

Commentary

The ventilator and the vaccine: Necropolitics and fat in the Covid-19 pandemic

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During the Covid-19 pandemic, the fat body was caught up in complicated logics of life and death in the North American context, where “obesity” was regarded as an “underlying condition” for greater risk of severe disease and death from Covid. As such, bodies with high Body Mass Indexes (BMIs) were refused Intensive Care Unit (ICU) ventilator care in certain jurisdictions, which fat activists classified as eugenics. At the same time, in some jurisdictions, vaccination campaigns prioritized people with higher BMIs for scarcely available Covid vaccinations, also on the basis of fat bodies’ higher risk status for Covid death. This paper explores the seeming tension between two articulations of fat during the Covid pandemic, whereby fat bodies were simultaneously worthy of life and of death in the same moment. Using MBembe’s conceptualization of necropolitics, which draws out and expands upon Foucault’s notion of biopolitics, I argue that the two perspectives on fatness operated in tandem, within an overall temporal shift in classification of obesity: from that of a risk factor for eventual death to that of an emergent threat. Such a temporal shift, I argue, relied on well-worn eugenic patterns in Canada, through which “normative” white bodies were prioritized for life through a complex necropolitical practice by which fat bodies were both made live and let die.

Introduction

In March, 2020, as the world shut down due to the unfolding nightmare of Covid-19, I sat anxiously in my apartment texting a colleague. “Are you worried about all this?,” I asked them. “Are you scared of getting Covid?” “No,” they replied. “I don’t have asthma and I am not overweight so I’m not worried about getting sick.” I was dumbfounded. I was surprised that my colleague would say such a thing to an actual fat person. Also, I had yet to hear that fat had been dragged into Covid. But, of course it had been. That year, a discourse was soon to emerge that blamed fat people for increasing rates of Covid, with Bill Maher declaring on his HBO show: “Obesity was already killing us slowly. But you mix it with Covid and it kills you fast. . . . We can’t have body positivity be a third rail anymore. Political correctness can kill, I’ve seen it before. This issue is too fundamental to who lives and who dies...” (Maher July 31 2020).

As the pandemic unfolded, fatness continued to be caught up in Covid in confounding ways. On the one hand, rumblings began that fat people were being denied life-saving ventilators in Intensive Care Units (ICUs) in North America (Baker & Fink 2020, NAAFA 2020, Tidgwell & Shanouda 2023, Ward 2020). On the other hand, fat people over a certain BMI were prioritized for vaccination in Manitoba, the province in Canada in which I reside, and other provinces as well. In Manitoba and elsewhere in

Canada (Tidgwell & Shanouda 2023), these two events occurred at the same time as the vaccine was rare and sparsely available, and ICUs were inundated with patients even as priority populations were beginning to be vaccinated (NAAFA 2021). Were fat people expendable or not? Were fat people to live, or were we to die in this epidemic?

Drawing on Mbembe's (2019) theories of necropolitics, this paper attempts to think through the contradictions in the articulations of fatness during the height of the Covid-19 epidemic. I argue that during the pandemic fatness underwent a kind of temporal shift – from something, in Bill Maher's words, that would “kill slowly” as a chronic illness, to one that would “kill fast” as an emergent disease. Such a temporal shift, I will argue, relied on well-worn eugenic patterns in Canada, through which “normative” white bodies were prioritized for life through a complex biopolitical and necropolitical logics by which fat bodies were both made to live and let die.

