OSTOMY SURGERIES have been performed for over 300 years to treat a range of gastrointestinal (GI) issues. Historically, ostomy-creating surgeries have been used to treat both acute and chronic GI problems, including hernias, battlefield wounds, and intestinal blockages. In 1710, after the death of a six-day-old infant who was born without an anus, a French physician, Alexis Littre, hypothesized that creating an opening on the abdomen to reroute the digestive system might have saved the infant. Nearly 100 years later, Littre’s ideas were proven viable. In 1793 Duret, another French physician, performed one of the first “deliberate” ostomy surgeries on a three-day-old infant (Anyanwu et al., 2013, p. 32). The baby died just one week later, but Duret’s application of Littre’s original idea fortified ostomy surgery as an option for previously untreatable bowel conditions. In the time between Littre’s ideas and Duret’s implementation, another revelatory ostomy procedure was performed, in 1743, that extended the life of an elderly woman by several years. This time, a seventy-three-year-old woman, Margaret White, began experiencing extreme pain and vomiting when a “rupture at her navel” that she had lived with for over twenty years unexpectedly “burst” (Cheselden, 1750; 1. An intestinal blockage or obstruction, as the names suggest, occurs when digested material is unable to move through the intestines and/or when the intestines are narrowed, often because of scar tissue or a tumor.
Wu, 2012). Her doctor, William Cheselden, reported finding White with what is known today as a hernia but he described as over twenty inches of “gut hanging out.” According to his notes, Cheselden removed the exposed damaged intestine and deliberately left White with the end of her gut (presumably the end of her colon) exposed to prevent further internal damage and enable digestive evacuation, effectively creating what we would today call an ostomy. After recovering from this surgery, White went on to live for “many years,” according to her doctor’s account.

These surgeries serve as the origin story for ostomies, but it took hundreds more years before ostomy surgery developed into its modern form. In the meantime, ostomy surgery took its place as an option for treatment, but only as the final option to be pursued if and when all other treatments had failed. Until the early twentieth century, ostomy surgery itself was still very much developing in technique, which meant that it truly was a last resort or worst-case scenario for most patients. As these and other historical accounts reveal, ostomy surgery was only considered after attempting a range of other treatments including mercury, enemas, bed rest, sitz baths, or, in Margaret White’s case, after living with a hernia for over twenty years (Cataldo, 1999; Doughty, 2008; Nichols, 2016).

Moreover, ostomy-pouch technology did not develop until hundreds of years after the first ostomy surgeries, making life with an ostomy between the 1700s and early 1900s rife with challenges. Historical accounts of ostomy surgery prior to the mid-1900s depict ostomates as “pioneers” who were “very much on their own” in terms of managing the stoma and handling stoma output (Doughty, 2008, p. 37). With surgical techniques still developing and ostomy-pouch technology virtually nonexistent, life after ostomy surgery was nothing if uncertain. The first mention of a collecting device was reported in 1795, but it wasn’t until nearly two centuries later, in the 1970s, that the ostomy-appliance industry took off. Before manufactured ostomy appliances were available, ostomates innovated their own systems for handling output. These included moss, rags, tin boxes, leather pouches, metal cans, and rubber bags held over the stoma with belts, cement, adhesive tapes, and paste (Cataldo, 1999). For example, one historical account depicted a woman named Mabel who underwent ostomy surgery in the late 1930s at a time when ostomy-pouching technology had not yet developed (Riome, 2018). After surgery, Mabel returned home to use rags that she changed and cleaned in her family’s outhouse. Mabel’s husband, hoping to make her life easier, invented an at-home device made from a tin can and belt strap, and, while reportedly better than rags, this homemade device was described as “leaky and stinky”
(Riome, 2018). Even when “strapped tightly around her waist,” Mabel’s home-made device could only “reduce the leakage (not prevent leakage . . . just reduce)” (Riome, 2018).

Some historical accounts report that such homemade waste-collection systems were successful and often better than nothing, as Mabel’s story showcases. However, not every ostomate had the ability or resources to develop such at-home devices, so it’s perhaps unsurprising that historically ostomates are described as “dread[ing]” life with an ostomy (Wu, 2012, p. 34). These early adversities, no doubt, led many ostomates to hide their surgeries and embodied differences. Without effective appliance technology, managing a stoma and stoma output were undoubtedly difficult since stomas are not controlled by muscular sphincters that enable deliberate opening and closing. That is, ostomies essentially render those living with them fecally incontinent in that ostomies excrete waste whenever there is waste to be excreted, not when it is convenient or decided on by the ostomate. Given the historical lack of social, physical, and technological support for ostomates, it’s ultimately unsurprising that leaks and other negative experiences have dominated public ostomy stories.

Since the first documented description of ostomy surgery at the start of the eighteenth century, the procedure itself has transformed substantially, as have the technologies used to protect stomas and collect waste. By most accounts, both ostomy surgery and technology have improved immensely. The mid-1900s, in particular, saw advancements in both ostomy surgery technique and pouching technology. Quality of life for ostomates has also “dramatically advanced” alongside these improved surgeries and technologies (Cataldo, 1999, p. 140). In the 1960s and 1970s, ostomy-supply companies began to focus on the needs and desires of ostomates themselves (Nichols, 2016), thereby enhancing ostomy-pouching technology and ostomates’ lived experiences. In particular, many kinds of pouching systems now exist, which gives ostomates options to find a pouch with the best fit for their individual bodies to most effectively mitigate leaks and other unwanted or potentially stigmatizing experiences.

