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Abstract

People with gut issues are often constrained in the foods they are able to eat. The choices they are able to make about food, however, are shaped not merely by specific medical and dietary needs but also by social, relational, and environmental factors such as the presence of trusted and supportive others who take their needs seriously. Drawing on work in disability theory and relational autonomy, as well as interviews undertaken in summer 2019, the paper explores the ways that choices are enabled or undermined, and argues that these should be taken into account in work on the ethics and politics of food.

Keywords: food, health, gut, relational autonomy, disability theory

Work on the ethics and politics of food and eating often focuses on the merits of various choices, such as the food we should eat (local, imported, vegan, meat, processed, raw) and the form and manner in which we should eat it (eating out, staying home, preparing it oneself, having it prepared by others). In considering how we make our food choices, we might sometimes be faced with an apparent dilemma of focusing on either the individual agent's autonomy and responsibility, or the broader social, relational, and environmental structures and circumstances that might shape the agent's choices.[1] We can also perceive these as intertwined, as is done by feminist work on relational autonomy, which characterizes selves as relationally constituted and their autonomy as augmented or diminished through relational factors. Paying attention to how an agent's autonomy and broader social structures work together can help us consider how an agent might be supported in making choices about food that reflect their values, goals, and commitments.

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[1] For example, Beth Dixon (2018, 615) discusses a similar "false dichotomy" in how obesity discourse is framed: "Either individuals are unequivocally responsible for their condition of being obese or individuals are excused from moral accountability because their condition of obesity is owed primarily to external conditions, namely, the 'toxic' food environment, social institutions, public policy, the corporate food industry, or more fundamental unjust structural conditions."

It is also important, however, to note that the choices we make around food are affected by the condition and needs of our body. The body is not generally discussed as a component of relational autonomy, with some exceptions.[2] This might be because theorists assume the body to be identical with the agent. However, it is not uncommon for people to experience a sense of alienation from their bodies or, at least, to not always experience their bodies as fluidly exercising their will and agency in the world.[3]

This is readily apparent in the case of gut issues. I use this term very broadly to mean any experience of the gut where its normal functioning seems to have been disrupted in some way; as Drew Leder (1990, 38–39) notes, for the most part the workings of our viscera are outside of our experience. Gut issues present obstacles to agency: they interfere with our chosen plans while being largely outside of our conscious control.[4] Gut issues may have a variety of causes and be associated with different diagnoses: Crohn's, IBS, anxiety, and migraines are all examples of conditions that give rise to "gut issues." I use this vague term deliberately since I am more interested in the phenomenological quality of the gut being an *issue* for us than any particular biomedical diagnosis. Gut issues frequently lead to constraints on our food choices and can shape our attitude toward eating and food, particularly in the context of shared or public meals.

The worry motivating this paper is that given the way that society often treats anything related to health as solely an individual concern, it might be all too easy to

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[2] Examples of exceptions are Meyers (2004), Burrow (2009), and Mackenzie (2014). Tereza Hendl (2016) provides an overview of the resources that relational autonomy has for thinking about embodiment.

[3] Catriona Mackenzie (2009, 2014) discusses this with respect to agency and identity. Bodies do not always align with our conscious commitments. Feminist geographer Ann Bartos tells of a situation in which even though she had long since given up meat, she was on a fieldwork visit where her politics around locally raised food and feminist research led her to accept a meat dish from her hosts. As she writes, while the meal "seemed to represent [her] ideal food politics," her body—unprepared for animal meat—revolted, and she was quite ill all night (Bartos 2017, 155–56).

[4] As Leder (1990, 45) notes, "My corporeal depths disappear not only from perception but relative to my structure of will and action." He notes that some have been able to train their bodies to control some of their autonomic bodily functions (Leder 1990, 52–53). This paper does not examine that possibility but will focus on choices around food and diet as a means of mitigating gut symptoms. While one of the participants in the study that I discuss in this paper had success in regulating her gut with the use of yoga and deep breathing, a number of others did not have this success (even trying the same techniques). There is certainly no general ability to control our guts.

stop there: to note that some people experience constraints on their food choices due to a biomedical condition, and then suppose our theorizing about the ethics and politics of our food choices can simply bracket that out as an exception. For example, in a paper arguing against picky eating, Matthew Brown (2007, 202) argues that it is wrong not to eat something that has been served to you "unless you have a very good reason. It would be appropriate for someone who is lactose intolerant to politely refuse ice cream." No additional explanation is provided about what a "very good reason" might be, short of acknowledging a few pages later that one may have "moral, health, or safety reasons that lead you to avoid certain foods" (Brown 2007, 205). This assumes that our "very good reasons" are always clear-cut and not themselves shaped by context. For example, someone who knows that they might get judged as a "picky eater" might feel pressured to eat something that will cause gut discomfort or other symptoms, despite having "a very good reason"—those "very good reasons" are not always easily communicable or taken seriously, nor are they always safe to disclose.

As this paper will demonstrate, the constraints posed by gut issues are not simply biomedical in origin. If this were the case, then understanding the constraint would simply be a matter of understanding the underlying biomedical condition and how it is triggered or exacerbated by certain foods, and no more. Gut issues themselves, however, do not occur in isolation from social, relational, and environmental factors. In raising this point, I am following work within disability studies that argues that the experience of a disability is not solely due to the biomedical features of a person's impairment or illness but also due to the accessibility of their lived environment, the presence or absence of supports, the presence or absence of stigma, and so forth. Similarly, with regard to gut issues, while the biomedical condition plays a role, the experience of making food choices is highly affected by social, relational, and environmental factors. Factors like the presence or absence of trusted friends, reliable transit, or available bathrooms can affect the range of available and plausible food choices. Drawing attention to the importance of these factors helps to point to ways in which we could collectively respond and thus enable more possibilities for food choices.

If we want people to be able to make ethical choices with respect to their food, it makes sense to pay attention to the kinds of constraints they experience as well as what could mitigate those constraints. While there has been work on ways in which the environment affects food choices in general,[5] it does not seem to consider the kinds of constraints at play for people with gut issues. Existing work on food ethics

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[5] Megan Dean (2018) provides a useful overview of environmental and situationist models of eating agency.

does not generally consider constraints related to gut issues,[6] despite the fact that these issues affect agents' range of choice with respect to food, and despite the prevalence of gut issues (for example, 18% of Canadians have irritable bowel syndrome [IBS], a common source of gut issues).[7]

This paper will explore the context in which food choices are made by people with gut issues, in a way that recognizes the interplay between bodily experience and social, relational, and environmental factors. Without endorsing any particular ethical choices or requiring that health be the only or primary goal, I want to identify factors that support or diminish a person's ability to have meaningful options with respect to their food and eating practices. To do so, I make use of relational autonomy and disability theory.