Fat & Public Health Before and After

For over a century, as the historiography of fat has demonstrated (Erdman Farrell 2011, Mitchinson 2018, Stearns 2002), the fat body has been anathema to so-called “western” medicine and, later, Public Health. As a body “out of bounds” (Braziel & Lebesco 2001), the fat body not only pushes back against the white, cisgender, male, taut, able “normative” body that founds medical training and practice, but also confounds it. Not able to quite capture the complex and slippery ways in which bodies become sized in diverse ways – does a high fat diet cause “obesity”? Sedentary lifestyle? Natural set point? Epigenetic predisposition? – medical discourse has disciplined fatness through an ongoing and intense process of medicalization (McPhail & Mazur 2019). As a companion discipline to medicine, one which relies upon and contributes to medical epistemologies of health and disease, public health has towed the line regarding fatness and has re-enforced the pathologization of fat – for the most part (Alberga et al. 2018, Beausoleil & Ward 2009, Thille et al. 2017). While for a brief moment in the mid 2000s epidemiologists, some associated with the Centers for Disease Control (CDC), analyzed statistics showing larger bodies lived longer with certain types of disease (Flegal et al. 2005), this was indeed a brief moment. Overwhelmingly, public health cultivates an affect of loathing for fat people, and one of the major pillars of public health continues to be combating obesity (Thille et al. 2017).

During Covid, fatness was, as usual, classified by medicine and public health as a risk – but there was a new classification, too – it was now a “pre-existing” or “underlying” condition that could heighten the chances of “severe outcomes” from Covid (McPhail & Orsini 2021; Pausé et al. 2021). It is impossible to understate how little was known, systematically, about Covid in these days and, in particular, about the *specific* causality of the link between Covid and “obesity.” As O’Connell et al. argued in 2021: “the inaccuracy and harm that comes from assuming causality and homogeneity on the basis of BMI along must not be forgotten” (p. 144). In a way, then, and despite gaps in evidence, obesity during Covid was re-imagined and re-articulated. Pre-pandemic, obesity was understood as a chronic condition that some said was a precursor for disease, and some (for example Obesity Canada) said was a disease in itself. Very rarely, however, was obesity understood as a truly *emergent* problem, as it was during the peak of the epidemic. Certainly, obesity had, during the early 2000s, taken on a hue of crisis in the form of “the obesity epidemic” (Gard & Wright 2005). As such, it was mobilized within what Vincanne Adams, Michelle Murphy, and Adele Clarke (2009) have called the “anticipatory regime” of recent public health, in which discourses of risk and future (un)certainities generate affective responses that compel particular biopolitical projects and individualized health behaviours on the basis of what is likely to come. Within obesity epidemic discourse, western countries were threatened by an increasing wave of fat people who, due to increasingly available fast food and decreasing physical activity, were ostensibly about to crush health systems with their heart attacks, diabetes, and eventual deaths. As a 2016 report from the Canadian Senate opined: “There is an obesity crisis in this country. Canadians are paying for it with their wallets –

and with their lives” (Senate Canada 2016, p. iv). The obesity epidemic, however, always rested uncomfortably within a logic of crisis, as it continued to occupy the dubious category of “the eventual,” or even “the perhaps” or “the maybe.” Fatness was the body type which may or may not be a disease, which may or may not be a crisis, which may or may not be *in and of itself* causing illness and death (Bombak et al. 2019; see Ellisson et al. 2016, for Canadian context). At any rate, the urgency of the “obesity epidemic” petered out to such a degree that critical obesity scholar Michael Gard declared the “end of the obesity epidemic” as early as 2011, in a book of the same title (though perhaps that was a little bit too early for such a prediction, given the 2016 report of the Canadian Senate).

The Covid pandemic gave fatness a new caché and temporal meaning, as it was drawn into what was increasingly called the “battleground medicine” of the ICUs and Emergency Rooms (ERs) – the fragile “front line” against epidemic. Fatness was no longer a potentiality. Fatness was now life or death – not eventually or down the road due to diabetes or cardiovascular disease (CVD), but in the moment. Actually, fatness was not life or death. Fatness *was* death.

Fatness was not the only thing out of time in Covid-19, however. Public health also shifted temporalities. Scholars are just beginning to reckon with what happened to public health during Covid. In Canada, public health has always been comprised of two complementary yet sometimes disparate arms – one of containment and one of prevention. In post-war times, these two components had been slowly recalibrating, with fits and spurts, from one of epidemic containment to one of chronic illness prevention (McPhail 2017). Of course, there were moments in which epidemic containment was re-animated, such as during the SARS scare of the early-2000s (Ries 2006), or the outbreak of H1N1 in the mid-2000s (Spika & Butler-Jones 2009). Further, given the profound health inequities founding and resulting from programs and processes of colonial genocide, mechanics of containment were also racialized, as contaminated food and water, forced relocation, the starvation induced and deplorable housing in residential schools, and lack of appropriate healthcare have precipitated higher rates of contagious illnesses in Indigenous communities post WWII (Lux 2016, Mosby 2013).