2. This is not the case for every ostomate. Some people living with colostomies can “train” their stomas to excrete waste at predetermined times. The technical term for this process is colostomy irrigation. Many folks who choose and are able to practice irrigation use an ostomy plug rather than a pouching system. Plugs, as the name implies, are small devices inserted into the stoma that plug or block the opening to prevent fecal output from being excreted. To irrigate, ostomates remove the plug and flush the ostomy with a water enema. Over time, repeating this process consistently (at the same time of day) regulates the GI tract to excrete waste on a schedule.
What has failed to advance alongside these technological, surgical, and embodied improvements, however, is the public ostomy story. Lived experiences with ostomies may have been riddled with leaks and social isolation in the 1700s, 1800s, and early 1900s, but advances in surgical technique, ostomy appliances, and the potential for increased social support through advocacy organizations and online communities have all significantly changed what life with an ostomy can be. Nevertheless, the public story about ostomies and ostomy experiences seems to have retained ostomy’s historical reputation as a dreaded last resort. Indeed, public ostomy stories, as I explore in this chapter, have remained relatively consistent, focusing exclusively on negative experiences. Recall Julia, the participant in the Tips from Former Smokers campaign whose ostomy story focused on how she “hated” her ostomy because it leaked, smelled, and made her feel stuck at home (see chapter 1). Even though Julia’s story may have been consistent with her lived experiences, her story angered thousands of people living with ostomies and chronic GI conditions because, according to their responses, Julia’s story engendered stigma and unfairly suggested that life with an ostomy was unquestionably negative and, worse yet, a punishment for poor health choices. Julia’s participation in the Tips campaign, in addition to other stories I review in this chapter, suggests that negative ostomy experiences persist as the primary, if not only, story about ostomies circulating widely in the public sphere. Accordingly, the stories presented in this chapter point to the public’s continued familiarity with and acceptance of this negative, stigmatizing ostomy story.

This chapter picks up Julia’s story again to examine how public ostomy stories both feed and feed on stigma. I argue that the public stories that rhetors like Julia (and the CDC) tell about ostomies emphasize negative lived experiences with leaks, uncontrollability, and social outcasting. In doing so, these stories (aim to) evoke emotional and embodied responses in their audiences, particularly fear, which rhetorically fuels the stories as they enter and circulate in the public sphere. These stories thus tap into what Johnson (2016) has called “visceral publics”—publics united by intense, embodied feelings—by forwarding a familiar metanarrative about ostomies (ostomies are leaky, smelly, and disabling) and enacting the ostomy as unilaterally negative. As a result, these stories and the experiences featured in them simultaneously rely on and calcify ostomy stigma.

In the remainder of this chapter, I review previous scholarship that has demonstrated the interconnectedness of stigma, leaks, disability, and visceral publics. In doing so, I build on the histories of ostomies outlined in the introduction of this chapter and detail the social relationship between leakiness / bodily leaks and fear and disgust directed at disabled bodies, a connection
that subsequently activates stigma. I then examine four key public ostomy stories: Julia’s story in the Tips from Former Smokers campaign; a story told by the Cincinnati, Ohio, Police Department to teenagers at risk of gun violence; and two stories told in the popular medical drama Grey’s Anatomy. Examining these stories together reveals consistency in terms of the kinds of practices shared and the kinds of rhetorical moves used to effect change or evoke response in the stories’ listeners. I specifically demonstrate that highly public ostomy stories consistently omit important details, which helps maintain a negative meaning of ostomies; frequently rely on discussions of bodily leakiness and on disability stereotypes; and, ultimately, rhetorically leverage fear of ostomies to accomplish often unrelated goals. Further, I illustrate the immense rhetorical importance of these public ostomy stories, especially given their broad audiences. In many cases, these stories may very well be the only ostomy story viewers have access to, thus compounding their rhetorical impacts and risks.

Together, these highly public ostomy stories evidence that the public ostomy story rhetorically serves as what Adichie (2009) might describe as a single story that shows ostomates “as one thing, as only one thing, over and over again.” This single ostomy story, in turn, communicates that ostomy experience is singularly negative and undesirable. As Adichie (2009) explained, “The single story creates stereotypes, and the problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story” (emphasis added). Critically, Adichie was referring to the dangers of a single story about a culture or race; nevertheless, her sentiment illuminates the stigmatizing danger of telling a single ostomy story. Indeed, “the danger of a single story” is that single stories breed misunderstanding; they prey on fear, stereotypes, and incomplete, flattened experiences. With Adichie’s insights in mind, the analysis of the public ostomy story presented in this chapter provides insight into why ostomy stigma is so pervasive and difficult to counter.

Finally, these ostomy stories, and the single public story they collectively create, complicate a commonly held notion about the rhetorical effects of stigma, which I discuss in the final sections of this chapter. Much of the work on stigma in rhetorical studies focuses on stigmas’ rhetorically disabling effect—reducing credibility or replacing it with anticredibility (kakoethos) altogether (Johnson, 2010; Molloy, 2015; Prendergast, 2001). This is not always the case, however, when it comes to the stigmatization of ostomies. Instead of removing ostomate rhetors from the polis, these public ostomy stories and the experiences within them have proved highly persuasive in the public domain. So persuasive and credible, for instance, that the CDC selected Julia, an ostomate, to tell her story as part of a national antismoking health cam-
paign that would be viewed by millions of Americans. These public enactments of ostomies become especially credible because they use (potential) ostomates and their lived experiences as evidence to support negative understandings of ostomies that are, in turn, often used to motivate audiences to action. What is more persuasive, after all, than an ostomate herself, trusted sources like the CDC and police officers, or even a favorite TV show, arguing that ostomies are terrible?

**Leaks, Stigma, and Visceral Publics**

Ostomies’ historical reputation (as leaky, uncontrollable last resorts) is deeply rooted in powerful, oppressive systems and ideologies that cast particular kinds of bodies as threatening, frightening, disgusting, and unruly. This reputation, as the stories explored in this chapter highlight, remains insidiously powerful in our present moment. First, however, an overview of the interconnectedness of leakiness, stigma, and disability helps contextualize the stories and analysis in this chapter.

