1-1-2013

Weighing In: The Public Problem of Obesity

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Abstract
The definition, significance and consequence of the disease of obesity have changed dramatically in the last few decades. Formerly regarded as a common comorbidity of other chronic diseases, obesity has become a discrete medical condition deserving public attention and resources. This dissertation studies the organizational and cultural process by which obesity came to recognized as a public problem through three interrelated papers critiquing claimsmaking via expert authority, the news media apparatus, and populist television. Chapter 1 analyzes the medical literature on obesity published between 1980-2000 in order to trace the social trajectory of obesity as a contemporary public problem through interrelated three stages of medical moral entrepreneurship: claimsmaking, consolidation, and institutionalization. It argues that the efforts of medical moral entrepreneurs moderated public scrutiny of individual health behavior but expanded the jurisdiction of biomedicine. Chapter 2 examines how the print news media reports on obesity as a predominantly biomedical and behavioral problem, specifically parsing who gets to say what about obesity. Based on a sample (n = 256) of news stories published in the New York Times and USA Today between 1995-2004, this paper analyzes how expert and lay statements are used to package obesity as a medicalized human interest story. Findings indicate media support of individualized blame during this period, which promoted clinical treatment to reform obese people and problematic health behavior. Chapter 3 considers how celebrity entrepreneurs leverage the makeover television genre as a popular media platform for demonstrating lifestyle and behavior interventions. Whenever celebrity entrepreneurs adopt new moral causes, their influence with audiences must be evaluated against personal brand promotion and misrepresentation of the original mission. In sum, this study shows how moral entrepreneurs are very much invested in promoting the obesity problem while also making claims to its imminent solvability. The obesity epidemic remains a serious health threat because expert authorities, methods, and stakeholders construct it as such.

Degree Type
Dissertation

Degree Name
Doctor of Philosophy (PhD)

Graduate Group
Sociology

First Advisor
Charles L. Bosk

Keywords
Expert, Moral Entrepreneur, Obesity, Social construction of health, Social problems

Subject Categories
Public Health Education and Promotion | Sociology

WEIGHING IN: THE PUBLIC PROBLEM OF OBESITY

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A DISSERTATION

in

Sociology

Presented to the Faculties of the University of Pennsylvania

in

Partial Fulfillment of the Requirements for the

Degree of Doctor of Philosophy

2013

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ACKNOWLEDGMENTS

This work was completed generous support from the National Science Foundation's National Graduate Research Program Fellowship and California Governor's Scholarship Program.

My appreciation extends to the many wise and thoughtful individuals at the University of Pennsylvania who formed my graduate education and experience. Chuck: your insatiable curiosity will always impress and inspire me. Alison: my research design and productive processes owe much to your mentorship. Dave: your encyclopedic knowledge of popular culture makes for interesting conversation and complex analyses. Audra, Aline, Nancy, and Carol-Anne were my guides for navigating the program.

I am grateful for the support and encouragement demonstrated by my friends and family. Ari: you always said I was "nearly there;" you were right. Sabrina and Joanna: it has been wonderful to share and witness this season of life together. Aaron: you are the best teammate and cheerleader any person would hope for – go Team McKhuu! Anne: you're next. Mom and Dad: your faith in me has made this accomplishment possible.

ABSTRACT

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The definition, significance and consequence of the disease of obesity have changed dramatically in the last few decades. Formerly regarded as a common comorbidity of other chronic diseases, obesity has become a discrete medical condition deserving public attention and resources. This dissertation studies the organizational and cultural process by which obesity came to recognized as a public problem through three interrelated papers critiquing claimsmaking via expert authority, the news media apparatus, and populist television. Chapter 1 analyzes the medical literature on obesity published between 1980-2000 in order to trace the social trajectory of obesity as a contemporary public problem through interrelated three stages of medical moral entrepreneurship: claimsmaking, consolidation, and institutionalization. It argues that the efforts of medical moral entrepreneurs moderated public scrutiny of individual health behavior but expanded the jurisdiction of biomedicine. Chapter 2 examines how the print news media reports on obesity as a predominantly biomedical and behavioral problem, specifically parsing who gets to say what about obesity. Based on a sample (n = 256) of news stories published in the New York Times and USA Today between 1995-2004, this paper analyzes how expert and lay statements are used to package obesity as a medicalized human interest story. Findings indicate media support of individualized blame during this period, which promoted clinical treatment to reform obese people and

problematic health behavior. Chapter 3 considers how celebrity entrepreneurs leverage the makeover television genre as a popular media platform for demonstrating lifestyle and behavior interventions. Whenever celebrity entrepreneurs adopt new moral causes, their influence with audiences must be evaluated against personal brand promotion and misrepresentation of the original mission. In sum, this study shows how moral entrepreneurs are very much invested in promoting the obesity problem while also making claims to its imminent solvability. The obesity epidemic remains a serious health threat because expert authorities, methods, and stakeholders construct it as such.

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INTRODUCTION

The definition, significance and consequence of the disease of obesity have changed dramatically in the last few decades. Formerly regarded as a common comorbidity of other chronic diseases, obesity has become a discrete medical condition deserving public attention and resources. What was once the private concern for a minority of Americans has been elevated to a public issue warranting widespread interventions, public health campaigns, and the expansion of medicalized control into everyday life. This dissertation studies the organizational and cultural process by which obesity came to be recognized as a public problem. Specifically, I examine obesity entrepreneurship through three interrelated papers critiquing expert authority, the news media apparatus, and populist television. I apply a social constructionist perspective to the study of obesity as a social problem and biomedical condition by explicating the influence of claimsmaking and cultural production between 1980-2010.

THE SOCIAL CONSTRUCTION OF HEALTH AND ILLNESS

The etiology of obesity has consistently attributed causation to the triumvirate of overnutrition, decreasing physical activity, and lifestyle factors. This simple calculus firmly places the responsibility of weight maintenance onto individuals. A social constructionist framework seeks to understand how social forces and biomedical conditions produce the formal and informal definitions of

disease (Aronowitz 1998; Brown 1995; Rosenberg 2002). In contrast to biomedical models attributing illness to viral, bacterial, or physiologic causes, this theoretical framework considers how population health is configured through cultural processes and the jurisdiction of medical knowledge.

Within the subfield of medical sociology, social constructionism derives explanation from the symbolic interaction of expert knowledge and authority set within the political economy in which their activities take place (Rosenberg 1992; Brown 1995). Existing disease concepts are contingent upon but not reducible to the social conditions influencing its exposure and experience (Aronowitz 1998). Social constructionists argue that there is no "unadulterated biological core" of disease because the process of disease recognition, naming, and classification is iterative and social in nature. Aronowitz declares: "The emergence of new diseases and etiological concepts is often more profitably viewed as a complex reclassification process, rather than as instances of cumulative scientific progress" (1998, 178). Without dismissing the biological and material origins of disease, social constructionist arguments consider how social contexts shape understandings and actions towards health, illness and healing.

Consider how the problem of obesity has yielded commercial and social opportunities. Reining in hearty American appetites became a marketable problem in the prosperity following World War II, and an increasingly profitable industry in the modern era of fast and processed foods. Weight-loss diets, prescriptive cures, and specialized equipment were developed to mentally rescue

and physically reduce users. As time passed, the population segment identified to be at risk rotated as historical and social contexts evolved. A century ago, the middle class were most susceptible to developing the “automobile knee,” when the preference for motorized sport over walking resulted in an “increasing disinclination to activity and the weakening of the muscles of locomotion from limited use” (1912, 816). Today, condemnation has shifted to disadvantaged communities because of sedentary lifestyles, fast food consumption, and inadequate health education.

The fact that Americans value health dearly, and internalize the effects of illness so broadly, reflects the expansion of medical discourse into everyday life. *Medicalization* describes the process by which social problems enter the jurisdiction of medicine, and the way abnormal behaviors or conditions may become normalized (Conrad 1992). It occurs when social behavior develops into an illness bearing medical definitions, medical frames of knowledge, and medical supervision. The tyranny of medical diagnosis has become a "cognitively and emotionally necessary ritual connecting medical ideas and personnel to the men and women who are its clients" (Rosenberg 2002, 256). Formal diagnoses are indispensable for placing individuals in the social and biological narrative of their disease and treatment course. Deviant behaviors that society once deemed immoral, sinful, or criminal have been recategorized as symptoms of mental illness. Surveillance of alcohol abuse related to drunk driving or fetal alcohol syndrome extends the social control and influence of healthcare professionals

and related industries (Armstrong 2003; Gusfield 1981). Social constructionist arguments utilize medicalization to show how social forces produce and eliminate medical categories.

Medical consensus about illness is the outcome of intense negotiation and management of scientific credibility (Hilgartner 2000). Although modern society aspires for the "purity" of a risk factor approach that matches the scientific identification of risk factors with specific disease profiles, the social constructionist perspective criticizes the ahistorical biases of biomedicine and epidemiology. "Existing disease concepts are contingent upon but not reducible to social factors" that structure relative exposure and active disease (Aronowitz 1998, 14). What the public interprets to be cumulative scientific progress for diagnosing chronic diseases such as coronary heart disease more accurately reflects a game of idiosyncratic reclassification. Alternatively, audiences may be perceptive to the motivated claimsmaking that results and cynically dismiss frequently changing standards.

Aronowitz (2008) proposes "framing effects" as an additional perspective for understanding the social determinants of health. Explanations rooted in socioeconomic deprivation and psychosocial explanations fail to account for how consumption behaviors, cultural beliefs about health and illness, and social attitudes enhance the self-perpetuating qualities of health disparities. He argues that a social constructionist framework helps researchers explain the influence of culture by examining contextual factors that contribute to individual health.

Aronowitz seems to imply that reforms in diagnostic definitions, clinical practices, and popular beliefs can positively influence health at the aggregate level. At the same time, such framing effects could operate heighten surveillance and medicalization on the sickest – and poorest – segment of Americans.

One example of how doctors treat the disease and not the patient is Armstrong's (2003) research on the problem of maternal drinking during pregnancy. She frames the rise of Fetal Alcohol Syndrome (FAS) as a case for how medical knowledge serves to control women's actions and bodies with the threat of post-hoc diagnosis. Armstrong argues that the maternal-fetal conflict evolves from social anxieties resulting from women's advances in economic independence and social status while continuing to bear responsibility for societal reproduction. Drinking during pregnancy is highly correlated to race, advanced maternal age, malnutrition, and poverty. In contrast to popular belief, her analyses indicate that non-pregnant minority and poor women are less likely to drink or alter behavior after becoming pregnant. The tiny fraction of women who drink heavily continues to do so regardless of pregnancy. Armstrong is therefore critical of current public policy interventions because they promote a discourse of individual responsibility while ignoring how socioeconomic conditions function as a risk factor for FAS. The movement for patient-centered health care can be critiqued as a case of how medical professionals – and society – treat patients as if they were only the disease.

THE SOCIAL CONSTRUCTION OF PUBLIC PROBLEMS

The critiques and arguments presented in the following chapters draw from the body of literature explicating the social construction of public problems. According to Blumer (1971), social problems represent projects of collective perception rather than objective societal conditions. Social problems do not exist in isolation from each other, or the institutionalized systems from which they formulate. Even when the extent of harm is established, the idea of the problem itself is "essentially contested" in meaning and marketability. Hilgartner and Bosk define a social problem as "a putative condition or situation that is labeled a problem in the arenas of public discourse and action" (1988). This definition treats public attention as a scarce resource that must compete in public arenas. Best (2008) defines *social problems* as troubling conditions, to which people subjectively judge and respond.

Gusfield's (1981) work on the culture of public problems further distinguishes the difference between private troubles and public issues. He proposes that public problems come to be known as such when three conditions are fulfilled. First, a person, organization, or entity assumes *ownership* by defining the reality of the problem. *Claimsmaking*, the process by which troubling conditions are promoted, typically precedes widespread public attention to troubling conditions (Best 2008). Becker describes a moral entrepreneur as someone "whose initiative and enterprise overcame public apathy and indifference" to result in a significant outcome or public policy (1973). Causal and political *responsibility* are allocated to problems deemed be solvable. Claimsmakers and mass communication platforms explain to the public how the problem came to be and what is to be done (Gusfield 1981). To contend for attention in the public arena, the news media must shape the public perception of disease. Having

piqued the concern of lay audience and their political leaders, something must be done to control and prevent the obesity problem.

The mass media and culture industry carry out news work through artistic, cooperative, and organizational conventions that constrain the range of troubling conditions introduced to the public (Becker 1982). The relationship between media discourse and public opinion operate as parallel systems as journalists construct the essential context by which audiences interpret new information or public appeals (Gamson and Modigliani 1989). Media *packages*, or familiar constructions of public problems, compete and succeed as dominant frames through a combination of cultural resonance and fit with media norms and practices (Best 2008). *Frame alignment* is the ongoing-process of resource mobilization to enhance the resonance between individual and social movement organizations orientations towards issues. Frame alignment occurs through interactional processes that bridge, amplify, extend, or transform the subject and public reaction (Snow et al. 1986).

The influence of mass media is not as benign or informative as the culture industry represents itself to be. Academics and media critics lament the overriding value of entertainment in nearly all examples of mainstream television content, superseding nuanced public discourse of "serious" and complex news in the realms of education, religion, and politics (Postman 1985). Audiences are trained to process bold headlines and 10 second sound bites, both of which provide useless and unconnected data that cycle through artificial seasons of coverage. How the media direct and limit public discourse may undermine democratic dialogue, and therefore the construction of social reality (Postman 1985).

THE OBESITY PROBLEM

American obesity epidemic has been a long time coming. Alternatively, it has taken this long for the public to identify individual prevalence rates as a problematic or harmful condition for society (Best 2008). National health surveys have registered the upward tick of scales over the past four decades. Data from the National Health and Nutrition Examination Survey report that approximately 32 percent of Americans aged 20 years and over, and 17 percent of children and adolescents aged 2-19 years old weigh more than is ideal for their age and gender (Ogden et al. 2006). Worldwide, it is estimated that approximately 22 million children under five years of age are overweight due to sedentary lifestyles and Westernized dietary habits (Deckelbaum and Williams 2001). Developed countries report unprecedented rates of comorbid chronic diseases and the earliest onset ever of type 2 diabetes among children and young adults (Ebbeling, Pawlak and Ludwig 2002). While obesity rates have leveled off, the prevalence of the condition continues to be a public health concern for current and future generations (Kersh, Stroup and Taylor 2011; Kumanyika 2011). In economic cost and public consciousness, obesity has gained a prominent position in the arena of social problems by soliciting concern and controversy, and stimulating public action on behalf of afflicted citizens (Gusfield 1981).

The obesity epidemic was discovered as far back as a century ago by experts observing a trend in heavier Americans. A 1912 *New England Journal of Medicine* editorial listed modern inventions such elevators and automobiles as culprits for reduced physical activity and labor. Americans with hearty appetites and reduced physical activity suffered limbs weakened from disuse and the debilitating technological interference. Rapid industrialization and agricultural prosperity from 1920-1950

reversed historical associations between weight and wealth as social elites in Western countries increasingly valued thinness (Aronowitz 2008; Levenstein 2003). In the United States, the negative social valuation of body weight moralized fatness as badness (Sobal 1995). Obese individuals were (and continue to be) stigmatized as weak and irresponsible deviants subject to discrimination in education, employment, and other social arenas (Aronowitz 2008).

The institutionalization of professional medicine after World War II supported the expansion of medical expertise and treatment into new domains of human life, resulting in the *medicalization* of deviant conditions such as addiction and obesity (Conrad 1992; Starr 1982). Obesity became medicalized throughout the 1960s and 1970s when heavy body weight was treated as an indicator of disease and a risk factor for early death. By 1985, obesity was widely regarded as a disease in its own right distinct from conditions such as diabetes or arthrosclerosis, in medical reference materials (Chang and Christakis 2002). The American Association of Family Physicians dates International Classification of Diseases codes (ICD-9) used to classify overweight and morbid obesity diagnoses in health care systems back to 1997. Obesity became an illness to be diagnosed through "bureaucratic and biological circumstantiality," defined through the accumulation of institutional logics and tools (Conrad 1992; Rosenberg 2002). Socially, the medicalization of obesity defined heavy people by the "sick role" due to the risk to their personal health, cost to society, and social marginalization (Fox 1989).

Now more than ever, the weight status of the nation is referenced daily in consideration of public policy reforms and health care spending. Whether motivated by vanity, profit, or cost-cutting strategies, the prevalence of obesity has evolved into a public issue resulting in a Call to Action report by the Surgeon General, the launch of a

national public health campaign helmed by a First Lady, and makeover television shows inspiring Americans to eat better and lose weight. Alternatively, obesity remains a private matter without a socially constructed or informed solution. Health is a condition to be achieved and maintained through individual effort and responsibility; one has to put in the work to be healthy or suffer the risk of premature death and chronic disease if not (Clarke et al. 2003; Crawford 1980).

How and why did obesity transform from a private trouble to a public issue? By invoking C. Wright Mills' (1959) sociological imagination, this dissertation aims to unite the narrative arcs of obesity as a personal and social problem. Although individuals are unlikely to distinguish private troubles "in terms of historical change and institutional contradiction," personal values and experiences are indeed embedded within the macrosocial environment. This dissertation explores how the meaning of obesity has changed over time, among various social actors, and between levels of social interaction. The sociological imagination helps us understand why the solution to obesity is beyond the "range of opportunities open to any one individual" once personal weight has been framed and proven to be a public cost (Mills 1959, 9).

Most public health and health communications research on obesity has quantified and compared competing etiological models and interventions. These are useful for describing what the general public is exposed to through exposure and advocacy. Left unexamined are the rhetorical and narrative elements that make the obesity story compelling. This dissertation discusses the obesity problem as an outcome of moral and medical initiative, and organizational conventions.

OUTLINE OF CHAPTERS

Reflecting the complex medical and moral frames that have elevated obesity into a matter of public controversy and action, the dissertation exploits varied data to answer interrelated questions. Chapter 1 describes how medical experts use biomedical knowledge and authority to assert ownership of the obesity problem. Chapter 2 examines how the news media represents obesity as a health and human interest story, portraying obesity as a resonant problem for society at large. The last chapter profiles a celebrity entrepreneur's moral crusade, optimized for public viewership through the medium of makeover television. This dissertation treats the topic of obesity as field to build bridges between disciplinary "islands" in the sociological subfields of medicine and science; public health; and media studies.

CHAPTER 1. EXPERTS WEIGH IN: MORAL MEDICAL RHETORIC AND THE OBESITY PROBLEM (1980-2000)

ABSTRACT

The problem of obesity is regarded as a widespread and costly public health issue. This study explores the influence of medical moral entrepreneurship in transforming obesity from a private issue to a public problem. This study analyzes the rhetorical tensions expressed in a sample of health science articles on obesity published between 1980-2000. Medical moral entrepreneurship promoted obesity as a public health problem in three interrelated stages: claimsmaking, consolidation, and institutionalization. Bolstered by technoscientific discoveries, expert claimsmaking biomedicalized the disease as a "complex" scientific and medical problem. Next, expert rhetoric sought to build professional consensus about obesity as a significant and treatable chronic disease. Finally, efforts focused on institutionalizing obesity as a public problem necessitating political responsibility and investment. The efforts of medical moral entrepreneurs moderated scrutiny of individual health behavior but expanded the jurisdiction of biomedicine.

INTRODUCTION

The medical and social definition and significance of obesity has changed over time. Since 1998, the Centers for Disease Control and Prevention has defined obesity by approximate adiposity calculated from height and weight, where a Body Mass Index (BMI) score over 25 indicates overweight and a score over 30 indicates obesity. Weight thresholds indicating under-, normal, and overweight were adjusted from previous guidance to align with international standards put forth by the World Health Organization. This policy received widespread public criticism for instantly reclassifying 97 million people - roughly 55 percent of Americans - as "overweight" absent an objective change in their physical health condition (Hellmich 1998; Press 1998). Previous to the

standardization of BMI, medical diagnosis for obesity employed actuarial height-weight tables originally developed by the Metropolitan Life Company in 1959. These charts extrapolated the "stockiness" of a person's build from death hazard ratios calculated from aggregated insurance records. Criticized by experts as lacking inference for evaluating individual or public health, actuarial tables were phased out in the 1980s in favor of BMI. In the years since, experts have vigorously debated the value and precision of BMI for individual medical diagnosis and average body composition. From signifying personal risk to a public health problem, the meaning of heavy weight has been debated, refined, and reconstructed by expert rhetoric.

