level of fatness, etcetera. I’ve actually posted on social media, I’ll post those articles together, because I have a lot of fat friends, and I have a lot of trans friends, and I think sometimes people don’t look at the overlap.

The overlap here, as Darrel points out, is that both fat people and trans people are categorized as not credible, as morally and medically deviant (Paine 2018). After actually breaking an arm, Charlotte’s (white cis femme lesbian woman) recollection of a nurse asking to capture her weight illustrates how this scenario approaches reality: “They asked if I had insurance ... [and then] they asked me to get on a scale and I was like, ‘I mean my arm is broken ... maybe if my leg were broken and you needed to give me weight appropriate crutches but like, my arm is broken you don’t need to weigh me.’” Darrel’s theorizing also introduces another key theme that characterized patients’ narratives: the importance of the “overlap.”

Mutually constitutive identities: intersectional stigma Patients described their body size to be inseparable from queer or transness, and therefore patients interpreted provider attitudes toward size to indicate how well they do or do not understand minority sexual and gender identities and behaviors. In short, patients felt that providers stigmatized them not only as fat people, but also—for example—as lesbians, queer women, trans men, nonbinary people, and gender non-conforming women. Carolynn (white queer cis woman), for example, shared her experience at the Center, which she perceived to center mainstream gay men’s culture, including the ideal of muscularity and thinness (Edmonds and Zieff, 2015):

There’s this one gay male nurse who, any time he checks me in, weighs me. And I hate it more because he’s this gay man who’s very invested in his physical appearance. He’s quite thin. He’s very muscular. It’s clearly a thing for him. And I will say that I do have some shame around—I often do this thing where [I think to myself], “Carolynn, lesbians often are the most, are more physically”—this is actually how I think, so please don’t laugh [laughs]. But I’ll think, “Carolynn, lesbians on average are more physically active than heterosexual women, but lesbians, on average, are heavier.” And then I’m like, but why do I have to be a stereotype? I do this thing where I—if I put on weight, I’m like why do you have to be another fat lesbian?

Carolynn’s internalization of fat stigma, too, is intersectional—highlighting how medical framing of lesbian obesity infuses her experience (McPhail and Bombak 2015). She concluded by saying, “I

don’t want to validate a stereotype.”

For other patients who identified as “fat femmes,” being fat was conceptualized as a positive, reclaimed and central part of queer identities, akin to how “queer,” although historically derogatory, has been reclaimed by many LGBTQ people as a salient and positive identity marker. As Gabby (white nonbinary queer femme) said: “I strongly identify as fat, that’s really important to me, and it’s really important to the way I move through my daily life, and also in terms of health, that identity and my lived experience have sort of intersected with my healthcare in a pretty big way.” Ray similarly described their thought process after being told by their doctor that they were overweight; they said “it’s all tied in,” and if someone does not understand diversity in body size, they do not understand gender diversity:

I haven’t gone back cause they’re just going to tell me to go on a diet ... if people are that clueless ... that bodies come in different shapes and sizes and ... that people can have different—I feel like that’s part of being queer—like people have different bodies and by like criminalizing—it’s not criminalizing their body, but it’s pathologizing my body, pathologizing a part of my body that’s not illness. Being overweight isn’t an illness in itself at all ... sometimes it’s affiliated with blood sugar issues or whatever ... it’s not an illness in itself, okay? But I feel in medicine it’s considered like, this is a sickness ... instead of, you have a different body type than me.

Ray interprets the conflation of overweight with illness to indicate inability to recognize embodied diversity and therefore affirm queerness more broadly—a perspective that aligns with frames deployed by fat acceptance and body positive activists, who assert that fatness is a natural part of body diversity (Greenhalgh 2015; Saguy 2013). Patients commonly challenged medical fat frames as they made sense of care interactions (Kwan 2009), and were united in asserting that a provider could not determine the best course of action before ascertaining health behaviors, patient understandings of their bodies and weight, and health “goals.”

People I interviewed did not, however, describe the phenomenon of “fat broken arm syndrome” as racialized. For example, when I asked Patricia (African American queer and bisexual cis woman) whether she attributed negative healthcare experiences to racism or racial discrimination, she responded: “If I do experience any kind of uncomfortable interaction with a medical provider, it’s usually less to do with my race and more to do with probably my weight.” Participants of color did, however, intersectionally frame their broader health experiences. They understood, for example, eating disorders as connected to anxiety, depression and trauma that resulted from encounters with racism, sexism, homophobia and transphobia, and struggled to find healthcare that was both “trans competent and racially competent.”