I outlined in chapter 1 that disability scholars and rhetoricians have theorized the deep entanglement of disability and stigma. Specifically, disabilities and embodied differences are stigmatized as a measure of exacting control through demarcation and oppression (Garland-Thomson, 1997; Johnson, 2010). Being disabled has historically “been read as a sign of evil, and associated with weakness, criminality, asexuality, vagrancy, dangerousness, and worthlessness” (Johnson, 2010, p. 465). The “disabled figure,” as Garland-Thomson (1997) so poignantly demonstrated in *Extraordinary Bodies*, “operates as the vividly embodied, stigmatized other whose social role is to symbolically free the privileged, idealized figure of the American self from the vagaries and vulnerabilities of embodiment” (p. 7; emphasis added). In other words, disability and embodied differences have been positioned as antithetical to normality, creating a “perverse taxonomy of ‘normals’ and the ‘stigmatized’” (Garland-Thomson, 2014).

This opposition between so-called normals and stigmatized is generated, at least in part, by social structures that stage particular bodies “as less bounded and more porous” (Johnson, 2016, p. 5) and thus “dangerous because they are perceived as out of control” (Garland-Thomson, 1997, p. 37). Indeed, scholars across rhetorical, feminist, disability, and cultural studies have demonstrated that fear and stigma regarding embodied differences are commonly tied to fear and stigma regarding leaks and leaky bodies, including physical leaks (leaky urine, saliva, feces, blood) but also leaks that blur the separation of mind and body and subsequently challenge the idea that the mind con-
trols the body. Most systems of power in Western society, particularly able-

•ism and sexism, are predicated on the idea that “normal” bodies are stable, bounded, and neatly controlled by the rational mind. To be normal is to be male, young, White, cisgender, heterosexual, athletic, and stereotypically able (Goffman, 1963, p. 128). Anybody that defies these “normal” characteristics is deemed abnormal and is thus vulnerable to stigmatization. For example, disabled, female, trans, queer, and non-White bodies are often figured as leaky, uncontrollable, and erratic, and thus problematic, threatening, and inferior.

Leakiness and uncontrollability—whether physical or cognitive, actual or anticipated—challenge a “sense of order” in which bodies are tightly bounded, rigidly able, and tidily controlled by the rational mind (Turner, 2003, p. 4). Leaks, such as menstrual blood, breast milk, and stoma output, “breach the boundaries of the proper” (Shildrick, 1997, p. 12) and “remind us that total control of the body is an unachievable goal” (MacDonald, 2007, p. 329). Leaking excrement, in particular, Elizabeth Grosz (1994) argued, “poses a threat . . . to life, to the proper, the clean,” and compels people to “establish as great a separation as possible from the excremental” (p. 207). In fact, some of the very first social training we receive as humans (potty training) teaches us to manage our bodies such that bodily fluids are contained, controlled, and invisible (Gunn, 2006; Turner, 2003). This social training responds to the cultural expectation that perceived or actual leaky bodies are dangerous threats to self-certainty, autonomy, and social norms, and are consequently stigmatized (Grosz, 1994; MacDonald, 2007; Shildrick, 1997; Turner, 2003).

Centralizing bodily leaks, particularly leaking fecal matter, is rhetorically powerful in ostomy stories given the historical and continuing stigmatization of leaks. As I mentioned in the introduction to this chapter, ostomy stories and the experiences shared within them are marked by leakiness, particularly before ostomy-pouching technology was developed, when ostomates were forced to create their own pouching systems. Despite significant advances in such technology, public stories of ostomies and thus public understandings of ostomies remain characterized by leakiness. Consequently, public fear regarding ostomies and their leaks rhetorically fuels public stigmatization of ostomies. The public stories retold in this chapter indicate how immensely persuasive and entrenched fears regarding leaks and uncontrollable bodies are.

In particular, public ostomy stories not only target but rely on audiences’ fear of leaky, disabled bodies and, relatedly, the stigmatization of ostomies. In this way, the audiences of the public ostomy stories I analyze in this chapter constitute what Johnson (2016) has called a “visceral public” or publics united by shared, intense feelings. Johnson theorized, “Visceral publics have two
defining qualities: they emerge from discourse about boundaries, and they cohere by means of intense feeling” (p. 2). Unlike other notions of publics that focus on discursive and ideological affinities that bring together individuals into publics, Johnson’s concept of visceral publics focuses squarely on the emotional and embodied responses that unite people in the public sphere (Johnson, 2016; Winderman et al., 2019).

As Johnson and others have further pointed out, these unifying emotional and embodied responses often include fear, disgust, and hate (Johnson, 2016; Winderman et al., 2019). These feelings are felt so deeply and so viscerally that they “present as self-evident forms of truth” (Johnson, 2016, p. 4; see also Ahmed, 2003, 2015). For instance, fear and disgust as responses to human waste or blood are often experienced and positioned as natural, even primordial. In other words, feeling disgusted at the site of blood is seen as a natural response. In the contexts of public ostomy stories, such seemingly self-evident visceral feelings, particularly those that emerge in response to stories about leaky, disabling ostomies, make the stigmatization of ostomies also appear self-evident. That is, fear and disgust are presumed to be unquestionable, obvious, and natural reactions to public ostomy stories and the visceral publics these stories evoke and sustain.

In addition to sharing these intense, embodied feelings, visceral publics are often united by the shared desire to do something about those feelings, to prevent or mitigate them in the future. Johnson (2016) argued, “Collective visceral feelings of vulnerability and fear often serve as inarguable, self-evident rationales” for policies like government-mandated fluoridation of water and public health responses more broadly (p. 5). Similarly, fear, Michael William Pfau (2007) has argued, “is an influential emotion whose history reveals its impacts not only on individuals, but on entire communities, economies, and political systems” (p. 216). Shared feelings of fear mobilize visceral publics to take action, to respond not only individually but also communally, to assuage that fear and neutralize threats. As we’ll see with ostomies, intense, visceral reactions often emerge in response to particular and embodied practices that rely upon and concretize stigma.