The profession of medicine is a "moral enterprise" inclined to actively discover and control health conditions it considers undesirable (Freidson 1970). If previous regard of obesity as a private issue limited responsibility to personal behavior and risk, the promotion of obesity as a public health problem expanded professional opportunities for crusading reform (Becker 1973; Mills 1959). This study examines the influence of *medical moral entrepreneurship* in framing the condition as a professional and scientific problem to solve (Becker 1973). Medical moral entrepreneurs have been instrumental for claiming social phenomena such as drunk driving (Gusfield 1981) and drinking alcohol while pregnant (Armstrong 1998; Armstrong 2003) as medical conditions requiring broad medically-centered public health interventions. The moral rhetoric underlying the public health crusade against obesity is one of protecting society against the evils of excess and apathy. Medical experts "own" or maintain definitional authority of the obesity problem by adapting standardized definitions, methods, and etiological models to diagnose and treat the condition. According to Gusfield (1981), expert "ownership" of a public problem is an outcome of power, authority, and influence. I argue that expert

rhetoric framing obesity as a biomedical (rather than strictly moral) condition enhanced professional morale and expanded the jurisdiction of medical expertise.

Public problems are distinct from other troubling social conditions in that they are deemed solvable, typically accompanied by public appeals for political responsibility to be assumed by a governmental body tasked with controlling or solving the problem (Gusfield 1981). This study analyzes the medical literature on obesity published between 1980-2000 in order to trace the social trajectory of obesity as a contemporary public problem through interrelated three stages of medical moral entrepreneurship: claimsmaking, consolidation, and institutionalization.

Obesity as a Private and Public Problem

The obesity epidemic was "discovered" as recently as nearly a century ago by experts observing heavier Americans (Gusfield 1981). A 1912 *New England Journal of Medicine* editorial listed modern inventions such elevators and automobiles as culprits for reduced physical activity and labor. Americans with hearty appetites and reduced physical activity suffered limbs weakened from disuse and the debilitating "automobile knee." Rapid industrialization and agricultural prosperity from 1920-1950 reversed historical associations between weight and wealth as social elites in Western countries increasingly valued thinness (Aronowitz 2008; Levenstein 2003). In the United States, the negative social valuation of body weight moralized fatness as badness (Sobal 1995). Obese individuals were (and continue to be) stigmatized as weak and irresponsible deviants subject to discrimination in education, employment, and other social arenas (Aronowitz 2008).

The institutionalization of professional medicine after World War II supported the expansion of medical expertise and treatment into new domains of human life, resulting in the *medicalization* of deviant conditions such as addiction and obesity (Conrad 1992; Starr 1982). Obesity became medicalized throughout the 1960s and 1970s when heavy body weight was treated as an indicator of disease and a risk factor for early death. By 1985, obesity was widely regarded as a disease in its own right distinct from conditions such as diabetes or arthrosclerosis, in medical reference materials (Chang and Christakis 2002). The American Association of Family Physicians dates International Classification of Diseases codes (ICD-9) used to classify overweight and morbid obesity diagnoses in health care systems back to 1997. Obesity became a "sickness" to be diagnosed through "bureaucratic and biological circumstantiality," defined through the accumulation of institutional logics and tools (Conrad 1992; Rosenberg 2002). Socially, the medicalization of obesity defined heavy people by the "sick role" due to the risk to their personal health, cost to society, and social marginalization (Fox 1989).

The lens of *biomedicalization* became an important component of the expert "tool kit" whereby specific frames and symbols were used to reconfigure obesity as a public problem (Swidler 1986). Biomedicalization processes intensified the symbiotic jurisdiction and commodification of medicine and technology such that "health itself and the proper management of chronic illnesses are becoming individual moral responsibilities to be fulfilled through improved access to knowledge, self-surveillance, prevention, risk assessment, the treatment of risk, and the consumption of appropriate self-help/biomedical goods and services" (Clarke et al. 2003). Three specific bioemdicalization trends are relevant for informing expert strategies for action: 1) the adoption and proliferation of molecularization, geneticization, and computerization, 2)

the elaboration of risk and surveillance, and 3) the commodification and rationalization of biomedical services. As technical and scientific innovations came into prominence after 1985, experts sought to enhance control of external conditions by harnessing the powers of biomedicine to transform human bodies and lives.

One example of biomedicalized risk assessment is the standardization of the Body Mass Index (BMI) as a simplified calculation for comparing an individual's body fat ratio with the national average body composition. Current weight classifications are as follows (Table 1).

Table 1. CDC Definitions for Overweight and Obesity

	Children (2-19 years old)	**Adults (20+ years old)**
Extreme obesity		40 ≤ BMI
Obese		30 ≤ BMI
Overweight	95th percentile for age and gender ≤ BMI	25 ≤ BMI < 29.9
At risk for overweight	85th percentile for age and gender ≤ BMI < 95th percentile for age and gender	
Healthy weight	5th percentile for age and gender ≤ BMI < 85th percentile for age and gender	18.5 ≤ BMI < 24.9

Source: http://www.cdc.gov/obesity/defining.html and http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

The validity of BMI had been called into question as early as 1965, when a comparison with data from a national survey indicated that the tables were very far off from the average weight observed for men, women, and children (Seltzer 1965). Numerous critiques have been directed against the continued use of BMI to evaluate weight standards (Burkhauser and Cawley 2008; Campos et al. 2006; Roubenoff, Dallal and Wilson 1995). Using the ratio of height and weight is so a crude measure that very muscular athletes will qualify as obese under current classifications. Furthermore, the

numerical upper limits between weight classifications is designated and reclassified by the Centers for Disease Control and Prevention (CDC).

A limited social movement to demedicalize obesity was borne from the civil rights and identity politics movements of the 1960s to shift public attention to social oppression rather than badness or sickness. Activists emphasized social restitution rather than punishment or medical treatment for overweight Americans. Efforts to destigmatize heavy weight championed the "fit but fat" thesis and focused on overall health rather than an arbitrary number on the scale (Blair and LaMonte 2006; Campos et al. 2006). Nonetheless, the release of two high-profile official reports titled "Prevention and Management of the Global Epidemic of Obesity" (WHO, 1997) and "The Surgeon General's Call To Action To Prevent and Decrease Overweight and Obesity" (USDHHS, 2001) metaphorically compared rising prevalence to an active disease outbreak (Mitchell and McTigue 2007). These reports promoted obesity as a public health problem by acknowledging risk and stimulating public action on behalf of citizens (Hilgartner and Bosk 1988).

National health surveys have registered the upward tick of scales over the past four decades. Data from the National Health and Nutrition Examination Survey report that approximately 35 percent of Americans aged 20 years and over, and 17 percent of children and adolescents aged 2-19 years old weigh more than is ideal for their age and gender (Flegal et al. 2012; Ogden et al. 2012). Although the prevalence varies considerably by country, a comparative analysis estimated 1.46 billion adults worldwide to have a BMI qualifying them as overweight or obese in 2008 (Finucane et al. 2011). Approximately 20-30 percent of children and adolescents under 18 years of age living in North American, Europe, and the Western Pacific are overweight (Deckelbaum and

Williams 2001; also see Wang and Lobstein 2006). Industrialized countries report unprecedented rates of comorbid chronic diseases and the earliest onset ever of type 2 diabetes among children and young adults (Ebbeling, Pawlak and Ludwig 2002). Though debates persist about measurement protocols, the international expert community interprets such trends as a major threat to the public health of current and future generations (Kersh, Stroup and Taylor 2011; Kumanyika 2011).

Expert claimsmaking often precedes widespread public attention to troubling conditions (Best 2008). Becker describes a moral entrepreneur as someone "whose initiative and enterprise overcame public apathy and indifference" to result in a significant outcome or public policy (1973). Medicine maintains an entrepreneurial orientation to disease by seeking to diagnose and eradicate illness through the enforcement of medical rules, and expanding opportunities for practice (Freidson 1970). Decades of rhetorical claimsmaking from **medical moral entrepreneurs** advanced a new etiological model, consolidated expert opinions, and institutionalized the treatment of obesity as a chronic disease. Whereas previous studies have described trends in the social construction of obesity (Sobal 1995) or the transformation of medical knowledge on the condition (Chang and Christakis 2002), this study directly analyzes the specific rhetoric of medical moral entrepreneurs seeking public health reformation for the evils of obesity. Obesity serves as a case study for medical moral entrepreneurship; how private moral troubles became elevated to the status of a public health problem through medical claimsmaking activities.

DATA AND METHODS

In order to show how medical moral entrepreneurs established obesity as a public health problem, I analyze a sample of medical literature on obesity published between 1980 and 2000. PubMed, a federally funded and maintained database for compiling and categorizing biomedicine and health citations, was the primary search tool for identifying and extracting the data set. The search strategy utilized the Medical Subject Heading (MeSH) indexing function within PubMed to limit the scope of results to citations concerning the diagnosis, classification, and etiology of obesity. This strategy was intended to detect how experts proposed definitions, treated empirical evidence, and debated obesity within the medical narrative (see Hedgecoe 2001, for a similar analysis of how scientists constructed schizophrenia as a genetic disease). The initial search resulted in 1872 citations about obesity concerning human subjects published in English-language core clinical titles within the specified period. Limiting results to editorials, reviews, and guidelines (the most rhetorically rich texts for content analysis) further reduced the sample to 321. Articles were manually reviewed to confirm relevance to the topic. Titles that did not specifically refer to obesity, body weight, body mass index, adiposity, metabolism, weight loss or maintenance, bariatric or gastric surgery, dietary modification, and relevant variations in the title or abstract were excluded. So while excluded articles may have mentioned obesity as a comorbid condition, it was not discussed as a primary finding or feature expert rhetoric. The final data set totaled 182 articles (see Table 2).

Table 2. Sample by Publication Year and Article Type (1980-2000)

Publication period	Review	Editorial	Guidelines Total	Total	Publication period as % of sample
1980-1985	9	3	0	12	7%
1986-1990	8	9	0	17	9%
1991-1995	19	11	1	31	17%
1996-2000	71	41	10	122	67%
Total (n)	107	64	11	182	100%
Article type as % of sample	59%	35%	6%	100%	

The sample distribution indicates subdued but increasing interest in the condition until the mid-1990s, when the publication rate spikes. The sampling period includes significant biomedical milestones in obesity research such as the popularization of BMI, breakthroughs in genetic and endocrine biomedical research, and development of pharmaceutical and surgical treatment for weight loss. In 1997, the World Health Organization convened an International Obesity Task Force to discuss global trends of obesity. By 2000, the problem of obesity was primed to become the political responsibility of government agencies and policymakers (Barry et al. 2011; Gusfield 1981). U.S. Surgeon General David Satcher released the Call to Action to Prevent and Decrease Overweight and Obesity in 2001, which compared the preventability and societal cost of obesity to cigarette smoking.

Expert claimsmaking constitutes all professional journals, official reports, specialty organizations, conferences, and press releases to mass media. The rhetorical purpose of expert claimsmaking is to construct an official and authoritative position towards a disease or condition (Gusfield 1981; Hilgartner 2000). This study treats obesity experts as “medical moral entrepreneurs” and publications as mediums for

"expert rhetoric" in order to highlight the persuasive language, logic, and evidence adopted throughout the claimsmaking process. The coding scheme emerged inductively, with special attention paid to disease concepts, treatment modes, and motivational statements. These broad categories generated 100 code labels during the open coding phase; successive coding stages narrowed the focus to biomedical and professional claims expressed in the texts. Emergent themes resonated with extant research on biomedicalization and the social problems process. All data were analyzed by the author using QSR International's NVivo 10 qualitative data analysis software.

FINDINGS

Claimsmaking: Obesity is a Biomedical Problem

This section analyzes how expert claimsmaking shaped the etiological model for obesity within the time period sampled. Beginning in 1985, the claimsmaking efforts of medical moral entrepreneurs sought to promote obesity as a complex and multifactorial disease to be scientifically explained and measured. Rather than limit attention to individual behavior morally repudiated as "unhealthy," new concepts occupied a strategic tool kit for reconfiguring body weight through the logic and evidence of biomedicine. Having established the condition as a biomedical disease, obesity experts expanded the mission of diagnosis, treatment, and prevention advocacy to public health.

The most basic and prevalent etiological model expressed throughout the sample invoked the mathematical logic of energy balance for weight maintenance, where calories in equaled calories out. The thermodynamic model for weight gain hypothesized any

intake of energy in excess of what was expended through physical activity resulted in storage as fat mass.

> *For the adipose tissues of an animal or a human being to increase, more calories must be ingested and absorbed than are needed to satisfy the organism's metabolic requirements. In normal persons, there is a close coupling between metabolic demands and caloric intake, so that weight normally remains relatively constant in adults.* (Bondy 1980)

Despite the neutral language used to present the energy balance model, this passage was laced with moral rhetoric and allusions to biological deviance. Experts such as Bondy interpreted obesity as a metabolic abnormality, an exceptional physical state where the body had been chronically overfed. (No matter that slowing metabolism, decreased physical activity, and caloric intake in excess of a mere 11 calories per day would result in 25 extra pounds over two decades, as later experts countered.) That someone would tip the scale from normal to obese weight without provoking personal awareness or accountable health behavior was seen as a repudiation of innate thermodynamic function. Energy balance was the most popular etiological model (45 percent) expressed throughout the sample, at times moderated or substituted by mention of genetics (33 percent) and the socio-structural environment (29 percent).

One common variation to the energy balance model suggested that obese persons were metabolically efficient, therefore predisposed to storing adipose tissue despite an average caloric intake.

> *There is some evidence that persons with mild obesity often eat no more than the nonobese, and the most likely explanation is that physical indolence frequently plays a major role in mild obesity*. (West 1980)

West's word choice equated inactivity with laziness, morally evaluating the obese person against an arbitrary standard of "normal" exertion. If obesity was not the result of outright gluttony, then sedentary behavior was to be modified in compensation for

sluggish metabolism. Another hypothesis equated normal metabolic function to fortuitous biological programming.

> *Some people who do not seem unduly afflicted by gluttony or sloth are very fat. Others, with a similar pattern of food intake and activity, are thin. This suggests that the thin people have some mechanism which burns off any excess of energy intake over normal requirements.* (Garrow 1983)
>
> *By definition, to attain the obese state, an adult must consume more calories than he or she expends or use for basal metabolism, temperature regulation, dietary-induced thermogenesis, and periods of physical activity. Nonobese adults usually can finely tune their caloric input and expenditures, thus maintaining constant body weight. This balance is disturbed in obese patients. Furthermore, this balance is more important than the actual quantity of food ingested, as obese adults often consume the same or fewer calories than leaner people.* (Kliegman and Gross 1985)

If energy regulation was somehow more difficult for some proportion of the population, experts sought to effectively control - or compensate – for such metabolic "disturbances." Negative personal characteristics such as "gluttony or sloth" could be overcome with diligent attention to personal health status and behavior. Since the metabolic "rules" for normal or heavy weight were largely in the realm of moralized behavior, obesity as a comorbid condition did not yet represent a meaningful professional challenge or opportunity. Still, these hypotheses introduced nuance to the energy balance model by deconstructing the mathematical premise.

Beginning in 1985, articles discussed new technologies and breakthrough discoveries in genetics, endocrinology, and nutrition supporting the biomedicalized construction of obesity. Rather than interpreting obesity as a condition where the individual was morally responsible, the obese body came to be seen as constrained by internal biological and genetic processes. Biomedicalization reinforced expert claims that obesity was a discrete chronic disease, which required health professionals to play diagnostic and gate-keeping roles on behalf of afflicted patients. Consider the change in

tone expressed in the following passage published in the *Annals of Internal Medicine* in 1986:

> *The obese patient presents a **challenge** with regard to both treatment of a primary disorder and its secondary complications. Although there are various theories to explain the origins and persistence of obesity, no single hypothesis has been completely satisfactory, and most investigators agree that obesity represents a **complex interaction of physiologic and psychosocial factors**. Obesity greater than 30% over desirable body weight, as defined by the Metropolitan Insurance Company weight tables of 1959, should be considered a chronic illness; beyond this level, it is as associated with increased morbidity and mortality.* (Pasulka et al. 1986, emphasis added)

The authors expressed a shift in the professional valuation of obesity research and treatment. Their mild disclaimer is underscored by the professional challenge to explain and treat obesity in clinical settings and expert debates. This quote signaled a broader rhetorical shift in the expert community as the etiological model became a scientific and medical problem to solve rather than a moral condition to monitor. Lastly, the authors proposed a standardized and evidence-based measure for obesity. Though expert disagreement about measurement and classification would persist, a metaphorical line was established to delineate illness and risk of undesirable health outcomes.

The standardization of weight thresholds in the late 1980s reconfigured body weight and enforced biomedical rigor on obesity diagnosis. The Quetelet Index or BMI quantified height and weight into a value that indicated approximate adiposity, which was interpreted along a scale of weight classifications associated to morbidity and mortality.

> *This table translates the BMI into a meaningful number that can be defined to a patient in terms of health risk as well as pounds overweight. Classification by grades of obesity is essential to identifying patients at risk for illness and mortality associated with obesity.* (Blackburn and Kanders 1987)

Blackburn described BMI as a "meaningful" diagnostic tool that objectively assessed and communicated obesity-related health risk in clinical settings. He also expressed

eagerness for adoption of a classification scheme that would stratify individuals and bodies by level of biomedical "interest" - that is, by risk and perceived need for intervention. Some experts welcomed the technoscientific complexity gained from laboratory and field experiments for how such tools would reshape clinical interactions with obese patients. In the following quote, Bierman acknowledged the prevalence of moral rhetoric when discussing obesity or heavy individuals.

> *Our understanding of the pathogenesis of obesity is finally beginning to emerge from mythology into the realm of biologic science. The widely held, simplistic notion that all of our obese patients are gluttons is passing without too much regret.* (Bierman 1988)

Situating the root cause of obesity in "biologic science" was seen as moral liberation in clinical interactions and professional debates.

Despite having broadened the thermodynamic model, there was no overwhelming consensus of what factors were more consequential.

> *Obesity is a disorder in which there is an excess of body fat as a result of an imbalance between energy intake and energy expenditure over prolonged periods of time. Obesity also may have endocrine, hypothalamic, and genetic causes. However, in most instances, the cause of obesity remains unclear.* (Blocker and Ostermann 1996)

Hypotheses were distributed across an array of individual and structural contributing variables, ranging from high-level scientific discussions of metabolic thermogenesis to the catch-all category of "multifactorial origin." It was common for etiological explanations to simultaneously acknowledge the tension between nature versus nurture, between individual behavior and structural conditions, and between clinical and public health models of disease. Explanations were prefaced with the disclaimer that obesity was a complex disease attributed to genetics *and* lifestyle, thus causing difficulty in expert diagnosis, treatment, surveillance, and public policy recommendations.

The contemporary construction of obesity originated from the advent of biomedicalized standardization of BMI beginning in the mid-1980s. Biomedicalization

emphasized the role of technical and scientific innovations in expanding the jurisdiction of biomedicine in every day life. Public discourse on obesity referred to genetic models of disease, repertoires of scientific terminology, and expectations for empirical proof.

> *Obesity is a disease that is neglected—indeed, frequently it is not even thought of as a disease but more as a self- inflicted condition, easily prevented and cured by self-control and determination. Unfortunately, this is not just the opinion of lay people; doctors too, including endocrinologists sometimes, give low priority to obesity as a medical illness. One reason for these negative attitudes is that although a positive energy balance, which is the pathogenesis of obesity, should be easy to correct, in practice it is not. Most physicians know this from their own clinical experience—so why spend time and energy?* (Bjorntorp 1997)

Bjorntorp's rhetorical entreaty framed obesity as a professional and scientific problem to solve. Not only did obese patients require greater attention due to the consequences of excessive adiposity, but obesity as a condition became more consequential in the realm of research and public policy. It became worthy of professional "time and energy" due to the medical moral incentive to control the condition at the individual and population level.

Biomedicalization diverted moral judgment from the obese individual to repudiating the condition itself as a problem. Medical moral entrepreneurs did not suddenly "discover" obesity so much as reclassified the condition as medically relevant, particularly warranted by technological and scientific advances after 1985. Moral rhetoric that had associated heavy weight with "bad" personality traits such as gluttony, sloth, or irresponsibility was moderated by discussions of technoscientific complexity (Clarke et al. 2003; Sobal 1995). Ultimately, what "complexity" and "multifactorial" origins indicate is an incomplete knowledge of what causes obesity, and what can be done about the problem. In the next section, the analysis turns to how expert rhetoric reinforced professional confidence for the clinical treatment of obesity.

Consolidation: Reinforcing Professional Responsibility and Confidence

Having framed obesity as a "complex" scientific problem to solve, how did experts approach campaigning for professional responsibility and confidence for its treatment? This section describes how medical moral entrepreneurs rhetorically presented two professional missions: 1) convincing peers of obligations and opportunities as well as 2) reinforcing professional confidence in obesity treatment and counseling. Domain expansion of the obesity problem imparted relevance and opportunity to fields outside of medicine given that not all obesity experts operate in clinical settings. Broad agreement that obesity should be treated did not preclude conflict and contestation between expert factions advocating for how care should be managed.