In the main, though, public health in Canada was becoming a discipline of chronic illness prevention (McPhail 2017), as reflected in such documents as the Lalonde Report of 1974 and the Ottawa Charter for Health Promotion of 1986, both of which were celebrated internationally as seminal documents in the field of health promotion practice (Pederson et al. 2017). In addition, and following the Lalonde report, public health at national and provincial levels released campaigns encouraging the populace to adopt practices that would avoid chronic illness, and especially the “big two” that were beginning to emerge as most concerning to health researchers and government: CVD (particularly heart disease); and cancer (McPhail 2017). Within this project of prevention, a suite of “techniques of the self” (Foucault 1990a, b) became paramount which, in the burgeoning vocabulary of health promotion, came to be known as “personal health behaviours,” the juggernauts of which were diet and exercise (Rice 2007). As fat studies scholars such as Carla Rice (2007), Jenny Ellison (2020), Wendy Mitchinson (2018), and McPhail (2017) have previously shown, adiposity became a key component of biopedagogical public health and health promotion campaigns in Canada, accompanied by a complicated logics of measurement, as the varying BMI charts of insurance companies were streamlined into one classification of weight via the World Health Organization. This public health focus on body fat and the general shift towards chronic illness was, importantly, one of temporality, through which state agents could articulate Canada as a nation of “modernity” no longer haunted by the plagues of the past (McPhail 2017).

Discussions of fat temporality are not new. An entire issue of the journal *Fat Studies*, for example, has been dedicated to “fat time” wherein authors explore the “chronobiolitics” (McFarland et al. 2018) of the fat body. Drawing on concepts of “queer temporalities,” authors articulate “fat time” is an interruption to what Harvey (1999) has called the “time-space compression” of late colonial-capitalism orientated by linearity and progress:

The opposite of fat time is not thin time, but no time. No time is capitalist and lean in character. Unlike no time under capitalism, which shrinks, compresses, and staves off time, fat time offers

more. The tempo of fat temporality may be understood as swift and big because of its immediacy and dimensionality—it moves toward many places at once. It is an anticapitalist production of time akin to collective self-care—it recuperates and increases time by producing it now and later. Fat time makes fatness more knowable. It satisfies and celebrates time, space, and who and what exists within it. (Tidgwell et al. 2018, pp. 115-6)

Thus, while fatness offers up a possibility to embody time, or to “flesh it out,” perhaps, historically the discipline of public health has folded fatness into a (complicated) progressive timeline. In such a manner, places such as Indigenous communities, in which contagious illness remained due to violent health inequities, were comparatively articulated as what McClintock (1995) has called “atavistic spaces,” or out-of-time “backward” spaces. Yet at the same moment, the increasing growth of bodies imagined by public health, the medical establishment, and the popular media signified the downfall of modern life, where machines such as cars allowed bodies to move less, and mass production allowed food to become more available (McPhail 2017, Mitchenson 2019). As such, chronic health issues such as fatness adopted a strange schism in health discourse; on the one hand signifying death and social decay, on the other modernity and progress. Fatness, then, came to be a stand-in more generally for a bifurcated affect of un-ease which accompanies modernity more generally (Dummitt 2011).

