Food Ease in the "Ozempic Era"

AS A BIOETHICIST AND philosopher who studies fatness, and a woman with an obese BMI, my life around food has been exploded on a professional level by the academic discourse around GLP-1 receptor agonists (GLP-1s), and on a personal level by doctors trying to prescribe me appetite suppressant drugs. Not once have doctors asked me about my desired relationship with food. I develop the concept of *food ease* to explain why this is a problem.

GLP-1s, originally developed to help treat diabetes and regulate blood sugar, are now being prescribed to "treat" obesity. GLP-1s create feelings of satiety and have a variety of negative side effects like gastroparesis (paralysis of the stomach), nausea, vomiting, diarrhea, and fatigue (Ghusn et al. 2022). Most people who take these drugs for weight loss lose between 5 percent and 15 percent of their body weight, with little evidence that weight loss can be sustained post-use (Rubino et al. 2021; Weiss et al. 2022). Those who take the dose required for weight loss report feeling a range of affects toward food, from disinterest to disgust. Jen Juul Holst, a physician who helped to develop these drugs, describes how users lose not only their appetite but also the pleasure of eating: "You don't eat through GLP-1 therapy because you've lost interest in food . . . once you've been on this for a year or two, life is so miserably boring that you can't stand it any longer and you have to go back to your old life" (Reynolds 2023).

Philosophers have critiqued these drugs on the grounds that they pathologize normal hunger, arguing that medicalizing eating "stigmatizes non-pathological thoughts and behaviors around food" which is especially bad for fat people, who face stigma for their eating practices (Ward 2024). Historically speaking, appetite suppressant drugs have not boded well for fat people. Take the weight loss cocktail "fen-phen" (fenfluramine/phentermine), which was prescribed to millions of fat patients in the 1990s before it was withdrawn because it causes pulmonary hypertension and heart valve problems (Mundy 2001; Johnson et al. 2004). Rachel Fox (2024: 29–59) critiques anti-obesity medical initiatives insofar as they form an *elimination assemblage* which targets a *way of being* (in this case, being fat) for elimination. In Fox's view, the problem with anti-obesity measures is that in attempting to eradicate obese embodiment from the world, they harm people—through pathologizing them, stigmatizing them, encouraging disordered eating, and so on. The "diet-industrial complex" has also been critiqued for its profit-seeking nature: there are frequently financial conflicts of interest between individuals spearheading anti-obesity initiatives and weight loss companies (Harrison 2021; Mollow 2016).[1]

People have different aims and values. Some value running marathons, while others value being parents. People then organize their lives around these priorities. Bioethicists articulate ethical principles a good doctor ought to consider when they interact with their patients (Beauchamp and Childress 2001; Rhodes 2020). Bioethicists tend to agree that when considering whether to offer a medical intervention, a good doctor thinks to themselves: What does my patient value? Physicians usually assume their patients value physical health. If a patient asks for weight loss drugs, a doctor will likely assume that their patient values losing weight. However, a good doctor should consider *more* than a drug's capacity to treat an illness. They should think about life from their patient's perspective, and the extent to which a proposed intervention is compatible with a patient's life constraints, goals, and values.

I argue that medical providers who prescribe GLP-1s ought to consider that their patient may value having an easy relationship with food. I'm calling this *food ease*. Food ease allows one's experience of the eating process (procuring food, cooking, consuming, ordering takeout, etc.) to exist as activities constitutive of a life well-lived without becoming objects of anxiety or obsession. Food ease is what someone experiences when they don't worry about their portion size when eating at a new restaurant, or when they order their favorite snack at the movie theater without thinking about whether they really "need" it. Ideally, food ease allows the objective facts about food (calories, nutrients) to fade into the background of experience while subjectively experiencing the goods (and bads)

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of self-making through eating. While perfect food ease is perhaps never attainable, the pursuit of food ease is something that can be valued (by me, for one).

How might considering food ease as valuable change the way that physicians prescribe GLP-1s for weight loss? Food ease can be undermined here in at least three ways.

First, GLP-1s can make eating and digesting unpleasant. In *Phenomenology of Illness*, Havi Carel (2016) describes how illness undermines one's ability to live without feeling unencumbered by one's body. Illness brings to the fore that your body is a *body* in all its fleshiness. When you're feeling unwell, many of your bodily goings-on are beyond your control: they happen *to* you rather than *because* of you. You experience your body as an object, something apart from *you*. When GLP-1s make you feel unwell, they undermine your ability to experience the ease you might usually experience through eating and can lead you to regret alimentary activities. Food becomes nauseating, and the body becomes a hurdle rather than a vehicle of the eating experience.

Second, GLP-1s can limit a person's opportunities to experience and cultivate food ease. Where before you identified as a foodie, now you've "lost interest" in food (Reynolds 2023). Where before you would look forward to going to Flushing because you love eating dumplings under the twinkling lights of your favorite New York street, now you stay in. GLP-1s not only undermine the frequency and quality of taste experiences but also deprive one of socially valuable experiences that some argue are constitutive of your very self (Bell and Valentine 2013). Annemarie Mol (2021) argues that we come to know the world, ourselves, and each other through food and eating.[2] Food-related experiences can turn us toward or away from places (Mol 2021: 67). They can be a means through which we strengthen social ties; for example, cooking food for your daughter might also nourish your parent-child relationship (Mol 2021: 63). Food can be a means through which we stake out our identities: as critics, investigators, cooks, or parents (Mol 2021: 65). Since GLP-1s suppress one's appetite, the drug alters the importance of food in one's life, subsequently robbing one of opportunities to pursue food ease. This can have unanticipated knock-on effects in one's wider life.

Third, GLP-1s can create a problematic dependency on a drug that, when withdrawn, can wreak further havoc on one's relationship with food. Data suggests "ongoing treatment" is necessary to reap the benefits of GLP-1s (Wilding et al. 2022). People who suddenly stop report an "insatiable hunger" and gain back weight lost (Camero 2024). Providers cannot ensure that the drug will always be available to or tolerated by patients, covered by insurance, or be medically indicated (for instance, GLP-1s have not been tested on pregnant people). Since stopping the drug can cause overpowering hunger, taking it risks undermining food ease in the long run.

Even if losing weight is valuable, food ease is also valuable. Doctors should be open to a patient valuing neither, one, or both of these things, and should consider how to provide care that balances patient's priorities appropriately. Indeed, it is possible that GLP-1s might sometimes help a patient cultivate food ease, especially for those who have disorders which make them obsess over or binge food. If medical providers consider food ease as one valuable priority of many, they can better help their patients make medical choices that align with their values: whether that means taking or abstaining from GLP-1s. To properly advance patient care, medical providers should thus consider their patients' relationship with their alimentary practices, habits, and preferences before they prescribe GLP-1s. Furthermore, the historical context of fat marginalization warns us to pay attention to these clinical encounters. When a drug is developed for use in one population, that population becomes more exposed to the side-effects of that intervention. In this case, fat patients are more likely to be deprived of food ease. Medical providers therefore also have reason to recognize food ease's potential importance and value out of a concern for justice.

NOTES

1. Thank you to the second anonymous reviewer for inviting me to expand on the historical and cultural significance of appetite suppressants in medical discourse, especially thinking about how this relates to fatphobia.

2. Thank you to the second anonymous reviewer for suggesting I look at Annemarie Mol's work in order to further explore the epistemological implications of GLP-1s.

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