The paper draws from semistructured interviews that I carried out in 2019 with twenty adults in Canada, the United States and the United Kingdom who identified as having "gut issues." The interviews concerned their experiences overall, as well as their ideas around how concepts of autonomy, vulnerability, and relational autonomy might reflect their experiences with their gut. Food and eating were not the specific focus of the project, but they were mentioned frequently. People's relationships to food were connected deeply with feelings of vulnerability and with both the achievement and the frustration of autonomy.

Relational Autonomy and Food Choices

Relational autonomy as an idea has been present for roughly three decades (Nedelsky 1989), and has had significant uptake within bioethics and public health ethics (e.g., Sherwin 1998; Ho 2008; Wardrope 2015; Sherwin and Stockdale 2017). As Mackenzie and Stoljar (2000, 4) note, it is not a unified theory but "an umbrella term, designating a range of related perspectives" with a focus on analyzing "the implications of the intersubjective and social dimensions of selfhood and identity for conceptions of individual autonomy and moral and political agency." The goal of this paper is not to argue for any particular version of relational autonomy,[8] but to make

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[6] Neither "gut," nor "gastrointestinal," nor any of the various gut disorders (such as IBS, Crohn's, or colitis) are mentioned in the indexes of the *Oxford Handbook of Food Ethics* or the *Routledge Handbook of Food Ethics*, either as their own headings or as subheadings under "health." On a related note, neither is "disability" listed, though one chapter by Moore and Del Biondo (2017, 23) mentions limitations imposed by parents upon the eating choices of young adults with learning disabilities.

[7] From Canadian Digestive Health Foundation (n.d.), citing Lovell and Ford (2012, 716).

[8] For the purpose of this paper, I am referring to relational autonomy fairly broadly; the overall argument of the paper, that we ought to collectively pay attention to the social, relational, and environmental factors contributing to gut issues in discussing

use of the insights gained from this general approach in order to draw attention to the social and relational dimension of our agency within food choices, and how those choices might reflect the values, goals, and commitments of people with gut issues.

Despite the fact that our practices and decisions around food have a self-evidently relational character, there has not been much attention given to the way in which we can use relational autonomy as a way of thinking through our food choices. On the one hand, research on food ethics and politics that has highlighted the relational aspects of food (such as Heldke 2012) has not generally taken up the concept of relational autonomy, despite being attentive to the ways in which food choices often express features of our identities, values, and commitments (e.g., Bailey 2007; Oyserman et al. 2014; Moore and Del Biondo 2017; Dean 2019).

Meanwhile, research on food ethics that has examined autonomy, such as investigating the enabling of consumer choices, has not generally looked at relationality but has retained an individualist conception of autonomy (e.g., Dieterle 2016). As Mary Rawlinson notes, with some exceptions, food ethics often “focuses narrowly on the ethics of individual choice or apparent conflicts between liberty and state paternalism” despite the fact that “individual choices occur in a specific culture of possibilities that makes healthy eating difficult or impossible. Centering food ethics on individual choice ignores the structural determinants of what and how we eat and defers the necessity of structural change” (Rawlinson and Ward 2017, 1). A relational autonomy approach is useful for recognizing the way in which our identities and our decision-making are intertwined with social, relational, and environmental factors.

Of course, the concept of autonomy has been heavily criticized within feminist philosophy and theory, as has its prevalence within bioethics. While work on relational autonomy attempts to address some of these concerns, one could nonetheless ask what is gained by continuing to use the term. Autonomy involves the self-determination of values, goals, and commitments. Being able to have some measure of authority over what we put into our mouths seems relevant to any concept of self-determination. Food choices are connected to ethical and religious choices, family and cultural traditions, and aspirations related to bodily capabilities (such as being an athlete). Food choice thus seems a key part of bodily autonomy.

My focus here is a conception of autonomy not as a bar or standard that people must achieve but as something to be cultivated. For Diana Meyers (2004, 69–70), autonomy involves self-discovery, self-definition, and self-direction. Autonomy is

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food choices, does not hinge on any specific account. I do think that taking the gut (and gut microbiome) seriously ultimately involves a highly relational ontology of the self and an account of autonomy that reflects it, but delineating and justifying that view requires a separate paper; I engage in some of this work elsewhere (see Dryden 2016). I thank one of the anonymous referees of this paper for raising this point.

cultivated through the acquisition of autonomy competency and the development of various agentic skills for navigating the world. These skills include not only our capacities for rational deliberation, but also our adeptness at social situations, our ability to maintain friendships, and our body's capacities for carrying out our goals (Meyers 2004, 57–62). Others around us can help contribute to that development, as well as detract from it. Work on autonomy also acknowledges the importance of self-trust (Govier 1993), which can be affected positively and negatively by our relations with others and by social norms and expectations. A deficiency or lack of ability in agentic skills or self-trust does not imply that an agent is not autonomous at all, but it implies that their autonomy is limited or hindered in some way. Rather than causing exclusion from advantages or privileges, the goal of this account as I take it up here is to identify the lack in order to mitigate it.[9] It is a way of examining the context of our decision-making, for the sake of understanding our food choices.

We can then ask cogent questions about how people are supported in being able to make and follow through on choices about the food they eat that reflect their own values and goals in the context of their gut issues. This is not just about, say, education about nutrition, food production, or animal welfare but also about—as the examples in this paper will demonstrate—normalizing gut talk, creating trusting social and relational contexts, and maintaining supportive environments.

Thinking of autonomy as self-determination leads us to ask what kind of self we are creating and furthering in and through our food choices. What possibilities are we opening up for improved awareness of our enmeshment in complex systems and for ensuing decisions about our food practices as well as broader social and political commitments? Framing this work in terms of relational autonomy does not cover over this complexity and interdependence but allows us to better respond to it.

A full exploration of relational autonomy when it comes to our food choices could also help us to think further about the relations that we develop with both human and nonhuman others (including gut microbes) through our eating practices (as per Heldke 2018). This paper, however, will focus specifically on the factors that

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[9] Serene Khader argues that relational autonomy accounts pose a problem insofar as they take autonomy to be diminished by oppression, since this can turn into a liability for oppressed agents: "If autonomy entitles one to having decision-making authority in one's own life, and if autonomy consists partly in access to morally desirable social conditions, oppressed individuals will have a lesser entitlement to making decisions about their own lives than the dominant do over theirs" (Khader 2020, 514–15). There is not space here to respond fully to this concern, but to clarify: I do not take the form and purpose of relational autonomy account I describe here to be quite the same as the socially constitutive conceptions of autonomy (SCA) that she describes; rather, I take myself to be using it in the broader sense Khader recognizes (506–7).

shape our food choices. These conditions involve the interaction of the physical condition of our body with our interpersonal relations with others around us, our social context, and the lived and built environment around us, as well as the interactions between these factors.