Asking (the right) questions No patients suggested that providers refrain from asking about body size or weight. Instead, patients described the “right” questions to be those that establish trust as well as recognize and center patient embodied health knowledge, including experience gained from navigating the world as a fat person. Unanimously, patients wished providers would assume patient awareness of the dominant medical-moral perspective that fat is bad for you, and that exercise, eating, and surgery are potential paths to weight loss. Multiple patients mentioned struggling with eating disorders, and that hearing negative comments about their weight or routinely being weighed at the doctor’s office caused distress. In short, patients understood why providers felt the need to discuss their body size as part of healthcare, but felt affirmed and empowered when discussions were perceived to be patient-centered, free of assumptions, warranted, and often patient-driven.

For example, Patricia lived with a recurring eating disorder as well as PTSD and depression. She contrasted a negative experience with a specialist with a positive experience with her primary care provider at the Center. Patricia recalled the specialist told her to “lose weight and

come in see the nutritionist, and eat 1200 calories a day, and like—you see me? I love to eat.” Beyond the casualness and perceived impracticality of such advice, Patricia explained that this interaction was distressful in light of her fraught relationship to eating: “I think that was really nerve-wracking because, for me, there is no middle ground. I was afraid of slipping back into my eating disorder, and for me, counting calories is very dangerous, like danger zone, I don’t do it. So whenever people start to ask me to diet, I get really nervous.”

Patricia did not follow up with this provider. Her narrative demonstrates that she understands eating to have a multifaceted influence upon her particular experience of health. By issuing recommendations instead of asking questions, Patricia believed this provider missed an opportunity to gain insight into her experience and instead caused distress that became a barrier to adherence. Beyond the theme of disordered eating, including fear of relapse, many patients described concealing other health and bodily goals—such as the desire to become pregnant—after perceiving weight bias, in an effort to avoid further stigmatizing interactions. In sum, patient narratives suggest that provider weight bias, perceived as intersectional stigma, may erode health and well-being over time, contributing to the sexual and gender minority health disadvantage by causing acute distress, diminishing patient-provider communication, and reducing adherence and future care-seeking (Lick et al., 2013; McPhail and Bombak 2015; Paine 2018).

Patricia later shared an experience where she felt she and her relationship to health were understood and supported at the Center:

I have a weird blood sugar thing, and I saw [provider] and she said, “Okay this all sounds like diabetes. Last time you were here was like six months ago, you were pre-diabetic then, it’s possible that you could be full-blown diabetic, type 2 diabetes, we don’t know. We’ll have to wait for the test results to come back,” but, “It’s totally manageable, and these are the things ... you’ll wanna eat more of because then you’ll crave these things less.” And so that felt more doable than just saying, “You can’t drink soda ever again and you can’t do this and you can’t do this,” and it’s like ... she was very encouraging and I mean I went and I joined the gym.

Perhaps more important than having already established their patient-provider relationship, responding to a specific patient concern, framing diabetes as manageable, and suggesting positive actions, the provider next acknowledged that Patricia’s mental health was key to her overall health. Patricia continued:

One thing that she said to me was, “Yeah you know it seems overwhelming to have to have this restrictive diet when you aren’t”—cause I’m in between psychiatrists right now, I have to wait three months for my psychiatrist’s appointment ... basically, my depression is not really treated right now, efficiently at least. And she was like, “I get it, if your mental illness isn’t being treated and the one thing that gives you some solace is eating, or if that’s something you do when you’re stressed is eat, then yeah I get that taking that away from you seems really fucking scary.” And the fact that she acknowledged that, cause a lot of people are like, “Well just stop eating so much” ... Like, oh shit really? You know, but she understood, and that means the world, cause—you get it.

This encounter—emerging from the context of a trusted relationship with a provider who possessed a comprehensive view of Patricia’s health—left her feeling empowered and understood, rather than in fear of losing support, being judged or shamed, or at risk of worsening her mental health and feelings about her body and eating.

Similarly, Charlotte, who reported fear of many medical screenings, described how her primary care provider at the Center put her in control of the process of evaluating herself. Charlotte said that her provider did not initiate conversations about her weight, but supported her when she inquired about weight loss surgery by referring her to a specialist and suggesting different screenings they could complete in-house or together

first. Her provider put her in control of when and how she would proceed:

Her approach was, “Look, I’ll just put [the order] in here and whenever you’re feeling brave.” And that super worked for me. I feel like if she had pressed it and been a bully about it then I would have gotten really avoidant and not gone back. But giving me the freedom to do it when I felt comfortable doing it. And then I felt brave one day and I scheduled an appointment with her after so I could be like, “I did the thing!”