Temporality, Fatness, Public Health, and Covid

Covid created a staggering re-calibration of public health in Canada, between the public health of the past and the one of the present, as containment once again became *the* project of public health. Judith Green has noted this with colleagues (2022), alluding in a distal fashion to the temporal displacement of Covid’s public health response: “[governments] have largely evoked behavioural techniques from bygone eras of contagion management and have relied heavily on border closings and quarantines as mitigation measures” (pp. 592-3). Green et al. continue:

During the COVID-19 pandemic, international and national responses have relied on traditional public health response modes, with the ‘public’ largely engaged as the passive recipients of interventions, and not as a set of active partners who bring valuable insights and interpretations. Publics not conforming or complying with governmental and institutional expectations have been seen as misinformed, ignorant of science, and as easy prey for ‘infodemics’ of fake news from social media. (p. 593)

It is uncomfortable to make an argument that is critical of public health measures during the Covid pandemic, as I am cognisant that such conversations may lend credence to primarily right-wing Covid conspiratorial and often anti-vaxx protests and arguments. Certainly, that is *not* my intent. However, as Green et al. are describing, here, it is crucial to attend to the lack of sociological thought or consideration during Covid measures – a lack that manifested as the exacerbation of social marginalizations, oppressions and articulations of power during and after Covid.

The experiences of queer communities provide an example of this. In Manitoba, where active cases in the latter half of 2020 were the highest per capita in Canada (Malone 2020), lockdown measures were severe and focussed primarily on the household (Manitoba 2021), mandating that Manitobans could not socialize beyond members of their immediate “household unit” (Geary 2020, Geary 2021). Such enforcement measures did not acknowledge non-normative kinship practices and queer configurations of intimate relations not confined to singular households due to homophobia or transphobia in families of origin (Bailey 2013, Blair

& Pukall 2015, Conrad 2014, Weston 1997). It is no surprise, then, that evidence is mounting demonstrating disparities in Covid-related mental health outcomes in queer communities (Trans PULSE Canada 2020; Egale & Innovative Research Group 2020). Thus, while public health measures were of course necessary and crucial to humanity's well-being during an unprecedented pandemic of an unknown and unpredictable virus for which there was no available vaccine, it seemed to those of us in marginalized communities (such as the queer community I describe and cite; see also Usher et al. 2023 regarding concerns about gender-based violence) that the sociality of these measures were not duly considered by those implementing them. Here, too, temporalities must be considered, as public health had to act quickly and nimbly during a time of emergency. At this historical moment in which I write, though, as most Covid rules have eased, the social sciences and humanities are crucial epistemes through which to comprehend what has just happened to public health and, more widely, what has just happened to us – the biocitizens that negotiated and continue to negotiate Covid. As Green et al. (2022) ask: “what can a critical social science and humanities perspective contribute in terms of rethinking how *varied publics* are constituted, mobilised, and acted-upon in public health policy and practice?” (p. 593, my emphasis).

Covid Publics: Fatness and Necropolitics

One such “public” that I would argue was “constituted, mobilized and acted-upon” during Covid were fat people who were drawn into a kind of an interstitial space between new public health and the public health of old. On one end, the anticipatory biopedagogies of diet and exercise integral to contemporary neo-liberal public health promotions were re-emphasized. The “quarantine 15” trended on social media platforms, as a people concerned about the closure of gyms and lockdown-induced stress eating worried about gaining weight during Covid (Pausé et al. 2021). Further, as Pausé, Parker, and Gray have argued, Covid re-invigorated public health anti-obesity campaigns that had been, prior to Covid, waning in the face of their abject failure. They state:

Governments on the defensive about the lack of pandemic preparedness and responding to the patterns of health disparity illuminated by COVID-19, have been quick to mobilise fatness as an underlying driver for vulnerability to COVID-19 and as an avoidable strain on health systems responding to the COVID-19 pandemic. ...As a result many of the core assumptions of the weight-based paradigm are being reproduced despite now ample evidence that they are ill-founded. These assumptions are starkly reflected in policy initiatives being proposed to tackle obesity in the context of COVID-19 that target individual's food choices and physical activity, along with proposals to reboot public funding for bariatric surgery programmes (Pausé et al. 2021, pp. 49-50).

Yet, while Pausé et al. argue that fatness continued to be articulated during Covid as a neo-liberal problem of poor health behaviours, it also, I argue, shifted backwards in time, pulled into the mechanisms of epidemic containment practiced by a public health of days gone by.

