

ABSTRACT

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Rates of bariatric surgery have increased in the last 20 years in the U.S. This rise is often attributed, in part, as a social response to the country's "obesity epidemic" (Saguy and Almeling 2008). Of those Americans who received some type of weight loss surgery (WLS), 80 percent identified as women (Fuchs et al. 2015; Young et al. 2016), even though the percentage of obese Americans is nearly identical for American men and women, at around 30 percent for both (CDC 2017a). Studies have yet to unpack the gender disparity in who undergoes WLS. Building on previous research comparing meaning making via medical and media discourse, I argue that these outlets reveal gendered patterns in how the public and medical community views WLS. In this study, I explore how both the media and medical research frame WLS for men and for women. Drawing on insights from stigma theory and fat studies literature, I analyze media and medical articles about WLS to consider how framing legitimates the discrimination of fat people, and to contribute to an improved theoretical understanding of stigma related to body weight. This analysis reveals that media and medical articles frame WLS in ways that are both gendered and raced, perpetuating sexism, racism, and stigma within the institutions of media and medicine.

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The Gendered Framing of Weight Loss Surgery

by
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I. Introduction

“All Jerry Poole wants in the coming year is this: that a surgeon’s scalpel slice his great girth open, and that his digestive organs be permanently reconfigured so that he can eat no more than will fit into a pouch the size of a small egg. He wants it so badly, Mr. Poole says, that he would crawl through broken glass for it.”
(Carey Goldberg, *The New York Times* 1996)

The preceding quote represents a common media framing of the weight loss surgery (WLS) patient: a person who is desperate to no longer be fat and willing to take extreme measures, even cutting into their bodies or intentionally harming themselves, in the hopes of losing weight. Also known as bariatric surgery, WLS results in significant weight loss by altering the stomach or intestines in one of two ways, through either restrictive surgery or malabsorptive surgery. Restrictive surgeries decrease the amount of food one’s stomach can hold, while malabsorptive surgeries limit the amount of nutrients one’s body can absorb by shortening, or altogether bypassing, the small intestine (Mayo Clinic 2019; Throsby 2008). The three most common types of bariatric surgery include laparoscopic gastric bypass, laparoscopic adjustable gastric band, and sleeve gastrectomy. The first requires reducing the size of the stomach to about that of a walnut which is then connected to the middle of the small intestine, reducing the amount of calories absorbed. With the second, a band is placed around the stomach to restrict food intake. Finally, with the third, the stomach is stapled to restrict the amount of food that can be consumed in a sitting (ASMBS 2013). With a successful WLS, the patient can expect to transform their body quickly losing up to 60 percent on their weight just six months after surgery (ASMBS 2013). To qualify for WLS, a person usually must have a BMI over 40, or a BMI greater than or equal to 35 and an obesity-linked disease like sleep apnea. Alternatively, the patient must have failed to achieve sustained weight loss through traditional means, such as diet and exercise (ASMBS 2019).

Currently, there are varying opinions on the efficacy of WLS, which opens questions about how the surgery is promoted and understood by specialists and the public. Published medical studies suggest WLS leads to significant and sustained weight loss, unlike behavioral interventions like diet and exercise (Johns Hopkins 2017; Maggard et al. 2005), and provides relief from obesity-linked diseases such as diabetes (Cummings and Rubino 2018; Holst et al. 2018). Many medical professionals believe WLS is the only real long-term solution to treat severe obesity in the individual (Gloy et al. 2013; Hofmann 2010). Conversely, those opposed to WLS believe it can be detrimental to the receiver's physical and mental health. Research reveals that WLS poses health risks of its own, including the possibility of postoperative infection or stomach obstruction (UPMC 2019), as well as chronic pain and malnutrition (Groven et al. 2010). Within this ambiguity, what messages are media and medical articles conveying to their audiences?

Rates of bariatric surgery have increased in the last 20 years in the U.S. This rise is often attributed, in part, as a social response to the country's "obesity epidemic" (Saguy and Almeling 2008). As of 2018, the Centers for Disease Control and Prevention (CDC) classifies roughly 40 percent of Americans as obese (CDC 2018). As public and institutional concerns over people's rising weights have become more prevalent, so too have the number of WLS patients. In 2017 alone, over 200,000 Americans underwent some form of WLS, an increase of 44 percent since 2011 (ASMBS 2018). This number has a strong gendered component. Of those Americans who received some type of WLS, 80 percent identified as women (Fuchs et al. 2015; Young et al. 2016), even though the percentage of obese Americans is nearly identical for American men and women, at around 30 percent for both (CDC 2017a).

Thus far, sociological research on this WLS gender disparity remains limited. Social scientists exploring WLS most often focus on the psychological impacts of surgery, such as patients' emotions or quality of life after surgery (Groven et al. 2010; Hoole 2014). While these are undoubtedly significant issues to understand, a gap in existing literature persists. Studies have yet to unpack the gender disparity in who undergoes WLS. Building on previous research comparing meaning making via medical and media discourse (Saguy and Riley 2005; Boero 2007; Saguy and Almeling 2008; Saguy and Gruys 2010; Saguy 2013; Waggoner 2013), I argue that these outlets reveal gendered patterns in how the public and medical community views WLS. In this study, I explore how both the media and medical research frame WLS for men and for women. Drawing on insights from stigma theory and fat studies literature, I analyze media and medical articles about WLS to consider how framing legitimates the discrimination of fat people, and to contribute to an improved theoretical understanding of stigma related to body weight. This analysis reveals that media and medical articles frame WLS in ways that are both gendered and raced, perpetuating sexism, racism, and stigma within the institutions of media and medicine.

II. Literature Review

Media and Medical Framing

I draw on Erving Goffman's conception of frames and the academic tradition that builds on his research in order to analyze how both media outlets and medical literature frame WLS. According to Goffman, we use conceptual frames, or definitions of situations, to organize our experiences and make sense of the world (Goffman 1974). Frames orient and guide the interpretation of individual experiences (Johnston and Baumann 2007). Different frames alter

the ways we understand and interpret events and people, providing order and meaning construction. Frames often ensure we ignore certain information while focusing our attention on other topics (Hilgartner and Bosk 1988). Institutions, like the media, use frames to help individuals construct meaning (Gamson and Modigliani 1989).

Print media often employs certain frames to direct our attention in certain ways, such as narrating individual actors as participants in or as responsible for events, as well as highlighting the morality of those actors, rather than structural causes (Entman 1993; Semetko and Valkenburg 2000; Staniland and Smith 2013; Van Gorp 2005). In doing so, media sources focus on select aspects of issues in order to align them with their audiences' perceived interests (Entman 1993). Dominant discourses from powerful societal actors, such as politicians or other public figures, often dictate which items journalists choose to make more salient in their reporting (Benwell and Stokoe 2006; Entman 1993; Fairclough 1989; Vliegthart and Zoonen 2011). Indeed, dominant societal views are often the most salient in media and thus control the language we have and how that language aids in the ideological construction of issues, especially those that are labeled as social problems (Entman 1993; Saguy 2013). Today, an increasing number of people use social media, like Twitter and Facebook, to access news and public opinions. Wasike (2013) found that social media editors still employ frames, similar to those found in newspapers, as a way of engaging audiences. This indicates that media of all types are arenas where "various social groups, institutions, and ideologies struggle over definitions of social reality" (Gurevitch and Levy as cited in Gamson and Modigliani 1989:3), and help make meaning for audiences.

The media also plays an important role in disseminating and translating medical research to the public (Conrad 1997). Journalists often reference medical literature when communicating

ideas about health to a general audience (Caulfield 2004; Carvalho 2007; Kwan and Graves 2013; Waggoner 2013). At the same time, medical discourse plays an important role in the framing of social problems related to health, as it denotes professional expertise within the media constructions of certain phenomenon. Scholars posit that medical literature reflects ideological beliefs and power dynamics in subjective ways (Kuipers 1989; Kwan and Graves 2013) that are then interpreted by the media (Petersen 2001).