Disability Theory, Gut Issues, and Food Choices

Like relational autonomy, disability theory also directs our attention toward how social, relational, and environmental factors enable or undermine agency. Disability theorists have criticized what they term the "medical model" of disability, in which disability is a biomedical problem experienced by an individual, for which the relevant expertise is possessed by health-care professionals (Goodley 2017, 7). This is often perceived to be the default view, and the one emphasized in professional and administrative contexts.

In contrast to the medical model, a variety of alternatives have emerged that argue that "social, cultural, historical, economic, relational and political factors *disable* people" (Goodley 2017, 9). The social model of disability posits that *impairment* is an individual's embodied difference, and *disability* is then caused by society's exclusion and oppression of those with impairments. The proper focus of policy and activism, then, is to change society in order to eliminate that oppression (Goodley 2017, 11). Other theories, including other versions of the social model, have modified the distinction between impairment and disability, while nonetheless continuing to hold that "the problem of disability is located in inaccessible buildings, discriminatory attitudes, and ideological systems that attribute normalcy and deviance to particular minds and bodies" (Kafer 2013, 6). On Alison Kafer's political/relational model, medical intervention may be desired, but we should nonetheless recognize "that medical representations, diagnoses, and treatments of bodily variation are imbued with ideological biases about what constitutes normalcy and deviance" (Kafer 2013, 6). Shelley Tremain's Foucauldian model points out that since our conception of the body "has not been stable, not even over the last two centuries, nor have practices to observe, understand, manipulate, and control the body, nor subjective experiences of it, remained invariable" (Tremain 2015, 39), our understanding of disability should reflect this, and understand it as "historically and culturally relative and specific" (41). On her account, disability is "a historically contingent network of force relations in which everyone is implicated and entangled and in relation to which everyone occupies a position. That is, to be disabled or nondisabled is to occupy a certain subject position within the productive constraints of the apparatus of disability" (Tremain 2019, 145–46). With respect to gut issues, this means that it is not so much a question of whether a given gut issue "is" a disability or not, as a question of whether the person is positioned as disabled with respect to societal expectations—consider, for example, the strictures caused by workplaces with very tight regulations on bathroom breaks. Ableism works to disqualify certain bodies.

While there are significant disagreements amongst these models, they share a questioning of the assumptions that underlie judgments that disabilities are naturalized properties of an individual. The way we experience our bodies and make choices that affect it is significantly shaped by social and cultural norms and expectations and by the possibilities enabled by the accessibility (or lack thereof) in our world.

What does this mean for our food choices amidst the presence of gut issues? It means that we should be attentive to the framing of "gut issues" as an individual problem to be solved by medical expertise alone (though it does not mean rejecting medical expertise or treatment altogether). It means putting them into a social and political context.

Work on food and disability helps draw attention to this context. Elaine Gerber (2007, n.p.) points out that we should think about food and disability together in order "to think about ways in which the social construction of food and eating may create disabling conditions and/or maintain disability boundaries or, for that matter, help to reduce and eliminate disabling and stigmatizing conditions." Specifically, she notes that "the common so-called 'food-related' disorders: diabetes, Crohn's/IBD (Irritable Bowl Disorder), food allergies" cause significant financial and social disadvantage through the barriers they create for "the business lunch, to networking opportunities, to ritualized and religious events" (Gerber 2007). Disability scholars point our attention to the constraints on food experienced by disabled people, constraints which often have more to do with poverty and access issues than with the particulars of their impairments. As Kim Hall (2014, 88) points out, many of the expectations of "ethical" food consumers are not possible for many disabled people and people living in poverty. Further, Natasha Simpson (2017, 407) notes that while the food justice movement identifies access concerns with "proximity to food, affordability of food, and knowledge about food," additional access considerations occur for disabled people "such as experiencing social isolation and being homebound; inaccessibility of transportation options and inaccessibility of grocers; difficulties transporting groceries and preparing and cooking food." Both Simpson and Hall remind us that the constraints experienced by disabled people are political: "While these barriers are often framed as being a result of disabilities themselves, effectively depoliticizing disability, I would argue that they are all evidence of systematic oppression within society, in which myths of independence, expectations of economic productivity, and abledness are glorified" (Simpson 2017, 407).

In connecting food and disability, it is important to avoid treating food primarily as "medicine, prevention, and cure" (Hall 2014, 179). Simpson notes that in "references to 'diet-related' illness and disease," the mainstream food movement often implies that diabetes, hypertension, and heart disease can be cured through the right diet; as she notes, this attitude is shaming and fails to acknowledge "those for whom diet is not a primary cause of illness or disability, those who cannot be 'cured' by adopting a produce-rich diet, or those who don't desire to be cured to an abled standard" (Simpson 2017, 414). This should be understood in the context of the concerns that disability studies generally has about cure. Many writers have argued that charities and nondisabled people focus on the need for *cure*, whereas they are primarily concerned with accessibility and supports to help them live with their disability. As Eli Clare argues, the insistence on cure can work as an ideology that seeks to eliminate different kinds of bodies; toward the end of his book, he envisions "a world where many kinds of body-mind difference will be valued and no one eradicated; where comfort, pain, well-being, birth, and death all exist. Cure promises us so much, but it will never give us justice. In this world reconfigured, cure may not exist, but if it does, it will be only one tool among many" (Clare 2017, 184). Drawing on Foucault, Hall (2014, 184) notes that food practices have long been tied toward notions of bodily purity: "Self-improvement through eating 'appropriate' food is a practice of bodily purification and boundary maintenance and, as such, is a food practice oriented toward security against others who are perceived as threatening." She cautions that a focus on food as "cure" can intermingle with conceptions of purity, thus excluding disabled bodies.

Of course, for those with gut issues, food is tightly intertwined with health; for celiac disease, for example, a gluten-free diet is the only treatment (Bandini 2015, 1578). With regard to the food choices that people with gut issues make, the aim is not generally "cure" or purity but the mitigation of symptoms; the process often involves trial and error, and keeping track of their responses to various foods.[10]

Disability theory has a complex relationship with the concept of autonomy, given that it has often been used against disabled people. There is a concern that autonomy, if conceived of primarily as involving independence, can be exclusionary. While describing an alternative ideal, "a queer crip feminist conception of food and food justice," Kim Hall pushes against an individualized concept of autonomy, noting that:

> Good food, I contend, not only sustains life, it enables flourishing. Flourishing, as Chris Cuomo notes, is not an accomplishment of

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[10] The kind of mitigation being aimed for here is similar to the one described by Clare (2017, 53) when he describes messaging with someone with chronic pain who was having a "bad pain day": "Before I log off, I type a good night to you, wish you a little less pain for the morning. Later you thank me for not wishing you a pain-free day. You say, 'The question isn't whether I'm in pain but rather how much.'"