Among articles analyzed in this study, the first instance of an explicit professional entreaty for medical moral responsibility occurred in a 1985 editorial featured in *The Annals of Internal Medicine*. Public health campaigns targeting smoking and alcohol abuse were compared as case studies for educating the public and developing behavioral modifications:

> *Overeating has not yet become a target of organized social pressures, probably because it does not immediately affect other people. Physicians and other health care professionals will continue to have to take major responsibility for efforts to reduce overeating as a hazard to health.* (1985)

Having described obesity as a latent public health problem, expert rhetoric pushed for a re-prioritization of professional attention. The appeal to medical moral "responsibility" implied that dismissing obesity treatment would amount to a professional shortcoming in regard to serving the public health. Physicians promoted clinical services for obesity as a necessary duty for protecting or improving patient health in the long run. Other health professionals such as nutritionists and psychologists advocated for patient- and family-

based behavior education and modification in tandem with a medically-supervised weight loss program. Consistent with findings from the previous section, obesity treatment strategies were limited to the scrutiny of individual behavior by the comparing overeating to hazardous behavior. A editorial by the Council on Scientific Affairs (1988) reiterated professional ownership of obesity: "The physician has a responsibility to explain the rationale for advising weight loss and its importance to health."

Given the primary audience of health science articles, the purpose of expert rhetoric was to serve as a rally-cry for health professionals to seriously consider obesity as a treatable and preventable disease. In doing so, medical moral entrepreneurs confronted the reality of professional prejudice and discrimination directed towards the same obese patients they intended to help. Stunkard and Sorensen (1993) argued for the expansion of rights and protections reserved for disabled Americans, in order to reform public and professional treatment of the obese.

> *The authors suggest the extension of the Americans with Disabilities Act to include the overweight, which would certainly be a beginning. Overt discrimination against overweight people is only part of the problem, however, and we in the medical profession are among the chief offenders. Who among us has not heard the horror stories told by obese persons about their treatment at the hands of insensitive and prejudiced physicians?* (Stunkard and Sorensen 1993)

Medical moral entrepreneurs framed obesity as a disease with broad social, political, and economic implications. Not only would professional sympathy earn the trust and cooperation of obese patients, but simultaneously consolidated medical authority over the condition. The expansion of the disability classification would have represented an enormous expansion of demand - and reimbursement - for long-term services.

Expert rhetoric also urged for increased professional respect for obesity as a condition.

> *Obesity is a disease that is neglected—indeed, frequently it is not even thought of as a disease but more as a self-inflicted condition, easily prevented and cured by self-control and determination. Unfortunately, this is not just the opinion of lay people; doctors too, including endocrinologists sometimes, give low priority to obesity as a medical illness. One reason for these negative attitudes is that although a positive energy balance, which is the pathogenesis of obesity, should be easy to correct, in practice it is not. Most physicians know this from their own clinical experience—so why spend time and energy? (Bjorntorp 1997)*

Bjorntorp's rhetorical entreaty posed obesity as a professional and scientific problem to solve. The statement implied that obesity was *not* a preferred physical state by unmotivated individuals relegated to the margins of medical service. Bjorntrop joined with others in arguing that health professionals committed to their medical moral responsibilities should *not* neglect obesity. Health professionals were urged to approach obesity treatment with "great humility" and caution given the controversies over pharmaceutical treatments such fen-phen, and the limited success from existing treatment protocols (Yager 2000).

In clinical settings, professional counsel ranged from diagnosis and classification; recording family and personal health history; patient education regarding risk, medication interactions, and complications with comorbid condition; devising treatment plans for weight loss; and supervising treatment, recovery from bariatric surgery, and medication therapies. Providing such a range of services was not always a welcome professional challenge.

> *Obesity is an entity that physicians may approach with trepidation…Obesity is famously and markedly refractory to long-term improvement. It also is a condition that requires multidisciplinary attention, often presenting with intertwined physical, biochemical, and psychosocial strands. By the time a patient is seen clinically, he or she may have undergone many failed self-help and proprietary treatments, experienced rebound weight gain, and not maintained diet discipline. More than many other patients, an obese patient is a challenge to the physician's clinical and psychosocial skills.* (Blocker and Ostermann 1996)

Physicians responsible for overseeing care are tasked with coordinating between specialists who provide (perhaps conflicting) counsel to their patients. Communication

was a never-ending challenge that required enhanced interpersonal communication and problem-solving skills. While the biomedicalization of obesity enhanced expert authority and power in general, the responsibility of offering “doctor's orders" was both daunting and fractured across medical disciplines.

In addition to requiring a significant investment of time during appointments, clinical interactions for obesity heightened expectations for enhanced communication, sensitivity, and good bedside manners. These expectations interfered with organizational pressures on primary care physicians to increase volume of reimbursable services. Communicating professional confidence towards patients was necessary for treatment to have any chance of success. Unfortunately, pessimistic attitudes towards the condition and overweight patients were abundant among experts.

> *…The assumption that the general practitioner can scientifically monitor a weight control program is fallacious. The best the physician can do is to monitor symptoms which may appear only after substantial damage has already been done.* (Mallick 1983)
>
> *Severely obese people often have low self esteem and excessively optimistic expectations of each new treatment. This attitude sets traps for the doctor, who may say that the problem is trivial or easily solved or incurable, none of which is true.* (Garrow 1991)

Working with incomplete knowledge or ability to monitor, health experts regarded the condition as difficult to treat and manage. The chasm between expert knowledge and treatment protocols for the condition would increase over time. Whereas physicians continued to develop regimens combining low-calorie diets with exercise programs, the advent of pharmaceutical or surgical treatments complicated both expert and patient expectations. Convincing health professionals to invest time and energy into obesity treatment necessitated overcoming defeatist attitudes and instilling confidence in clinical protocol. To manage patient and professional expectations, the mantra for small losses in weight begetting substantial health benefits became the focus of treatment.

Expert rhetoric asserted a wide range of responsibilities for treating and preventing obesity, thus consolidating professional authority and confidence. The prevailing rhetoric promoted expert skills, knowledge, and duty for treating obesity as a chronic disease. The next section explores how experts discussed obesity as a public problem, particularly around the issue of prevention.

Institutionalization: Obesity is a Chronic Disease Worth Treating

Expert rhetoric culminated in the institutionalization of obesity as a public problem, which spurred political responsibility on behalf of public health and fiscal logic (Gusfield 1981). Medical moral entrepreneurs presented evidence and opinions that supported a singular, alarming message: obesity was a worsening condition that endangered the economic and social prosperity of the United States of America. Medical moral entrepreneurship capitalized on heightened awareness from high profile reports on prevalence trends and health care costs to rhetorically campaign for prevention. The effect of medical moral entrepreneurship was an expanded biomedical jurisdiction over human bodies, structural environments, and public policy.

Appeals for political responsibility, unsurprisingly, appeared as soon as the problem of obesity gained traction among experts. Frustrated by the limited success of treatment in clinical encounters, medical moral entrepreneurs argued that public officials were mutually obligated to do something about the problem.

> *For more than 50 years obesity has been one of the commonest health problems in the United States and other affluent societies. Although obese Americans now spend hundreds of millions of dollars annually trying to lose weight, the national investment in obesity-related research has been contrastingly small and progress in prevention and treatment scant. (West 1980)*

> *Efforts are urgently needed to combat the obesity epidemic and reverse the current prevalence trends… Despite being a chronic disease affecting more than half of the population, obesity is still not seen by policy makers and many public health officials as a serious threat to the health of Americans. It is not on the radar screens of foundations that allocate funds toward issues of critical importance to the health and quality of life of Americans. (Hill, Wyatt and Melanson 2000)*

Both authors argued that the obesity problem was widespread and likely to worsen over time given certain socio-structural conditions. Though lucrative for select industries, private attempts to control the problem were seen as inefficient, stopgap measures given the scope of the problem. Experts pushed to hold government officials politically responsible for failing to act towards funding and planning long-term solutions for a disease of "critical importance" for the health and prosperity of many Americans. Treatment independent of a broader public health campaign was regarded as a medical moral quandary.

> *At some point, it becomes unethical to continue to treat the comorbidities of obesity without preventing and treating obesity itself. For any significant progress in changing population obesity prevalence, obesity treatment and prevention need to move higher on the priority list for clinicians as well as government, education, industry, and community action groups.* (Schmitz and Jeffery 2000)

The "ethics" invoked were medical, by facilitating professional resources, as well as moral, for the sake of the greater public good. Schmitz directed expert claimsmaking towards advocacy in a cross-section of political, social, and economic realms.

Medical moral entrepreneurs pushed for political responsibility as the most comprehensive "common sense" solution that would achieve the intention of saving lives and downstream health care cost. Rising prevalence and escalating health care costs in the population were cited as medical evidence or elaborated the moral grounds for institutionalizing obesity as a public problem.

> *Overweight is associated with adverse economic as well as health outcomes. Adolescents who enter the job market overweight start at lower salaries than do nonobese adolescents and fail to achieve parity in later years even if they lose weight. Overweight*

> *also places a severe financial burden on the health care system in the United States; the estimated economic effect of associated illnesses is >$39 billion per year*. (Rippe 1996)
>
> *"Adult obesity is an important risk factor for many chronic diseases that are leading causes of morbidity and mortality, lost work days, and disability. The economic cost of adult obesity in the United States was estimated to be $68.8 billion in 1990, which did not include the additional $33 billion spent yearly on weight-reduction products and services.* (Schonfeld-Warden and Warden 1997)

Rising medical expenses, as more Americans at all ages became obese, was regarded as a real threat and prominent theme throughout the medical literature. Estimates for costs of obesity-related treatment varied but larger numbers created an undeniable shock value that resonated among experts and the public. Moreover, the economic impact of reduced productivity, social discrimination, or even disability would eventually threaten the standing of the United States as a political superpower. Medical moral danger to public health justified intervention and investment to address the public problem.

The rhetoric of prophylactic public health intervention was a prominent theme in the institutionalization process. If treating existing obesity was a frustrating professional duty, then public health advocacy would potentially reach and affect more people before the disease actualized.

> *The complex etiology of obesity is, in part, responsible for the difficulty physicians encounter in treating this condition. Prevention is the 'treatment' of choice. (Council on Scientific Affairs, 1988)*
>
> *…A better understanding of the ways in which genetic factors contribute to obesity could be useful in its prevention, with prophylactic efforts refocused on the most vulnerable.* (VanItallie 1990)

Prevention implied that there existed multiple instances and resources for intervention over the course of the life span. Prevention did not require that the complex etiological origins of obesity be settled definitely, but that action be taken immediately based on prevailing guidelines. Lastly, prevention sought to identify groups that were especially vulnerable or susceptible to the disease – a targeting strategy that would not be possible without public health resources.

By the late 1990s, expert rhetoric circulated through the academic press and mass media had convinced the American public that the obesity problem was real, problematic, and increasing in scale. Although the etiology of the obesity "epidemic" remained debated, the condition was firmly institutionalized among governments and international public health organizations as a public problem (WHO, 1997, USDHSS, 2001). Medical moral entrepreneurs compared the public health problem of obesity to anti-smoking campaigns carried out a generation ago:

> *Primary care physicians have an important role in this process. Just as several published studies have shown that physicians can effectively help their patients quit smoking or become more physically active, physicians can integrate behavioral weight control counseling into routine practice.* (Simkin-Silverman and Wing 2000)

If the prevalence of obesity compromised population health, then the sphere of responsibility extended beyond the scope of the doctor-patient relationship. The rise of obesity as a public problem inspired mobilization on behalf of diverse causes, but the input of numerous experts added to confusion about what and whom the public believed. However, Simkin-Silverman reiterated that primary care (and specialist) physicians played a central role in helping patients and policy-makers navigate the complex dimensions of the disease.

DISCUSSION

This paper explores three interrelated stages of medical moral entrepreneurship. Biomedical progress encouraged the conceptualization of obesity as a “complex” and “multifactorial” biomedical disease. Having claimed obesity as a *biomedical problem*, expert rhetoric consolidated peer support for obesity as a worthwhile condition to treat. The institutionalization of obesity as a *public health problem* in the late 1990s reinforced

medical expertise in treatment and prevention efforts. Decades of medical moral entrepreneurial activities convinced experts (and the public) that obesity was a treatable biomedical disease and preventable public health problem.

Until the latter half of the 20th century, obesity was a relatively marginal physical condition, secondary to the concern for underweight and malnutrition in the population. With population studies reporting that obesity had become a common condition in the United States (Flegal et al. 1998), medical moral entrepreneurs sought to promote a more complex, technoscientific, and commodified perspective on health and disease. As moral reformers, they equated health risks with moral and material danger to public health (Becker 1973). Brandt summarized in his analysis of public health reform over cigarette smoking, "the process by which risk is assessed and perceived reveals deep social, cultural, and political values" (1990). This study adopts a similarly critical position towards obesity medical moral entrepreneurship by evaluating expert and professional bias towards disease and intervention.

Findings are consistent with Chang and Christakis' (2002) analysis of the Cecil Medical Handbook in which experts maintain the basic model of "mechanical/economic function and efficiency." The medical meaning of obesity evolved throughout the 1980s and 1990s as experts focused on the fundamental and clinical experience of the disease. The ethological model for obesity broadened to account for "multifactorial" root causes. Expert rhetoric abandoned the simple thermodynamic formula of energy balance in favor of complex biomedical systems and interactions. Building on existing research, this study analyzes a broader sample of the medical literature to consider the impact of biomedicalization on the social construction of obesity. Biomedicalization promoted a depersonalization and destigmatization of the obesity condition as an outcome solely

attributable to personal habits and individual responsibility. The expert perception of obesity changed from a moral problem to a disease to scientifically explain and measure (Arney and Bergen 1984).

A multifactorial etiological model, in effect, allowed medical moral entrepreneurs to draw from a tool kit of explanations that could be strategically deployed or discarded according to claims put forth by emergent research. Similar to the fields of law or religion, the practice of medicine is inherently evaluational about what is normal or healthy – or more often, what is abnormal and unhealthy (Freidson 1970). That doctors perpetrated obesity as a medical moral problem coincides with the broader influence of biomedicalization in shaping values and rationalizing intervention. Experts did not so much discover obesity as a disease as much as reconfigured treatment as risk management for personal and public health.

Framing obesity as a public health problem in the late 1990s heightened prevailing biomedical values of risk management and medical surveillance. Obese individuals are expected be proactive about their health problem, lest American society be burdened with the cost of excess medical service and lost productivity. Proper management of health and disease obligates individuals to become educated about personal risk factors, and remain vigilant in "self-surveillance, prevention, risk assessment, the treatment of risk, and the consumption of appropriate self-help/biomedical goods and services" (Clarke et al. 2003).

This study does not take a position as to whether or not obesity is a "real" public problem, only noting that government leaders have recently evaluated the evidence sufficient to motivate controversial and costly interventions. Findings are limited in that the data do not offer precision for identifying the exact dates when frames and definition

shifted, only what emerged from on-going debates that continue to the present. This study described the evolution of medical diagnosis towards public distinction rather than aligning each stage with precise biomedical epochs. It reveals the haphazard and contested nature of the social problems process, particularly the disproportionate influence of experts and medical professionals in advocating for political responsibility for population-level solutions. Another limitation to acknowledge is the bias inherent in sampling for the dependent variable – that is analyzing biomedicalized ownership within the medical literature. It is not clear biomedical ownership is uncontested since the majority of weight-loss interventions are nonmedical. Replicating a similar post-hoc analysis for other medicalized conditions (such as alcoholism) or related industry players (such as Weight Watchers) would introduce complexity to the analysis presented.

One conspicuous aspect of entrepreneurship that could not be directly assessed from the data was the financial incentive for expertise and treatment. Claims put forth by the thriving weight loss industry compete for limited reserves of public attention and private resources (Hilgartner and Bosk 1988). Weight loss treatment (to distinguish from obesity management) remains a largely commercial enterprise dominated by promoted brands such as Weight Watchers, Nutrisystem, and Jenny Craig. In establishing obesity as a public health problem, medical moral entrepreneurs staked a claim as rule enforcers who could be employed and entrusted as clinical advisers acting on behalf of the American public (Becker 1973). Experts positioned themselves in the media and public policy as advocates for structural solutions such as soda taxes, trans-fats bans, and public health education and services. If any industry was to benefit, why not physicians and other health care professionals who were already treating obesity within the existing "Biomedical TechnoService Complex, Inc.?" (Clarke et al. 2003). Medical moral

entrepreneurship underscores experts' vested interest in framing public problems and attendant policy measures in the medical realm in order to maintain definitional ownership for determining what can and should be done.

CONCLUSION

By 2000, experts and the American public were actively combating the obesity "epidemic." Obesity becomes a "policy relevant" disease as a result of expert rhetoric that called attention to the increasing population prevalence and the economic burden of the disease (Rier 1999). Media attention was deliberately cultivated to warn Americans about their diet and exercise habits, or correct public health knowledge based on new reports or recalls. Health experts, including physicians, became public leaders trusted to interpret scientific findings and translate implications to the average American viewer. Despite the inconclusive findings and applications of epidemiological studies, "many citizens will use them as the basis for making important changes in their personal health behavior" (Brody 1998, Rier 1999).

Expert consensus was - and remains - influential on obesity's status as public problem. The interpretation of body weight as a manifest health risk results from the presentation of scientific discovery and rhetorical persuasion. Rhetoric is embedded in the writing process, where language is crafted with the intention of affecting lay, expert, and official audiences. The data serve to persuade as much through artful drama as the weight of logic and truth. Normal science is infused with literary rhetoric that transforms a research question into a social problem, evidence into narrative, and conclusions into performance to convince the audience to act on the meaning produced (Gusfield 1976).

The American public has been moved to understand and treat obesity as a public health problem.

CHAPTER 2. BLAME, CLAIM, SHAME: EXPERT AND LAY COMMENTARY ON OBESITY IN THE PRINT NEWS MEDIA (1995-2004)

ABSTRACT

Reporting about scientific or medical topics is typically translated, contextualized, and brought to life by selective commentary from experts and "normal" lay informants. This study examines how the print news media reports on obesity as a biomedical and behavioral problem by identifying who gets to say what about obesity. Based on a sample (n = 256) of news stories published in the New York Times and USA Today between 1995-2004, this paper analyzes how expert and lay statements are used to package obesity as a medicalized human interest story. It argues that obesity narratives quote figures as archetypical characters based on professional authority or personal stigma. Experts gain claimsmaking leverage from their diagnostic and clinical skills to promote obesity as a biomedical problem. Shameful experiences distinguish lay accounts as cautionary tales or anchor testimonials for overcoming personal health conditions. Journalistic conventions individualize blame by reifying expert authority and clinical treatment to reform obese people. This study contributes to understanding of health communications and the social problems process.

INTRODUCTION

Over the past 20 years, the news media has depicted obesity as a worsening public health and social problem. The public has been made aware of health statistics estimating approximately 35% percent of Americans aged 20 years and over and 17 percent of children and adolescents aged 2-19 years old weigh more than is ideal for their age and gender (Flegal et al. 2012; Ogden et al. 2012). Headlines and sound bites repeat dramatic and pessimistic predictions for the state of public health and fiscal burden of treatment of obesity for American society (Finkelstein, Ruhm and Kosa 2005; Kersh,

Stroup and Taylor 2011; Kumanyika 2011; Thorpe and Philyaw 2012). From the margins, a vocal minority discount the obesity problem as a moral panic (Campos et al. 2006), debate whether the "obesity epidemic" actually represents a disease outbreak (Mitchell and McTigue 2007), and argue for tolerance of body diversity (Saguy, Gruys and Gong 2010). On rarer occasion, audiences encounter commentary from the "man on the street," someone who provides entertainment with relatable or poignant anecdotes (Hughes 1936).

The mass media and culture industry depend on journalistic and organizational conventions to streamline the reporting of the obesity narrative (Becker 1982). The journalistic "reality" represented to the public is constructed with input from various **sources**, whether they be members of professional and scientific organizations or lay witnesses with direct experience. Critics of media argue that **operatives**, typically activists or experts presenting claims about social problems, receive and benefit from preferential access or bias to promote ideological values. Nonetheless, the temporal and structural pressures of producing news analysis prioritizes authoritative claims and packages with core ideas easily communicated for public consumption (Best 2008). The relationship between media discourse and public opinion operate as parallel systems as journalists construct the essential context by which audiences interpret new information or public appeals (Gamson and Modigliani 1989).

Where claims about troubling conditions coexist and compete, the most successful media packages include both expert-certified facts and dramatized emotional rhetoric (Hilgartner and Bosk 1988). How does the news media represent obesity? How are lay and expert commentary deployed in obesity coverage? This study proposes that obesity is depicted in newspapers as a medicalized human interest story such that casual origins

and treatment strategies are framed as individual concerns. The news media draw on expert and lay commentary to construct a resonant package: obesity is a serious medical condition that negatively impacts the quality of life. Complex packages, or packages implicating systemic conditions (which are almost always more resistant to change) usually have less exposure in the media and less traction in the public imagination. Using print journalism as a case study, I argue that obesity narratives represent lay and expert operatives as archetypical characters based on expertise and stigma.