**Worst-Case Scenarios: Ostomies in Public Health Campaigns**

Three years after launching the Tips campaign, the CDC continued to roll out additional stories, and in March 2015 Julia’s story was released both online and on national television. In step with the other Tips participants, Julia shared the
negative consequences of her smoking, which include colorectal cancer, chemotherapy treatments, surgery, and a colostomy bag. According to her profile on the Tips campaign website, Julia—a smoker for over twenty years—began noticing a variety of GI symptoms including cramps, bloating, diarrhea, and vomiting, which she originally tried to manage “on her own” (CDC, 2015a). However, when these symptoms escalated, she underwent a colonoscopy that found that not only were her intestines blocked but, worse, this blockage was due to a cancerous tumor. Immediate surgery successfully removed the tumor but left Julia in need of a temporary colostomy bag as she underwent treatment for cancer and while her GI tract healed from surgery.

Years later, after she both recovered and quit smoking, Julia joined Tips to share her experiences in “hopes that people who hear her story about smoking and colon cancer will quit as soon as possible” (CDC, 2015a). Like other former smokers in the campaign, Julia shares these experiences through a series of online materials and videos, as well as national TV ads. Julia's first video aired in March 2015. This thirty-second video featured Julia in what appeared to be her home as she narrated her smoking-related experiences and concluded with a tip for viewers. The video opened with Julia looking squarely into the camera, as she explained:

I smoked and I got colon cancer. I had chemo and two surgeries, but what I hated the most was the colostomy bag. That’s where they re-route your intestines, so you have bowel movements that go into a bag through a hole in your stomach. (CDC, 2015a; emphasis added)

Julia's smoking experience, as depicted in her video, centered on living with her colostomy bag. In the video's next scene, she continued, “You go wherever it goes. You have no control. If it comes loose, it smells. I had no control.” Here and throughout the video, Julia referred to her ostomy as it as she narrated her experiences and held her colostomy bag away from her body and toward the camera.

Elaborating on the impact of this lack of control and potential leakiness on her life, Julia told viewers that she “had to wear it for a whole year,” which meant that she “was at home the majority of the time because [she] was scared it would come loose and it would smell.” Julia explains that the risk of the ostomy coming loose and smelling meant that she “didn’t want to be around anyone” and was, therefore, “stuck at home.” Finally, Julia summarized her experiences and sentiment in her tip for viewers. As she sat on the edge of her bed and held her colostomy bag, the video closed with the following message:
“My tip is to get over being squeamish. You’re going to be emptying your bag six times a day.”

Julia’s experiences with an unexpected cancer diagnosis, surgery, and chemotherapy, undoubtedly “communicate the real-life health consequences of smoking” (CDC, 2020b). However, Julia stressed that “what she hated most” was her colostomy. The risk of her ostomy leaking, and the leak’s potential smell, left her feeling trapped in her home and completely isolated from others. Julia’s story positions herself and her body as physically and socially abject through the bodily breaches and potential leakiness caused by her ostomy. Julia’s focus on leaks and feces throughout her story serves the larger rhetorical purpose of her story—to convince viewers to stop smoking—by assuming that they will be disgusted by her story, body, and ostomy. The goal of the Tips ads is to promote smoking cessation; thus, it seems the CDC assumed that their national audience would be persuaded by Julia’s story and agree that ostomies are abject and undesirable. Julia’s focus on the embodied leakiness and smell of her ostomy (and its contents) assumed an audience that agrees with Julia’s own disgust with her ostomy.

Some of Julia’s additional campaign materials further shared this ostomy-negative message. For example, a print ad featured Julia looking directly at the camera with the caption “Jokes about gas are funny, until they find a tumor in your colon.” Additionally, in a podcast released alongside her original video, Julia admitted:

I certainly don’t want to tell you about having a colostomy bag . . . I don’t want to talk about emptying or changing that thing . . . There’s so much I don’t want to tell you, but I did because my tip is tell what you know about smoking because someone might listen. Then there’d be a lot less stories to tell like mine. (CDC, 2017)

Julia’s reference to her ostomy as that thing is notable. This discursive practice, like her use of the word it in her video, creates rhetorical distance between Julia and the ostomy and, in turn, communicates to audiences that the ostomy is something to stay away from, to avoid if at all possible. The distance created through this language as well as the physical distance staged in her video by holding the ostomy bag away from her body materially reflects Julia’s stated aversion to engaging with her ostomy and telling about such experiences. These material-discursive practices, alongside Julia’s overall story about her lived experiences with fear, leaks, and being stuck at home, rhetorically enact her ostomy as dehumanizing and undesirable. Embedded within the
Tips campaign, Julia’s negative ostomy story forecasts for viewers a bleak but potentially avoidable future so long as viewers take action and quit smoking.

Julia’s message within the Tips campaign isn’t an anomaly as far as its public staging of ostomies goes. In fact, the negative ostomy experience shared in Julia’s campaign materials relies on a familiar ostomy narrative—one that positions the ostomy as a worst-case scenario, something that can be prevented or avoided, and something to fear. For example, just two years before Julia’s materials were released, the police department (PD) in Cincinnati, Ohio, told a similar ostomy story as part of an anti-gun-violence campaign for teens. Specifically, the Cincinnati PD was visiting local high schools across the city to speak to at-risk teenage boys about the harms of gun violence. In preparing for these presentations, the police officers contacted a local trauma center to learn more about the health consequences of gun violence directly from victims themselves. Through this local trauma center, the officers learned of one gunshot victim whose abdominal bullet wound led to surgery and the need for a colostomy bag. With this example in mind, the police officers delivered their presentations at local high schools, using colostomies as a key illustration of gun violence’s risks and consequences. A lieutenant shared photos of colostomies while describing the following scene during the presentation: “You’re not killed, but you’re walking around with a colostomy bag and that’s just not the way to get a girl’s attention, by limping down Warsaw Avenue with a colostomy bag” (Warren, 2013).