> autonomous, self-reliant individuals; real flourishing takes time and can be accomplished only with others (1998, 74). Flourishing, in other words, is made possible by our complex enmeshment in community with human and nonhuman others. A commitment to food justice requires critique of underlying assumptions that thwart flourishing of queer crip feminist lives and community. The goodness and desirability of food choices are inseparable from how we are positioned in and negotiate our communities and how ways of thinking about food and health can open and foreclose resistant possibilities. (Hall 2014, 178)

Hall (2014, 188) argues that "self-sufficiency is an illusion rooted in the able-bodied assumption of control over one's body and life." While there is not space here to enter into a full discussion of the meaning of autonomy for disability theory,[11] I note that work in relational autonomy argues that the concept of autonomy need not imply complete control over our bodies and lives, or self-reliant independence. I take the sense of relational autonomy I draw from Meyers and others to be compatible with interdependence and Hall's sense of flourishing amidst complex enmeshment. This paper aims to draw attention to the way that social, relational, and environmental contexts help "open and foreclose" possibilities for people with gut issues. It positions gut issues as a part of human living that we can collectively attend to and make space for, rather than denying or silencing, in a way that allows for food choices consonant with agents' values, goals, and commitments.

Interview Methodology[12]

This article draws on data that was collected as part of a larger study on the relationship between the experiences involved with gut issues and how autonomy and vulnerability are conceptualized. The study was approved by Mount Allison University's Research Ethics Board. In the summer of 2019, I conducted semistructured qualitative interviews with twenty people who responded to calls put out on Twitter and Facebook for adults who identified as having "gut issues."[13] Participants had a range of diagnoses and backgrounds. Participants were interviewed

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[11] A helpful discussion of individualist vs. relational autonomy approaches to ethics (in this case bioethics) within the context of disability is found in Ho (2018).

[12] Information about funding and conflict of interest disclosure is provided at the end of this article.

[13] The relevant section of the recruitment posts ran as follows: "If you are an adult & identify as having 'gut issues' (of any kind! Crohn's, colitis, anxiety that manifests in the gut, food intolerances, etc.!) & are willing to chat with me about your experiences, please let me know."

once, with interviews ranging from 35 minutes to two hours (most were approximately 45–60 minutes); in a couple of cases, participants emailed with follow-up points that they wanted to share after further reflection. Interviews were carried out online on Skype, Zoom, or Google Hangouts, as well as in person in my office, a cafe, or people's homes.

A written consent form was used and either returned by email or in person, depending on the circumstance; at the opening of the interview, I went through the form, and participants had the chance to ask questions and get any needed clarification about the purpose and goals of the study. Participants were asked whether or not they preferred to be referred to by pseudonyms, and I followed their preference. One participant who wanted her real name used explained specifically that she wanted it in order to recognize her agency. Some used pseudonyms in order to feel safe in saying whatever they wanted. Pseudonyms are indicated with an asterisk. Participants also provided the pronouns that they wanted me to use in referring to them.

Following discussion of the consent form, the first part of the interview itself concerned people's experiences. I asked them very generally about their experiences with their gut, and then followed up with questions about their experiences of diagnosis (or misdiagnosis); their encounters with medical professionals; their experiences with families, friends, and colleagues; their habits and regimens; and the kinds of images and metaphors they used to describe their relation to their guts. The second part of the interviews invited them to explore what "autonomy" and "vulnerability" meant to them, both in general and specifically with regard to their gut experiences. Then I would briefly explain the concept of relational autonomy and invite them to consider whether it was something that would fit any of their experiences, whether good or bad.

Interviews were recorded and transcribed verbatim. The transcripts were analyzed and the data coded with the use of Dedoose software, in order to explore themes and cross-participant comparisons. Transcripts were shared with participants who had requested them. An earlier version of this article, delivered as a conference paper, was shared with all participants. The purpose of the study itself was exploratory, to get a sense of the kinds of experiences and priorities people with gut issues might have; similarly, the goal of this article is primarily to draw attention to experiences of people with gut issues that have been overlooked in discussions of food ethics and to encourage further exploration.

Experiences around Gut Issues, Food, and Agency

A simple account of how constraints on food choices caused by gut issues affect food choices would state that gut issues often limit the range of acceptable foods. This simple account is complicated significantly once we begin to explore the ways in which those constraints are shaped by relational, social, and environmental factors.[14]

Food choices can be complex on their own. For most people with gut issues, certain foods will pose more of a problem than others. Sometimes this will be readily apparent (eating a certain food will regularly cause a negative reaction), and sometimes the limitation on food will be part of a diagnostic or treatment plan.[15] For example, people with IBS might try a very strict version of a low-FODMAP diet for a period of time and then gradually reintroduce certain foods in order to determine which trigger their IBS symptoms.[16] Foods that trigger symptoms can often be unpredictable and hard to pin down. Unlike a vegetarian or vegan who can establish a generally accurate set of acceptable foods (barring the odd surprise unlabeled ingredient, or other such mishaps), it's not always clear exactly which foods will cause discomfort or pain. This uncertainty is itself frustrating. The restriction on food can also be a source of frustration, particularly as eating is often described as one of the pleasures of life. As Leah* said, "My therapist is really great, and he's like, 'Let's think about why you're angry . . .' and I'm like, 'It's because I can't eat anything!'"

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[14] By relational, I refer to interpersonal relationships with those people immediately around us. By social, I mean the broader norms and expectations of society and culture. By environmental, I mean the features of the lived and built environment, including infrastructure. These are not necessarily sharply demarcated—the efforts of others around us can make a difference to the accessibility of a built space, such as when a friend with a car enables us to bypass public transit—but are useful to separate out in order to explore their relevance to gut issues.

[15] Note, however, that food is usually not the only aspect of someone's treatment plan. As the writer of a blog post explains, "No amount of 'healthy food' would fix my diseased intestines. You know what did help? Actual medical care—surgery and medications" (Sarah 2014). However, for this writer, some foods do trigger symptoms, and so avoiding those foods would be important to overall well-being (ironically some of these are "traditional 'health' foods, like salads or fiber-rich vegetables" (Sarah 2014).