News Media Coverage of Obesity

News media coverage of obesity in the United States and abroad has increased since the mid-1990s through around 2007 (De Brún et al. 2011; Gearhart, Craig and Steed 2012; Kim and Willis 2007). Epidemiological trends tend to drive news volume where the "deadliest" high-mortality diseases receive higher rates of coverage (Adelman and Verbrugge 2000). Chronic diseases that develop over the life course, such as obesity or heart disease, require "sufficient" advocacy from health science operatives to publicize increasing population prevalence rates over the past two decades (Adelman and Verbrugge 2000; Best 2008). In an 10-year (2000-2009) analysis of US media coverage on obesity, Barry et al. (2011) find the news coverage to be consistent with the "issue attention cycle" where public attention corresponds to heightened urgency but does not sustain over time. Indeed, attention from the news media or general public represents a scarce resource for which the population of social problems compete for dominance (Hilgartner and Bosk 1988).

Dating back to its printed inception, journalism produces a popular literature comprised of a mix of political and populist interests and messages (Hughes 1936). The

idealized mission of the news media is to disseminate information in an accurate, timely, and relevant manner that resonates within the context of individual lives and broader society (Gamson et al. 1992). Extant health communications and health policy research indicates the news media select for drama and novelty while privileging actors with economic or social power, thus resulting in imbalanced coverage of the topic (Bartlett, Sterne and Egger 2002; Entwistle 1995; Roy et al. 2011). For example, UK newsprint coverage of the human papillomavirus (HPV) immunization program introduced in 2008 largely portrayed the intervention as a positive public health strategy for preventing cervical cancer in future generations of women (Hilton et al. 2010). However, "risk" was presented in social and cultural terms, where the vaccine had the potential of promoting promiscuous sexual behavior among women (rather than men). While positive media coverage can facilitate public acceptance of public health interventions and influence health behaviors, secondary frames can perpetuate underlying conditions of social inequality (Hilton et al. 2010). Thus, journalism functions similarly to other sectors the culture industry by deploying accepted experts and thematic **conventions**, or moral beliefs that make audience reception and news work efficient (Becker 1974).

Since the general public depends on the mainstream news media (including newspapers, magazine, and television) as their primary source of health information (Dutta-Bergman 2004), the function of journalistic enterprise elicits important considerations. The news media informs the public about heath and health policy through agenda-setting practices by selecting which stories will be covered and brought forward to public and governmental attention, and **packaging** information to resonate with dominant cultural narratives (Entman 2007). Media packages are constructed around one or more **frames**, or a "central organizing principle that holds together and

gives coherence and meaning to a diverse array of symbols" (Gamson et al. 1992). Operatives, frames, and interpretive packages interact and compete at the level of individual cognition as well as the public arenas that influences social and economic policy (Gamson and Modigliani 1989; Hilgartner and Bosk 1988). **Frame alignment** is the ongoing-process of resource mobilization to enhance the resonance between individual and social movement organizations orientations towards issues. Frame alignment occurs through interactional processes that bridge, amplify, extend, or transform the subject and public reaction (Snow et al. 1986).

Lay and expert operatives are primary media sources of information or commentary that journalists selectively integrate to form newsworthy narratives (Gearhart, Craig and Steed 2012). Facing deadlines and tasked with covering beats as broad and technical as “health” and “science,” journalists utilize institutional cues and gatekeepers to identify and interpret what is newsworthy (Conrad 1999). The health sciences and news media share interconnected roles in framing obesity as a social problem: medical journal press releases signal “noteworthy” research and the news media dramatize or enhance entertainment value, sometimes at the expense of furthering public health education or public policy (Bartlett, Sterne and Egger 2002; Entwistle 1995).

Institutional constraints and alliances incentivize journalists and operatives to cooperate in order to advance their respective missions (Conrad 1999). The most enterprising operatives advocate frames that attribute casual responsibility and claims for viable solutions in service of their profession or organization (Gusfield 1981). **Biomedical** frame emphasizes health risks and clinical interventions that are reformed at the individual level (Saguy and Almeling 2008). Other dominant frames implicate

personal nutritional and exercise **behavior** as the cause and treatment for obesity (Barry et al. 2009); or **environmental** conditions (including the food and agricultural industry) as the primary causal mechanism for the rise of obesity (Brownell and Horgen 2004; Hillier 2008). These frames are situated along a range individualistic and societal/systemic attributions reflecting how society constructs risk and responsibility (Kim and Willis 2007; Lawrence 2004). Although individualized biomedical and behavioral frames are the most consistently mentioned frames in the mainstream media, newspapers are more likely to propose system-level solutions while television news focused on behavior change in obesity reporting from 2000-2009 (Barry et al. 2011).

Sources engage in agenda-setting activities by offering claims and delivering perspectives packaged into familiar news narratives (Driedger 2008). Rather than determining the entire content of public discourse, the news media imparts salience to issues that engages the collective public imagination. Hall et al. (1978) argue that primary definitions of social problem are shaped by social elites who leverage privileged access to the media to advance definitions that suit their purposes and ambitions (cited in Driedger 2008). This reciprocal relationship is structured by the media's reliance on experts as "official" and validating primary definers (see Welch 1997 for an analysis of newspaper coverage of crime). Non-technical commentary from advocacy organizations or lay individuals also participate in secondary definitions that function to politicize expert opinion or contribute "human interest" (Conrad 1999; Gamson 1998; Grindstaff 2002; Welch, Fenwick and Roberts 1998).

Whether used to juxtapose or reinforce the narrative, sources are used to embellish news stories with interesting or authoritative accounts. How does the news media employ – and are in turn used by – operatives to report on health news and policy? This

study examines print media practices in obesity coverage that favor certain actors to package certain frames. I present three levels of analysis for the data: 1) a quantitative analysis of casual frames, 2) an in-depth case study of one article, and 3), and an overarching synthesis of expert and lay characterization. Experts gain claimsmaking leverage from their diagnostic and clinical skills to promote obesity as a biomedical problem. Shameful experiences distinguish lay accounts as cautionary tales or anchor testimonials for overcoming personal health conditions. Findings indicate support for individualized causal frames during this period, which promoted the need and availability for clinical treatment to reform obese people and their health behavior. I draw on medical sociology, the sociology of social problems, and health communications to further understand claimsmaking and the social problems process.

DATA & METHODS

The study compares obesity articles published in the *New York Times* (NYT) and *USA Today* (USAT), two nationally-circulated mainstream newspapers, to examine how the print media reported on obesity between January 1995 and December 2004. Similar to studies analyzing media coverage of social problems (Kline 2006; Kupchik and Bracy 2009; Shugart 2013), the newspaper titles were chosen to represent the "mainstream news" perspective writing for a general audience. Both titles have similar circulation rates totaling over 1.5 million but target different audiences; *USAT* content is primarily read in print while online readers have helped *NYT* establish a significant digital media presence (see Table 1). *USAT* content follows a concise, broad-scope format that is typically accompanied by informational graphics. Promising to deliver "all the news

that's fit to print," *NYT* content is perceived as journalistically rigorous but biased to the political left. The top-circulated *The Wall Street Journal* with an average daily readership of 2.38 million was excluded because its primary content and readership is business-focused. Though potentially biased towards readership based in the Northeastern United States, these media outlets comprise a nationally representative sample for assessing trends in the volume of obesity coverage and variation in how subject matter was reported (Kupchik and Bracy 2009). Although the data set was designed for rhetorical comparison between the respective reporting styles, the final analysis reflects themes that cut across both newspapers and represent the entire data set.

Table 1. Newspaper Circulation Rates for March 2013

Title	Circulation
The New York Times	Print: 731,395 Digital: 1,133,923 Total average: 1,865,318
USA Today	Print: 1,424,406 Digital: 249,900 Total average: 1,674,306

Source: (Alliance for Audited Media, 2013)

The time frame captures the period preceding and following two significant events signaling obesity as a public health problem. In 1997, World Health Organization convened the International Obesity Task force to discuss global trends and policies. In 2001, United States Surgeon General David Satcher released the Call to Action to Prevent and Decrease Overweight and Obesity. This report, echoed by the highest ranked American public health official at the time, characterized obesity as an "epidemic" and escalated the social and economic circumstances of the disease.

Obesity articles published in *USAT* and *NYT* between January 1, 1995 and December 31, 2004 were identified and accessed via LexisNexis Academic, an online research service for legal and journalistic documents. The search strategy utilized the LexisNexis index feature to identify 588 (*USAT* 263, *NYT* 325) empirical articles, book reviews, editorials, and letters of correspondence subcategorized in "Diseases & Disorders" under the Medicine and Health heading. The primary criterion for selection was the inclusion of lay and expert quotes (noted within quotation marks) in order to capture which explicit experiential and professional "testimonials" were deployed by the news media. Conrad explains that "quotes are places in the story where [professional and lay] 'experts' directly present their viewpoints in their own words. Although quotes are selected by the journalists, they are uttered by the experts and can have a significant impact on how the news is written and read" (1992, 300). Manual screening to eliminate duplicate entries and articles that did not feature direct quotes from experts or lay individuals reduced the final sample to 353 (*USAT* 191, *NYT* 162), or 58% retention overall.

The data set was imported into QSR Nvivo 10, a qualitative software analysis program, for coding and analysis of direct quotations from operatives (experts, spokespeople, or lay) as well as casual frames (biomedical, behavioral, environmental) mentioned in the body of the article. Casual frames were tabulated to assess prevalence. Thematic codes emerged inductively, driven by interest in the rhetorical function of expert and lay quotes. Analysis began with a semantic approach of aggregating and describing what commentators said, then shifted focus to the latent social constructions (expert claimsmaking, shame and deviance) produced by their characterization. Consistent patterns emerged throughout procedural coding stages that affirmed the

prevalence of expert and lay archetypes for packaging obesity as a health and human interest story. One representative article was selected for in-depth analysis in its entirety.

The sample indicates that overall print news coverage on obesity was moderate until the latter part of the sampling period, increasing 300% in 2003 before seemingly stabilizing (see Figure 1). Although *NYT* published a greater annual volume of obesity-related content, coverage equalized after 2001 as *USAT* increased health and science-related coverage. Frequent inclusion of expert and lay quotes defined *USAT*'s journalistic style whereas approximately half of *NYT* articles cited direct references (see Table 2). Experts appeared to have a greater presence as quoted sources in *USAT*, potentially influencing a more "populist" national readership. Difference in the quote rate reflects the former newspaper's heavy dependence on experts to summarize or represent health or science news. Rather than biasing the results, it further emphasizes experts' claimsmaking leverage in framing obesity as a biomedical problem.

Figure 1. Obesity Article Frequency, *The New York Times* and *USA Today*, 1995-2004

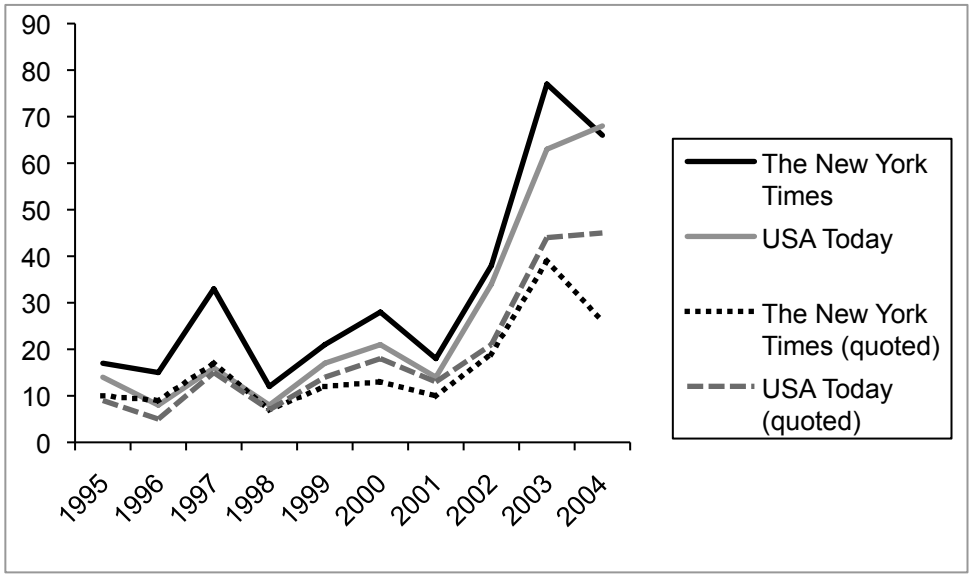


Table 2. Percentage of Articles Featuring Quotes, *The New York Times* and *USA Today*, 1995-2004

Year	NYT articles quoting expert or lay (n=325)	USAT articles quoting expert or lay (n=263)
1995	58.8%	64.3%
1996	60.0%	62.5%
1997	51.5%	93.8%
1998	58.3%	87.5%
1999	57.1%	82.4%
2000	46.4%	85.7%
2001	55.6%	92.9%
2002	50.0%	61.8%
2003	50.6%	69.8%
2004	39.4%	66.2%
Overall Average	49.8%	72.6%
Annual Average	52.8%	76.7%

FINDINGS

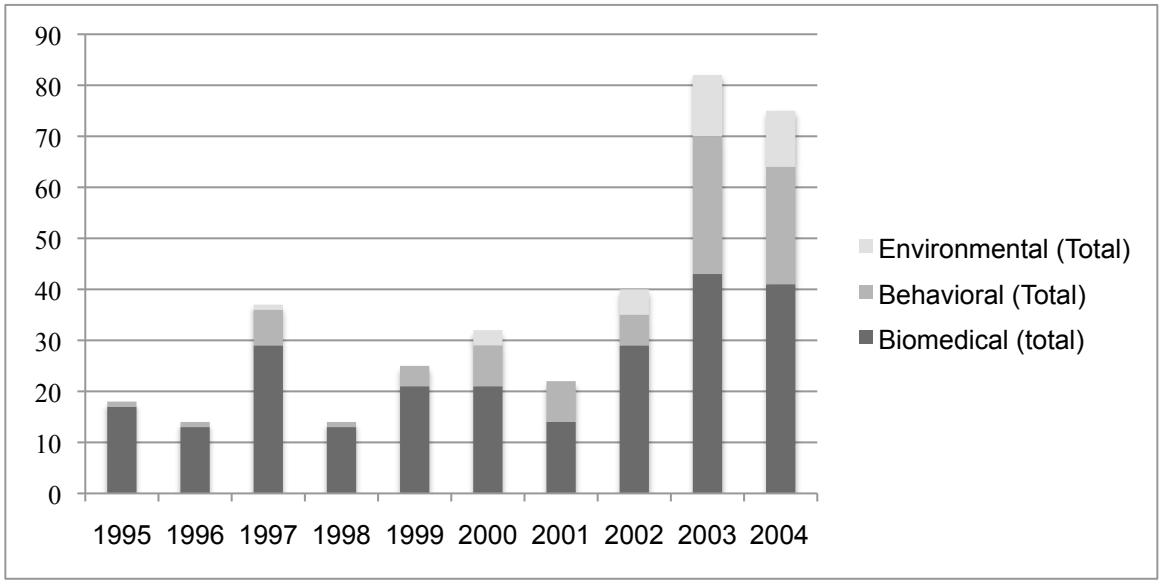
Blame: Obesity as a Health and Human Interest Story

From 1995-2004, print news media coverage of obesity consistently and predominantly framed the issue as a matter of health and human interest. This finding is supported in quantitative comparisons of frame references across the entire data set, and in-depth textual analysis of a front-page *New York Times* article published on October 12, 2000. Having established public audiences' frequent and typifying exposure to the biomedical frame, I consider what lay and expert sources have to say in a case study of

how obesity news is reported.

Figure 2 shows the total annual volume of *New York Times* and *USA Today* stories on obesity over the 10-year the sampling period. Reflecting the multifactorial etiology of obesity, it was common for frames references to overlap and vary in rhetorical strength, thus resulting in a greater number of frames reported than the number of articles in the sample. While the overall volume of obesity news coverage increased over time, biomedical explanations were prominently deployed in obesity coverage. Behavioral factors such as diet and exercise received consistent but marginal attention until the last two years of the sample. Similarly, the environmental frame began to gain traction around the same time as experts and advocates spoke against obesegenic conditions such as poverty, fast food, and targeted food marketing towards children. Though the complementary or competitive interaction of casual frames remains unclear, the data indicate that expert and lay sources were represented in news stories featuring biomedical attributions and treatment for obesity.

Figure 2. Total Frame References By Year, 1995-2004



Lay and Expert Commentary Tell the Obesity Story

Exposure is but one aspect of packaging obesity as a significant health problem. Public understanding is also shaped by journalistic reports of tangible human experiences resulting from a particular troubling condition. Consider Denise Grady's *New York Times* article, titled “Exchanging Obesity’s Risks for Surgery’s," which compares accounts of bariatric surgery from the perspectives of lay patients and obesity experts (2000b). Over the course of 3570 words, six experts (all male, five of whom were surgeons with expertise in bariatric procedures) and four lay sources (one male, three female) were directly quoted. Minor sources included one unquoted surgeon, a 1991 National Institute of Health report, and numerous unnamed patients who had undergone bariatric surgery. This section examines this article for its in-depth discussion of obesity and high representation of direct quotes from sources.

The first and last impression comes from Lori Silverman, a lay patient who lost over 100 pounds after undergoing bariatric surgery but remains 80 pounds shy of her goal weight. Her liminal experience is amplified by other bariatric patients participating in a “weigh in” meeting at Mount Sinai Hospital in Manhattan. Their commentaries represent explicit “…testimonials from people who, thanks to steep weight losses, no longer needed medicine for diabetes, high blood pressure, high cholesterol, heartburn, gout or arthritis. Some had become able, for the first time in years, to fit into movie and airline seats, to reach down and tie their own shoes.” Contrasted with the shameful conditions of their prior state, patient testimonials indicate significantly improved health statuses with decreased utilization of medication therapy, enhanced function, and social assimilation in every day life. Everyone praises bariatric surgery as a transformative procedure offering real treatment for morbid obesity and redemption of patients’ health

and lives.

Positive experiences elevate the romantic narrative, moderated with one cautionary tale of death and sketchy accounts of complications or discomfort resulting from the procedure. Having established Silverman's personal vignette as the initial "talking point," the article proceeds to educate readers by tracing the rise of bariatric surgery in the United States as a drastic but increasingly popular treatment; the potential risks related to surgical treatment; a non-technical historical account of how weight loss surgery evolved over 40 years; and a discussion of the root psychological and genetic causes for morbid obesity. The second section titled “High Benefits, High Risks” features the cautionary tale of Christi Finch, who died from complications resulting from bariatric surgery. Finch’s sister provides the lone critique of the professional judgment of her sister's operating surgeon, Dr. Louis Flancbaum, who defends his skills and services as outweighing the risk incurred from morbid obesity and related conditions. This sentiment is echoed by “other surgeons” including Dr. Latham Flanagan, former head of the American Society for Bariatric Surgery. Expert commentary interprets Finch’s death as an unfortunate casualty of biomedical intervention, which always incurs some degree of calculated risk but largely benefits the vast majority of morbidly obese patients. Her death anchors the plot as a grave warning of a *potential* risk, but expert communication of professional confidence and biomedical entrepreneurship undermines the cautionary tale.

The middle section, titled “The History of the Surgery,” provides a non-technical overview of bariatric surgery from its inception in the 1960s through later iterations of the procedure to balance malabsorption (preventing the absorption of calories by rerouting food) and restriction (reducing the size of the stomach limit intake). Written in

a neutral tone, this section is the most intentionally educational and lacks any reference to expert commentary. Set between other sections with stronger human interest potential, it functions to build suspense within the narrative while reinforcing medical precedent for the surgical treatment of obesity.

The concluding section, titled “The Emotions of Eating,” features the most interaction between lay and expert commentary discussing root causes for the extreme overeating underlying obesity. Etiology is presented as a complex puzzle to solve (for “what creates such a drive to eat is not fully known”) with lay commentary supplying initial hypotheses and excuses. Robert Altman, a patient with a “new lease on life” after losing 220 pounds, confesses that emotions control his behavior: “Asked why he ate so much, Mr. Altman laughed and said: "Joy. Sadness. Loneliness. Boredom. Food was always my best friend." His rueful response is a confession; though highly relatable in the range of emotional stimuli triggering overeating, it assigns blame to Altman's personal behavior. Following two other lay quotes echoing the emotional and mental compulsion to overeat, the reader encounters the expert opinion of Dr. Elliot Goodman, a surgeon at Montefiore Medical Center in New York City. Goodman offers a highly-medicalized evaluation of the psychological and genetic conditions underlying morbid obesity:

> *I think there's a great psychological overlay. It may be the idea that there's some solace in food. We see a high degree of physical and sexual abuse in patients like this. One of our patients had a terrible history, a rape history, and our psychologist felt that by putting on weight she was somehow insulating herself from the interest of men." But Dr. Goodman said he doubted that emotional factors alone could bring on massive obesity in most people. "I don't think there's a morbidly obese patient sort of lurking in every normal-size person," he said. "I think there are a subset with a genetic predisposition.*

By adopting a plural pronoun, his commentary becomes situated in the accumulated experience and authority of the medical profession. Although his expertise is surgical,

Goodman convincingly invokes psychological trauma and genetic predisposition based on personal observations and anecdotal evidence. His first professional opinion uses a second-hand professional anecdote to impose a casual relationship between patients' personal histories and eating behavior. Goodman's quantification of obese patients' exposure to abuse is vague but sweeping, implicating the behavioral frame in "a high degree" of cases where patients seek comfort in food. Goodman later employs the biomedical frame to moderate the perceived risk of morbid obesity. Not everyone who experiences trauma will suffer the same fate of emotional eating; an internal predisposing trigger determines the difference between "normal-size" and extreme weight gain.