Taken in context, the lieutenant’s fictional story seems to be an attempt to appeal directly to his audience. As a local news outlet described at the time, this “first of its kind” initiative “will appeal to the vanity of teenage boys living a life of drugs and crime” (Warren, 2013). It appears the lieutenant assumed that his teenage audience was highly invested in being attractive and would therefore be motivated to avoid gun violence if it risked appealing to “girls.” Drawing on hypermasculine, heteronormative messaging and stereotypical teenage pressure to fit in by being perceived as good-looking, the lieutenant’s comments feature ostomies as an antithesis of attractive, able, masculinity. In other words, limping and having an ostomy conflicts with being attractive and “getting a girl’s attention.” To support his audience in drawing this conclusion, the lieutenant rhetorically strung together a series of events and consequences that enthymematically communicated two potential outcomes of participating in gun-violence and gang-related activities. In the worst case, as he explicitly described, the teens participate in gun violence, end up shot, wounded, and with an ostomy that disables, stigmatizes, and renders them socially, sexually, aesthetically ruined. As the lieutenant projected these all but certain negative consequences of participating in gun
violence, the lieutenant also implicitly painted a contrasting and ideal or at least much more optimistic future for the at-risk teen audience: the only way to stay normal, attractive, and physically able is to avoid gun violence and avoid an ostomy. These oppositional and hypothetical stories stage the ostomy as one, if not the scariest, outcome of participating in gun violence, second only to death itself.

The binary futures depicted and implied by the lieutenant also disturbingly weaponize disability as a scare tactic. The lieutenant, like Julia’s video, asked audiences to envision themselves with an ostomy through the use of second-person language. This imagined future self not only has an ostomy but is limping down the street, debilitated and unable to attract a romantic partner. In other words, according to the lieutenant’s prediction, an ostomy will both physically and socially disable anyone who needs one, and that disability will automatically and irreparably stigmatize them. Through this brief but nonetheless significant story, the lieutenant played on a highly entrenched trope connecting disability and stigma (see, e.g., Brune et al., 2014). In claiming that an ostomy will make you “limp down Warsaw Avenue,” the lieutenant warned his audience: having an ostomy will disable you and make you worthless and weak.

When enacted as part of these public campaigns, whether Tips or Cincinnati PD gun-violence prevention, the ostomy becomes not just a terrible outcome but, worse, the result of bad choices. So, the story goes like this: Lifelong smoker? Quit so you don’t need an ostomy and get stuck at home all the time. Considering joining a gang? Don’t, because you could get shot, need an ostomy, and become an outcast. Julia lost her freedom and, in its place, found herself isolated in fear that her ostomy would leak and smell. Similarly, in the Cincinnati PD story, a life full of opportunity and confidence is replaced by a crippling ostomy. These are stories of undesirable experiences gained and desirable experiences lost. Particular rhetorical practices including use of the second person, discursive distancing (e.g., use of thing or it to refer to the ostomy), and physical distancing (e.g., visuals of the ostomy being held away from the body) propel these negative ostomy stories. Moreover, the experiences highlighted in these campaigns’ stories focus exclusively on the limitations of an ostomy, specifically physical, embodied limitations like limping and leaks, as well as social limitations including social isolation or loss of sexual attractiveness. These stories leverage lived and embodied experiences to stigmatize ostomies and advance additional rhetorical goals such as smoking cessation and gun-violence prevention. In highly public contexts like these public health campaigns, the ostomy is enrolled exclusively as a scare tactic in a cautionary tale.
Ostomies on TV: Fear and Disgust in Popular Media

In addition to campaigns like Tips from Former Smokers and the Cincinnati PD’s gun-violence prevention, negative ostomy narratives permeate other public contexts, including random celebrity references, like those mentioned in chapter 1, as well as popular media like TV shows. For example, in 2009, season 6 of *Grey’s Anatomy*, the longest-running medical drama on American television, premiered complete with a two-episode ostomy storyline. With millions of viewers’ eyes peeled, the first episode of season 6 begins as a young woman, Clara, arrives at the hospital via ambulance after an accident involving a boat propeller that severed both legs and one arm, leaving her near death (Vernoff & Ornelas, 2009).

Clara remains hospitalized for several days to recover, during which her health deteriorates when an abscess (a pocket of infection) develops in her small bowel, probably from “something she picked up in the water” during the boating accident that took her limbs. Clara’s doctors urgently recommend immediate surgery to address the abscess, but Clara quickly refuses, repeating several times, “No. Not another surgery.” Wanting to give Clara space and time to process this news, Clara’s primary doctor, Dr. Bailey, steps out of the room, but not before quietly instructing the two residents in the room to order preoperative antibiotics and book an operating room, a move suggesting that Dr. Bailey assumes Clara will come around to the idea of this necessary GI surgery.

However, as soon as Dr. Bailey is gone, Clara turns to the residents, clearly panicking over the thought of another surgery, and asks, “What are the options? Can you give me drugs?” The residents reassure Clara that the surgery would be simple and straightforward, but she pushes them for a “worst-case” prognosis. After a hesitant pause and exchange of glances between the residents, one warily replies, “Well, worst case is that we’d have to take out a part of our colon and give you a colostomy bag.”