[16] The FODMAP diet, intended for people with IBS, involves three steps in order to help identify which foods are most likely to trigger IBS symptoms. First people engage in a diet low in FODMAP foods (foods low in a particular group of short-chain carbohydrates that can be hard for the small intestine to absorb: fermentable oligosaccharides, disaccharides, monosaccharides, and polyols). Then they gradually reintroduce foods to monitor their tolerance. Finally they achieve "a balance between tolerated FODMAP-rich foods and the avoidance of others" (Monash University 2019).

This feeling does not occur in a vacuum but in a social and relational context with expectations around appropriate food and eating practices. The pressures these expectations cause are often taken for granted. Eating is often connected with social occasions: family gatherings, workplace events, and dates often center around food. A number of participants reported that these occasions were fraught. Tara* put this bluntly:

> How many times do you hear like, "Everyone loves to get together and share a meal," or "Getting together and sharing a meal is how we show we love each other." [. . .] that is never questioned [. . .]. And it can't just be the handful of us who are like, "Getting together and sharing a meal is terrifying, and the fact that you want me to do that is [. . .] it's emotional work, it's not paid—but it's about me performing gratitude so you feel good that you did something for me, rather than actually doing something for me."[17]

This echoes Matthew Brown's (2007, 202) statement that "meals are a universal social event, and their gravitas is nearly ubiquitous." His argument against picky eating claims that it creates harms to others by inconveniencing them and by cutting the eater off from shared experiences with others (201–2). As he writes, "When trying to coordinate meals with other people, whether you are going out or cooking together, a picky eater constrains the choices and makes the decision that much more difficult" (201).[18] Whether or not people with gut issues might be recognized by Brown to have a valid reason, the kind of attitude he expresses creates significant pressure. As Nathan* says, referring to a group of family friends:

> I am less comfortable in, in our own family group [laughs] than when I could eat everything. I have noticed that my anxieties that way has, has picked up since I can't just gorge on whatever anybody's eating. And I feel like an asshole, because people are like, "Oh, we're making

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[17] Throughout this paper, unbracketed ellipses indicate pauses; all bracketed ellipses indicate my omissions from quoted text or speech.

[18] As Megan Dean (2019, 354–55) writes, "A lively comment section on a blog post originally titled 'The Most Difficult Dinner Guest Ever and Five Delicious Meals to Feed Them' reveals expectations that guests should eat what is offered, and not make a fuss about dietary preferences or constraints (allergies excepted—at least sometimes)." The blog post has since been retitled as "The Most Challenging Dinner Guest Ever" but still contains the language of "the Most Difficult Dinner Guest" in the body of the text (Durand [2012] 2019).

> this for dinner." And I'm like, "Yeah, I can't eat that. I'll bring rice cakes."

He is obviously not "an asshole" for his dietary limitations or for bringing rice cakes, but within a social context where people are expected to share foods (as Brown, for example, expects), it is understandable why he might feel like one.

The shared meal creates challenges that might not be readily apparent when we are not attending to the experiences of people with gut issues. First, there may be a pressure to perform health. As Kim Hall (2017, 143) notes, the family meal is often romanticized, particularly by the modern food movement, as a place of health and well-being: "Disability is erased from the scene of the sustainable family meal to the extent that it is posited as that which is prevented by sustainable eating practices." In her interviews with people with chronic illnesses and nonapparent disabilities, Simpson (2017, 406, 415–16) notes that they experienced "pressures to perform abledness as well as lack of recognition of access needs."

Second, there is an expectation of universality—the food is shared *together*, rather than anyone receiving a "special" meal. Schroeder and Mowen (2014, 458) note that it is hard for those with celiac disease to conceal their food habits, noting that "regardless of the explanation given for the avoidance of food in social situations or the outwardly noticeable symptoms [. . .] individuals with CD clearly stand out in public gatherings as being 'different' or 'odd.'" Similarly, Cecilia Olsson and her coauthors report stigma for adolescents with celiac disease in the process of having to request and eat different food (Olsson et al. 2009). The expectation of universality can challenge self-trust and confidence in voicing one's needs. As Nathan* reported, he feels like an "asshole" for needing something different, and like a "wrench" in everyone's desire to "get together and eat great food." Similarly, Amanda reported "always navigating this 'am I picky, am I a pain, am I like . . .'"

These two things create a scenario where in order to participate in the *sharing together,* someone has to *perform health*, concealing the way that their food choices would normally have been constrained by their gut issues. For example, Lin* described the following situation when being invited to eat at her then-boyfriend's house:

> We didn't have a lot in common so one of the things was [. . .] eating [. . .]. His mom is like an amazing cook, [. . .] he's Caribbean, and [. . .] they use a lot of flour as like beginners in their delicious like ox tail, and [laughs] goat, and so then like I couldn't eat. And then I felt bad [. . .], I felt like I couldn't eat his mom's cooking, and it was hard to explain to her why [. . .]. And so then sometimes I'd try to eat a little bit, but then I wouldn't feel good, and then I'd be anxious—and oh my god, it was

> just like an endless cycle. And [. . .] I don't really drink either, so then it just felt like I was being such a party pooper, literally.

Note the difficulty caused by *not being able to explain*. This silence is common and makes it difficult to resist the pressures of performing health and the expectation of universality. Cindy LaCom points out a reticence to talk about gastrointestinal symptoms even within the context of disability studies. As she writes,

> Shit is filthy, and it represents contagion in ways that many physical and cognitive disabilities do not. I have found it relatively easy to publicly negotiate symptoms of my MS (even bladder incontinence); in fact, many are curious and will pursue conversations about the disease and its symptoms. But when people discover that I might shit my pants or pass gas through an open fistula on my buttocks as a consequence of my Crohn's, conversation stops cold and verbal constipation becomes the order of the day. (LaCom 2007, n.p.)