However, when reporting on health-related studies, evidence, and medical information, the media often amplify risks (MacKendrick 2010; Waggoner 2013). The media are often critical actors in the construction of medical phenomena as social problems (Gamson and Modigliani 1989). Indeed, Waggoner (2013) found that the media often participate in amplifying risk, contributing to public panics over certain health phenomena, and the social construction of medical issues as epidemics. In the case of fat, both medical and media research consistently frame obesity as an epidemic (Borero 2007; Saguy et al. 2010; Saguy 2013), amplifying perceptions of fat as risky.

Framing the Body: Fat, Gender, and Race

In 2013, the American Medical Association officially recognized obesity as a disease (Kyle et al. 2016). However, the medicalization of obesity existed long before this formal codification. At the turn of the twentieth century, when plumpness among women was fading out of fashion in favor of the thin and svelte female figure (Boero 2007) and women began seeking ways to attain this fashionable form, doctors began providing solutions (Fraser 2014). Diet advice began to appear in popular American magazines as doctors prescribed drugs (including strychnine) to induce thinness, with women as the primary targets (Stearns 1997; Fraser 2014). By the 1950s, the first surgeries designed for the sole purpose of weight loss were performed in

the United States (ASMBS 2004). This intensified medicalization of fatness legitimized these new surgical treatments and eventually led to the more advanced and accepted surgeries that are used today.

Given the gendered history of weight loss advice and programs, it is unsurprising that women today make up a majority of the U.S.'s WLS patients. Since the early 20th century, fat has been a visual marker of immorality and bad citizenship (Veit 2013), with fat people stereotypically regarded as lazy and weak-willed (Oliver 2006). Previous research has identified several distinct ways media have framed fat. One of these is “blame frames,” where fat individuals are deemed culpable for their girth and thus viewed as morally inferior (Kwan and Graves 2013; Lawrence 2004; Saguy et al. 2010; Saguy 2013). Saguy (2013) found that within blame frames exists the personal responsibility frame wherein fat people’s overindulgence is considered the cause of the obesity epidemic. This framing is gendered, with women being more heavily judged for their own and others’ fatness than are men (Bergman 2009; Saguy 2013; Yancey and Abel 2006). This is due, scholars argue, in part to patriarchal views on the female body, but also because women are traditionally responsible for feeding their families (Biltekoff 2013; DeVault 1991; Veit 2013; Vester 2015). If a child or husband is fat, it is thus an ostensible sign of an irresponsible and morally reprehensible mother or wife (Warin et al. 2012).

Both media and public health sources view childhood obesity as an issue of child welfare, which also genders the way people relate to fat bodies. Initiatives and critiques designed to combat childhood obesity often promote mother-centered solutions while eschewing systemic problems in our health, social welfare, and food systems (Friedman 2015). As social concerns about obesity mount, pregnant women have also fallen under increased scrutiny. Recent medical research claims that the children of fat pregnant women are more likely to be fat as adults

(Leddy, Power, and Schulkin 2008). Fetuses of fat women are also believed to be more at risk of congenital abnormalities, premature births, and stillbirths (Cedergren 2004). Often, these claims translate into body shaming of fat pregnant women by healthcare providers (Parker 2017; Warin et al. 2012).

However, research also finds that women subvert and resist the implication that fatness defines them. Women show they recognize the stigmatization of fat bodies and the connotations that come with such a body, and do not always accept that these connotations fully apply to them (Tunaley, Walsh, and Nicolson 1990; Saguy 2013). Fat women may ultimately take up fat as a part of their identity, but not necessarily as a negative identity marker. In recent history, some fat women have reclaimed the word “fat” as a neutral descriptor of their bodies, whereas overweight and obese still hold negative connotations (Saguy and Ward 2011). For this reason, I use “fat” as an objective way to describe these specific body types.

Thus far, the majority of aforementioned research has focused specifically on the tie between fat and gender. However, this marginalizes the lived experiences of non-white women by privileging the experiences of white women as the experiences of all women (Collins 2000; LeBesco 2004). In reality, race is a central category (LeBesco 2004), or risk factor in the construction of the obesity epidemic. The medical community often frames black women as social dead weight wherein their perceived gluttony is a public health danger and burden (Strings 2015). Additionally, LeBesco (2004) suggests that medical organizations in the United States problematize the high self-esteem of black women in particular. Whereas white women find fault with their fatness, black women may not view fatness as similarly problematic or an automatic marker of ugliness (LeBesco 2004). Thus, high self-esteem could be framed in some medical

literature as a barrier to black women choosing to diet. In this research, I examine if this is true for WLS. Do medical articles frame black women's self-esteem as a barrier to WLS?

American anti-black attitudes also frequently overlap with anti-fat attitudes (LeBesco 2004; Oliver 2006). Scholars have noted that meanings around the white female body are often contrasted with those of the black female body in the context of beauty and identity (Beckles 1999; Collins 2000; Shaw 2005; Wiegman 1996). For example, in Western societies, whiteness has long been held as the dominant standard for attractiveness. A slender white woman with European features has come to be the standard against which society judges all others. Therefore, fat black women are the "beauty foil," providing bodies against which others judge themselves (LeBesco 2004; Shaw 2005). Fat black bodies are excluded from attractiveness and become the body that non-black women strive *not* to be. Patricia Hill Collins notes that "African-American women's status as outsiders becomes the standard from which other groups define their normality" (Collins 2000:70). If we consider body size an intersectional identity (van Amsterdam 2013), then the fat black woman becomes the ultimate outsider. Fat black women clarify the boundaries for other groups. Therefore, gender, race, and body size bear co-consideration in an analysis of how WLS is framed.

Stigma, Fat, and WLS

For those who are fat, the wish to escape stigmatization often motivates weight loss, surgical or otherwise (Granberg 2006; Granberg 2011). Stigma refers, broadly, to "attributes" or parts of one's identity that are "deeply discrediting" (Goffman 1963:3). A trait becomes stigmatized when society views that trait as undesirable, abnormal, or unusual, thereby reaffirming the "usualness" of those *without* the trait (Goffman 1963). Body size is indubitably ripe for stigmatization in the Goffmanian sense, in that it is highly visible and therefore readily

available for social scrutiny and judgment. Those with fat bodies often feel stigmatized in that they feel undesirable and abnormal due to their size (Carr and Friedman 2005; Granberg 2011; Schafer and Ferraro 2011). Media images constantly confirm the grotesqueness of fat bodies (Carr and Friedman 2005; Granberg 2006). Additionally, corollary negative stereotypes about fat people - that they are lazy, immoral, and unable to control themselves - remain pervasive in society, strengthening the power of the felt stigma by those affected (LeBesco 2004; Puhl and Heuer 2010).

The pervasiveness of anti-fat attitudes often results in “fat” becoming a salient part of one’s social identity, leading in turn to the salience of fat stigmatization (Link and Phelan 2001). Those deemed fat are hyper-aware of their body size and how others view them, in part due to the very real social consequences of fatness. Indeed, recent studies suggest that those perceived as fat report experiencing workplace discrimination and exclusion from social situations (O’Brien et al. 2013; Rothblum et al. 1990; Schafer and Ferraro 2011; Spahlholz et al. 2016), in part because they are believed to be directly responsible for their body size (DeJong 1980). Those who hold jobs with fat individuals believe them to be less hardworking and less competent than non-fat individuals (Puhl and Brownell 2006; Hunt and Rhodes 2017). Fat individuals in higher education indicate that they take on more responsibilities to appear as capable as their thin counterparts (Hunt and Rhodes 2017). Additionally, fat individuals often report discriminatory treatment by healthcare professionals based on their body size (Carr and Friedman 2005; Schafer and Ferraro 2005).