Without hesitation, Clara begins to plead with the residents, seeming both repulsed and confused by the idea that she could wake up from surgery with an ostomy. “Colostomy bag? A poo bag outside of your body?” Clara’s initial panic and rejection of the surgery seem only solidified by the mere thought of an ostomy. Thinking aloud about this distressing news and implying to viewers that ostomies are only for older people, Clara then shares that her “grand-dad” had an ostomy and questions how someone so young, like herself, could possibly be at risk of needing one. Both residents attempt to emphasize that a colostomy is really only a small possibility, but neither attempts to reframe
Clara’s response by offering that an ostomy might actually save Clara’s life, nor do they mention that worldwide, thousands of people, young and old, live happy, successful lives with ostomies. Instead, the residents remind her that the infection will kill her if she does not have the surgery. The scene ends as Clara firmly refuses the necessary, but potentially ostomy-creating, surgery.

Viewers are brought back to Clara’s story when the attending physician, Dr. Bailey, angrily confronts one of the residents in a hospital hallway, demanding to know why the resident is “trying to kill” Clara. A short, heated exchange reveals Dr. Bailey felt that, in effect, the resident has served Clara a death sentence by merely mentioning the risk of an ostomy because it has led her to refuse surgery. Dr. Bailey further explains that she certainly would not have told Clara about the risk of a colostomy. Even more, Dr. Bailey laments that she would not have shared details about a potential ostomy with any patient without careful consideration, which implies that an ostomy is something so feared by patients that it requires unique rhetorical planning or complete obfuscation. The impression to viewers: obviously a more experienced physician would know better than to mention so bluntly or haphazardly the terrifying possibility of an ostomy.

The conflation in Clara’s storyline between ostomies and death, specifically that death is perceived by patients as preferable to living with an ostomy, is both significant and familiar. Indeed, disability studies scholars have dubbed this way of thinking about disability “the personal tragedy model,” in which life with a disability is inherently and always tragic. According to the tragedy model, living with a disability is considered antithetical to a positive, happy, full life. In other words, better to be dead than disabled (see Reynolds, 2017; Swain & French, 2000).

This tragedy framing is so pervasive that its appearance in this Grey’s Anatomy episode is nearly unremarkable. As disability studies scholars John Swain and Sally French (2000) explained, “the idea that disabled people cannot be happy, or enjoy an adequate quality of life” (p. 572), is not only “dominant” and “prevalent” in Western public culture; it is “infused throughout media representations, language, cultural beliefs, research, policy and professional practice” (p. 573). Indeed, this better dead than disabled narrative is the core of Clara’s storyline. Embedded within the exchange between Dr. Bailey and the resident physicians who mention an ostomy to Clara is this worn tragedy model: either the potential of needing an ostomy is itself a death sentence or being dead would be better than having an ostomy.

It’s not until Clara has nearly succumbed to the infection that she not so much consents to the potentially ostomy-inducing surgery but passively allows the nursing staff to take her to the operating room. The infection has
escalated such that Clara needs to have part of her small bowel resected, but the small possibility of receiving an ostomy is actually avoided. When viewers next see Clara, she has recovered from the GI surgery and is preparing to take her first steps with her new prosthetic leg. An ostomy isn’t mentioned again.

Just weeks later in season 6, ostomies make yet another appearance in Grey’s (Cragg & Rimes, 2010). This time, a character named Mary arrives at the hospital to undergo surgery to have her ostomy reversed. Like Clara, Mary is being cared for by Dr. Bailey, and viewers meet Mary for the first time as the two of them, along with another physician, Dr. Percy, discuss Mary’s surgery. In the scene, Dr. Bailey and Dr. Percy deliver “bad” news to Mary; she is ineligible for her reversal surgery that day because her red-blood-cell counts are low. Mary, clearly frustrated, protests:

Do you know how long I’ve been living with a colostomy bag? A bag of poop is attached to me. Do you know what that’s like? It’s gross. It’s truly the grossest thing I’ve ever had to deal with.

In response, Dr. Bailey calmly offers that Dr. Percy will give Mary a blood transfusion to hopefully improve her cell counts and enable the surgery to take place. Dr. Bailey ends their conversation by promising they’ll soon revisit the timing of Mary’s surgery: “tomorrow, we’ll see if we can help lose the poop bag.” Viewers don’t hear about Mary, her “poop bag,” or her surgery again for several episodes until she returns for takedown surgery and unexpectedly dies from unrelated organ failure caused by the anesthesia.

Like the ostomy enacted in the Tips and the Cincinnati PD’s campaigns, the ostomy and ostomy experience staged in Clara and Mary’s storylines is highly negative, even abhorrent. Similarly, too, both stories stage the ostomy as a worst-case scenario. Clara’s potential ostomy is literally described as the worst-case scenario, and Mary’s actual ostomy is staged as a gross nightmare she’d like to end as soon as possible. The stories in these episodes fixate on fearing and resisting ostomies through avoidance (Clara’s surgery refusal) and reversal (Mary’s desire for reversal surgery). Through these stories, either the lived experiences with ostomies are predicted to be deeply undesirable or the lived experiences are stated as such.