In *Necropolitics*, MBembe (2019) argues that modern colonial occupations, of which Canada is of course one, operate through a combination of “the disciplinary, the biopolitical, and the necropolitical (p. 80). MBembe maintains that Foucault's concept of biopower (Foucault 1990a), while critical to understanding contemporary modes of “making live and letting die,”

does not adequately capture the ways in which “letting die” are essential to modern forms of sovereignty. As such, MBembe (2019) explores the concept of necropolitics, which he defines as “cotemporary forms of subjugating life to the *power* of death” (p. 92). In his work, MBembe draws on Agamben’s concept of “states of exception,” wherein the sovereign, through a declaration of emergency, operates “outside the law” and shifts at least somewhat from the biopolitics of “letting live” to a complicated necropolitics of “letting die,” and, in fact, of killing. For MBembe, such “states of exception” are no longer the exception. He states: “Nearly everywhere the political order is re-constituting itself as a form of organization for death...” (Mbembe 2019, p. 7).

I argue that Covid was a state of exception – one in which the sovereignty of public health was dusted off, and the old epidemic control measures of the suspension of the freedoms of movement were enforced through fines and, in the case of houseless people, through arrest, which unevenly affected QTBIPOC (Queer, Trans, BIPOC) communities (Harrison 2020). This state of exception came with a *biopolitics* of *letting* the fat community *live* and the *necropolitics* of *making* fat people *die* were in constant conversation. The classification of fat bodies as “at risk” for more severe Covid symptoms, including death, continued to reproduce the anti-fat biopedagogies of health promotion, of encouraging the usual “healthy diet” and exercise regimes in order to reduce obesity at a population health level and thus Covid morbidity and mortality. This classification also laid the groundwork, perhaps more happily, for public health to do one thing it does best: vaccinate “at-risk” groups against contagious illness, through which “obese persons,” as defined differently according to province, were prioritized for early vaccination (Wharton 2021). This did not occur everywhere, but did in Manitoba, Alberta, and Ontario where people with a certain BMI (typically 40 and above; LeBel 2021) were eligible, though it is unclear how BMIs were specifically determined when people showed up to vaccine clinics (Wharton 2021).

Making Die: Eugenics and Fat

While fat people were “let live” through vaccination, they were also *made* to die – not just let die – within ERs and ICUs. It was in these spaces that an on-the-ground, eugenicist necropolitical hierarchy of who were most likely to survive Covid was considered and in some cases operationalized. MBembe articulates necropolitics as a political paradigm that occurs within racist nation-building projects of colonized and settler spaces. Canada is both of those, and Manitoba itself is a particularly intensified microcosm of ongoing and violent colonial regimens, given that it is the province in Canada with the highest number of Indigenous people, per capita (Statistics Canada 2022). The argument I am making, here, must thus be contextualized within this environment of colonial necropolitics and genocide, wherein eugenics have been practiced continually on the bodies of Indigenous people to prevent pregnancy and thus growth of Indigenous populations (Clarke 2021, Stote 2015). Less bluntly but no less insidiously, such eugenic logics have and continued to be levered in what has problematically been described as “softer” ways (Bashford & Levine 2010) through social “improvement” schemes whereby children have systemically been apprehended by state institutions and placed into residential schools, white families (known as the Sixties Scoop), and foster care (a current ongoing practice) (Truth and Reconciliation Commission of Canada 2015).

Within eugenic projects in Canada and elsewhere, the building of “racial fitness” and ideal whiteness have been a further aspect of white supremacist eugenicist schemes, whereby racialized and/or “less ideal” embodiments, often physical and cognitive disabilities, have attempted to be “bred out” of white populations either with explicit intent (McLaren 1990) or, as is most common now in Canada, with “unintentional” bio/necropolitical practices and protocols that operate tangentially to the State – by medicine, for example (Bashford 2010). I have argued elsewhere that fertility and reproductive care that discourage and prevent fat people from having children is part of this eugenics logic (Bombak & McPhail et al. 2016, McPhail et al. 2016). This is *not* to say that white fat people experience racism, because they certainly do not. It is to say, rather, that fatness as a body type has become a stigmatized physicality (Goffman 1963) that is actively “weeded out” from the “ideal” populace in sophisticated and subtle ways, which on the individual level will be experienced much differently given the confluence of other identities a person may inhabit; an Indigenous fat person in Canada would experience the Covid ICU much different, for example, than a white fat person given that a white person can at least leverage their white privilege and social capital to try to access care.