Others emphasized the importance of providers asking whether or not they wanted to talk about weight, as well as asking what eating and exercise habits they already had, and whether they have bodily and health goals they would like to discuss. Patients interpret such questions to acknowledge that they have complex relationships with their bodies that are informed by their comprehensive health experiences as well as larger cultural schemas related to fat, health, and identity. Providers who questioned (rather than assumed) and showed sensitivity to diverse and intersecting experiences and goals were interpreted to be trustworthy and likely to deliver care out of genuine concern for patient well-being, rather than moral-medical bias against fat. These narratives highlight the importance of patient-centered, stigma-reduction approaches to addressing health disparities, including the incorporation of body positive fat frames (Kwan and Graves 2013; Pausé et al., 2016; Saguy 2013).

2.2. “Do no harm”: framing risk and sensitivity as competing aims

Contesting risk and stigma Employees at the Center were divided about how to conceptualize and approach fat. Regardless of position, those who vocalized belief that the Center needed to prioritize implementing stigma-reduction protocols that did not inadvertently shame or discriminate against large patients typically identified—during meetings or private interviews—themselves, their partners, or their immediate family as currently or previously fat or “of size.” They considered a change in organizational attitudes toward fat to be necessary to protect cis women and transmasculine patients in particular, because they tend to have higher BMIs than cis men and trans women (see Eliason et al., 2015). These employees leveraged the organizational mission—to protect LGBTQ people from stigma they face in typical health settings—to argue for structural changes, such as putting larger chairs in the waiting rooms and ending the practice of weighing patients in hallways. They also asked for the creation of focus groups of patients who identify as fat or of size to learn about any other factors negatively impacting their experiences at the Center. This group of employees highlighted negative feedback gathered from patients and other LGBTQ community members, in addition to their own experiences navigating fatphobia across different contexts, to make the case for a patient-centered approach to weight. Employees argued that if the Center is able to deliver non-stigmatizing sexual health care for gay and trans patients who engage in stigmatized sexual behaviors deemed “risky,” then they can and should deliver non-stigmatizing care for patients with body sizes deemed “risky.”

Employees on the other side of the debate struggled to accept this logic. These employees did not, in my interviews and or in meetings and interactions I observed, identify as fat or of size. They used dominant medical fat frames, argued that the health risks associated with fat were too dangerous to write off in the name of sensitivity, and that failing to emphasize the importance of weight loss strategies to patients with high BMIs would harm patients’ health. Employees who disagreed with destigmatizing weight interventions sometimes objected in meetings, but—despite (non-fat people) being the visible majority, including within positions of power—largely acquiesced to the opposition. My observations corroborate Carolynn’s experience suggesting that organizational culture at the Center aligned with dominant cultural norms

that equate thinness and muscularity with health and achievement. For example, one employee, who also worked as a personal trainer, started an organization-specific hashtag so that employees could share and circulate exercise selfies. According to one employee, however, the selfies celebrated thinness and constructed fat loss (not exercise) to be a central goal. More generally, men embodying the thin and/or muscular body types idealized within mainstream gay culture were over-represented in patient-facing positions and in positions of authority at the Center.

Nonetheless, when a vocal minority of employees argued for shifting care protocol to protect patients from stigma related to size, those who disagreed largely refrained from debate that took place in interdepartmental meetings. In private interviews with me, a thin person at the time, they expressed that—although they knew they could not successfully counter arguments deployed within a stigma-reduction framework—they remained troubled and unconvinced. As one said, after sharing that an educator was hired to give a presentation to reduce sizeism and anti-fat bias among providers:

I have to say that there's this push that if we're going to support women, we need to not talk about weight. And not ever encourage people to lose weight, and I'm like, okay, but we have to first do no harm. And I would not even bring this up in a meeting ... but real talk: there're people in my life that are overweight, and I know that they are at greater risk for cancer, diabetes, heart disease. And I would like them to lose a little weight. That doesn't make me less of a feminist ... So I feel contradictory feelings about us moving in the direction of, let's not talk to people about how it would be good for their health to lose a little weight.

This view is emblematic of the concerns of other employees who disagreed with making changes to reduce stigma faced by patients of size. Here, fat is constructed to heighten risk of poor health, and weight loss is framed to lower risks—the medical fat frame. These employees adopt the role of Greenhalgh's virtuous biocitizen (2015), viewing the maintenance of not only their own, but also their loved ones' weight as their moral duty (2015). The idea that stigma-reducing, body positive approaches to fat is the best path to affirm marginalized groups is conflated with ending health-promotion conversations that include suggestions of weight loss and contested on this basis.