While emotions and failure are experienced at the individual level, the article suggests that they are largely communicated and transacted in biomedical and behavioral terms for obese patients. Dr. Philip Schauer, a bariatric surgeon a the University of Pittsburgh, describes his work as a champion of patients' epic and losing battle with their weight:

> *"Patients who come to us, all their lives they've been overweight. Typically they've been on 10 to 20 major diets. They lose 10 or 15 pounds here and there and gain it back, and more. They are constantly battling obesity, and it's an unfair fight, for reasons that are not clear. Surgery gives them a tool to make this battle a fair fight."*

The war metaphor is a prevalent cultural construct for describing obesity as an insidious and invasive threat to personal health. Schauer's commentary locates agency in the individual patient, whose behavior and psyche are successful rehabilitated with the aid of biomedical expertise. Inequality is translated into the biological inability to maintain normal weight rather than external socio-structural factors affecting patients' lives and circumstances. From Schauer's advocate position, the conditions setting up for a "fair fight" to lose weight are mediated through individualized clinical treatment over public

health initiatives serving to prevent incidence or educate patients. Lay commentary from his patient, Cheryl Grieco, confirms the premise that surgery is the solution to her perpetual struggle to get thin:

> *In the first three months, she lost 77 pounds and six dress sizes. "It's going great," Ms. Grieco said. "It's everything that diets weren't." She walks and bicycles now, and hopes to get her weight down to 115. "To me it's been a lifesaver," she said.*

Grieco's testimony provides objective evidence in quantifying her weight loss, demonstrates redemptive behaviors facilitated by surgery, and attributes salvation to biomedical treatment.

The hopeful tone is reiterated by a return to Silverman's weight loss story to conclude the narrative and reinforce themes of deviance and redemption previously discussed in the article. She regards her former, heavier self as a cautionary tale with a body so distressed that her "back felt like a twig about to snap" and doctor warned, "'You have to do something. You're going to die.'" Silverman's shame is clearly expressed in her account of gaining social acceptance after managing to "diet down" before her weight "surged out of control" again. Compliments from coworkers elicited self-rejection of her formerly heavy body, while encounters with neighbors or strangers on the train confirmed prejudice based on her physical appearance when they treated her better after losing weight. Upon undergoing laparoscopic bariatric surgery and losing 127 pounds, Silverman contributes with a heartfelt testimony:

> *"For all my complaining, I have no regrets," she said. "I was a lot worse before. The weight loss makes up for everything. I've never had a life. I don't know what it's about. I've always been on the outside looking in. I believe I'll be given a chance at life that I never had."*

Despite the nausea she experiences from eating and resentment of formerly unfriendly acquaintances, Silverman's physical transformation has a redemptive effect on her psyche and personal narrative. The shame and unhappiness experienced at her previous

weight has been symbolically and surgically excised. In losing weight, she has become a better - and a thinner version - of herself.

Largely framed as a biomedical narrative whereby the miracle of modern medicine saves and restores the lives of suffering Americans, the article also discusses the influence of complex etiological factors such as health behavior and modern obesegenic environments where “life has become an endless feast.” Nonetheless, invocation of these latter frames is overshadowed with biomedical rhetoric invoking psychology to explain compensatory eating behavior, or genetics to theorize humans’ evolved ability to store body fat to survive times of famine. Journalists depend on expert sources to provide directional cues, explanatory services, and alternative perspectives – details that give obesity stories meaning as a social problem. The next section will explore what experts say in greater detail.

Claim: Expert Knowledge and Claimsmaking

Experts, defined by their authoritative knowledge, have a significant impact on shaping cultural values and social expectations. Scientists and medical professionals rely on the research process, evidence, and peer review to develop knowledge and theory. Since a majority of the public cannot access or interpret scientific evidence, journalists solicit obesity experts in medicine, demography, nutrition, and public health for their diagnostic evaluation of "breakthrough" discoveries and reports. Expert commentary functions by: 1) **translating or evaluating** research and policies, typically into biomedicalized concepts, and 2) advocating medical and expert **responsibility** for

treatment. These two functions comprise the most consistent claimsmaking activities when obesity experts are given the opportunity and platform to apply their knowledge.

Evaluative claimsmaking

Readers expect and trust experts to interpret the validity of the findings, place them in context of the existing body of knowledge, and evaluate their overall impact. Physicians, in particular, are used to translate scientific findings into meaningful interpretations for the lay public:

> *"This study is saying that if you are overweight by your mid-30's to mid-40's, even if you lose some weight later on, you still carry a higher risk of dying," said Dr. Serge Jabbour, director of the weight-loss clinic at Thomas Jefferson University Hospital in Philadelphia. "The message is that you have to work early on your weight. If you wait a long time, the damage may have been done."* (Associated Press, 2003)

Jabbour addresses the "so what?" dilemma for readers by identifying apathy and inertia as potentially risky behavior. The study and evidence in question is evaluated as sufficiently motivating to support claims that obesity is a dangerous health condition that *individuals* should not deny. The time for action is now, and any reader qualifying to the parameters listed (age, weight) is issued a warning that they are at risk and must act quickly to ameliorate the damage. On another level, Jabber's latter statement has broader implications for *public* health intervention, where the task of prevention and health education are public initiatives to mitigate damage to the work force or fiscal health.

Given the deliberate pace of science, readers are confused about how to relate new information on the etiology of obesity, assess the relative healthfulness and effectiveness of certain diets, and understand what to make of scientific breakthroughs at an individual level. Providing source quotes to the news media grants opportunities for experts to apply their knowledge and offer advice to readers. Interviewed at a time when

dietary fat was regarded as a major contributing factor to heart disease, Ornish is tasked with educating his patients - and readers - about nutrition:

> *Many [dieters] assume that "nonfat" means "nonfattening," said Dr. Ornish, whose low-fat program advocates eating larger quantities of complex carbohydrates like vegetables but fewer simple carbohydrates like honey, sugar, white flour and alcohol. "The week that Entemann's rolled out its fat-free desserts, a number of our patients gained weight," he said. "They thought that as long as they were eating something fat-free, they could eat as much as they wanted."* (O'Neill 1995)

Physicians such as Ornish privately and publicly counsel patients who overestimate the effectiveness of low-fat diets. He advises readers against investing too much faith in the discovery and the intentions of food manufacturers. While lay people are excused for not knowing better, experts are tasked with dispelling misleading assumptions or moderating overly hopeful enthusiasm over new-to-you scientific findings.

It is vital that experts formulate definitive statements that are consistent with existing frames in the cultural narrative. Competing scientific claims can only confuse or frustrate the public. Obesity experts sponsor an overarching frame for the obesity problem: many Americans are overweight and the negative social and economic effects of obesity are undeniable (Best 2008):

> *"We want to emphasize that the problem of obesity and (being) overweight for adults and kids is getting worse," says Cynthia Ogden, an epidemiologist with the National Center for Health Statistics, part of the Centers for Disease Control and Prevention.* (Hellmich 2002)

> *John Foreyt, director of Behavioral Medicine Research Center at Baylor College of Medicine in Houston, estimates that almost every American will be overweight or obese by 2040. A few, possibly 5% to 15%, might able to maintain a healthy weight, he says. "But most of us are in trouble," Foreyt says. "We are affected so strongly by the environment ---- fast food, big portion sizes and the lack of a need to be active ---- that we are doomed."* (Hellmich 2003)

Not only is the condition problematic at the individual level, but Ogden identifies rising prevalence in the adult and child population as equally noteworthy. Foreyt presents obesity as a collective problem facing a majority of Americans, save for the slim minority

whose genetics or compensatory health behavior defy the odds. He describes the socio-structural conditions "dooming" Americans to inevitable gain weight to be so insidious as to constitute a complete obesegenic environment (see Hillier 2008). While his prediction could be interpreted as hyperbole, it resonates with expert consensus that obesity is a major public health problem.

Advocacy claimsmaking

Translational and evaluative responsibilities provide a high degree of professional capital that can be leveraged into overt claimsmaking about public health risk. This occurs when an issue has survived contestation within the institutional arena to gain collective recognition as a solvable problem. The first step towards recognition in the public arena is piggybacking on comparisons of obesity to conditions the public has come regard as intolerable:

> *Last week, Dr. C. Everett Koop, the former Surgeon General who now heads a public health campaign called "Shape Up America," fired off a press release quoting a letter to The New England Journal that he wrote with Dr. JoAnn Manson of Harvard Medical School and Dr. Theodore VanItallie of Columbia University. In their letter, the doctors argued that obesity causes 318,000 excess deaths a year and said, "It is difficult to justify complacency in the face of this growing epidemic now afflicting more than 58 million Americans." "The only disagreement is among people who don't know the facts and don't have the scientific evidence," Dr. Manson said in a telephone interview.* (Kolata 1998)

> *"I think what's surprising all of us in public health across the nation is that obesity is not only getting worse, it's getting worse faster than any of us thought it could," unlike other serious health threats like smoking, said Dr. Thomas R. Frieden, the city health commissioner. "This is not genetics. This is our balance with our environment. And obesity isn't just an issue of looks. It's an issue of life. Obesity kills."* (Perez-Pena 2003)

In the first statement, several high-profile physicians pen an editorial published in the most esteemed medical journal in the world reprimanding public and political complacency towards obesity. Their knowledge of the "facts" and evaluation of "evidence" is leveraged against the relative ignorance of non-experts. Frieden similarly

capitalizes on his expertise as a physician and public health official to rhetorically amplify the insidious quality of the obesity problem. Rejecting potential excuses such as innate genetic predisposition or personal vanity, he puts forth the principle claim that "obesity kills." In converting the well-established claims about smoking, experts anchor their claims to a widely-accepted and motivating public health problem.

Obesity experts base claims to their professional responsibility to protect the public from obesity-related health risks and expenses, thus justifying immediate and early intervention. This rationale allows for medical moral entrepreneurship, in which obesity experts stake their professional claim to the necessity and virtue of their skills. Rather than focus attention how far biomedicine has expanded into the jurisdiction of every day life, experts instead claim that untreated or unsupervised overweight people suffer a deficit or disservice:

> *"Expensive as we think health care is today, with these chronic conditions coming on it's going to be very threatening to quality of life as well as cost issues," Dr. Vinicor said. "If we saw a 33 percent increase in infectious diseases like tuberculosis or AIDS, I believe there would be an understandable demand for action. We can't just view inactivity and overweight as purely a kind of cosmetic thing. It's got to be viewed as a serious public health issue."* (Grady 2000a)

> *"There are 8 million to 10 million people who are morbidly obese in this country, and we're operating on only about 1% to 2% of them," says lead author Henry Buchwald, a professor of surgery at the University of Minnesota School of Medicine. That "wouldn't be tolerated if it was any other illness."* (Hellmich 2004)

Vinicor frames obesity treatment as a moral issue concerning the "quality of life" and economic incentive for containing downstream health care costs. Likewise, Buchwalk describes the rationing or restriction of gastric bypass surgery as morally and medically contentious.

Medical entrepreneurship is most evident among health professionals who treat obesity in clinical settings. These claims advocate for a biomedical model justifying

payment for expensive and prolonged treatment for weight control and management of comorbid conditions. In 2004, these claims were successful in lobbying for reimbursement of obesity treatment:

> *"Medical science will now determine whether we provide coverage for the treatments that reduce complications and improve quality of life for the millions of Medicare beneficiaries who are obese," says Mark McClellan, administrator of the Center for Medicare & Medicaid Services. The new language won't extend coverage to weight-loss drugs. What it will do is tell the public "that this is something that needs to be medically dealt with," says Carlos Hamilton, president of the American Association of Clinical Endocrinologists. "It's not just a lifestyle or a habit issue."* (Weise 2004)

Lobbying the federal government and insurance companies for payment for clinical services occurred simultaneously with advising patients that they need treatment. McClellan acknowledges the influence of medical and scientific expertise in prescribing the course of obesity treatment. A spokesperson for a medical organization hails coverage as a public signal that obesity is, indeed, a biomedical problem.

The journalistic use of expert sources functions to package obesity as a health story. Much of what is covered as "breaking news" is driven by reports released by various scientific groups or governmental agencies. Thus, a distinctively political agenda drives the information and claims proliferated to the public. Though some experts may present as politically neutral, other colleagues solicited for commentary actively pound their fists on the table. This section has shown how expert translation, evaluation, and advocacy support the biomedical frame and professional claimsmaking. The next section will explore how health stories are rhetorically embellished with the inclusion of lay commentary.

Shame: Lay Cautionary Tales and Testimonials

A common journalistic device is to open a story with a personal vignette or feature that rhetorically contextualizes the scientific or political narrative to follow. Typifying examples embed a human face and interest among the cloud of words (Best 2008). This section briefly describes two archetypes brought to life by lay commentary: **cautionary tales** and **testimonials**. These roles symbolize the obesity problem vis-à-vis narratives of shame, deviance, and redemption. These "human interest stories" feature respondents who publicly confess to their deviant (obese) status. They are the anti-heroes of their personal story, through potentially redeemable through healthy intentions and follow-through behavior. Other respondents testify their desire and willingness to transform themselves through weight loss. Such people are "everyday" heroes who triumphed above epic struggle of weight loss. However, testimonials are always set against the latent shame of former obesity.

The Shame of Obesity

While typifying examples are intended to illustrate problematic patterns, they are in reality selected for shock value or dramatic narrative. The cautionary tale is a cultural archetype exploiting the deviant state of morbid obesity, where individual anecdotes illustrate the negative consequences of uncontrolled weight gain. In a 1996 article covering the popularization of weight loss surgery, the lead paragraph uses graphic imagery to hyperbolize the painful state of obesity:

> *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 this so badly, Mr. Poole says, that he would crawl through broken glass for it. This is the determination of a 570-pound man who, at 39, has been told by doctors that he should have been dead by now, who has tried every diet in existence and who can only sigh at the excitement that periodically sweeps the country about promising new anti-obesity drugs or genetic*

> *research to pinpoint obesity's causes..."An operation may be radical for a 200-pound person, but for a 700-pound person it's the only option," Mr. Poole said, noting that he has been getting progressively heavier since childhood. "I'm on the verge of not being able to get out of bed."* (Goldberg 1996)

In contrast with perfunctory professional introductions listing affiliations and titles, lay accounts benefit from precious space for character development. Lay operatives are introduced with details or anecdotes that demonstrate their arduous, self-reflective, or apologetic experiences with obesity. Such details set up what the narrative tension between desire and reality, the failure of individual effort and salvation of medical treatment. That Poole confesses a willingness to suffer acute physical pain in order achieve weight loss communicates the level of shame and desperation he feels for his condition. Moreover, he acknowledges having defied the medical odds by surviving into middle adulthood. Poole's justification of weight loss surgery as a matter of life and death crystallizes the extent of his disability, most evidently in terms of health but also alluding to his capacity to work as a productive adult.

Cautionary tales feature individuals with *atypical* levels of obesity in order enhance the drama of the narrative arc. The cautionary tale is premised on physical assimilation, where obese individuals admit to humiliation experienced in public settings. The same vignette detailing Poole's morbid obesity also reveals how deeply he harbors the desire to weigh, feel, and interact normally:

> *"I've felt like an alien all my life," Mr. Poole said...Mr. Poole says he is fantasizing about freedom, about what it would be like not to be stared at and ridiculed every time he goes out. "My dream is to walk on the street and not be noticed," he said. "To walk into a theater and sit down in a seat."* (Goldberg 1996)

The ability to ride public transportation or order food without condescending stares may be routines and behaviors taken for granted, but deeply aspirational for someone hundreds of pounds overweight. In desiring physical inconspicuousness, Poole affirms normative cultural values about weight and, implicitly, readers' own weight status. Lay

operatives expressing positive body image and “fit and fat” testimonials are in the minority, acknowledged as for their contradictory rejection of cultural norms and medical claimsmaking.

Redemption from Shame

Where cautionary tales dramatically represent what the physical, emotional, and social burden of obesity can be, testimonials inspire hope for novel weight loss regimens. What is expressed by “testimonials” is the vigilant willingness to try new (perhaps untested) treatment plans, and mentally commit to losing weight. Individuals - and not shameful former weight - are central to the optimistic narrative of personal transformation or redeeming one's health:

> *Three years ago, Mike Gwaltney of South Hill, Va., weighed 515 pounds, could barely walk 15 steps without getting winded, had sleep problems and was the object of jokes and ridicule. Then Gwaltney had a standard open gastric bypass operation, a procedure that creates a much smaller stomach and rearranges the intestine. He lost weight quickly -- 70 pounds the first month after the surgery -- and now the 6-foot deputy sheriff weighs about 240 pounds, jogs regularly, lifts weights and hunts…Mike Gwaltney calls it "**one of the best decisions I ever made**." "A lot of people may disagree with me, but I felt it was the only option I had," he says. "I couldn't get active enough to lose the weight. Diets had failed for me in the past. **There is no way I could have lost the weight on my own**. I couldn't do anything but sit and eat.” “I would probably have been dead or in a wheelchair by now if I hadn't done something."* (Hellmich 1999, emphasis added)

Gwaltney's narrative is bracketed by the real and implied consequences of obesity, a condition for which he was made to feel ashamed in his personal life and health. Taking stock of his physical and emotional suffering, the passage paints a “before” narrative that practically necessitated surgical intervention. His endorsement of surgery implies that weight loss enabled him to actualize a better quality of life. Acknowledging the controversy surrounding the procedure, he nevertheless provides his weight loss story as a public testimonial.

Testimonials display a bias towards success; sharing failures are unwarranted unless they are so sensational as to qualify as a cautionary tale. Testimonies can allude to weight-loss regimens that completely failed or only temporarily offset the excess weight, but must resolve with an accomplishment worthy of public attention. Gwaltney's story "after" surgery and weight loss is familiar but powerful; themes of transformation and self-actualization resonate in the American psyche (see Elliott 2003). Despite the discomfort and risk associated with the surgical procedure, Gwaltney's endorsement is unequivocal for actualizing an ideal self and life. Although testimonials capture an ephemeral snapshot of a respondent's life, body weight, and health status, they extend the myth of success. At the time the story went to press, lay respondents were hopeful that their weight loss and transformed lives would be permanently maintained for good.

In deconstructing lay commentary, cautionary tales and testimonials focus reader attention to: 1) the problematic consequences of obesity on heath and social status and 2) the rational response of weight loss and management. Cautionary tales are distinguished by shame, where overweight and obesity demarcate deviance despite its increasingly normative prevalence in the American population. Individuals overcome their shame through rational behavior that reduces weight, mitigates health risk, and improves their quality of life. Testimonials highlight roads to "success" that are relatable, serving as anecdotal evidence that individual initiative is the driving force in "good" health behavior. Both newspapers selectively feature lay commentary in order to make the biomedical frame relatable and generalizable.

DISCUSSION

This study compares how two national newspapers framed obesity as the topic gained prominence in public discourse and public policy as a widespread social problem**.** The print news media package obesity as a health and human interest story, expressed through featured commentary from lay and expert sources. Repeated exposure to the biomedical frame and contextual professional or personal details supported the media telling of obesity as a health problem to research and treat. Echoing Conrad (1999), it shows how expert and lay commentary have a real impact on how obesity news is written for and read by public audiences. Any informal survey of news media outlets would indicate that this obesity package continues to be prevalent and highly influential.

References to biomedical, behavioral, and environmental causal frames mentioned in *USA Today* and *The New York Times* are measured to understand exposure of this issue to the reading public. Meta-level analysis confirms increased media exposure over time, spurred by the advocacy of medical moral entrepreneurs (Khuu, submitted manuscript; Gusfield, 1981). Though biomedical frames were the most prominent construction of the causal "story" throughout the sampling period, behavioral and environmental frames were increasingly deployed to narrate the economic and social impact of obesity in American society. Indeed, the obesity genre is dominated by formulaic themes, characterizations, and forms of organizations that facilitate the production of news (Bielby and Bielby 1994).

Furthermore, analysis at the article-level focuses attention on lay and expert commentary to explicate *how* obesity frames were supported through claimsmaking or embellished with anecdotal details. Operatives have different motivations, gate keeping

responsibilities, and levels of authority in the collective definition of social problems (Hilgartner and Bosk 1988). While the public may not typically regard obesity experts as particularly motivated operatives, this study finds expert commentary to be very influential in packaging obesity as a biomedical and behavioral health problem. Obesity experts are able to capitalize on their authority as news sources and frame "shapers" through the provision of context and commentary (Conrad 1999).