Eugenics and Covid

During the pandemic, people with marginalized bodies and identities watched in horror as state and medical actors in jurisdictions in Canada, the United States and elsewhere in the world began to formalize decisions about who would have access to the sparse number of ventilators on hand in hospitals (Harrison 2020, White & Lo 2020). Their decisions relied on old eugenicist standards of who were “more fit” for treatment and who were more likely to survive (Baker & Fink 2020). In Ontario, Canada, for example, the provincial government developed a “Medical Triage Protocol,” (Ontario 2020) which was ardently resisted – particularly by disability communities and the Ontario Human Rights Commission who objected specifically to the use of so-called “objective” medical tools that measured patients’ abilities to survive Covid either immediately or in the near future (AODA Alliance 2020). One such tool was the “Clinical Frailty Scale,” which the Accessibility for Ontarians with Disabilities Act (AODA) Alliance argued “present[ed] real and serious disability human rights concerns” (AODA Alliance 2020). Originally developed within the aging field by researchers at Dalhousie University, this scale measures bodies from “most” to “least” active, with “active” defined as being “fit” and as the ability to move one’s body without the assistance of various mobility devices used by many people with disabilities such as a wheelchair, walkers, and a cane (Rockwood et al. 2005; see graphic at Dalhousie University n.d.). The Clinical Frailty Scale is thus an edifying example of how a supposedly “objective” measurement deployed by medical practitioners is in fact a value-loaded system of evaluating bodies through norms of ability and physical activity, and also of colonialism and racism. As Tidgwell and Shanouda (2023) argue: “Fat, disabled, and ill people’s lives were at serious risk for care rationing, and systematic anti-Black and anti-Indigenous racism in medicine meant that fat, disabled, and ill Black and Indigenous people and people of colour were in even greater danger” (p. 265).

While BMI was not named within Ontario’s Clinical Triage Protocol, there was concern within the fat community that it would eventually be, given that the CDC had defined BMI of 25 and above as a “certain medical condition” associated with a higher risk of becoming “very

sick with COVID-19” (CDC 2023). Using this CDC classification, hospitals in the United States were already turning fat patients away from ICUs (Gardiner 2020), despite the facts that BMI had yet to be concretely linked to severe Covid outcomes as a stand-alone correlative (McPhail & Orsini 2021, Pausé et al. 2021), and despite the fact that usefulness of the BMI as a predictor for *any* health outcome has been highly critiqued not only by fat theorists but by obesity scientists and medical researchers (McAuley & Blair 2011, Nuttall 2015). Such concern was based upon the insight that the Clinical Frailty scale’s use of “fitness,” itself such a loaded term within the fat community (Ellison 2020, Rice 2007), and “activity levels” could be negatively applied to fat people. As stated on the fat activist website titled “Know Your Rights Guide to Surviving Covid-19 Triage Protocols for Fat Disabled People, Ontario Canada” (#NoBodyIsDisposable 2020): “...triage protocols... [exclude] certain patients – disabled, ill, older, fat, and people perceived to have *lower activity levels* – from treatments that offer the best chance of survival, even when a sick person is likely to benefit from that treatment, or will die without it” (emphasis mine).

The Clinical Triage Protocols were never enacted during the pandemic in Ontario in a formal sense, even though one wonders whether this was practiced by individual physicians on the ground. In Manitoba, such a protocol was never made public by government, however anecdotally there was concern within some Indigenous, disability, and fat activist circles that this was in the works or would show up eventually (personal communications with the author; also see Hansen 2020).