In sum, opposing views are underpinned by the motivation to affirm LGBTQ health, but this motivation is filtered through different frames of how to “do no harm.” They also both rely on personal and relational arguments, as well as opposing constructs of fatness and health. In private interviews, employees who promote body positive approaches to care emphasized their personal experiences—for example, a stranger criticizing the contents of their grocery cart; a mother denied knee replacement surgery “because all the doctors kept telling her she was too heavy”—when relaying beliefs that negative attitudes about fat inevitably shape interactions, with deleterious consequences for LGBTQ health and health-seeking in the long run. Employees promoting this frame did not equate weight with health. One shared:

As someone of size, I've experienced it in the medical world, where everything is made about weight ... I don't make it about [patient] weight. I try to talk about health. I'm like, “Okay, let's get the number, are you eating healthy, are you being active, you know, I care about that much more than what your weight is. I don't care about your weight ...” Forget the number ... And there's enough data to kind of support that, no one is going to say that being overweight is a healthy thing, but, they've definitely shown it's really about what your diet is, whether you're active, don't smoke, you know, those types of things much more than anything else.

For some employees who could not agree with the construct of fat as not necessarily unhealthy, experiences with patients had convinced them to shift toward a destigmatizing approach. One such employee

shared their attempt to reconcile both views:

We as a clinic as a whole would under-diagnose obesity ... But for example, being body positive and sensitive is one thing, but then the health outcomes with regard to obesity um, can sometimes kind of go—we might even avoid talking about it because we're being so sensitive and not really fully understanding how the person feels necessarily or what their motivation is or what their goals are.

This employee suggested a middle ground, which resonated with most patients' proposed ideal: asking patients what their feelings, motivations, and goals are, rather than refusing to broach the subject of weight or size. This person emphasized that it is necessary to both bring an empathetic awareness of how patients often “struggle” with fat-based stigma their “whole life,” as well as to evaluate your relationship and interaction with each patient individually in order to determine when is helpful or harmful to ask about weight and weight goals. This narrative aligns with extant themes—including those emphasized by patients—of patient-centered, patient-driven, individualistic and comprehensive approaches to care. Other employees connected queer and trans identity to embodiment to argue for sensitivity to the intersection of multiple axes of marginalization, similar to the theme of intersectional stigma expressed by patients.

2.3. Quality goals versus individual goals

Individualistic approaches to assessing patient relationships in order to diminish stigma also conflicted with the larger shift toward setting and meeting quantifiable quality goals. Routine BMI counseling as well as smoking cessation counseling were set as quality improvement goals and framed as “low hanging fruit,” compared to other quality goals that, to be met, required far more than a conversation. Many providers, however, challenged the meaningfulness of these measures. Providers were frustrated and mystified by the methods used to assess their rate of adherence to goals they interpreted to be “off the mark.” At the same time, employees were aware that failure to deliver and document quantifiable measures of care was evaluated as “underperformance” that put the organization at a disadvantage when competing for funding initiatives. Employees from different departments, tasked with different assessments of “quality,” often held opposing views of whether or not weight should be routinely addressed. These competing priorities emerged during interdepartmental meetings tasked with deciding how to move forward with efforts to address sizeism, at times engendering animosity between practitioners and administrators, and complicated the process of rolling out interventions.

3. Discussion

This study reveals the interactional process through which sexual minority cis women, nonbinary (recorded female) and transmasculine people perceive weight bias within healthcare interactions, and how such perceptions become barriers to meeting health needs, adherence, and seeking future care. Patients interpret their experiences in relation to community health knowledge, understanding provider bias to diminish care and put their health at risk. Patients perceive fat stigma as intersectional, wherein bias against fat is perceived to be bias against diverse gender and sexual identities and embodiments. This bolsters and extends studies arguing for an intersectional understanding of embodied experiences of discrimination in general, and in particular, LGBTQ people's interrelated conceptualizations of embodied categories of marginality (Chrisler and Barney 2017; Ingraham, 2019; McPhail and Bombak 2015; Strings 2019). These findings complicate the typical framework deployed in research on LGBTQ health disparities that homes in on how minority stress related to sexual identity contributes to, for example, sexual minority women's weight disadvantage (Eliason et al., 2015). Instead, findings encourage a shift in perspective by showing

how perceived anti-fat bias has *become* a minority stressor, which—over time—“get under the skin” and contribute to the sexual minority health disadvantage (Lick et al., 2013; McPhail and Bombak 2015). I posit that addressing weight bias—including structural barriers, such as “thin” chairs in waiting rooms, as well as interpersonal barriers, such as assumptions about patient health behaviors on the basis of appearance or weight—is therefore a necessary component to any effort to diminish stigma related to sexual and gender identity in healthcare.