Obesity expert come from a diverse range of professional backgrounds working in research, clinical, and public policy settings. Experts claim high levels of specialized knowledge related to obesity, whether working in the field of surgery, nutrition, epidemiology, education, advocacy, or public policy. Though a certain level of "noise" or disagreement is expected, a clear message of biomedical ownership rises above competing and conflicting expert claims. This study confirms journalistic preference for expert primary definers in reporting on obesity, which likely results from the organizational routines of news work as well as the entrepreneurial orientation of experts who have made themselves available and quotable (Welch, Fenwick and Roberts 1997).

Professional authority represents a validating source of knowledge and opportunity to advocate for solutions expanding the biomedical and health science industries. Leveraging their status as insider informants and claimsmakers, expert quotes consistently represent a biomedicalized rendering of obesity news. The relatively late introduction of the environmental frame and dearth of operatives with an authoritative media presence results in limited exposure for socio-structural themes in public dialogue. However, this study and others indicate that discussions of environmental risk and causes are on the rise and have become regular themes in obesity news (Kim and Willis 2007; Lawrence 2004). Casual frames implicating economic, geographic, and

healthcare disparities can induce politically contentious debates concerning social welfare and the role of governmental institutions. To relocate risk and responsibility from individual troubles to systemic issues would require the American public acknowledge and address the social determinants of health (Gollust and Lantz 2009).

Additionally, the use of lay testimonies detailing success or failure is a powerful journalistic tool for personalizing the human experience of disease or poor health conditions (Hilton et al. 2010). First-hand accounts translate claims into normative stories about obese individuals. Tales of personal shame are central to the news media's rendering of the obesity narrative as dramatic, urgent, preventable, and solvable through clinical and behavioral interventions. Lay profiles rarely deviate from journalistic formulas of shame or success, for they are most resonate with broader social constructions of physical appearance and individual responsibility. Most lay accounts affirm the relative normality of readers' lives by perpetuating notions of morality and stigma that undermine the acceptance of body diversity (Saguy and Riley 2005). Similar binary characterizations operate in the entertainment industry, where talk and reality television formats exploit the entertainment value of "ordinary" participants with their own energetic, opinionated, and "authentic" voices (Gamson 1998; Grindstaff 2002). Non-emotional and interchangeable experts can be depended on for a separate normative delivery of facts, enhanced or edited in post-production by cultural producers (Grindstaff 2002).

This analysis reveals the highly conditional and restricted media coverage given to lay claimsmakers. Lay accounts are disadvantaged from articulating viewpoints that may undermine the dominance of biomedicalization or behavioral frames. The same groups seeking reparation can inadvertently perpetuate stereotypes of helplessness or sickliness.

Should “affected” lay operatives seek to follow the example of the gay/lesbian/transsexual/transgender (GLBT) community for politicizing the cultural context of obesity, a louder and more diverse “voice” could be established through advocacy organizations providing a public face and political platform (Conrad 1999). Savvy engagement in agenda-*building* activities can potentially appropriate the “media-ted” processes that deliver alternative claims to reshape public discourse (Driedger 2008).

Repeated exposure to certain operatives and inferences in news discourse influences public opinion over time. Interdependence between journalism and the health sciences has been shown to affect information that reaches the general lay public (Bartlett, Sterne and Egger 2002; Conrad 1999; Entwistle 1995). On one hand, press coverage can serve public health by directing public attention to educational campaigns or supporting funding for research and public policy. However, expert rhetoric can reify professional authority and perpetuate the stigmatization of an increasingly common condition. The incentive for lay operatives to speak is less obvious if their personal behavior and context continue to be exemplified as wholly problematic (see Shugart 2012 for a regional and cultural analysis of obesity frames).

While many more obesity packages proliferate from a vast network of news media outlets, “obesity as a health and human interest story” represents an intuitive package readily accepted by public audiences. Given how greatly the social problem of obesity has evolved over the past 30 years, how the news media utilizes archetypical characters will very likely to change according to which frames are in wider circulation. However, the news media is constrained from generating just any claim; public audiences must believe the sources and the package presented. Presently, the media package that obesity a

chronic disease of control and overcome commands public policy and commonsense thinking.

How does lay and expert commentary resonate with the public? Although beyond the insight that could be generated from this analysis, future research should test and measure the casual impact of commentary from obesity operatives on public opinion. Research indicates that media exposure may not influence public response evenly given embedded values-based cues that can provoke political partisanship (Gollust and Lantz 2009). If audiences are more likely to respond positively to media packages consistent with their worldviews, targeting messages to specific market segments could result in enhanced communication of public health messages. To that end, findings reflect populist packages generated from a limited data set reflecting a specific group of reporters, editors, and journalistic missions. It does not intend to speak about the news media as a monolith, but rather interrogate prevalent themes circulated throughout influential news outlets and popular culture. Other limitations for interpreting findings include a lack of geographic granularity by excluding regional newspapers; and the limited generalizability of lay archetypes for other chronic diseases (for example, a death may serve cautionary tale for heart disease).

Most public health and health communications research on obesity framing has quantified and compared competing frames across various periods and media titles or outlets. These are useful for describing how the general public becomes exposed to specific discourses that are amplified through repetition and advocacy. Left unexamined are the narrative elements that make the obesity story compelling. The obesity problem is presented as a health *and* human interest story, with lay accounts communicating more than idiosyncratic anecdotes. Additionally, many studies compared biomedical,

behavioral, and environmental frame as if they were equally relevant in public discourse. Extant research supports the dominance of the biomedical frame championed by expert claimsmakers with enhanced access to the press. Thus, this paper explores how the press promotes the biomedical frame through exposure and repetition expressed through expert and lay commentary.

CONCLUSION

Obesity is now regarded as a "newsworthy" health and human interest story. This study confirms that the social construction of obesity, like other public problems, “depends on which formulations are accepted by which operatives who intend to do what about them in which public arenas” (Hilgartner and Bosk 1988). The premise that media outlets enhance free thinking or dialogue is contingent on unbiased reporting corroborated by expert and lay sources. In reality mainstream journalism reproduces the social hierarchies between expert and experiential truths, thus constraining public discourse and response.

CHAPTER 3. A FOOD REVOLUTION OR CELEBRITY SELF-PROMOTION? JAMIE OLIVER'S MORAL ENTREPRENEURSHIP IN MAKEOVER TELEVISION

ABSTRACT

The makeover television genre is a popular media platform for demonstrating lifestyle and behavior interventions. British celebrity chef Jamie Oliver optimizes this medium for anti-obesity advocacy as the host and producer of *Jamie Oliver's Food Revolution*, a reality showcase for school food reform targeting the "fattest city in America." What does Jamie Oliver symbolically and strategically accomplish for the anti-obesity movement through makeover television? This study critiques Oliver's dueling agendas as a celebrity personality and moral entrepreneur, someone whose influence as a crusading reformer is diminished by self-promotion and the narrative conceits of reality television production. Deviance and "evil" are personified and personalized in terms that prioritize Oliver's celebrity persona over broader public health initiatives. Ultimately, Oliver's food rules fail to improve the fundamental social and economic conditions affecting health and obesity. Whenever celebrity entrepreneurs adopt new moral causes, their influence with audiences must be evaluated against personal brand promotion and misrepresentation of the original mission.

INTRODUCTION

The past decade of television programming has promoted makeover shows as a popular media platform for demonstrating lifestyle and behavior interventions. Structured as informative entertainment, makeover shows combines colorful media personalities with expert advice for improving personal style or initiating DIY home improvement projects. Underlying the strategic content is an intent to motivate "television viewers into the role of resourceful, enterprising and active citizens" (Ouellette and Hay 2008). For example, viewers tuning into *The Biggest Loser* receive

informative tips from the same fitness experts training the show's contestants. Viewers tuning in for weekly contestant's weekly weigh-ins are urged to take advantage of commercial breaks for intervals of cardio or strengthening exercises. While such weight loss competitions approximate an anti-obesity agenda via individualized intervention, it is unclear how well makeover television shows and celebrity personalities serve the purpose of public health.

British celebrity chef Jamie Oliver has mastered the medium of makeover television for championing his lifestyle brand and anti-obesity advocacy. Since 2005, he has recorded three documentary television series in the United Kingdom premised on reforming the nutritional profile and preparation of school and household meals. For his efforts, Oliver has been lauded by the British medical community as a "rebel chef" challenging skeptics and bureaucrats to get "into the community where the real action is" (Lancet 2005). It was not long before Oliver set his ambitions on tackling the American obesity epidemic with his personal brand of exuberant blokeishness and omnivorous lifestyle expertise (Johnston and Baumann 2010). In 2010, the American Broadcasting Corporation (ABC) aired *Jamie Oliver's Food Revolution* chronicling the celebrity chef's misadventures in Huntington, West Virginia. Premised as a community makeover show, audiences witness Oliver attempt school- and community-based food reform in the city distinguished by the U.S. Centers for Disease Control and Prevention as the fattest and unhealthiest in America (Strobbe 2008).

I analyze the dueling agendas of "Jamie the Activist" and "Jamie the Celebrity" as represented through the medium of makeover television. What does Jamie Oliver symbolically and strategically accomplish for the anti-obesity movement through makeover television? To what extent is the show's dramatic reality constructed through

the collective enterprise of television production and celebrity influence? How does Oliver's celebrity endorsement contribute to, or detract from, communicating obesity claims to public audiences? I argue that the culture industry and reality television genre reduce the rhetorical and social impact of the anti-obesity message. Television producers construct narrative drama as personal attacks against Oliver himself rather than the social problem he represents. Ultimately, the conflation between Oliver's personal brand identity and the food revolution he leads fails to improve the fundamental social and economic structures affecting poor health and obesity in Huntington.

The Culture Industry

Drawing from the sociology of popular culture, we can compare the premise of makeover television to early twentieth century social work field visits instructing working-class and ethnic communities on the "science of right living." Whereas print and radio formats limit audiences' direct observation of the lifestyle ideals conceptualized by the culture industry, the mass distribution of visual mediums function as a ideal platform for cultural consumption. Regardless of socioeconomic condition or geographic locale, most American viewers have access to the cultural tastes and attitudes of distinction represented in serialized television shows and documentary-style investigative programming. The implicit aspirational tone and normative content of mainstream media constructs a "contrived presentation of 'reality'" that viewers are presumed to accept and emulate (Grazian 2010).

The influence of televised media is not as benign or informative as the do-it-yourself (DIY) home or personal makeover shows present. Media critics lament the overriding value of entertainment in nearly all examples of mainstream content,

superseding nuanced public discourse of "serious" and complex news in the realms of education, religion, and politics (Postman 1985). Audiences are trained to process bold headlines and 10 second sound bites, both of which provide useless and unconnected data that cycle through artificial seasons of coverage. The epistemological implications of mass media on enhancing intellectual discourse or human empathy are grim, as the public is served endless helpings of disjointed story-telling and commodified information. How the media organize and direct (even limit) public discourse undermines democratic dialogue and, therefore, the construction of social reality (Postman 1985).

While promoting media literacy may eventually lead to a public rejection of style over substance (Postman 1985), countervailing dynamics in the culture industry will seek to maintain the extant aesthetic value and order. Collective action and adherence to conventions are central to Becker's model of art worlds, such that "members of art worlds coordinate the activities by which work is produced by referring to a body of conventional understandings embodied in common practice and in frequently used artifacts" (1982). The high-stakes environment of television production mandates cooperation between creative and technical personnel, each fulfilling their responsibility within a specialized and hierarchical organization governed by professional and creative conventions. While artists working in traditional "high" art mediums may exert greater executive control over their creative products, producers and network executives reign supreme in the world of television.

Television show producers oversee concept development, financial management, technical support and production, and distribution and promotion of the final cut (Becker 1982). They manage expectations for prime time shows' success through

"organized discourse" and rhetorical strategies substituting "imitation, routines, and rules of thumb for rational calculation as decision criteria" (Bielby and Bielby 1994). When all hits are flukes - or considerably less predictable than network programmers would hope - the decision criteria for proceeding inevitably cycle back to trust in popular genres, leveraging the reputation of industry figureheads, and imitation of previously demonstrated success. While a television series' trajectory is ultimately defined by viewership and the advertising revenue generated, producers and network executives seek to rationally manage the content and critical reception of new media before shows debut in prime time.

Familiar, tried and true genres with prescribed formats, themes, and characterizations not only facilitate the efficiency of production, but also resonance with audiences (Postman 1985). The genre of reality television (premised on the conceit that individuals act like themselves rather than portraying a scripted character) reflects the political and social context of the late 1990s through the presidential terms of George W. Bush (2002-2010). Prime time reality shows such as *Survivor*, *Hell's Kitchen*, or *The Apprentice* visibly demonstrated the triumphant results of industrious ambition and individualistic success, mirroring political rhetoric and policymaking undermining labor unions, unraveling the social safety net, and promoting laissez faire capitalism (Grazian 2010). Gitlin notes a similar programmatic shift of scripted content during Reagan presidency in the late 1980s, when executives sensed audience response to content that externalized enemies, enforced social order, and affirmed symbolic values such as family and authority (2000). The longevity of the reality show format indicates strong societal resonance with the past decade's presidential zeitgeist and prevailing national values.

In contrast to increasing privatization of everyday life in politics and social welfare,

the reality show genre selectively externalizes private or taboo behavior for public consumption. In the 1990s, carnivalesque talk shows such as *Jerry Springer* and *Ricky Lake* operated on "paradoxes of visibility" democratizing queer participation in public discourse, but exploiting deviance and stigma by reinforcing norms (Gamson 1998). Members of the public are empowered to “talk back” as expert witnesses, whether sitting on stage as the guest role or initiating dialogue from the audience. The evolution of talk TV from rational tolerance (Donahue) to therapy (Oprah) to staged democracy (Ricky Lake) reframed queer people as regular Americans with relatable "relationship issues.” However, the narrow representation of gayness (predominantly white, middle-class, gay or lesbian) is defined at the expense of increased public discourse for the spectrum sexual identities, social construction of gender stereotypes, and correlation of respectability with class hierarchy (Gamson 1998). While controversial issues may gain exposure through media exposure, the parameters of representation often exploit deviance and stigma to reinforce existing norms.

Makeover Television and Model Lives

The popularization of makeover television further explores the private-public boundaries of representing “reality” and encroaching surveillance of mundane behavior. According to Ouellette and Hay (2008), most makeover or lifestyle intervention shows follow a generic narrative recipe:

1. Chosen "experts" observes, assesses, and diagnoses something "problematic" in an individual, family, or situation.
2. The same experts introduce a new health or lifestyle regimen.
3. Cameras capture the personal journey and mastery of the new regime. Subjects come to endorse their new lifestyle.
4. A desirable “outcome" is demonstrated with before and after comparisons.

Scrutiny of “problematic” individual conditions is naturalized because show participants

and viewers have been acclimated to the reality television paradigm of citizenship formation through behavior experiments and role modeling (Ouellette and Hay 2008).

The makeover television formula hinges on the narrative crafted and controlled by cultural insiders, who are either lifestyle experts in front of the camera or producers backstage precisely managing the narrative. Reality show guests experience agency and manipulation when "performing" on camera as themselves, thus mirroring the social and structural conditions in which they are embedded and filmed. The "money shot" where guests lose composure and express joy, anger, and sorrow is heavily orchestrated by the collective activity of reality show workers and further corrected in post-production editing (Grindstaff 2002). Producers are biased towards exhibiting and exploiting the stereotypical behavioral temperament of "ordinary" (poor and working-class) guests. While reality shows privilege the lived experience of lay individuals, sometimes at the expense of minimizing the contribution of expert knowledge, producers actively manage the representation of guests and the issues at hand (Grindstaff 2002).

Ouellette and Hay (2008) critique the pedagogical style of self and lifestyle transformations as a rejection of government control and regulation. For example, home improvement reality shows such as *Extreme Home Makeover* coordinate non-state resources and manpower to achieve privately-funded post-welfare projects presented to grateful recipients. Neoliberal "governance" is mediated through lifestyle tutorials that activate audience participation and reenactment. Behavioral experiments and role modeling teach audiences how to behave and perform techniques in real life. While the cultural economics of entertainment television is well-established (Gitlin 2000; Postman 1985), the "political rationality" that makeover shows promote is a recent emergence of neoliberal values in American society (Grazian 2010). These shows pivot to endorse

personal responsibility and self-enterprise for shaping personal health, happiness, and success while devaluing state intervention and welfare in the process. The market logic of entrepreneurism is particularly relevant for makeover television's strategic alignment with public health messaging. Shows such as *Jamie Oliver's Food Revolution* and *The Biggest Loser* capitalize on increasing public concern towards the personal and economic cost of the obesity "problem." Given the reluctance to intervene in a manner that would undermine the neoliberal values of personal responsibility and deregulation, these shows empower participants and viewers to actualize good health through individual empowerment and self-governance (Ouellette and Hay 2008).

In effect, the narrative arc of makeover television depicts moral rule creation and enforcement on a case-by-case basis that consistently reinforces upper and middle-class values (Becker 1973). American society interprets culinary preference and food-related behavior within a moral and "cultural realm where individuals can effectively engage in status displays" (Johnston and Baumann 2007). To wit, the adage that "you are what you eat" associates aesthetic taste, class status, and personal responsibility vis-à-vis cultural consumption. The contemporary mode of "omnivoriousness" has inspired legions of "foodies" (non-food industry denizens with a strong interest in food) to sample exotic and authentic culinary experiences from all cultures and geographies (Johnston and Baumann 2010). Foodies' democratic desires nonetheless function on the neoliberal ideology of consumer choice, thus reinscribing moral boundaries between class groups and structures of inequality that inhibit access.

Celebrity and Moral Entrepreneurship

Celebrity entrepreneurs are a prototype of moral entrepreneurs whose activities are those of a crusading reformer to overcome public apathy and inspire social reform (Becker 1973). There are rule creators, who seek to introduce corrective orders and regulations prohibiting, suppressing, and preventing the existence of evil. They fervently believe that a better way of life and social order can be achieved if people do what is good for them. If moral crusades are successful, new rules and enforcement machinery are created to ensure that rules and consequences maintain relevance in society. There are also rule enforcers, who are motivated by the parameters of their job rather than the content of the rules. Becker argues that deviance and outsiders who personify such values result from a socially-constructed "process of interaction between people, some of whom in the service of their own interests make and enforce rule which catch others, who in their own interests, have committed acts which are labeled as deviant" (1973). In the case of celebrity entrepreneurs, humanitarian commitments may be complicated by motivations that are less pure than promoting humanitarian welfare. Their ability to solicit support from industry results in strategic alliances and brand marketing, manifesting dividends beyond the original parameters of the moral enterprise.

Jamie Oliver is an active and successful celebrity entrepreneur. In addition to developing concepts and recipes for his five restaurants, Oliver helms a successful lifestyle empire with projects spanning television, social media, cookbooks, and home goods. His role as a "Food Revolutionary" represents two different projects and missions. The philanthropic and advocacy angle seeks to reduce obesity rates, particularly in children and youth, through education and behavior modification. This ambitious conceit takes form in *Jamie Oliver's Food Revolution*, a six-episode reality television

series that aired on ABC in the spring of 2010. Oliver's "celebrity cause" piggybacks with a broader social movement and public health imitative, while the reality show represents a capsule showcase of moral intervention and personalized solutions. The rhetorical implications of these dueling priorities are selectively magnified and obscured in the media production process.

Oliver's professional success as a chef and lifestyle guru is evident in how he frames the etiological conditions for obesity (Hollows and Jones 2010). Oliver's "passion for great food and cooking from scratch" is the origin and solution for the behavioral reform premised in his community makeover show. His moral crusade is premised on teaching families how to eat better by rejecting prepared and processed foods in favor of cooking from raw ingredients. Oliver's strategy promotes variety, balance, and intuition despite a self-admitted lack of professional training and credentials for nutritional guidance. On his personal and Food Revolution websites, Oliver proposes specific frames for diagnosing obesity problem, motivating swift action, and proposing a plan for action (Best 2008).

Oliver *diagnoses* the root of the obesity epidemic as an outcome of postmodern lifestyles and contexts. Structural, cultural, or medical conditions are not specified, but fear and despair are negative sentiments Oliver assumes in evaluating contemporary patterns of food and eating. Oliver's *motivational* frame seeks to enhance individuals' control over their behavior and mental prudence, contrasted with the implication of distracting, nonsensical rhetoric about diet and nutrition:

> *My philosophy to food and healthy eating has always been about enjoying everything in a balanced, and sane way. Food is one of life's greatest joys yet we've reached this really sad point where we're turning food into the enemy, and something to be afraid of.* (Oliver)

In seeking to rehabilitate "common sense" and personal behavior, Oliver's claims echo neoliberal rhetoric enforcing personal responsibility. The empowerment Oliver professes is actualized through individual initiative rather than state-guaranteed welfare. This rhetorical strategy fosters identification between Oliver's celebrity brand and his audience, such that consumers' self image and psychological needs are fulfilled in the transmission of this motivational narrative (Gamson 1994).