Not paying attention to gut issues—or greeting their disclosure with aversion—can have significant effects. The example of Adele* demonstrates that the way in which gut issues are received plays a role in the experience of eating and dealing with symptoms, and how this affects self-trust and agency:

> When I was a child it was so bad that [. . .] I couldn't have bowel movements for like a month at a time, [. . .] which caused [. . .] my adult caretakers [. . .] to do various unpleasant, intrusive, painful, things to try to correct the problem. **And nothing corrected the problem, but those things often made the problem worse, or upset me, or as I got older, embarrassed me, [. . .] so I learned to really, really keep it all to myself,** not tell anybody if [. . .] I had issues because that might just make things worse. [. . .]. As I got older, you know, it affected things because sometimes **[. . .] I'd have to, as soon as I ate a couple of bites of food, go running off to the toilet. [. . .]. And so again felt like I was drawing attention to myself you know, in the least desirable way.** [laughs] Who wants to share their toilet information with everyone else, you know? [. . .] **Those kinds of things were kind of difficult and embarrassing, and it took me a long time to actually tell a doctor what was going on, you know?** And then I realized I had classic IBS, but I'd been brought up in a family where you weren't supposed to complain about pain and difficulty and [. . .] problems in general, and where people who complained of chronic conditions,

> especially if they were girls, were considered to be malingerers. And so, you know, I took on that attitude myself: "oh women," because it's mostly women, "who claim to have IBS, they're just malingerers. They're just trying to get attention." **And [. . .] then I found myself in the embarrassing predicament of admitting, "oh, oh, I must be one of those, hysterical women who has these problems now because look I've got classic IBS."**

For Donna*, the experiences of her sister significantly affected her own ability to talk about her gut experiences. Her sister was diagnosed with ulcerative colitis at the age of four in the late 1960s, when there was a belief that it might be a behavioural disorder and shaped by family environment. She ended up being placed in a home for emotionally disturbed children. So for Donna*, when she was growing up, gut issues meant being sent away: "So this is severely fucked up, right. So any gut issues I had, I certainly didn't tell anybody about it! Right?! I'm going to keep it to my damn self."

These issues also play out at work. The following account from one of the participants demonstrates not only the pressure to share and perform health but also the difficulty of a simple polite refusal, as envisioned by Brown. Andrea* describes the following situation with her workplace, in which her desk is in a highly trafficked area:

> With work-related life there's always socializing. [. . .] I've learned ways of circumventing . . . **people always think something is wrong the minute that you say, "I can't eat that." And you end up having to get into a full conversation while you're in the middle of your workday**. [. . .] It's that constant interruption of people that will come and get something and like, "Oh, here, why don't you have the last one?" "No thank you." And every time you say "**No thank you" to something because you're trying to manage your own issues, it's questioned. And it's time consuming, which I do not have when I'm sitting at work. I don't want to get into a conversation about you know my IBS in the middle of [work].** Thank you very much, but . . . yeah. So, that I find an inconvenience at work. Yeah. Having to answer everyone's damn questions. It's none of their business! It's none. You know. **And the minute you say, "I really don't want to talk about it," [makes shocked noise] people put their backs up.** So what do you do?

In these situations, even though at one level the particular constraint on food choices is caused by the person's gut issue, the experience of the constraint is determined by the social, relational, and environmental context. In this text from Andrea*, we note the effect of her interpersonal relationships with her coworkers, social and cultural norms around performing health and sharing food, and the specific layout of her workplace. People with gut issues experience pressure to live up to certain norms, such as being a certain ideal of professional at work, being attractive on a date, and not being the needy one in a group of friends.

This is even more pronounced, and the account gets more complex, as we recognize that stress and anxiety themselves have a physical effect on the gut (Foster, Rinaman, and Cryan 2017), as well as the interaction between gut and brain (Drossman 2016).[19] As Donna* put it, "For some people, their head is the barometer of their stress. For me, my gut is the barometer of stress." Looking again at Lin's story, the anxiety that she felt in the situation exacerbated the already existing gut issue, creating an "endless cycle." Indeed, most of the participants noted interrelations between gut issues and stress and anxiety. Shawn* described this extensively:

> So, it's like double whammy, it's just like this big ball of frustration. [. . .] To me it just feels like a physical manifestation of anxiety. Like the tension. And this is where it gets kind of interesting, I don't know—it's kind of chicken and egg? I don't know if my physical tension exasperates my anxiety and then that, you know, if it stems from there? Or if the physical complications are a result of anxiety where I'm tense, my brain is tense, and then that's tensing up my body, and then causing kind of dysfunction to occur so, yeah.

Participants noted that stressful situations often led to increased food restriction because of the increased danger of certain foods. One participant, Dave, who works part-time in a highly demanding job noted that "when I'm working, the stress of work does have an effect on my diet, and I've learned when I'm working, to only eat really bland food." Dave connected increased stomach problems to the stress caused by significant life events and losses.

These complex gut-issue dynamics that create constraints around food choices are omitted in discussions of food ethics. Many of these constraints are shaped by not being able to speak up about gut issues. Conversely, relational, social, and environmental contexts that are consonant with speaking up and acceptance of gut issues can enable a wider range of food choices and a greater sense of autonomy

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[19] Elizabeth Wilson (2004, especially 68–69, 78; 2015) critically explores some of this work on gut and mood as well as encouraging feminist thinkers to engage biological data more fully in their explorations of the body.

with respect to those choices. I will discuss each dimension—relational, social, and environmental—in turn.

Relational factors—our interpersonal relationships and immediate interactions with others—play a significant role in the experience and navigation of gut issues. In an article about expanding our conception of autonomy away from the purely unitary, intellectual self, Diana Meyers (2004, 54) gives an example of how friends can support one's autonomy, in which she had to adopt a special diet in response to having developed "a metabolic condition." While the diet is not easy, she has managed it as a "complex relational achievement" (54). Her husband and close friends have "patiently listened to my gripes, and they've even abstained from ordering or serving forbidden dishes when I'm around" (54). While this helps reduce temptation, Meyers focuses on another advantage of talking about her situation:

> I have discovered that, when I am with people who know of my condition but who don't refrain from indulging in pleasures I must forego, I seldom succumb to temptation. The mere knowledge that there would be witnesses to my delinquency curbs my appetite. I don't ask people to encourage me to stick to my diet, and no one ever has. Yet, their knowing presence prevents me from violating my diet. (Meyers 2004, 54)

She describes her autonomy as thus enhanced through her relations with friends who know about her condition. In order to make this possible, she must be able to feel comfortable disclosing.

Donna*'s family, which has come to be much more open about gut issues, provides an example of this kind of comfort around disclosure:

> I would say that in my family, it's completely normalised, that when people need the bathroom, we need a bathroom. And we . . . like if we're travelling, we stop, or we just take care of it immediately, and that's that. You know, there's no, like, "Oh, but wait. We're doing this." I mean, I don't know what other families are like; you know, maybe all families are like this, you know? Actually, I don't think they are. [laughs] You know, but, so it's completely [. . .] sort of normalised. It's also pretty normalised in my family that people get the food that they need. Like my sister . . . unfortunately, she goes to a bunch of fast-food places, but she will go to multiple places to get people what they want, [laughs], and she just completely accommodates people's food needs, right. So does my mother. You know, like, if I want a salad, but she wants chicken, then we will get me a salad, and her chicken, and [. . .]

> my Aunt Clare has a wonky stomach. Like, everybody is all about the "Let's customise the food for what people need." That's completely normalised in my family.