Despite the documented negative impact of fat stigma on the health and well-being of fat people, moral-medical framing of fat as an urgent health risk resulting from poor individual choices has overwhelmingly prevailed over challenges from actors in both healthcare and fat-acceptance social movements (Bombak et al., 2016; Greenhalgh 2015; Phelan et al., 2015; Puhl and Heuer, 2010; Tomiyama et al., 2018). This study contributes insight into how healthcare providers and employees—at a Center tasked to deliver non-stigmatizing care to LGBTQ populations—contest different fat frames to determine care practices (Kwan and Graves 2013). Employee perceptions of how to discuss weight with multiply-marginalized patients illuminate areas for theoretical and clinical interventions. Some employees express alarm at the idea of making routine weighing and weight counseling optional—despite acceptance of an “opt-in” approach for the discussion and assessment of other health behaviors, such as sexual behaviors, understood to introduce health risks. Unlike employees who advocated for the implementation of destigmatizing practices, employees who expressed a medical-moral duty to counsel fat patients about the health risks associated with BMI typically did not share a standpoint with fat patients, or specialized knowledge of the bias faced while “navigating the world” as a fat person (see Collins 1991). Narratives suggest that the lack of shared standpoint may allow employees to maintain incorrect assumptions that 1) fat patients are ignorant about negative health outcomes associated with fat and 2) body positive approaches to care preclude any discussions about associations between health and weight.

Patients and advocates of stigma-reduction, however, did not ask providers to avoid conversations about weight. Instead, their experiences and in vivo theorizing map approaches to discussions about fat and health that take patient thoughts, goals, and feelings as starting-off points, which aligns with the patient-centered approach now the professed—if not always performed—best-practice in U.S. healthcare (see Timmermans et al., 2018). This process requires providers to be reflexive of assumptions that may result from their positions of embodied privilege within these conversations. Such tactics, however, are already in play at the Center, deployed within approaches to care for patients stigmatized by sexual and gender identities. As one employee said during a meeting: “I think we need to get providers on the same page with fat as they are with sexual behavior. Cause we’re pretty good with that.” Patients agree; these approaches can and should be deployed in order to affirm patients of size and avoid care practices that patients report trigger eating disorders, distrust, avoidance of care, and concealment of health goals.

Yet patient narratives further enhance the conversations taking place in this setting by demonstrating the intersectional nature of fat stigma. Such findings could help advance discussions among providers—across contexts—by reframing the nature of fat stigma as interdependent with sexual and gender minority, as well as racialized, stigma (see Strings 2019). Of note, participants did not describe provider weight bias as racialized. Future studies designed specifically to learn about weight bias as a form of intersectional stigma may produce different results; it is also possible that participants of color did not feel comfortable describing their racialized experiences with me, a white researcher. Additional research to further examine how racialization and racism may be shaping LGBTQ experiences of weight bias is warranted.

Although anti-fat moral and medical panic is not new, these narratives emerge out of a rapidly transforming post-ACA policy and delivery landscape. Employee practices are increasingly surveilled and regulated by additional non-medical employees tasked with measuring and

reporting care quality; measurement requires new categorizations to allow for quantification and comparison (Cruz, 2017). These findings show that, despite their intention to keep healthcare organizations accountable for providing high quality care to patients in general and health disparity populations in particular, such practices may undermine attempts to deliver patient-centered care and disproportionately negatively impact multiply-marginalized patients. This reinforces the position of scholars on medicalization and the pernicious—if unintended—consequences of classifying and recognizing minority populations (see Cruz, 2017; Epstein 2003; Epstein 2007; Foucault, 1973), as well as studies demonstrating the deleterious impact of weight bias with different populations (Greenhalgh 2015; Mensinger et al., 2018; Tomiyama et al., 2018). Given medicine’s forward march into quantification and surveillance of health and care further enabled by advances in technology and digital health infrastructures, this case ultimately demonstrates the importance of community actors—able to provide insight into how marginalized groups conceive of health, identity, risk and embodiment—in central roles determining the design and innovation of health assessment and care if such advances are to ameliorate rather than exacerbate health inequities.

Credit author statement

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