Such mistreatment leads to further feelings of stigmatization, producing negative personal and social effects for those who are fat. Psychologically, those who feel stigmatized experience depression and anxiety at higher rates (Chen et al. 2006; Hatzenbuehler, Phelan, and

Link 2013). Those who feel stigmatized for fat also perceive a decline in the quality of their interpersonal and romantic relationships (Schafer and Ferraro 2005; Carr and Friedman 2006). Physiologically, feeling stigmatized causes stress that can exacerbate weight-based health problems or cause new health problems to arise (Crossley 2004; Thoits 1995). For these reasons, it is not hard to understand why fat individuals may wish to shed this part of their identity. Individuals may believe that losing weight, even through drastic measures, will deliver them from stigma (Puhl and Brownell 2003).

Given that women's bodies are more heavily scrutinized in American society, it follows that the fat women are more heavily stigmatized than fat men. A content analysis of YouTube videos found that women were more often the target of fat stigmatization than men (Hussin, Frazier, and Thompson 2011). Additionally, women seeking to lose weight report that this stigmatization influences their own decisions about their bodies. Groven and Engelsrud (2016) found that a small group of women who had undergone WLS felt that how others viewed their weight directly influenced their decisions to have surgery. Many women in the study even felt WLS was their only viable choice in order to exit the stigmatized identity of fat (Groven and Engelsrud 2016). Men have also indicated that fat stigmatization encouraged them to seek out WLS. Post-WLS, these men used memories of their past stigmatization to inform their new experiences of feeling "normal" (Groven et al. 2015).

At the same time, men and women who achieve massive weight loss often wrestle with changes to their identity. The individual attempts to exit the stigma of fatness in order to assume the non-stigmatized, face-saving identity of "normal" weight. However, exiting this stigmatized role is often difficult, as the individual reconciles their old and new identities and relationships. Individuals must also reorient the way they perceive others' actions, from a stigmatized point of

view to a de-stigmatized point of view (Granberg 2011). For mothers, whose identity often centers on feeding the family, identity change after weight loss can be particularly difficult. Food provisioning remains central to the identity of mother, yet often contradicts individual efforts to change one's diet (Warin et al. 2008).

While researchers have recently studied identity as it relates to weight loss, social effects of the ostensibly extreme measure of WLS remain an under-explored subject. Though weight loss is generally viewed positively, dominant discourse around WLS portrays it as an “easy-out” for those who are too weak-willed to diet (Groven 2014). Only those lacking self-control, in this view, resort to surgery (ASMBS 2017; Jose et al. 2017; Newhook et al. 2015; Vartanian and Fardouly 2013). In this way, WLS seems to be doubly stigmatized. First, a person has allowed themselves to become fat, and second, they cannot lose the weight on their own. Though an individual may have chosen WLS in order to exit a stigmatized role (i.e. fat), with this choice they may have also undertaken another stigmatized role (i.e. WLS patient). Recent research finds that women in particular recognize the potential stigma of the latter. Women more so than men take steps to conceal their history of WLS, choosing to share this information only with family and close friends in order to limit further stigmatization (Jose et al. 2017). Furthermore, both men and women recognize that stigma is greater for women in regard to both fat and WLS (Newhook et al. 2015). Recent research has found that WLS patients who recognize the stigmatization of WLS actively work to rebut the “easy-out” claim when discussing their experiences with surgery (Groven 2014). In this research, I aim to add to this body of literature by adding to the conversation around WLS and stigma. I analyze how both media and medical articles frame the stigmatization of WLS for men and for women, thereby filling a gap in the literature.

In this research, I look at how media and medical outlets frame WLS on the basis of gender. In doing so, I add to sociological work around the gendered body and WLS by 1) focusing on race as it relates to gender and WLS, an understudied area, and 2) focusing on how the stigma surrounding WLS is purveyed by media and medical outlets. This is important because it helps to reveal the meaning making process surrounding the WLS gender gap.

III. Methods and Data

Focusing on the period 1996-2016, I analyze print news media and medical journal articles from multiple sites. My dataset begins in the mid-1990s, when Americans became increasingly aware of rising rates of obesity due to the release of then-new dietary guidelines and several landmark research studies, such as from the U.S. Surgeon General in 2001. Since this time, many Americans have come to believe that obesity was and is a national epidemic (Biltekoff 2013). Such alarm bells, sounded by various actors, “led to increasingly vigorous attempts...to combat the trend” (Biltekoff 2013:117). Arguably, the increase in obesity awareness led to an uptick in medical research and media reporting on WLS as a way to “cure” obese bodies.

I began my research by collecting background information to inform my content and frame analysis. This included reading general media and medical articles on WLS. This also included a careful reading of The American Society for Metabolic and Bariatric Surgery’s (ASMBS) website and reporting on types and rates of WLS. This background research revealed the differences in rates of WLS for men and women.

In order to identify print news articles, I began with a targeted search using LexisNexis academic, searching for newspaper articles from *The Wall Street Journal*, *The New York Times*,

USA Today, and *The Washington Post*. *The Wall Street Journal*, *The New York Times*, and *USA Today* are the top circulating U.S. newspapers, respectively (Agility 2017). *The Washington Post* is also in the top 10 circulating U.S. newspapers and helps to set national news. Additionally, these newspapers cover a variety of readers, publishing material aimed at liberal, conservative, and popular audiences. I searched for the terms *bariatric surgery**, *weight loss surgery**, *gastric**, and *gastrectomy** in order to cover all terms associated with WLS. I limited my search further to articles that were longer than 500 words to allow enough content for analysis. This initial search yielded a return on 764 articles. I then read each headline or article to determine the relevance. I excluded some articles that mentioned the search terms but were ultimately unrelated to WLS or did not mention WLS. Because this research focuses on the gendered aspects of WLS, I also excluded articles that did not specifically discuss patients as men or women, but more abstractly. This eliminated a majority of the articles. Most articles discussed WLS, but did not include a specific mention of gender. I also eliminated articles that focused on WLS outside the United States.

I also collected magazine articles, using a targeted search of ProQuest with the same search terms and criteria. I searched the following major news magazines: *The Atlantic*, *Forbes*, *The New Yorker*, *The New York Times Magazine*, *New York*, *The Economist*, *Time*, and *Newsweek*. These magazines have a wide circulation and reach a national audience. Combining relevant news magazine articles with relevant newspaper articles produced a total 64 print news media articles, which are listed in Appendix A.

I then performed a targeted search on PubMed for clinical and medical journal articles published between 1996 and 2016 using several combinations of the following terms that must have appeared in either the title or abstract of the article: *bariatric surgery**, *weight loss surgery**

gender, sex, women, men, male, female (n=1,769). I eliminated articles that did not specifically refer to gender and some type of WLS. This eliminated a significant amount of articles from inclusion. As with media articles, many medical articles focused on WLS, but did not focus on gender. These articles were eliminated. I included articles that were published online in 2016, though not officially published in print until 2017. After eliminating unrelated articles and articles focusing on WLS outside of the U.S., 175 medical articles remained from 64 journals, which are listed in Appendix B.

For both types of articles, I analyzed how these materials framed WLS based on gender. I did not analyze shifts in framing trends over time, but rather focused solely on framing as a whole (trends and changes over time are important and should be studied in future research). The materials were first “open coded” inductively to examine themes that arose (Charmaz 2014). Then, I engaged in focused coding based on the most frequent and important initial codes in order to identify dominant frames. I cross-coded for key themes to explore how they overlapped with focus on men and women, as Figure 1 shows. This process revealed three main frames which I will discuss in the remainder of this paper: Institutional Sexism, Cultural Racism, and Double Stigma. Figure 1 shows themes identified for women and men in media and medical articles which I will discuss in the following sections.