Oliver asserts a direct casual relationship between enhanced control over the food one consumes and one's physical health:

> *Knowing how to cook means you'll be able to turn all sorts of fresh ingredients into meals when they're in season, at their best, and cheapest! Cooking this way will always be cheaper than buying processed food, not to mention better for you. And because you'll be cooking a variety of lovely things, you'll naturally start to find a sensible balance. Some days you'll feel like making something light, and fresh, other days you'll want something warming and hearty. If you've got to snack between meals, try to go for something healthy rather than loading up on chocolate or potato crisps. Basically, as long as we all recognize that treats should be treats, not a daily occurrence, we'll be in a good place. So when I talk about having a 'healthy' approach to food, and eating better I'm talking about achieving that sense of balance: lots of the good stuff, loads of variety, and the odd indulgence every now and then.* (Oliver)

This prognostic frame delineates Oliver's golden rules: 1) scratch cooking with 2) fresh seasonal ingredients produces "good" (moral) choices and behavior that will crowd out non-nutritive foods. The promise of balance recalls food manufacturers standard disclaimer that any product can be consumed as "a part of a balanced diet" (Nestle 2007). Adherents and viewers are comforted with the assurance that they need not give up indulgent treats that offer emotional and physical comfort. Oliver's inclusive promise that "we'll be in a good place" when adherents abide by his food rules offers reassurance that managing obesity and eating behavior only requires a dose of common sense.

Unlike the precious aspirations of high culture, mainstream television rarely seeks to push the boundaries of normative conventions. The final product broadcasted into

viewers' devices and private realms are collectively produced to elicit popular consensus rather. Becker (1974) touches upon the organizational cooperation and conventional shorthand for executing creative projects, but does not fully locate art worlds as a function of market capitalism and driving motivation for profit. This paper teases apart the Food Revolution as a social movement from the constructed reality of the television show. Oliver commands both constructs, so much so that viewers may confuse the man with the crusade. Oliver's function as an celebrity entrepreneur is to reinforce expert claims while capitalizing on emergent social and commercial opportunities as childhood obesity ascends into the jurisdiction of policymaking and social problems work (Best 2008; Monaghan, Hollands and Prtichard 2010). In reprising Becker's models for creative and moral enterprise, this case study considers the duality between capital returns and social impact in makeover television.

DATA AND METHODS

The data is compiled from multiple sources including Jamie Oliver's personal website, the UK and US Food Revolution website, and the first season of *Jamie Oliver's Food Revolution* televised on ABC between March 21 – April 23, 2010. Episodes from the six-part prime time series were reviewed and transcribed in their entirety for data analysis. Transcripts and website texts were imported into QSR Nvivo 10, a qualitative software analysis program, for coding and analysis of themes. Open coding developed inductively, driven by Oliver's interaction with local characters as he attempted to implement food reforms in the community. I then applied Becker's rule creator and rule

enforcer archetypes as thematic guides for developing a chronological narrative analysis of moral entrepreneurship.

FINDINGS

Evil Processed Food

"I walk into this school. I'm a tiny bit nervous. I want to be the polite English guy. But the first thing I see is pizza for breakfast." (Jamie Oliver, Episode 1)

Jamie Oliver is on a mission to help the children of Huntington, starting with the young cohorts attending Central City Elementary School. His first day of school begins with an unescorted visit to the cafeteria during breakfast, a meal particularly imbued with nutritional significance for mental and metabolic performance. Footage from post-production interview cuts in with Oliver explaining his methods (and the premise of the Food Revolution) as a cooperative process: "Before I start cooking my recipes and changing them, it's really important to see how they do it their way." This is a false statement, for Oliver's purpose for filming his makeover show is premised on the condemnation of existing conditions underlying the obesity problem in Huntington. Oliver has already set his mind to discredit established foods and preparation methods as perpetrating the conditions for obesity. Disrupting the status quo is a catalyst for narrative drama, and an underlying value driving the Food Revolution movement. Armed with television cameras and the confidence of a veteran media personality, Oliver sets out to document the existence of evil so that he may create and enforce a regime change. Humility and empathy, ultimately, are democratic values expressed for the

benefit of establishing mutual understanding with the television audience rather than the residents of Huntington.

Presumably, "they" are the school administrators and cafeteria staff responsible for planning and serving school meals. Footage of children's meal trays reveals that breakfast "their way" is remarkable for all the wrong reasons as Oliver problematizes the hyper-processed nature of meal components: breakfast pizza washed down with juice and sugary cereal swims in a "luminous" bath strawberry flavored milk. Oliver's reaction to the woeful nutritional landscape is stunned resignation: "It's not so much what's in the pizza, it's the fact that they're having pizza for breakfast. It just gives me all the wrong signals, do you know what I mean?" Surely Oliver was not anticipating Central City Elementary School to be an exemplary model for school food given Huntington's socioeconomic and health profile. His statement is alludes to the insidious nature of processed food, and establishes the problematic attitudes and conditions necessitating a culinary intervention. Oliver's identification of the "wrong signals" implies that he is intent to call out deviance that locals cannot discern (but audiences have been made aware of the regime change to come). Armed with scary health statistics, moral rhetoric, and the impassioned initiative of a rule creator, Oliver's moral crusade is clear even if locals cannot discern the evil around them.

Having donned his professional chef uniform, the outward symbol for his authority and expertise, Oliver joins five middle-aged female school cooks for the preparation of the lunch service for 450 students. The most outspoken cook is Alice Gue, a grizzled school cook in her 50s, whom Oliver determines to be the "real boss" of the kitchen. Gue's suspicion of Oliver is clearly expressed: "I don't really understand why he is here to change our system, which is working good." She personifies the criticism Oliver faces

from Huntington locals who resent brash intrusion and explicit judgment of their lifestyles. Gue becomes a visible target for Oliver's frustration and setbacks, which manifest as highly-personalized attacks on character on screen and in real life. Midway through his transformation of the school lunch program, Oliver interprets her skepticism as a real impediment to Huntington's public health and the Food Revolution social movement:

> *I want her on my side. But all we're doing is fighting at the moment. And she's blocking me. And also, she's not blocking me; she's blocking the whole country. As far as I'm concerned, she's blocking all the kids in this town. So I need to get her to care.* (Episode 5)

Post-production editing enhances such hyperbolized statements for dramatic emphasis, positioning Gue as a cynical foil and adversary when Oliver's ambitious experiments are less than successful. Abstracted from the context of Central City Elementary School and the show's plot line, Oliver's valuation of her power is grossly overestimated. Convincing Gue to "care" and converting her estimation of Oliver's moral crusade is a ploy to recruit audiences towards supporting the man himself.

Observing the cooks prepare mashed potatoes for lunch, Oliver uses this seemingly benign side dish as an exemplar case study of what is wrong with processed food. While Gue mixes dehydrated potato pearls (which she describes as "a cook's best friend") with water, Oliver reads the ingredient list out loud. Oliver assessment of school food is emotional and hyperbolic:

> *I'm like, "What is this stuff?" [Tasting mashed potatoes from the mixing bowl.] It tastes like starchy fluff with off-notes in it. Absolutely disgusting. I know it's only mashed potatoes - but when I start look at the mashed potatoes, then the nuggets, then the pizza…then the milk's got crap in it…the cereal's got crap in it. All of those little things all together – piss me off. And if you're a parent, it should piss you off. And I'm telling you that I've been to South Africa, in townships, and they're getting better food than your American kids. Now if I were you, I'd be really pissed off.* (Episode 1)

Oliver identifies evil against a seemingly benign standard of purity: mashed potatoes cooked from raw ingredients would not taste or look like the product served under such a guise. His assessment that an American school lunch containing processed foods such as chicken nuggets and flavored milk is inferior in quality to that served in a developing country is deliberately extreme and confrontational to audiences and Huntington locals. The implicit assumption is that American children should be eating better than anywhere else in the world, preferably cooked from raw, wholesome ingredients. Not only does he undermine societal anxiety about America's flagging exceptionalism, he taps into upper- and middle-class preoccupations with proactive childrearing. Oliver instructs parents to be worried, incensed, and motivated for a regime change by railing against processed and reheated food.

Upon inventorying the school's freezer, where he discovers an "Aladdin's cave of processed crap," Oliver expresses confusion and concern: " I didn't know what most of it was – and when I don't know what something is, the alarm bells go off. I would not ever feed that to my kids, ever" (Episode 1). Oliver's tone moderates to that of a savvy defender of consumer rights and food safety. His suspicion of frozen pre-cooked meat patties and scrambled eggs implies that individual consumers must be vigilant against manufacturers and insiders in the food industry. He draws on his experience as a chef and food industry expert to adjudicate of the relative safety of ambiguous ingredients. He proposes a personal litmus test with nutritional standards that are set higher than parents allowing their children to consume school lunches. Those parents and locals who are not angry are either uninformed, wrong, or on the side of evil. Oliver leverages righteous anger as a parent to justify his complete transformation of the school kitchen

and menu. Oliver is not here to get in the way of hardworking school cooks; he is here to enlighten their minds and improve the products they serve.

The Moral Crusade

"I'm talking about causing a big fuss and changing things. Change!" (Jamie Oliver, Episode 1)

Every crusade seeks to delineate an enemy to defeat, or convert. It becomes clear in the first episode that Alice Gue and Rhonda McCoy, Director of Food Services for Cabell County School District, are Oliver's primary adversaries to unrolling the Food Revolution. Oliver names these women as key actors in the success of his moral crusade: "Every time we talk to Alice, it all goes down again. I want Alice on my side. She's the trump card. But at the moment, she still ain't with us. She's far from it" (Episode 3). Exploiting the contrivances and enhanced drama of television, Oliver personifies Alice to represent one of his biggest critics and impediments to regime change. By hyper-personalizing the Food Revolution into a battle of wills between himself and select local characters, Oliver sets himself (as well as the audience) up for inevitable success when his celebrity influence compels their cooperation. Gue's support does not yield any advantage other than symbolic, for she is a small figure in a larger governmental apparatus.

Too often, Oliver's surveillance punishes these working-class women from doing their jobs according to best practice guidelines and professional experience. Where Oliver can clearly recognize the relevance of his moral crusade, the cooks are professionally and economically invested in the status quo. Oliver attempts to appear cooperative by promising that he is not attacking them personally; however, his promise

is repeatedly contradicted. When Oliver and Gue have a showdown over processed chicken strips, it becomes clear that the Food Revolution mission is about redefining and affirming "good" food rather than improving nutrition.

> Alice: [*Referring to chicken strip] What's wrong with that?*
> Jamie: *What's wrong with that? What's right with that?*
> Other cook: *Yeah, I think it's good.*
> Jamie: *And that list of ingredients doesn't bother you in any way?*
> Alice: *Not in the slightest.*
> Jamie: *You know, it doesn't bother me that adults eat it. What bothers me is that kids eat it.* (Episode 1)

His questioning and tone imply the kitchen staff (and parents at home) should feel shame for preparing and serving the "kind of food that's killing America." He uses children as moral leverage to make imperative the desire to protect especially "vulnerable" populations from danger of processed foods, and potential obesity. While adults have agency and self-responsibility guiding their decisions, children are supposed to be protected by parents, community leaders, and social institutions. Oliver's statement makes clear that he intends to raise school food to meet or exceed *his* standards, whether or not these school employees or administrators choose to publically acknowledge the problematic nature of processed foods.

On the other hand, Rhonda McCoy personifies a bureaucratic impediment to the Food Revolution. She is a gatekeeper for Oliver's access to cafeteria kitchens of 26 schools, including the elementary and high school where Oliver trials his school lunch program. They are in perpetual conflict over the new food rules Oliver seeks to roll out and existing United States Department of Agriculture (USDA) guidance for administering the National School Lunch Program. Rhonda is portrayed as a literal paper-shuffler, toting massive binders of materials stipulating budgetary and nutrition regulation to her first planning meeting with Oliver. Her experience and regulatory

knowledge is both dismissed and mystified: "I just wanted to cook some food. This is like a math test! There's so red tape there. It's so complex. I don't understand it. Normal people in America won't understand it," Oliver exclaims after his briefing in Episode 1. His intentions to "cook some food" are stymied by the complex regulations allowing bureaucrats to claim proficient nutrition while obscuring special interests and political inertia. When his meals exceed budget guidelines by 200% or fail to meet USDA nutritional requirements for vegetable servings, he dismisses these matters as bureaucratic and irrelevant to his moral crusade. McCoy personifies human ad bureaucratic impediments to the Food Revolution's success: she hovers over his plans with a clipboard in hand, checking off requirements and pointing out errors. To accomplish his Food Revolution, Oliver rejects or circumvents her (representation of the federal government's) nonsensical rules by flouting his celebrity influence and brand ambassadorship.

Over the course of the series, Oliver characterizes McCoy as unfit rule enforcer: someone who cannot recognize the negative outcomes of her job function. Several months after implementing his school food reforms, Oliver returns to Huntington to confront McCoy's decision to reintroduce processed food into schools due to an overflow of inventory:

> *Rhonda is basically saying, "We've got so much processed food backed up. We're going to have to put it back in on a Friday." Calling it Processed Food Friday. It's like, no! Imagine being an alcoholic and saying, "It's all right. I'll have a drink on a Friday." Going in for your drug habilitation and saying, "Have a nice bit of crack on a Friday. That's all right." It's not all right! It's 2010 and we've got the first generation of children expected to live shorter lives than their parents. Frankly, I do not give a [expletive] about frozen food, processed food, and a refrigerated place that's full. The only thing I give a crack about are beautiful little children getting a good start in life, especially elementary school.* (Episode 6)

Oliver castigates her budgetary concerns as ignorant bean-counting and misappropriation of government and local resources. Moreover, he implicates her decision as directly exacerbating the obesity problem by implying that school children are addicted to cheap processed foods. In expressing his extreme moral indignation, Oliver implies that he is the primary defender of "beautiful little children" from a fate of chronic illness and early death.

Despite these obstructive personalities, Oliver manages to implement his Food Revolution vision as a trial in two Cabell County schools. Oliver's immodest proposal follows that Huntington's children and families will be made over by "purer" food and methods of procurement and production: "Really, what I'm trying to do – I'm not doing healthy, hippy stuff. It's proper cooking. It's really not impressive stuff. But it is wholesome stuff" (Episode 5). As Oliver describes, the Food Revolution movement is not about forcing "hippy food" down the throats of Huntington but diversifying and redirecting their tastes and food options towards a cosmopolitan and health-conscious standard that resonates with most middle-class Americans, particularly the target audience tuning in. He attempts to disassociate his moral reform from the perception that it may be classist or represent alternative lifestyles distinct from mainstream American values. His desire to promote unimposing "wholesome stuff" is benignly humanitarian: if the key school personnel and parents will do what Oliver deems is right, they will be made over with better health and a way of life.

Oliver's school food makeover is not a critique of functional service standards, but rather a social movement rooted in the moral and class-based value of food. A showdown erupts in the kitchen when Oliver's planned menu cannot be served due to a deficit of utensils to the lunchroom. Oliver expresses extreme incredulity that school children are

not taught how to manipulate essential instruments for eating: "This is school. You teach them how to spell. You teach them to read. You teach them to write. You teach them to use a knife and fork. You don't want to bring up a nation of kids to only use their fingers and a spoon." When Gue accuses Oliver of British elitism, he later explains in separate interview footage that, "To not have any use for knife and fork isn't a class thing. It's not a proper English thing. It's basically saying: we have no use for real food in this school." Not unlike makeover television shows that delineate wardrobe "essentials" for participants' education, Oliver insists that the purpose of serving real food eaten with proper utensils symbolizes value beyond nutrition. By doing so, he chooses to ignore the historical and social antecedents for packaging food to be mobile and convenient for consumers too busy to cook and unskilled food service workers paid to prepare food, not cook it from scratch.

The Victorious Outcome

"All I would say is: you've got to be afraid of me or go with me. And I would suggest come with me, and let's make something that really is going to start off a real revolution." (Jamie Oliver, Episode 4)

With limited resources and time, Oliver focuses efforts on soliciting cooperation from minor actors rather than long-term reforms in public policy or USDA guidelines for school lunches. Oliver's reform efforts are divided between practical implementation of his "cooking campaign" and staging large, media-savvy demonstrations that generate public attention and shock value. Savvy to growing public awareness and support of food politics, Oliver adopts the crusading rhetoric of moral entrepreneurs with a modern buzzwords adapted from grassroots organizing: local, sustainable, change. Backstage

(beyond the gaze of the audience), Oliver negotiates corporate partnerships that are perhaps less "pure" than his stated motives but function as a means to an end. In the background, Oliver cultivates support from industry as a means to an end. He visits a US FoodService warehouse facility in order to demonstrate the availability of fresh, raw ingredients to Huntington schools, as well as publicize corporate responsibility to public audiences. During a cooking demonstration at the community kitchen (originally named "Jamie's Kitchen" and renamed "Huntington's Kitchen" at the end of the series), Oliver suggests using frozen vegetables from the Green Giant brand when recipe ingredients are out of season.

While Oliver may desire local support, he does not incorporate local input; and sustainability is achieved through corporate sponsorship rather than political or legislative reform. He identifies Cabell County Hospital administrator Doug Shiels as "a very important dude" whose charitable discretion would preserve Oliver's regime:

> *You know, the schools are going quite well at the moment. The community have now started getting involved. [Jamie's] Kitchen is buzzing. But the biggest problem is money. I would feel sincerely like I've let Huntington down if I hadn't made sure that everything I've started is sustainable and financed for when I leave. So I'm going to hook up with Doug Shiels. He's the guy that could sustainably pay for every single school in this district. But yeah, there's a lot been achieved. A lot been achieved. But so much to do.* (Episode 5).

As the largest employer in Huntington and the best source of funding for Food Revolution "sustainability," the hospital is unlikely to deny the $150,000 grant Oliver publically requests via national television. His claims for sustainability are problematic, for naysayers are constructed as perpetrators of evil rather than cogent critics of Oliver's claims and execution. When hospital administrators inquire about the long-term effects of Oliver's television show and accompanying negative publicity, Oliver dismisses their questions as defensive and unhelpful. He interprets their questions as a personal offense

rather than representing the broader interests of Huntington's parents and school children. As show producer and influential celebrity personality, Oliver demands – rather than requests – the cooperation and sponsorship of Huntington's businesses and leaders.

Tense stand-offs between Oliver and institutional actors and policies underscore the complexity of partnering with institutional and community actors to enact food reform. Oliver represents his moral crusade in Huntington as a battle of wills: against the local DJ who vehemently denounces Oliver's intentions to make everyone eat lettuce, the skeptical school cook with 20 years experience behind the lunch counter, and the rule-abiding head of food services for the local school district. Olive demonstrates success to himself and audiences by converting these subjects into Food Revolution allies who endorse and financially support Oliver's moral crusade. After hosting two community rallies showcasing parental, school staff, and local support of his new food regime, Oliver takes account: "I don't think I could have done anything more in this town. We got the [community] kitchen, we got the school program working. We've done the kitchen in that church. The work we done in people's homes" (Episode 6). In assessing how much the Food Revolution accomplished, Oliver lists a network of partnerships between corporate, non-profit, and municipal entities promoting local and personal responsibility for health. Oliver emerges as a Food Revolutionary and multi-talented celebrity personality, though it remains unclear how Huntington will fare after he leaves town.

DISCUSSION

The Food Revolution is an anti-obesity campaign focused on reforming eating and cooking behavior in the United Kingdom and United States. It is also a 2010 American makeover television series documenting celebrity chef Jamie Oliver's attempt to reform a skeptical and impoverished Appalachian town. Building on Becker's premise that deviance is conceived through moral enterprise, the representation of which is further manufactured through the collective activity of the culture industry, this study interrogates the tensions between Oliver's motivated action and celebrity persona. Oliver's success as a celebrity entrepreneur comes at the expense of the social problem for which he advocates. The show constructs "evil" and deviance in personal attacks against Oliver himself, obscuring the underlying economic and political conditions contributing to the prevalence of obesity. Findings illustrate how the conceits of celebrity and reality television reduce the broader impact of the anti-obesity message, where deviance and "evil" are personified and personalized as personal attacks against Oliver himself. Though successful in creating new food rules for individual and local contexts, Oliver's rule enforcement does little to improve the fundamental social and economic conditions affecting health and obesity in Huntington.

The obesity epidemic is seen as a quintessentially American condition, produced by the fruits of uninhibited ingenuity and industrial values. Obesity experts with various disciplinary backgrounds and interventionist agendas have promoted this disease through proactive moral entrepreneurship (Khuu, forthcoming). Despite a definite lack of expertise in American culture, public policy, medicine, and nutrition, Oliver promotes himself as a persuasive crusading reformer compelling action from the most obstinate critic to powerful corporations. Oliver's naiveté becomes an asset and strategy for

implementing the reforms he seeks by presenting a series of morally-changed questions to his detractors and audiences watching at home: Why shouldn't young school children use knives and forks to eat their school lunches? Why wouldn't a vegetable noodle stir-fry satisfy the vegetable requirement in a USDA qualified and reimbursable meal? Why would parents serve their children processed foods laden with chemical preservatives and providing minimal nutritional value? Oliver is on the moral offense in Huntington, measuring locals' standards against his own as a father, an anti-bureaucrat acting on common-sense assumptions, and as a member of the social elite educated in better nutrition and taste. At the risk of alienating the community he seeks to reform, Oliver establishes solidarity with the middle-class viewer base.