This kind of ethos can also occur amongst friends. Ryan* told this story about going to visit friends in Newfoundland:

> So when I got there, [my friend] was like trying to offer me some booze, and I was like, "Uh, no, my stomach's been like bad." And she was like, "I'm making you jook." And I was like, "I don't know what that is." And she was like, whatever. And she did this thing with rice, which was like leftover rice, and she was like, "It's the best thing for your gut." And she was like, "When [Kevin*] gets home from work I'm going to get him to make it up proper for you." And it was so . . . such a funny thing, [. . .] but this friend—who's an old, old, old friend I do see every other year or so—but it was just like, "Oh, [Ryan*'s] here. [Ryan*'s] got a bad gut." And they just went into like regular, "Oh, this is what we have to do."

In this situation, Ryan*'s food choices are not about choosing the food itself, but trusting his friends to help him respond to his "bad gut." Attending to his gut is a collaborative relational task: "this is what we have to do."[20]

Meanwhile, Donna's* description of making plans for a day with friends on a trip illustrates the way in which the ability to express gut-related needs to trusted friends and get appropriate uptake improves the ability to plan (and the feeling of safety) within a context of food uncertainty:

> I said something like, "Well you know," I said, "I know this is a TMI thing, but you know, at some point pooping will have to happen." And she said, "Yes. That's right." [laughs] You know? And she said, "Well, we can stop, you know, on the way." And I said, "Okay." And I decided not to get coffee because I knew that I was going to be out in a non-poop-friendly environment.

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[20] A connection can be drawn here to Leah Lakshmi Piepzna-Samarasinha's (2018, 251) description of "crip kindness" as "the wealth and skill where we notice each other's pain face and offer a chair, ask in a low-key way if we can help with a service task, sit without speaking, drop a bottle of tincture next to someone having a panic attack, raise thousands of dollars for someone to buy an accessible van, or mail a stranger our extra prescription. It's collective noticing and collective hustle."

Being able to do this was really important to her and made her feel "like I am a part of a community. I'm like them; they're like me; I'm not different. And that makes me feel more secure. And because of my social connections, I can be trusting, and say, 'Oh, I will have to poop.'"

These examples of relational support for food choices do not, of course, entirely remove the constraint posed by the particular gut issue. For example, even people who care about someone may not "get it" or may not feed them well, and social situations amongst people who care about each other can still be fraught. As one participant, Tara*, who has a number of allergies in addition to celiac disease, said, "I don't have many people I trust to . . . they love me, they care about me, and they just fuck it up too much, and the consequences of fucking it up are literally life and death for me." However, being able to discuss it and plan around it at least helps mitigate some of the pressure to perform health.

This kind of pressure is associated with the social dimension—including cultural norms and societal stereotypes, assumptions, and ideas, which can inform relational interactions. Whether people feel welcome to open up to those around them about their needs depends to a degree on communal recognition that their needs are important. Given this, recall that having specialized needs around food can be associated with being a picky eater or excessively fussy.[21] Tara*, diagnosed with celiac disease, noted that her diet felt "hyper-visible and also hyper-invisible. And then how it gets attached to ideas about like . . . like being a hipster or being a millennial or being like . . . I'm going to be like, 'I had celiac before it was cool.'"

Social norms can shift, however, to become more open to discussion of gut issues. Ryan* contrasted the situation now in his home town in rural Newfoundland where they now understand the idea of gluten-free food ("They might not have anything for you, but at least they acknowledge it") versus previously, when it was more difficult to talk about food needs, when "you couldn't say no to someone for food, and tell someone that you didn't like it." Within his large family, as his cousins have grown up, they have found that many of them have gut issues, and so it can be more easily talked about: "So I feel like I'm not the only one. So I have cousins, and the cousins and I will literally bond over it; we'll talk over, like, 'So how was your last colonoscopy?' Or 'How are you doing this week?' Or 'What kind of diet are you on, these days?'" The increased acceptance and increased discussion help to make sure that people have what they need, as well as family bonding.

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[21] Recall Brown, who argues that picky eating is a moral failing. He notes that individuals with health issues can simply decline, but then also recall the experience of Andrea*, who found that polite refusals led to further questions. This is not uncommon.

Social groups can also have more specific local norms, which can enable speaking up and paying attention to gut needs. For example, Donna* noted that it is normal for athletes to have very specific food choices (such as preferring a particular energy bar over another one) and have to regulate their gut carefully for highly active and intensive activities. Consequently, getting into cycling was helpful for her, "because it's kind of regularised, it's sort of normalised that, you know, everybody has to pay attention to this." This means that she does not feel as though she has to stand out because of her dietary constraints, and also makes it easier to get what she needs.

Environmental factors, including the built environment and infrastructure, have a significant effect on food choices made by people with gut issues.[22] The problem of the availability of adequate public bathrooms is well documented—whether someone can access a bathroom affects the riskiness of foods and whether they can remain in a space, which constrains their choices substantially.[23] But other factors, such as transit, also come into play. For example, Katie's gut issues often make them nervous about going out. Katie describes what it was used to be like going out to places with their ex: "[He] really liked to stay much longer at things than me and how much stress it used to cause me being like, I can't ask him to leave this thing yet, and we came together and I'm kind of trapped here." In this instance, the stress caused by the sense of being trapped might lead to further constraints on food choices than Katie might have experienced otherwise—because the gut is already engaged by anxiety, unpleasant symptoms might be more likely to be triggered by food that might otherwise have been innocuous.

Conversely, an environment that is safe and trusted—particularly a place where one has some degree of control—affects the experience and quality of food choices. Amanda (who has celiac disease) emphasized the way in which she feels free only when she is at home:

> Because my home is gluten-free, my friends know not to bring gluten into it, and so if we have a dinner party or something there is this freedom of just being able to eat anything and not talk about it. Like, when that happens in the environment that I have built, we . . . it isn't a topic, but like in every other food-related context in my life it is something that we talk about.

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[22] In cases such as when someone with gut issues is hospitalized, there may be very little choice at all, as Natalie, who has Crohn's, describes. I am focusing here on cases where there is at least some choice.

[23] See Lowe (2018) and Slater and Jones (2018).

In this context, the food that is present is all food that she can eat, and so the experience of constraint is diminished in comparison to when she is outside of her home. She contrasted this with the recent experience of having attended a conference where she had been told that gluten-free food would be provided. This turned out to be false, and so she and another attendee who also had celiac disease had to leave the conference space anytime there was a meal in order to seek out their own food. This reduced their opportunities for networking and taking advantage of the social dimension of the conference and made her feel excluded.