	Women	Men
Medical Articles	Pregnancy Sexual Function Race Stigma	Sexual Function Stigma
Print Media Articles	Pregnancy Caregiving Stigma	Stigma

Figure 1: Themes for Women and Men

IV. Findings

In total, 64 media articles and 175 medical articles met my scope conditions for content analysis. The majority of media articles came from *The New York Times* (n=25), *USA Today* (n=11), *The Wall Street Journal* (n=10), and *The Washington Post* (n=10). A large number of medical articles came from two journals: *Obesity Surgery* (n=37) and *Surgery for Obesity and Related Diseases* (n=33). Topics and themes varied according to source type. Medical articles focus pregnancy risks around WLS, changes in sexual function, and the influence of race. Media articles tend to focus on the patients’ pre and post-surgery life and lifestyle changes, highlighting pregnancy, caregiving, and sexuality. I also noted the differential use of emotion by outlets depending on gender. Taken together, I find that multiple outlets use these themes to structure normative conceptions about the practice of WLS for men and for women.

Institutional Sexism

Both media and medical articles focus on gender as it relates to WLS. Medical articles in particular focus on gender as it relates to pregnancy and sexual function, while media articles

focus on gender as it relates to pregnancy and caregiving. In doing so, these outlets perpetuate sexism within the institutions of medicine and media. Institutional sexism typically “refers to gender discrimination reflected in the policies and practices of organizations such as governments, corporations (workplaces), public institutions (schools, health care), and financial institutions” (Capodilupo 2017:2). As I show in the following section, both media and medical articles perpetuate sexist ideals by reinforcing strict gender norms, surveilling women’s bodies, and differentially treating men and women WLS patients based on gender.

First and foremost, media and medical articles discuss the issue of pregnancy after WLS. For medical researchers, overall, WLS posed the question: is WLS good or bad for pregnancy outcomes? Taking a step back, many medical professionals view fat as a risk factor for pregnancy (ACOG 2016). WLS may eliminate the risk of fat, and it can reduce the presence of harmful health conditions like high blood pressure and diabetes, meaning a likely healthier pregnancy (Maggard et al. 2008). Alternatively, based on evidence, some researchers posit that WLS may lead to a higher risk of a malnourished fetus or a low birth weight baby (Willis et al. 2015).

What is clear is how medical professionals in these articles talk about women generally. Articles consistently frame all women of a certain age as potential mothers. The phrase “women of childbearing age” arises repeatedly. This wording portrays women as childbearing vessels regardless of the individual woman’s actual plans surrounding children. As Waggoner (2017) notes, medical professionals often consider all women “mothers in waiting.” Moreover, concerns about pregnancy are no longer limited to the nine months of gestation, but months or even years prior to conception, regardless of whether a woman ever intends to have children or not. Waggoner (2017) refers to the potential months before conception as the “zero trimester,”

wherein non-pregnant women must now act as if they are, operating as though they are constantly being surveilled, lest they do something to harm their future children.

This kind of perpetual maternity takes on a different form in the medical literature when referencing women who are fat. Often, fat women's body size is interpreted to mean they are constantly harming any potential children they may bear in the future regardless of how they live their lives day to day. Negative pregnancy outcomes associated with obesity include hypertension, cesarean delivery, neonatal intensive care admission, gestational diabetes mellitus, and, later, obese offspring (Bennett et al. 2010; Stone et al. 2011). "Obesity" automatically marks women as unfit mothers. Researchers are quick to point out that obese women's children risk becoming obese as well, as if this is the worst outcome imaginable. They do not consider the effects that social environment or poverty might have in this instance. Therefore, medical articles about the effects of WLS on pregnancy often suggest that obese women of childbearing age should undergo WLS, if not for their health then for the health of their potential children. For example, Bennett et al. (2010) found that WLS prior to pregnancy reduced the incidence of hypertension related complications in pregnancy. From these results, they conclude that "bariatric surgery could be considered in the preconception management of women of childbearing age who have a BMI ≥ 40 or ≥ 35 with comorbidities" (Bennett et al. 2010:6). Here, the researchers suggest that WLS is a tool for managing the pregnancy risks for fat "women of childbearing age." This language suggests that all fat women of a certain age, regardless of their individual plans to have children, might undergo WLS to mitigate the risks of obesity on pregnancy. Because the medical field places women in a perpetual state of motherhood, WLS becomes a tool for reducing potential pregnancy risks for fat women of childbearing age. These

researchers fail to consider the actual childbearing plans of these WLS patients, operating under a zero trimester mentality.

However, WLS does not automatically render formerly-fat women proper childbearing vessels. While some medical articles report pregnancy complications following WLS (Abodeely et al. 2008; Beard et al. 2008; Bebber et al. 2011; Harris and Barger 2010; Maggard et al. 2008; Wax et al. 2008; Wittgrove et al. 1998), other medical articles present evidence that contest those claims (Belogolovkin et al. 2012; Kominiarek 2010; Willis et al. 2015; Willis et al. 2016). These medical articles present evidence that suggests WLS may cause adverse pregnancy outcomes. Belogolovkin et al. (2012) indicate that history of WLS prior to pregnancy is associated with increased incidence of anemia, hypertension, preeclampsia, cesarean sections, and delivery of babies small for their gestational age. These mixed results could have effects on how the media disseminates this medical information. Women may be presented with competing claims. Additionally, based on the assembled set of articles, authors of medical articles seem to agree that WLS is the only way to achieve long term weight loss. This places fat women who want to have children in a no-win situation. If they do not get WLS, they are harming any potential offspring, but if they do, they also risk endangering any potential offspring.

In many ways, the newspaper articles in my sample seem to take their cues about pregnancy and WLS from medical articles, with writers often asking doctors and surgeons for comment when presented with a pregnancy conundrum. Indeed, the ambiguity present in medical articles was often mirrored by the media. In these articles, pregnant women faced increased scrutiny of their bodies given their decision to undergo WLS. For example, one 2004 article recounts the death of an obese woman and her fetus following her pre-pregnancy gastric bypass surgery a year prior. The author writes, “An obese Massachusetts women and her 8 month old

fetus died of complications after the woman had stomach-stapling surgery... She still weighed 440 pounds” (The Associated Press 2004: 28). Here, even a year after surgery, there is still a risk of complications for the mother-to-be. When asked about these deaths, the former president of the American Society for Bariatric Surgery touted the positive effects of WLS, citing evidence of “lower rates of pregnancy complications after WLS” (The Associated Press 2004: 28). The message, then, is one of ambivalence. If patients become pregnant after WLS and face complications, it must be through some fault of their own. Perhaps they did not lose an “acceptable” amount of weight, like the Massachusetts woman who “still weighed 440 pounds.” However, if an obese woman does not undergo WLS, they also risk endangering their child, as being fat and pregnant is interpreted as risky. Overall, the message seems to be “don’t be fat in the first place.”

Here, I argue that fat women exist at the intersection of two risks: obesity and potential pregnancy. The catch 22 created for fat women in both medical and media outlets must be considered in the context of a contemporary age of uncertainty and risk. Today, “the defining markers of modern society are all associated with the phenomenon of risks” (Mythen 2004:1). In a neoliberal society, the individual is made responsible for mitigating and avoiding all possible risk, even those risks that affect a large number of people (MacKendrick 2018). Increasingly our lives are about eliminating potential health risks and fat pregnant women cannot escape this phenomenon. Public health officials encourage people to mitigate health risks in their everyday lives by consuming fresh fruits and vegetables and exercising every day, for example, regardless of socioeconomic status. In American society, fatness is framed as the antithesis to mental, physical and emotional health.