Additionally, Clara’s and Mary’s storylines highlight one of stigma’s most significant dimensions. Stigma is not just enacted by what is explicitly said or visibly done; stigma is perhaps most insidious when it is enacted through what is not said or done. In Clara’s and Mary’s stories, stigma is explicitly manifested through comments about poop bags and stereotypes about the elderly, but it is also emerges through what is left unsaid, unclarified, unseen
by the character’s lines and actions. For instance, there are several opportunities throughout Clara’s story in which characters could have complicated the idea of ostomies as the worst case. In the dialogue between Clara and the residents who first mention ostomies, a line could have been included that clarified the idea that any ostomy would be Clara’s worst-case outcome. For instance, one of the residents might have explained that while an ostomy may actually be considered the “worst case,” only because ostomy surgery is invasive and significant. Or the show might have incorporated an additional scene in which Dr. Bailey visits Clara to follow up on the conversation with the residents and explain that an ostomy is a lifesaving procedure that could enable Clara to live a meaningful and positive life. Similarly, the show’s writers might have included a small rebuttal to Mary’s comments about poop bags and the ostomy being the “grossest thing” she’s ever experienced. A simple line from one of the physicians like “I’m sorry you’ve had such negative experiences; I wish we’d done more to help you live more successfully with your ostomy” could have encouraged viewers to think in more complex ways about ostomies and to see life with an ostomy as multidimensional and something that can evolve beyond tragedy. These proposed suggestions would have been relatively small and simple additions that would not have otherwise altered the storylines; however, the show didn’t complicate the ostomy narrative running through Clara’s and Mary’s stories, which demonstrates just how rhetorically invasive a single ostomy story is within mainstream public culture. Too, these stories, in context with their millions of viewers, further cement that single story in public culture. Stigmatization of ostomies is ultimately reinforced through Mary and Clara and their connection to this single story repeatedly told about ostomies, disabilities, or other embodied experiences.

Staging Stigma through Fear

Although both Mary’s and Clara’s stories are of course fictional, they align with Julia’s and the Cincinnati PD’s stories. The similarity across these stories illustrates how pervasive negative ostomy stories are in American public life and how individual ostomy stories, like the four described in this chapter, sediment into a single ostomy story. All four stories enact the ostomy as a worst-case scenario through negative experiences focused on leaks, fear, isolation, unattractiveness, and disgust. These public ostomy stories cohere to create a single, consistent ostomy story that figures all ostomy experiences as negative. Additionally, they consistently draw on negative experiences as
the primary rhetorical strategy to connect with audiences, whether for entertainment (Grey’s Anatomy) or for public health purposes (Tips from Former Smokers and the Cincinnati PD).

Importantly, I do not mean to suggest that any of the experiences forwarded in these stories are invalid or not based in real experiences, including even the fictionalized stories on Grey’s Anatomy. My goal in tracking these stories is not to debunk them but, instead, to listen to the practices within the stories that shape how ostomies are made to mean. In an interview about her participation in Tips, Julia explained, “I shared my story with the Tips from Former Smokers campaign because now I know firsthand how dangerous smoking can be. My hope is that my message will get smokers to quit, for themselves and their families” (Fight Colorectal Cancer, 2015). It seems that Julia shared her story authentically in the sincere hope that it would help others avoid life-threatening experiences with cancer. My analysis suggests that Julia’s story had more complex outcomes than convincing viewers to avoid smoking; however, it’s unfair and harmful to villainize Julia and her lived experiences. Additionally, it would be inappropriate and inaccurate for me to suggest that Julia’s negative ostomy experiences were entirely unique; I’ve spoken with many ostomates who deal with leaks, embarrassment, and other challenges. The point here is that Julia’s experiences need not be invalidated by an analysis that identifies the practices within these stories that, when circulated in the public sphere, stage stigma.

Furthermore, research has demonstrated that leaks are a primary concern for many ostomates and that the fear of leaks does indeed push many to stay home, where they can more comfortably navigate issues, like leaks, that could occur with their ostomies (Davis et al., 2011). I discussed Julia’s case with many of my interview participants, most of whom critiqued her story and the Tips campaign (which I discuss at length in chapter 4). However, in response to excerpts from Julia’s video, one participant, Cade, emphatically said, “Yes. She’s exactly right.” Cade further explained that though his overall outlook and long-term experiences with his ostomy differed from Julia’s, his experiences immediately after his ostomy surgery were very similar to hers.

Julia and Cade remind us, much like the historical stories that open this chapter, that life with an ostomy does come with challenges and often undesirable experiences. My goal, therefore, in examining these stories is not to prove them wrong but to understand the potential motivations

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3. Here I am echoing Kelly Pender’s (2018) work in Being at Genetic Risk, in which she discusses the consequences of debunking and how praxiographic approaches can address the issues that emerge from rhetorical debunking (pp. 72–75).
and rhetorical consequences of the single, negative ostomy story. It is these challenges and undesirable experiences that public ostomy stories have perpetually highlighted as inherent and central to life with an ostomy. Moreover, negative experiences are featured as the only experiences enabled by an ostomy. Across the public stories presented in this chapter, the overarching message communicated is that undergoing ostomy surgery and living with an ostomy is definitively a worst-case scenario that is entirely undesirable and that should be prevented by avoiding risky behaviors, if possible. In other words, the takeaway repeatedly stressed to audiences is that life with an ostomy is the worst.

This message tells us something important about the kinds of assumptions that went into creating and telling these stories. Public ostomy stories, like those we’ve seen in this chapter, both assume and establish a visceral public—that is, a public defined “by intense, shared feeling over a perceived threat of boundary violations” (Winderman et al., 2019, p. 115). In these cases, the perceived threat is an ostomy. If the public does not already fear the ostomy or if the public is not moved to share in the fear promoted by these stories, the stories lose much of their persuasiveness. In other words, the rhetorical gravitas of these negative ostomy stories individually and collectively is supported by the “configuration” of visceral public(s) (Winderman et al., 2019). For instance, Julia’s story rhetorically heightens the (perceived) intense threat created by ostomies to convince people to give up smoking. Fear is central to the success of this strategy. That is, Julia’s video banks on a public that either intensely fears ostomies already or will fear them readily after listening to Julia’s story.