To be fair, I am, here, in discussing the necropolitics of Covid talking about what happened in medicine - ERs and ICUs - and not public health. However, public health laid the groundwork for these “battleground practices” through the very biopolitical projects and classifications of fat people as both “risky” and “at risk” as I have described above. I would argue that articulations of fat people as lazy, out-of-control, Cartesian Bodies (Lupton 2013) has served, over time, to de-humanize and animalize fat people and, as MBembe says about necropolitical acts, imagining targeted populations as “sub-human” allow those who cause their death to avoid both legal and affective responsibility. Interestingly, it is here, in the articulation of fat bodies as sub-human, that fat activists instinctually and rather nimbly honed their front-line work in Covid.

For example, the #NoBodyIsDisposable website encouraged potential Covid patients to “humanize themselves” to healthcare workers by preparing “connection kits” that “help providers connect with [fat and disabled people] as a human being worthy of life-saving treatment.” (#NoBodyIsDisposble 2020). They suggested: “Humanize yourself. Show pictures of your family. Share something unique about yourself. Do your best to connect and be seen as a person.” While public health and other government and medical actors were atavistically creating Covid’s “state of exception,” and implementing a number of measures to “make die,” it is heartening and I think simply important to recognize the animating demands of fat communities to “let live.” As Finn Gardiner (2020) wrote at the time:

We are people, not just BMI scores or diagnoses. I am not your cautionary tale. I am not your epidemic. Humane healthcare policy looks beyond actuarial tables and at the complex social, material, and medical realities in which we live. History will judge us by how our leaders handled the COVID-19 crisis. Medical practitioners are therefore faced with a moral dilemma: Do we embrace Social Darwinism, or do we embrace humanity?

Conclusion

Fat people during the first few months of Covid were caught in a terrifying and overwhelming moment of cultural conflict about their bodies. On one end, as I have demonstrated, fat bodies were prioritized for vaccination in some places, and recognized alongside People with Disabilities, Indigenous communities, and senior citizens as at-risk lives worthy of protecting. Yet, at times simultaneously, obese bodies were de-prioritized for life-saving ventilators in ERs and ICUs. This contradiction, I argue, was in part the result public emergency health acts which under-considered the sociality of Covid orders, as well as understandings of obesity – which are both located in cultural commentators such as Bill Maher and in public health documents such as the Senate Report on Obesity – as an embodiment for which fat people are themselves at fault by a lack of self-care. Covid-19, then, created a state of exception and a schism in time, in which contemporary biopolitics of obesity were confronted and confounded by the well-worn, eugenicist-based necropolitics of a brutal and blunt containment project of an older medico-public health regime. For fat people, this time travel was both oddly advantageous but also, less surprisingly, catastrophic, as projects designed to secure care and re-humanize fat bodies such as the #nobodyisdisposable demonstrated.

On a more personal, individualized level, I *felt* that schism in time sitting in my apartment during the first lockdown. Fat studies provides a robust critique of the science of obesity that equates fatness with ill health, as I alluded to at the beginning of this paper. I have always felt quite confident in that critique, having contributed to some of that research myself. But for the first time since discovering fat studies and fat politics I truly felt, deep in my bones, that my fat body was a real, true risk factor and might actually kill me. I heard the whispers of physicians and dietitians and Bill Maher and the public health colleague who texted me early on in the pandemic telling me that my fat was death, and suddenly those whispers became shouts. I thought: What if they were right all along? I myself had undergone a temporal shift. Back to that pre-fat studies time of shame, self-blame, disgust, but now an added component: a fear of my own fat. This is what it was like to live and embody fatness during the pandemic. Confusion. Fear. Self-hate; and others in the field have written of similar sentiments (O’Connell et al. 2021, Tidgwell & Sanouda 2023). This is what it is to have lived the delicate dance - between life and death. Between the vaccine and the ventilator.

Acknowledgments

I wish to thank my colleague at the University of Manitoba, Dr. Robert Lorway, for reviewing previous drafts of this paper, and for inspiring me to write it in the first place. A version of this paper was presented at the Congress for the Social Sciences and Humanities in 2023 at York University, Toronto.

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