At the same time, a risk mentality also puts women under increased scrutiny, as they are

now considered potentially pregnant at all times. As previously noted, concerns over pregnancy risks now means that concern about pregnancy related risks extend into the months or even years prior to pregnancy. During this pre-pregnancy period, women are expected to eliminate risks in their lives so as to ensure a healthy pregnancy, regardless of plans to have children. This hyper surveillance of fat women's bodies reinforces sexist ideals with the medical field and within the media. Both outlets frame woman as vessels for children, regardless of an individual woman's actual plans. Women's identities center around their ability to be "proper mothers."

Although the medical journals focus intently on pregnancy as it related to WLS, they pay little attention to men's reproductive functioning. According to medical researchers, doctors should counsel women of reproductive age who are considering WLS on proper methods of birth control, so they do not become pregnant too soon after surgery. However, there were few instructions to counsel men of reproductive age, even though they obviously play an important part in the reproductive process. Only *one* medical article did discuss reproductive function in men before and after surgery, namely reduced semen quality and erectile dysfunction as a result of obesity (Rosenblatt et al 2015). The authors concluded that WLS could improve both issues by increasing self-confidence in men and remedying physiological factors related to obesity. Still, the same attention given to women's reproduction was not given to men's reproduction. If anything, this article portrayed WLS as positive for male reproduction rather than as a catch 22. There was not the same concern over risks for men as there was for women. In this way, fat men are not placed in a similar state of perpetual fatherhood, while fat women face a no-win situation when it comes to pregnancy. Again, medical articles perpetuate genders norms by suggesting childrearing is the sole responsibility of women.

However, several medical articles did highlight men's sexual functioning as it relates to WLS. These articles specifically focus on decreased testosterone levels as a result of obesity, with weight loss deemed the solution. Rao and colleagues (2011) find that surgical weight loss increased testosterone levels more so than non-surgical weight loss methods. In this way, weight loss surgery is framed as returning sexual functions to men. This focus reinforces gender ideals around masculinity. Medical articles frame "proper" sexual functioning as an essential marker of manhood.

Similarly, several medical articles discuss sexual quality of life for both men and women following WLS. In a survey of men and women, Camps et al. (1996) found that WLS patients and their partners were more likely to find the patient more attractive at least one year after surgery. Patients also reported an increase in the quality of their sex lives at least one year after surgery. Similarly, Steffen et al. (2016) reported that both men and women WLS patients felt dissatisfied with their sex lives before WLS, concluding that WLS could improve sexual quality of life for both. Additionally, the thematic focus in these articles on sex lives before WLS gives the impression that fat people do not and cannot have satisfying sex lives unless they lose weight. This further stigmatizes fatness and plays into the stereotype that fat people do not experience interpersonal relationships in the same way as their thin counterparts.

The media articles in my sample did not focus specifically on sexual function for men or women. However, they did focus on a thematic realm that medical articles ignored: caregiving. For women, eight media articles in total focus on caregiving and WLS. In three cases, media articles frame WLS as restoring the ability to "properly" care for children or grandchildren, highlighting the idea that women are and feel disproportionately responsible for caring for their

families. For example, a *New York Times* article (Brody 2002) discusses one grandmother's life before having WLS saying:

Now 62 and about to become a grandmother for the second time, Mrs. Clapp, who is from St. Paul, had to face facts: physically, by some miracle, she was still healthy (and she wanted to stay that way), but she could not tie her own shoes, walk uphill unaided or travel to distant lands for fear she would not fit in narrow bus and airline seats. Nor did she want her grandchildren to grow up embarrassed by a hugely fat grandmother who could not take proper care of them.

The article portrays Mrs. Clapp's desire/decision to get for WLS as not an issue of health, but because she wants to "take proper care" of her grandchildren. In fact, the journalist makes it clear that Mrs. Clapp remains healthy, though he believes her weight should render her otherwise. The article portrays Mrs. Clapp as an embarrassment as a "fat grandmother," qualifying her size as "hugely." It is not just that she is fat; it is that she is huge. These traits culminate in a woman who cannot properly care for her grandchildren. The article makes the moral implication clear—fat women, even if they remain healthy, cannot take good care of children because of their body size. Then, WLS affords Mrs. Clapp the ability to become a proper caretaker:

It is now four years later and, despite some rough spots along the way requiring additional corrective operations, Mrs. Clapp is stable at 150 pounds, four below her target weight and achieved within 14 months. She is reveling in the joys and responsibilities of grandparenthood, retirement travel, a new wardrobe and a new lease on life (Brody 2002).

WLS renders Mrs. Clapp newly thin. Following the surgery, she can revel "in the joys and responsibilities of grandparenthood." This vignette, however, makes no mention of the surgery's health benefits. Instead, Mrs. Clapp is discursively reduced to her body size. Here, the journalist places emphasis on Mrs. Clapp's size again, clarifying that she is "four below her target weight." Such a clarification further emphasizes the size of her body.

Other articles also focus on caregiving, emphasizing feeding children. One 2010 *New*

York Times article (Beil 2010) addresses family feeding practices while discussing the weight loss of a teenage patient, Brittany Caesar. After her WLS, the journalist reports on Caesar's future plans:

For her part, Ms. Caesar loves her smaller body, and envisions a different start for the family she hopes to have one day. "They serve Tater Tots to kids as a vegetable," she said, shaking her head. "I'm not going to put my kids through that."

Here, the journalist frames WLS as connected to feeding practices. Because she is smaller, Caesar can think about how she will feed, and not feed, her own children. This framing again emphasizes women's role as a caregiver and places the burden of caregiving on women. Even though she is not yet a mother, Caesar is positively framed as a "good" future mother who is already considering what healthy foods to feed her children. Additionally, the article did not address Caesar's potential feeding practices before WLS. This article frames WLS as providing Caesar with the ability to care for and feed her children healthy food so they do not become fat as well. Again, now that she has had WLS, Caesar can "properly" feed her (future) children.

Indeed, the media often takes up the trope of fat women as *unable* simply because of their body size. In this case, Mrs. Clapp and Ms. Caesar are unable to be proper caregivers because of their body size. Media frames WLS as rendering them thinner, and thus miraculously better caregivers because of their body size. Warin et al. (2012) address this phenomenon. They find that media often constructs fat mothers as poor caregivers because these women are seen as passing obesity down to their children. If the mother is fat, the child risks being fat. Thus, a fat mother is a poor caregiver (Warin et al. 2012). This is especially true in the case of Caesar. The journalist frames her as a defense against obesity. By providing healthy food, Caesar can avoid putting her children through the experience of being fat. She first had to become thin to come to this conclusion. Here, fatphobia intersects with sexism. It is not only that the media reinforces

gender norms around caregiving. Media does so by suggesting that fat is a barrier to fulfilling these gender norms. Once the fatness is removed, these women fulfill can operate within gender roles.

Overall, both medical and medical articles highlight and reinforce traditional gender norms about bodies, roles, and sexuality for both men and women. Women are primarily mothers and caregivers, more emotional and potentially nurturing, leaving men out of the picture. Conversely, men play little to no part in their children's lives. At the same time, medical and media articles frame WLS as a tool for returning proper sexual function to men and women. This helps to frame sexual functioning as an important part of life. By highlighting these traditional gender roles and norms, these media and medical articles engage in sexist rhetoric that perpetuates gender inequality.

Cultural and Institutional Racism

Medical articles, as opposed to media articles, highlight race as a factor related to body weight and weight loss. Twelve medical articles and zero media articles discuss race. In analyzing those medical articles that discussed race, one particular frame emerges: cultural racism. This frame presents "cultural practices as fixed features," using minority culture "as the rationale for justifying racial inequality" (Bonilla-Silva 2014:87). The implication here is that non-European culture is morally worse than white culture. This frame allows institutions and those in power to blame minorities for their circumstances, rather than pushing to address systemic and structural causes of racial inequality. In this frame, the dominant narrative is that black Americans' "standing is a product of their lack of effort, loose family organization, and inappropriate values" (Bonilla-Silva 2014:88).