While cultural friction and ignorance drive much of the narrative arc, Oliver's celebrity persona and moral leverage successfully undermines local leadership, protocols, and values related to obesity. *Jamie Oliver's Food Revolution* and Oliver's previous makeover shows exploit schemas of cultural and material deprivation, effectively depicting the British and American working class as pathologically problematic where cooking and nutrition are concerned (Warin 2011). Hollows and Jones (2010) note that social exploration is a prominent theme to Oliver's depiction of the working class – tempered with the upper and middle-class moral evaluation that "at least he's doing something." Pragmatic endorsements such as this not only quell middle-class anxieties about charitable benevolence, but also reaffirm the dominant social construction of "good" nutrition and lifestyles. Comparing the gastronome snobs of the past with omnivorous "foodies" of today, Johnston and Baumann (2010) argue that democratization of taste does not displace middle-class arbitration of what consumables qualify as "good" and moral.

Self-appointed as the fearless leader of his self-initiated Food Revolution, Oliver's reserves of social and financial capital are unmatched by any mere domestic activist or grassroots organization. Armed with public legitimacy that only celebrity can afford, Oliver's crusade was fated to succeed regardless of local reception or television viewership ratings. Like tabloids crafting semifiction about celebrities' lives to sell more newspapers, the entertainment industry positions Oliver as a controversial personality and moral arbiter of cultural consumption. Oliver's broad body of work in lifestyle and makeover television develop a powerful "celebrity text," or biographical myth carefully produced for public consumption and response (Gamson 1994). At the same time, by functioning as an "outlet for whatever a celebrity wants to say," to enhance his celebrity entrepreneur, Oliver harnesses the media exposure to promote awareness for his lifestyle brand and future endeavors.

Perhaps a greater degree of contingency influences image and content than the theoretical model suggests, for producers, reality television participants, and viewers all participate to synthesize meaning. To draw on Becker's assessment of the social collaboration required to generate and exhibit creative endeavors, "works of art … are not the products of individual makers, 'artists' who posses a rare and special gift. They are, rather, joint products of all the people who cooperate via an art world's characteristic conventions to bring works like that into existence" (Becker 1982). Bringing makeover shows into existence requires "ordinary" participants who bring their own energetic, opinionated, and "authentic" voice to bear on the production process (Grindstaff 2002). In reality television, the driving narrative is premised on enhancing the performative potential of ordinary people with strategically opposing viewpoints that maximize opportunities for conflict. For ordinary guests exposing the vivid details of

their personal lives and shame, “the claim to stardom and expertise is rooted in different criteria” than experts and celebrities protected by professional or social status (Grindstaff 2002). Nonetheless, the reality television genre (including daytime and late night talk, makeover, lifestyle, and competitive shows) frames the viewing experience and interpretation gained from the text. Whereas documentary titles activate viewers' expectations of show as more informative, authentic, and truly artistic content, reality television competes for media market share as “trashy” morsels of unadulterated entertainment.

Jamie Oliver has set himself apart as a successful celebrity entrepreneur, firmly linking his personal brand and international lifestyle empire to the problem of childhood obesity. He joins a coterie of public figures whose names inspire well-publicized social causes that resonate and influences consumers. Rock musician Bono promotes development and public health initiatives in Africa through Product Red commercial partnerships with fashion and electronic brands, directly translating consumer behavior into philanthropy (Bell 2011). Actress and director Angelina Jolie is prominently photographed and publicized during visits to refugee camps in conflict zones or lobbying the governing bodies for humanitarian aid as a United Nations goodwill ambassador. While celebrity frame can be a powerful catalyst for harnessing public and media attention, it may also obfuscate claims and misrepresent solutions (West 2007). Such high-profile sponsorships can distract attention and resources from the troubling conditions and communities they claim to represent. The nature of celebrity and the culture industry in the United States exploits the entertainment value of fame rather than directing public attention and resources towards distinctive accomplishments or discursive content (Gamson 1994; Postman 1985).

Besides Oliver, First Lady Michelle Obama is perhaps the most famous public figure to promote obesity as social problem worth solving. "The physical and emotional health of an entire generation and the economic health and security of our nation is at stake," she declared at the Let's Move! press conference on February 9, 2010, echoing Oliver's imperative to reform Huntington. Similar to the co-branding sponsorships featured in *Jamie Oliver's Food Revolution*, the Let's Move! initiative has activated partnerships with celebrity entertainers, food manufacturers, and major retailers (including Wal-Mart) to coordinate public awareness and motivation for preventing childhood obesity. Encouraging and non-confrontational towards both lay and industry parties, Obama's brand of celebrity entrepreneurship inflects a "classier" tone appealing to middle-class constituents without alienating working-class or poor supporters (Grindstaff 2002). When First Lady Obama refers to herself as "Mom-in-Chief," a rhetorical play on her responsibilities as a parent and political figure, she effectively markets herself as a neutral mediator inspiring personal responsibility as well as collective mobilization on behalf the youngest, most vulnerable members of American society.

Most authority figures or experts have one public persona motivated by professional training and credentials. Celebrities are an interesting case of moral entrepreneurs because they have can wear many "hats" while maintaining public interest and trust in their "star quality." Gamson asserts that "the perceived ability to attract attention, regardless of what the attention is for, can be literally cashed in" for profitable gains in financial and social contexts (1994). In Hollywood, the "triple threat" label is applied to notable talent who demonstrate convincing skill in multiple entertainment outlets: dancing, singing, and acting. The modern celebrity "triple threat" takes on a

different formation for inspiring public respect and cultural relevance. Not only do they have to demonstrate mastery in a particular creative trade, celebrities are modeling themselves into activists and advocates for important causes. In the context of the culture industry, celebrity "names" are cobranded with social issues to enhance the commercial relevance of both entities. In a age when social entrepreneurship is a widely accepted neoliberal strategy, it would seem that the modern celebrity entrepreneur is limited only by the boundaries of his or her personal interests and social capital for leveraging industry partnerships for a makeover television show or fair-trade clothing line.

The "success" of celebrity entrepreneurship is both capricious and amorphous, with few external validating distinctions or awards. One noteworthy distinction between the American and British television shows is the longevity and resulting policy reforms inspired by Oliver's muckraking over school food. Whereas the British parliament quickly moved to pass legislation to increase funding for school meals, Oliver's American influence has been less remarkable in the political forum. The first season of *Jamie Oliver's Food Revolution* was generally well-received among "thought leaders" (the media and cultural elite), and distinguished with an Emmy award for "Outstanding Reality Program" in 2010. Oliver was honored with a 2010 TED prize and $100,000 grant to work on his "wish to change the world." These accomplishments are prominently advertised on the US Food Revolution website, with minimal follow up as to how communities fared in the aftermath of the shows' production and airing. A second season of *Jamie Oliver's Food Revolution* attempting school food reform in the Los Angeles United School Districted premiered on ABC in 2012. While Oliver successfully publicized the manufacture and sale of "lean finely textured beef" in place of hamburger

meat, the controversy alone was not enough to secure Oliver's third season of the makeover show in American prime time (Boffey 2012). Public dramas carried out "in the name of and in the sight of the collectivity, visible and observable," are inherently *unsustainable* given the limited capacity of public attention and resources to respond to social problems claims (Gusfield 1981; Hilgartner and Bosk 1988).

Although this case examines Jamie Oliver specifically, the observations here illuminate critical influencers and industry alliances that factor into the social problems process. Contemporary social politics has witnessed countless high-profile actors and musicians wade in the political and social morass of various conditions they deem evil, whether it concerns vaccination conspiracies, poverty in the developing world, gay-marriage rights, and myriad other troubling conditions. Celebrities have real influence for rallying public attention towards their causes, and demanding retribution through primary and social media channels. Whenever celebrity entrepreneurs adopt new moral causes, their potential influence with audiences must be weighed against the risk of personal brand promotion and misrepresentation of the original mission. The evaluation of success for interventionist showcases cannot be separated from the viewership and revenue metrics accounted by the entertainment industry, but should also prioritize the beneficence demonstrated towards individuals and communities participating in the production of shows.

Limitations that must be acknowledged in this study include narrow scope of content analyzed by this study. Comparison with a more mainstream makeover show such *The Biggest Loser* may have increased the explanatory power of Oliver's moral entrepreneurship by isolating the discrete rhetorical and production strategies between shows. Since *The Biggest Loser* reaches a large and consistent audiences, there is greater

potential to study more populist messages pertaining to nutritional and cooking reform, and neoliberal appeals for personal responsibility. Likewise, a comparative case study of celebrity entrepreneurship would have illuminated different marketing and production strategies used to convert consumer behavior. There is further uncharted research territory in the integration of other social media communication platforms such as Twitter, Facebook fanpages, and YouTube online videos that encourage public commentary and dialogue. Certainly public response and adoption of behavior interventions must be better observed and measured in sociological studies of social impact. Future studies to complement and contextualize findings presented here would explore the convergence between "reality" in traditional and new media channels, accounting for enhanced interaction, agency, and collaborative production by "ordinary" people themselves.

CONCLUSION

Celebrity chefs have been at the forefront of social and market reforms to change how Americans eat, purchase, and relate to food for decades. Chef Alice Waters receives much credit for her early advocacy for organic produce and local farmers dating back to the founding of her restaurant Chez Panisse in 1971 (Johnston and Baumann 2010). Waters dedicated herself to promoting organic ingredients through cooking and social activism after perceiving commercial agricultural practices to be detrimental to the environment and public health. Over time, food politics (the notion that food and eating are implicated in politicized systems) came to represent mainstream topics in media coverage and public discourse.

A new generation of celebrity chefs has emerged from the kitchen to advocate for social reforms related to food and health. Savvy to the power of media, celebrity entrepreneurs shape the public perception of obesity with sensational transformations and band-aid solutions with limited impact. Time will tell whether celebrity entrepreneurs can produce a paradigm shift in the fundamental social and economic conditions affecting the health of overweight Americans, or merely use their clout to sell product and produce predictable capital returns for themselves.

CONCLUSION

The public problem of obesity is seen as a quintessentially American condition, produced by the fruits of our very ingenuity and industrial nature. This dissertation explores the premise that personal, professional, and public responsibility for the condition is socially constructed through moral enterprise. Obesity entrepreneurs use news and popular media platforms to their advantage by producing a specific discourse about obesity. Motivated individuals recognize the economic opportunities of obesity prevention or intervention, and seek to invest their efforts towards solutions that value free market solutions, decentralization, and individualized responsibility. In sum, moral entrepreneurs are very much invested in promoting the obesity problem while also making claims to its imminent solvability.

In this final chapter, I will discuss the implications of my findings, suggestions for social or public policy reform, and suggestions for further research.

Professional Authority and Public Understanding of Disease

In Chapter 1, I consider how the social trajectory of obesity as a public health problem was driven by medical moral claimsmaking and entrepreneurship. Medical experts "own" or maintain definitional authority of the obesity problem by adapting standardized definitions, methods, and etiological models to diagnose and treat the condition. According to Gusfield (1981), expert "ownership" of a public problem is the

outcome of power, authority, and influence. I argue that expert rhetoric framing obesity as a biomedical (rather than strictly moral) condition enhanced professional morale and expanded the jurisdiction of medical expertise. Biomedicalization became an important component of the expert tool kit by framing obesity as controllable and solvable scientific and medical problem.

Nonetheless, it is clear that moral prejudice persists in shaping expert and societal discourse about obese people. Though successful in attenuating some degree of public antipathy, the stigma of heavy body weight (or "fatness" to model activist language) persists in discriminatory attitudes and behaviors demonstrated against obese individuals (Monaghan, Hollands and Prtichard 2010). Puhl and Brownell (2001) report that 24 percent of nurses admit to being repulsed by obese patients while 28 percent of teachers regarded the condition as the worst thing to happen to a person. Research confirms the prevalence of systematic discrimination and cultural condescension in social interactions dealing with employment, education, and healthcare – social institutions with the broadest reach and effect on individuals' personal outcomes. Bias against overweight individuals is based on the belief that they possess negative characteristics, are responsible for their state, and deserve what they get. The social and psychological effects of obesity-related stigma and discrimination are enduring, although it is unclear how negative perceptions will evolve as more Americans become overweight (Puhl and Brownell 2001).

Biomedicalized claimsmaking that obesity is a "complex" and "multifactorial" condition has moderated, but not replaced, the moral etiological model. The messiness of expert claimsmaking and treatment will continue to regress to earlier trends of moralization of health behavior and lifestyle. The outcome of standardized metrics for

understanding and classifying obesity is plentiful data and evidence, which can be interpreted as an indictment of "high risk" low income and ethnic populations. It is important to consider how obesity studies may reinscribe and solidify historical social fault lines related to class and race. Conrad describes the present-day "health morality" as an instance of "healthicization" by which lifestyles habits and behavior are used to explain the incidence of medical conditions such as heart disease or obesity. "One turns the moral into the medical, the other turns health into the moral" (Conrad 1992, 223).

As Americans confer greater influence to medical knowledge and professionals in everyday life, they also seek control over the personal management and experience of health. Such motivations can erode the expert authority of health professionals (Starr 1982), particularly physicians whose patients seek self-treatment from commercial diet, exercise, or supplement (pseudo-pharmaceutical) programs. Having confirmed the powerful influence of medical moral claimsmaking in institutionalizing obesity as a public health problem, it is unlikely that the social construction of obesity will ever fully divest from the biomedical framework of diagnosis and treatment. In the future, the biomedical model may have limited resonance for a public audience increasingly attuned and responsive to environmental and social determinants of health. One recommendation for obesity experts is to increase disciplinary collaboration to streamline recommendations and guidelines and enhancing communication and outreach to the public. Not only would organizations and budgets benefit from aligned research agendas, but the public health mission would see greater returns from specific interventions or health behaviors adopted by the public.

The Medium and the Message

In Chapter 2, I examine how public logic is shaped by the journalistic and organizational practices of the news media. I show how mainstream newspapers limit certain actors to stating certain claims in order to package obesity as a "newsworthy" health and human interest story. In effect, journalists construct obesity narratives promoting the professional prestige of obesity experts while perpetuating the social marginalization of obese lay individuals. This study confirms that the public representation of obesity, like other controversial public problems, "depends on which formulations are accepted by which operatives who intend to do what about them in which public arenas" (Hilgartner and Bosk 1988).

This is not to assume that expert claims are all powerful, or that lay respondents cannot represent themselves as experts of everyday life. Grindstaff's (2002) analysis of expert appearances on TV talk shows discusses the cultural distrust of intellectuals dating back to the fragmented specialization and professionalization that developed after the Industrial Revolution. The distinction for experts exists in the professional role itself and delivery of normative facts and assessments. When experts are represented in print or on television as interchangeable "talking heads" or expressionless robots, their message become utterly forgettable from the perspective of audiences. The balance of power shifts towards lay knowledge and emotional labor when the performance of "ordinary-ness" becomes central to telling the public problem narrative.

Having confirmed that who says what is highly contingent on the organizational practices media and public trust of professional authority, I recommend that pro-body image activists and public health groups alike utilize the power of the Internet and social media to develop content directly accessible to the public. Controlling or reconfiguring

content on the obesity experience is crucial for promoting alternative narratives that destigmatize and contextualize the condition. Campaigns in support of preventing, detecting, and surviving cancer indicate that public ownership of the disease experience is possible given the development of a strategic network of grassroots support and the implementation of key messaging.

Individual and Social Responsibility for Obesity

Finally, Chapter 3 examines how British celebrity chef Jamie Oliver produced a sensational story out of the mediocrity of the American school food system. As a celebrity entrepreneur specializing in the medium of makeover television, Oliver demonstrates how high-profile figures can successfully launch moral crusades without generating any lasting social impact or accountability. For all his heartfelt declarations and publicity-generating stunts, Oliver's Food Revolution offers no real solutions towards solving deep systemic conditions underlying obesity. Audiences passively witness a carefully scripted and produced community transformation that fails to live up to its original premise. The public perception that "at least he's doing something" manages to quell middle-class anxieties about charitable benevolence, but also reaffirm the dominant social construction of "good" nutrition and lifestyles (Hollows and Jones 2010).

If health is a condition to be achieved and maintained through effort and responsibility (Cockerham 2005), then some groups are prime targets for social censure for inferior "work ethics." Popular stereotypes medicalize "risky" behaviors or the prevalence of chronic conditions observed in cultural, racial, or gendered groups. This research confirms the inherent deficit in public understanding of social conditions as

fundamental causes of disease (Link and Phelan 1995). The economically disadvantaged inhabit neighborhoods with higher exposure to crime and pollution. Racial segregation patterns overlap with the geographic spread of urban “food deserts” where nutrition is a secondary condition after satisfying hunger. Single mothers forgo personal care because their full attention is directed to providing basic needs for their children. Marmot’s work indicates that the status gradient inherent in Western societies contributes to health inequalities related to stress and agency (2006).

The prevalence and moral anxiety over obesity has changed how Americans regard class differences in nutrition. Aronson (1982) describes how nutrition was framed as a policy strategy to manage social unrest under a "doctrine of efficiency" that maintained low wages while encouraging workers to eat more. The problem of diet became a moral and philanthropic issue by critiquing working class tastes, consumer behavior, and inefficient food preparation as contributing causes of poverty. Contemporary circumstances shift the causal explanation in the other direction by implicating poverty as the trigger for diminished population health. Moral and cultural critiques continue to be aimed at poor Americans, while better off citizens spend more money on calorie sparse fruits and vegetables. Thus, social conditions determine how society defines this social problem and its priorities and allocates scarce resources.

While not denying effect of illness on educational achievement or productive work, social epidemiology has demonstrated the causal effect of social conditions on ill health. The individual risk factor approach to social epidemiology or public health is inadequate if it does not take into account contextual factors or fundamental causes that heighten susceptibility to disease. Overemphasizing proximate risk factors can create an incomplete understanding of the importance and complexity of social conditions on

health over time (addressing "next step" risk factors rather than social conditions that are the "starting point"). Failing to account for the structural inequalities producing differential health outcomes allows these conditions to persist and increase in magnitude.

In reality, the entire American population is increasingly susceptible to the risk of obesity given the interconnected accumulation of environmental, cultural, and economic changes in our society (Anderson and Butcher 2006). Public responsibility shifts attention to macrosocial factors to understand how economic conditions shape the collective rise of obesity. Policy makers can play a role by creating conditions for healthier defaults that nudge individuals towards better choices (Thaler and Sunstein 2008). While some interventions would envision broad social changes, smaller changes can also produce significant gains towards addressing this problem. Using childhood obesity as an example of universally “deserving cause” (Kersh, Stroup and Taylor 2011), ensuring healthy food and environments to children will reinforce efforts to educate them about better choices (Hillier 2008). Subsidizing the purchase of fresh fruits and vegetables through government nutrition assistance programs for low-income mothers and families also show promise. Obesity intervention research must strive to meet the economic and medical needs of at-risk communities where they are, and integrate structural changes that affect how people engage with obesegenic environments.

Suggestions for Further Research

As more aspects of everyday life enter the purview of medicine, medical sociology illuminates the social processes by which “constellations of troubles become diseases”

with potential to compromise the health of American society (Bird, Conrad and Fremont 2000). While it is common to think of the social construction of disease as a critique to the dominant biomedical approach to illness, this dissertation considers how biomedicalization, culture, professional conventions, and moral entrepreneurship directly influence population health (or the perception of such). In doing so, it contributes to the extant literature on obesity by acknowledging the evolving claims constructed and cooperatively proliferated through professional and public communication channels. The meaning and consequences of obesity has no "unadulterated biological core that is the real disease" because the acts of disease recognition, naming, and classification are contingent on social factors (Aronowitz 1998).

When it comes to the social problems process, the function and impact of professional roles and influence extends beyond the work itself. My dissertation underscores the processes by which social actors make claims and are motivated to enhance their personal relevance, if not also to create or take advantage of economic and political opportunities. The obesity epidemic remains a serious health threat because expert authorities, methods, and stakeholders have constructed it as such.

When it comes to obesity, I believe that future research and advocacy agendas must focus on:

1. Enhancing consensus in the level of concern among medical and public health experts
2. Developing key guidelines guiding individual and societal action
3. Persuading and defaulting the public towards following healthier defaults
4. Redistributing and increasing access to healthy options
5. Promoting physical activity and "play time" for children and adults

The moral and medical complexity of obesity will continue to exacerbate public and professional apathy. Explaining why so many Americans are overweight requires a balanced account of the interaction between individual- and structural-level factors. Although individuals remain primarily responsibility for their health status, attention has been directed towards “toxic environments” that exacerbate overnutrition, underactivity, and imbalanced diets (Brownell and Horgen 2004). It will be the task of future work to overcome existing moral boundaries towards a deeper understanding of the meaning and implications of obesity.

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