The feeling of trust in an environment enabled some participants to try different things or eat foods that might normally be a problem. For example, Erin* described herself as being able to take "calculated risks" when she is "at home or in a place that I am familiar with," saying "when I'm in control of my surroundings, it doesn't bother me."[24]

The experience of an environment is shaped by the presence of trusted others, demonstrating the interconnection of relational and environmental factors. Recall the example of Katie being trapped while out with their ex. Since their current partner has a car, they know that if they need to, they will be able to simply leave and go home. Having the possibility of being able to get home easily makes it easier to be able to go out (which includes eating out). Trusted others can also help in feeling freer with food choices themselves. Melissa* described that when she lived with her family, there were "people who [. . .] really . . . don't understand, and [. . .] cause a lot of anxiety about it." It was different when she moved out to go to university, "once I got into a safer environment, I started to enjoy food a little bit and let myself try different things and have fun with it." She described what she called "safe friends," whom she trusts and who would understand if she suddenly needed something or felt unwell, and noted that she would generally not choose to go to an event in an unfamiliar space without a "safe friend." The presence of a "safe friend" mitigates the unfamiliarity of the space. (Recall the help Donna* had from friends in negotiating a "non-poop-friendly environment.")

The assessment of the riskiness of food for many participants is thus not solely a function of its nutritional or biological properties but also of the social, relational, and environmental context involved. As noted above, expectations of food universality and of performing abledness are themselves stressors, so they can make already existing gut issues worse. Reducing these expectations can help ease the

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[24] To be clear: for some of my participants, experimenting with foods is too risky in any circumstance, and so I do not want to claim that the danger of foods is entirely constituted by the presence or absence of a safe environment. Still, even in these cases, the experience of food constraints and the pressures around food choices is shaped by context.

pressure around food choices and can also help build trust and a feeling of home. Talking about gut issues and food needs helps to do this, but a number of participants reported that talking about gut issues was difficult. Erin* noted that while she could speak comfortably about her gut issues with close friends, it was frustrating that this was not more widely accepted:

> Even though I talk about feeling separate from this aspect of my body, I know I'm not and this is as much me as anything else. And so, it doesn't . . . we can add it to "I can't go for long runs because I have an ankle problem." Like that is another fact about me like I can't go for a super long hike because I ate something last night and [. . .] for sure will need to go poop in the woods over there. So, why can't we talk about them the same way?

To think of the kind of shift in values and commitments that could make this possible, we can look to a contrast that Kim Hall describes between two images of the family meal; one by Norman Rockwell (*Freedom from Want*), and one by Frank Moore (*Freedom to Share*). The first, depicting a grandmother setting down a turkey platter, is idealized, all-white; everyone is in an assigned place according to family hierarchy, and "any visible marker of disability is hidden from view" (Hall 2017, 439). In the second image, the family is racially heterogeneous, and the grandmother "presents a platter filled with pills, pill bottles, IV bags, and syringes" (442). As Hall interprets it:

> Everyone seated at the table is eagerly anticipating his or her medications and enjoying each other's company. They are disabled *and* happy, a disruption of ableist associations of disability with tragedy and unhappiness. [. . .] Happiness, pain, and woundedness are entangled in this scene and create a productive tension for opening more critical, resistant thinking about the shared meal, families, and disability than those found in the mainstream U.S. food movement.
>
> [. . .] Moore presents a view of disability that is not romanticized or pathologized. All seated at the table need their medications and want to share them with others who also need them. Disability is depicted as part of the desired community. (Hall 2017, 442–43)

The ideal of acceptance here does not *solve* gut issues but signals that one is welcome without needing to hide parts of oneself. Acceptance has room for messiness and imperfection. We see this in the stories of participants whose families and friends welcome them with their gut issues. This welcome allows people to discuss their needs and, by creating a place of safety, opens up further possibilities.

Conclusion

Given the issues raised by interview participants, we observe that prior to being able to make choices based on ethical concerns, people with gut issues have to navigate being able to eat safely. As we have seen, this is not solely a matter of individual medical or dietary precautions but also a matter of how well they are listened to, how much they can feel free to speak up, whether they feel safe or at home in their surroundings (or have a clear exit plan if needed), and so forth. These are things that the people around them—loved ones as well as coworkers and those setting up shared work and event spaces—play a role in shaping. They have a role to play in making sure that agents with gut issues have meaningful access to food choices that reflect their values, goals, and commitments and that allow them to flourish, as Kim Hall described. These relational encounters occur within a broader social and environmental context, which can also be resisted and reshaped. Our collective social conception of gut issues plays a role in the silence around the needs of people with gut issues as well as the deprioritization of gut-related access needs in our institutions and social practices.

This collective social conception suggests an obligation to collectively pay attention to gut issues. Tracy Isaacs argues that collective and individual levels of responsibility inform each other; as she writes, "The collective obligation can play a mediating role, providing some shape and order to the range of individual actions; it helps to narrow down the field of possible individual actions, making it more manageable" (Isaacs 2011, 131).[25] Collectively paying attention can motivate actions directed to relational, social, and environmental dimensions of gut issues. In terms of the relational dimension, people need to able to talk about their gut needs—to indicate, for instance, that "pooping will happen"—and receive appropriate uptake. This means making space for these conversations, taking them seriously, and signalling receptivity to them. It also means being attentive to the "safety" of a space and engaging in collaboration, by providing resources or help for strategizing. For the social dimension, we can attend to ways to resist and reshape the social imagination around gut issues, through the stories we tell, the bodily aesthetics we celebrate or reject,[26] and the norms and social expectations we endorse and pass on. In terms of the environmental dimension, we can work in solidarity with disability, social justice,

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[25] Thanks to Jennifer Szende for the pointer to Isaacs's work here.

[26] For example, Instagram currently has 3,511 posts under the "ostomyinspo" hashtag, challenging the stigma associated with ostomy bags. Tobin Siebers (2010) explores aesthetics and disability, and the idea of "disqualified" bodies.

and labour activists for things like better bathroom access,[27] workplace policies (including policies around breaks and working from home), and, of course, food access. The more this work is done on all levels, the more gut issues become a regularized part of our ethical attention.

Scholarship on food ethics can play a role at all levels here insofar as it concerns interpersonal, social, and policy-related interventions and analyses. In writing about the ethics and politics of food choices, we should think about the factors that enable them, and engage with the relational complexity of gut issues. This means that we should collectively pay attention to how we can create conditions for good food choices, which will involve learning to embrace (or at least accept) the messiness (and unpredictability) of the human body, not as an exception to our theory but as a core part of it. Disability theory and relational autonomy help us explore the interdependence involved in our food choices.[28]

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[27] For a successful story of activism in support of bathroom access near a public transit hub in Ottawa, see Lowe (2018, 71–76).

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