This frame arose repeatedly and in a relatively uni-thematic way in medical articles when considering the lower rate of African Americans undergoing WLS. One study performed at two medical centers found that 66 percent of patients were white, while only 18 percent were African-American (Stanford et al. 2015). When discussing the racial disparity between white and black patients, medical articles often cite racial differences in moral perceptions of body size, concluding that WLS was being “underutilized” by black Americans. To their credit, some of these articles do recognize that the lack of access to quality healthcare or insurance, and the high price of WLS, may be greater factors for black Americans than white Americans (Bayham et al. 2012; Mainous et al. 2013; Martin et al. 2010; Ng et al. 2015; Nguyen and Patel 2013). However, these discussion of socioeconomic disparities were usually followed by discourse about differing cultural standards. Articles conclude that “being obese is more culturally accepted in the African-American population” and therefore, “these patients...tend to have less motivation to try to lose weight and choose to have this operation” (Mainous et al. 2013).

Additionally, medical articles often conclude that WLS was underutilized among black women specifically. This conclusion was often preceded by a statement like “50% of African American women and 30% of white women are obese” (Lynch et al. 2007:908), and yet “[African American] women... are less likely to use bariatric surgery (Lynch et al. 2007:909). One way medical articles explain this was by citing higher self-esteem and body positivity rates among black women compared to white women. This is thought to be because obesity is more culturally acceptable in the black community and therefore black women feel that larger body sizes are more acceptable. In other words, medical researchers state that black women have different body standards as compared to white women due to “cultural factors,” which prevent them from seeking out WLS. For example, consider the following two excerpts:

One recent in-depth study found both AA [African American] and white participants struggled with their weight but, similar to our findings, AA women were more likely to face culture-specific barriers to weight loss, such as dietary choices based on family influence than their counterparts. Looking at body image and weight studies reveals that although both AA women and white women desired weight loss AA women expressed an acceptance of larger body types and were not as distressed by their heavier weight (Lynch et al. 2007:912).

Alternatively, gender and racial disparities may exist because of cultural factors. Culture has powerful effects on attitudes and behaviours regarding body shape and size. For example, beauty and attractiveness vary with cultural norms such that black women are less concerned and less dissatisfied with their weight when compared to white women, therefore, certain cultures may feel more comfortable and attractive at a higher BMI (Miller-Matero et al. 2015:60).

Here, the author of the latter study points to exactly what they mean by “culture” - “norms such that black women are less concerned and less dissatisfied with their body weight compared with white women” (Miller-Matero et al. 2015). This wording is powerful. Rather than stating that black women are happier and more satisfied with their weight, the authors say that they are *less* concerned and *less* dissatisfied with their weight. This implies that black women should be more concerned and more dissatisfied with their weight, making the accusation a cultural one instead of one based on known associations between such statuses as race and social class in the United States. Authors did not ask black women in their studies if and why they had high self-esteem. Instead, they cited other articles that had already come to this conclusion. Lynch et al. (2007) state that black women were “not as distressed by their heavier weight” (Lynch et al. 2007:), indicating that they should be *more* distressed and thus desire solutions. These medical professionals thus view black women’s culture of feeling “attractive at a higher BMI” as negative (Miller-Matero et al. 2015).

Other researchers focus on fatness as a part of black culture. In the excerpt below, the claim is that obese black women have positive self-image:

These differences are most likely due to cultural views concerning body weight since obesity appears to be more widely accepted in the black culture, and obese

BF [black females] may have a more positive self image than obese WF [white females] (Bayham et al. 2012).

Again, word choice is important. The term “obesity” medicalizes fat so that those with “obese” bodies are seen as morally inferior and bad citizens (Biltekoff 2013; Saguy 2013). Therefore, having a positive self-image of one’s obese body is viewed as negative. Having a positive self-image is seen as a part of black culture. The stigma of fatness and race intersect, constructing obese black women morally inferior.

The authors in these articles employ the cultural racism frame by suggesting that black culture is to blame for obesity and that black women do not care enough about their health to seek out WLS. As a result of this culture, black women accept their fat bodies and do not seek to remedy the situation, unlike their white counterparts. Because of their culture, black women are interpreted as not making the right choices. Because of their culture, black women are not “distressed” by their weight. This frame assumes that black culture is monolithic, bad, and immoral, leading to immoral bodies.

This framing of black culture and black women’s bodies as immoral also relies on the implied comparison with white women’s bodies, such as in the above excerpts ((Bayham et al. 2012:974; Lynch et al. 2007:912; see also Collins 2000). Comparing white women and black women in this context works to further demonize black women. Because fat bodies are medicalized as the antithesis of healthy bodies (Shaw 2005), this creates a racial hierarchy of fatness wherein obese white women are not as bad as obese black women due to “cultural differences.” Black women’s culture keeps them from seeking help, while white women’s “European” culture (as opposed to structural constraints like medical insurance) allows them to address their problem via WLS.

To be clear, my argument is that, in large part, medical discourse around WLS persecutes both fat white women and fat black women through the medicalization and stigmatization of obesity. However, an interpretive framework that incorporates race allows us to see how this demonization differs. Fat white women have the opportunity for redemption. Their “white culture” allows them to take control of their weight and view it as a medical problem. They can become thin and no longer immoral. Conversely, fat black women are seen as irredeemable. Black culture does not allow black women to view fat as problem. Therefore, they cannot “take control” of their weight and become thin. Black culture, in this view, condemns fat black women to immorality.

Interestingly, media articles ignore race for both men and women. The lack of discussion of race means that racial issues or complexities were ignored, even though there is clearly a racial divide in who undergoes WLS. In this way, media articles frame WLS as a colorblind issue, one that does not differentially affect people of different races. In doing so, they privilege the experiences of white WLS patients who may not experience issues with insurance or lack of access to healthcare. For example, one USA Today article discussed the possible benefits and risks to having WLS. The article notes that, “People who have the surgery risk their lives. One in 200 patients dies from complications. But Mike Gwaltney calls it ‘one of the best decisions I ever made’” (Hellmich 1999:7D). For one, the articles does not tell us the race of Mr. Gwaltney. Therefore, it is hard to know how race influenced his decision and outcomes. Here, the article makes it seem as if WLS is life saving for patients. However, the article fails to mention evidence that shows black Americans receive less health care than their white counterparts (Bhopal 1998). It is important to consider how race might affect the care of black WLS patient versus a white WLS. Will the level of care be the same? Evidence suggests not (Feagin and

Bennefield 2014). Had this article treated race as an important factor affecting WLS outcomes they may have cautioned patients differently. However, by ignoring race, the article also ignores the different outcomes white and black WLS patients may experience.

On a deeper level, this connects with issues of systemic racism within the broader medical community. Compared to white Americans, African Americans often experience barriers to quality healthcare due to their race. This in part stems from the medical communities unwillingness “to examine the current impacts of past racial oppression on U.S. medical and public health institutions” (Feagin and Bennefield 2014:9). Past racial oppression likely on racial WLS disparities today.

Overall, both medical and media articles perpetuate racism via the institutions of media and medicine, though in different ways. Medical articles rely on the cultural racism frame, claiming that high obesity rates among African Americans is a result of their own moral failings. These medical articles perpetuate racist stereotypes that harm black women in particular by problematizing high self-esteem. Conversely, the media is apathetic to race. This media colorblindness further harms non-white Americans by not reporting on or critiquing the differences in treatment based on race.

Double Stigma

Both media and medical articles discuss stereotypes and critiques of WLS patients themselves – what my analysis identified as a “double stigma,” wherein articles doubly stigmatize WLS patients. Journalists emphasize social stigma as a rationale for those seeking out WLS, for both men and women. Often, people featured in an article, both men and women, recall a time in their past when they felt stigmatized or socially excluded because of their weight. For

example, in a 2016 *New York Times* article, one journalist discusses a woman's stigmatizing experiences prior to WLS:

And she suffered unexpected humiliations, like when she went to an amusement park with friends and the ride attendant pulled her aside and asked her to try pulling the safety bar over her stomach. It didn't fit, and he turned her away (Kolata 2016).

This article discusses the humiliations and negative emotions this woman suffered as a result of being fat. WLS allowed her to no longer suffer these humiliations. Similarly, other articles discuss patients as having undergone WLS because of embarrassment and condescension they endured while fat. A 2010 *New York Times* makes this direct association when discussing a teenage girl who has chosen to undergo WLS: "One callous question turned Brittany Caesar into a medical pioneer: 'Why do you eat so much? It's not normal'.... She fled to the bathroom and wept, vowing to lose weight" (Beil 2010:D5). In this situation, the journalist proclaims social stigma as the primary reason this teenager chose WLS.

My analysis also finds gendered differences in the portrayal of men's and women's reactions to the social stigma of extreme fatness. For women, it is more typically interpreted as a highly emotional event. In the above excerpt, Brittany flees to a bathroom and weeps. Conversely, media frames men as laughing off stigmatizing events and not having nearly the same depth of emotional reaction. Men who feel stigma because of their weight are frame as "laughing it off" or trying to appear "jolly." For example, one 2002 article discusses the WLS of Congressman Jerry Nadler, explaining how he reacted to being called Jerry "Waddler":

Mr. Nadler said that while he has publicly shrugged off such incidents he was, in fact, wounded by them. "You try to ignore is," he said. "But, of course, it's hurtful. I've learned to laugh it off. But it's hurtful" (Hernandez 2002: A1).

Here, the article frames Mr. Nadler as reacting with an attempt at lightheartedness to a stigmatizing event rather than with sadness or despair. Similarly, a 2007 article highlights one

male patient's facework in response to the fat stigma he faced by stating that he "tried to make [himself] out to be the fat, jolly guy, because who wants to be around the fat, miserable guy?" (Finn 2007:14L11). Here, the media articles depicts the male patient as actively altering his personality with humor. In these instances, the media frames men as acting in accordance with masculine stereotypes that do not allow them to be as (publicly) emotional as women.

Overall, through portrayals of stigmatizing situations and encounters, the media relies on common stereotypes associated with femininity (the "sad fat woman") and masculinity (the "jolly fat man"). Women, because they are seen as inherently more emotional than men, are thus framed as more hurt by stigma. Thus, they must be sad because of their weight. Conversely, even though men in these situations indicate they are hurt by stigmatization, they still hide their emotions and are not portrayed as having the same emotional reactions to stigmatizing events. Such framing, I argue, hurts both men and women and stymies real reactions. Here, body size and gender combine to depict fat women as emotional and fat men as not.

In the above excerpts, media articles describe the decision to undergo WLS as a reaction to social stigma. Patients recount pre-surgery stigma in their lives as part of their impetus for undergoing this relatively extreme, surgical measure for rectifying fatness. Therefore, for those with fat bodies and thus stigmatized identities (Farrell 2011), undergoing WLS becomes a form of stigma management. In in-person interactions, body size is visible and stigma is unavoidable. Goffman (1963) calls this a discredited identity. Those with discredited identities have fewer strategies for managing stigma because their stigma is always visible to co-present others (Chaudoir et al. 2013; Goffman 1963). They cannot masquerade as thin people nor can they simply choose not to reveal their fat identities. Instead, those with discredited identities must

make choices that mitigate their already revealed status. Media article frame people as reacting by ridding themselves of fat.

However, in their efforts to eradicate fat stigma, patients unwillingly take up another form of stigma, the stigmatization of WLS. Many media articles were quick to frame WLS itself as a stigmatized act. In an article for the *New York Times*, Stephen Dubner and Steven Levitt, authors of the popular book *Freakonomics*, simplify the cause of obesity – “eating too much” - and simplify the cure – “eating less” (2007). They go so far as to say that WLS allows people to “eat all they want for years and years and then, at the hands of talented surgeons, suddenly bid farewell to all their fat” (Dubner and Levitt 2007:26). This language—which many others use as well—frames WLS as an “easy out” for people who do not want to pursue the hard work of exercise and restrictive dieting. The patient need not expend any effort to lose weight, according to this perspective, thanks to the miracle of surgery. Many similar articles portray WLS patients as lazy on multiple fronts. First, they had eaten so much and exercised so little that they had become fat in the first place. Then, through no hard work of their own, they choose the easiest option available: surgery.

Still, media articles portray patients as recognizing this stigma post-hoc. Unlike with fatness, those who have had WLS have the ability to conceal this fact in everyday presentation of self. However, in these articles, people chose to disclose their surgery experiences given that they talked with journalists. When doing so, they recognize the stigma that accompanies WLS and they have different strategies for managing this stigma. One particular strategy, which I call *minimization*, involves setting themselves apart from others diagnosed as overweight or obese. For example, Jerry Poole, a man about to undergo WLS, said, ““An operation may be radical for a 200-pound person, but for a 700-pound person it’s the only option...I’m on the verge of not

being able to get out of bed” (Goldberg 1996: 11). Here, the media frames Mr. Poole as setting himself apart from other eligible surgery candidates in order to legitimate the perceived need for the surgery. For him, dieting and exercise are not options because he can no longer perform simple daily activities.

Similarly, the media shows a majority of patients as using a more common stigma management strategy: highlighting their failures with dieting and exercising. Often times, patients describe WLS as a decision of last resort. Indeed, Sally Apuzzo, a WLS patient from New Jersey, describes the procedure as her final option, recalling that she “had been overweight for as long as [she] could remember” (Santora 2004:1). The reporter then comments that Sally tried every diet imaginable and even spent months away at ‘fat camp’ (Santora 2004:1).

Media portrays other patients as describing how diets did not work for them and so they gave up. For example, an article from *USA Today* describes one WLS hopeful as failing at diets her whole life. Journalist Nanci Hellmich writes, “After several failed attempts at losing weight, Raechel says by the summer, she’d basically given up and was eating ‘whatever, whenever. I know I eat too much, but I think, ‘Why stop now?’” (2003:1D). This and the preceding quote blame WLS patients for their weight and portray fatness as negative. Sociologist Abigail Saguy (2013) aptly calls this a “personal responsibility frame,” wherein a person is responsible for their weight through their own personal failings. By highlighting patients’ failures at diet and exercise, media blames individual patients for their large body size and for their failure to become thin. The media further paints the WLS patient as weak willed and ultimately unwilling and unable to lose weight on their own.

On the surface, mentions of diet failure appear to further stigmatize patients. However, I interpret such mentions as a stigma management strategy, that patients use the failure narrative in

order to mitigate WLS stigma and set themselves apart from fat people or others who have had WLS. Here, patients directly refute that WLS is an easy out, attempting to shift the narrative toward a different moral classification of the procedure. Before turning to WLS, they tried everything else but have been “struggling with weight [their] entire lives” (Hernandez 2002: A1). Failing at diets means that WLS is a legitimate option for them. By participating in—but attempting to subvert—the scripts of the personal responsibility frame, patients contribute to the stigmatization of fat bodies, but doing so allows them to manage the stigma of WLS.

Medical articles certainly mirror the stigmatization of fat, though patients are not given the same agency as within media articles. As explained prior, the medical community continues to view fat as a threat to American health. Researchers were quick to point out not only myriad health benefits to losing weight but used alarmist language when doing so. McCawley et al. (2009), for instance, wrote “90,000 deaths a year could be prevented if men and women maintained a normal weight” (1093). Other health researchers estimate that over 300,000 deaths could be prevented if obesity did not exist, although this number is highly contested as the designation of obese is a social construct (Farrell 2011). Being fat is literally equated with death.

Medical articles also highlight the financial costs of obesity, further stigmatizing fat individuals. The CDC estimates the annual cost of obesity in the U.S. was \$147 billion as of 2008 (CDC 2018). One study estimates that “the medical cost for obese individuals is approximately \$1,429 higher than for those of normal weight” (Yusufov et al. 2017:238). Here, the researchers portray fat men and women as costing “normal weight” U.S. citizens taxpayer dollars. Fat people are further stigmatized because they are seen as greedy and taking an unequal share. In reality, these numbers depend greatly on how one defines obesity and overweight because these terms are socially constructed. Medically, a person is currently considered

overweight if they have a BMI of greater than 25, but less than 30 and obese if they have a BMI of 30 or higher (CDC 2017c). However, this was not always the case. In 1998, the National Institutes of health changed the BMI guidelines. Prior the changes, a man had to have a BMI of greater than 28 and a woman had to have the BMI of greater than 27 to be considered overweight (Nuttall 2015). With the change to 25 for all adults, 29 million Americans automatically went from normal to overweight without gaining a pound (Brody 2014). From the outset, BMI was never intended to be an exact or accurate measure of a person's fatness (Nuttall 2015), though we often consider it as such. In reality, studies estimating the economic cost of obesity are based on arbitrary numbers and thus these cost estimations are flawed from the outset. However, researchers failed to consider this when estimating these cost measures, effectively portraying fat Americans as an economic burden.

Unlike the tone present in some media articles in my sample, medical articles did not stigmatize WLS. Instead, the doctors writing them often included statements such as “bariatric surgery is the most effective means to induce weight loss for the severely obese” (Maciejewski et al. 2010: 2419). One study even went so far as to claim that WLS actually *saved* the United States money (Poulose et al. 2005). In reporting such numbers, medical articles portray WLS as the only, and best, choice left for fat people wishing to lose weight. Still, though they may be praised medically, WLS patients face social stigma because of their “choice” to undergo surgery. These ambiguous messages place these patients, and fat people in general, in a no win situation.

I find that these medical and media frames each construct patients as trading one type of stigma for another, but in slightly different ways. Medical articles portray WLS as the only available option for obesity, indicating that this is the treatment fat people should choose. At the same time, media articles also portray WLS as an easy out for those too weak willed to diet. In

attempting to give up the stigmatized identity of fat, WLS patients take-up the stigmatized identity of WLS patient. In this way, I argue, WLS patients are doubly stigmatized—first, for becoming fat and, second, for choosing weight loss surgery. To escape stigmatization, they need to unrealistically not be fat in the first place.

V. Discussion and Conclusion

In this paper, I examine how media and medical outlets frame WLS for men and for women. Overall, my data frames WLS in ways that reinforce dominant societal narratives and reproduce social inequalities. Both media and medical articles perpetuate gender stereotypes about women's roles as caregivers and child bearers. Medical and media articles rarely mention men's role in caregiving, reinforcing the idea that men do not bear equal responsibility for reproduction or care. Additionally, medical articles (but not media articles) perpetuate racial stereotypes by framing the WLS gap as cultural rather than socioeconomic. Black women are seen as failing to view fat as a problem, leading to higher self-esteem about bodies and thus a lack of desire for bodily change. Medical articles employ cultural racism to frame black women's high self-esteem as negative because it is perceived to keep them from seeking out antidotes to fatness (like WLS). Finally, both medical and media articles perpetuate the belief that fat people are to blame for being fat, stigmatizing them as weak willed and immoral. Media articles also stigmatize WLS, emplacing patients in a context of double stigma. The ways that media and medical outlets frame WLS have implications for sociological understandings of the treatment and stigmatization of bodies, as well for public discourse and future dialogues about the procedure itself. If people take the medical reporting uncritically, they might readily blame black Americans for their weight and believe that their cultural practices are a contemporary

cause of obesity. For example, Coleman et al. (2014) describe black culture as communal, saying,

There are a number of barriers uniquely faced by...non-Hispanic black cultures in changing health habits related to weight loss and maintenance. These include eating with extended families and community groups, making it difficult to make an individual choice to eat differently.

This conclusion employs the cultural racism frame and ignores institutional racism and socioeconomic factors, which differentially affect racial groups.

Overall, I find that media articles and medical articles amplify different frames, and that there were somewhat surprisingly few clear thematic overlaps between the two. This counters previous studies that have found that the media often take their cues from medical research, reporting on specific studies or medical proscriptions (Boero 2007; Waggoner 2013). However, I found that media articles generally did not report on specific medical research studies. Instead, media articles tended to focus on the specific, individualistic experiences of patients, giving the reader a snapshot of only a small handful of individuals pre and post WLS and humanizing patients with personal narratives. Conversely, medical articles rarely highlighted the personal lives of patients. Instead, they relied on abstractions of patients with little room for personal details. Because media articles are writing for the public, they tend to be more accessible and humanizing than medical articles. Media articles have the potential to build empathy. Gamson (2002) argues that personal narratives have the potential to invite a more serious analysis of social problems, while abstractions do not have the same power. In terms of media reporting on WLS, the use of personal narratives has the potential to reach audiences in a way that promotes collective action around issues of race and the social construction of obesity. The articles that I studied did not address these issues but could in the future. Doing so has the potential bring people together around a common issues like systemic racism with the healthcare system.

Future studies could examine the direct link between medical research on WLS and media reporting on WLS, as well as issues and themes beyond gender related to WLS. Are there specific correlations between medical articles and media reporting, and what does this mean for how research about medical procedures considered by some to be a ‘last resort’ is disseminated? For issues and themes beyond gender, age is a crucial demographic characteristic to explore as it relates to public understanding of the legitimacy and social impacts of WLS. Several media articles covered the growing trend of recommending WLS for patients younger than eighteen. The youngest person to have had WLS was a 72-pound two year old with sleep apnea from Saudi Arabia (Williams 2013).¹ While these surgeries are not usually performed on children so young, it is increasingly common for doctors to recommend WLS for children as young as twelve (Fernandez 2018). Studying how medical and media outlets frame childhood WLS may reveal that age impacts the medicalization of obesity. Additionally, issues of consent arise, because at such young ages, the decision to undergo WLS belongs to their parents. The age of these children raises serious psychological questions as well as sociological ones. Further research is needed to explore this new social phenomenon.

Future research should also explore stigma as it relates to WLS patients. This research found that WLS, though stigmatized in media reporting, was often presented as the only practical choice for sufferers by medical outlets. This valence could change as more people undergo WLS. Additionally, as the number of adolescents undergoing WLS rises, WLS may become less stigmatized for certain age groups. At the same time, as obesity rates have risen, fat stigma has not lessened. It is not clear there is a correlation between incidence of fatness and decreased

¹ Doctors performed a laparoscopic sleeve gastrectomy after unsuccessful dieting attempts. The child lost at least 20 pounds following the surgery.

stigma around fatness. Based on this research, it is also worth further exploring double stigma at a qualitative level. This research found that people who undergo WLS are stigmatized for becoming fat and also choosing WLS. Conceptually, double stigma refers to an identity that is stigmatized, but the solution to that stigmatization is also stigmatized. Other identities, like those with other medicalized identities, yet to be explored, may suffer from double stigma.

Overall, this research establishes links between WLS and broader social categories of gender and race. Other qualitative methods, such as in-depth interviews, could complement the possible impact of this research. While I did identify issues surrounding sexism, racism, and stigmatization, I did not explore how people who have weight loss surgery address these issues. To specifically confront problems within the medical field and media reporting, it is important to understand the lived experiences of those impacted, such as rationales as well as changes in internalized self-meanings in the creation of post-stigma identities. Interview data would offer valuable insights into the problems and circumstances of sexism, racism, and stigmatization crossing the medical field and media reporting.

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