This rhetorical use of fear directly catalyzes stigma. As Coleman (1986) suggested, fear is central to stigmatization. This certainly seems to be the case in these public ostomy stories. Stigma tied to fear of ostomies circulates within the rhetorical ecology that enables these stories to be impactful. In turn, these stories individually and collectively assume listeners will share in the negative feelings enacted toward ostomies while heightening those negative feelings through exclusively negative ostomy stories. Specifically, fear functions to sustain visceral publics and consequently enact stigma in four key ways: (1) rhetorical omissions that obscure richer understandings of ostomies and isolate ostomies as inherently negative, (2) discussions of leaks and leakiness, (3) disability stereotypes, and (4) fear as a motivator for action. In the sections that follow, I trace each of these strategies within the public ostomy stories, identifying how they rhetorically stage the ostomy as a worst-case scenario and, in doing so, elicit visceral publics and enact stigma.
Rhetorical Omissions

Perhaps as rhetorically significant as what each of these public stories says is what each story doesn’t say. Such omissions have profound rhetorical purpose in that they reinforce the pre-existing negative single ostomy story. That is, these stories assume that people listen to or view them with the preconceived notion that ostomies are tragic, gross, and terrible, or, at the very least, that public(s) will be easily persuaded to see ostomies in those ways. Therefore, the public ostomy story shared, whether by the CDC, the Cincinnati PD, or *Grey’s Anatomy*, is designed to sync with the well-worn tread of a single ostomy story, like a record needle finding the groove in a vinyl. Each story depends on visceral public united by a single ostomy story and negative, visceral emotions evoked by that single story.

One illustration of the assumption of both a single story and an attendant visceral public across these stories is the rhetorical decision to not define *ostomy*. Not defining an ostomy suggests one of two things. Either these public rhetors, whether writers of *Grey’s Anatomy* scripts or a local police officer, expected their listeners to have some working knowledge of ostomies, or writers of these stories assumed that an actual definition of an ostomy was not needed and that listeners could infer all they need to know about ostomies through these stories.

To be fair, Julia’s story does provide a definition, though it is somewhat suspect. In the video’s opening moments, Julia explains that having a colostomy means that your bowel movements “go into a bag through a hole in your stomach.” Of course, this definition very well may be how Julia describes the experience of having an ostomy, and I do not mean to discredit her lived experiences. However, medically speaking, Julia’s definition is misleading. A colostomy is not a hole in the stomach; it is an opening in the colon. Regardless, Julia’s simplified characterization of ostomies supposes that this colloquial definition is sufficient for the context and purpose of the video. The goal of the video, after all, is not to educate viewers about ostomies so much as it is to encourage viewers to be so repulsed by ostomies that they quit smoking. The characterization of ostomies as a “hole in your stomach” through which excrements “go into a bag,” in combination with Julia’s seemingly bitter tone, impactfully simplifies (perhaps even stereotypes) ostomies and promotes negative connotations of their purpose.

This misstep in definition might seem insignificant to those outside the ostomy and chronic GI disease communities; however, it was and is highly important to many ostomates. When I asked interview participants generally about Julia’s story, many took issue specifically with the ostomy definition pro-
vided in it. As one participant, Shalane, stated, “Clearly, [Julia] doesn’t know what she even had. It’s not a hole in your stomach.” Shalane went on to say, in what I understood as an empathetic tone, that Julia appeared to be either not educated at all about her ostomy or misinformed. For Shalane, this was especially significant because she felt that much of the stigma around ostomies stems from such misinformation and lack of awareness.

In addition to definitional issues, these stories largely overlook or de-emphasize the conditions that lead to the need for an ostomy. This omission subsequently works to rhetorically spotlight the ostomy itself. Although two of the stories rhetorically operationalize ostomies in service of broader public health goals—decrease smoking and prevent gun violence—the ostomy and negative ostomy experiences become the focal point. Rather than emphasize that one in twenty-three men and one in twenty-four women will develop colorectal cancer (American Cancer Society, 2020) or stress that over 100 people die in the US each day from firearms (CDC, 2020c), these stories target ostomies. “What I hated the most was the colostomy bag,” as Julia puts it. Similarly, in the Grey’s Anatomy episodes, Clara is brutally injured by a boat propeller, but the climax of her story is her close call with getting an ostomy, and when Mary’s bloodwork requires that her ostomy-takedown surgery be postponed, her story tells viewers that just one more day with an ostomy is too long. Each and all of these stories neglect to offer viewers richer context about ostomies that would enable and even encourage viewers to understand the complex, often life-threatening experiences that can lead to an ostomy. In doing so, they fail to communicate that ostomies, though challenging at times, can be lifesaving. The rhetorical gaps that audiences are expected to fill and the matter-of-fact way in which each of these public stories expects negative feelings about ostomies to be self-evident illustrate the presumption of a visceral public.

Leaks

Centralizing bodily leaks, particularly leaking fecal matter, is immensely rhetorically powerful in ostomy stories, as illustrated in the four stories presented in this chapter. The connection between ostomies and feces is perhaps the most rhetorically significant dimension of ostomies. Fear and stigma regarding ostomies, leaks, and uncontrolled feces profoundly animate the “intense, shared feelings” that unite a visceral public (Johnson, 2016). Evidence of the invocation of a visceral public is most easily seen in the ways these public ostomy stories overlook specificity and assume audience familiarity. For exam-
ple, Julia’s Tips video is a mere thirty seconds, and her podcast clip is just over a minute, which suggests that Julia and the CDC were counting heavily on audiences’ previous knowledge, assumptions, and feelings about ostomies and ostomy experiences. When Julia says “I certainly don’t want to tell you about having a colostomy bag . . . I don’t want to talk about emptying or changing that thing,” she doesn’t (have to) explain why she wouldn’t want to open this discussion. Viewers, it is presumed, would be able to fill in these gaps; they would understand why Julia wouldn’t want to openly talk about “that thing.” Ideally, viewers would even empathize with Julia, seeing themselves in her story and using that identification to quit smoking. Similarly, the Cincinnati PD didn’t feel the need to explain why an ostomy would prevent “get[ting] a girl’s attention” (Warren, 2013). Their teen audience would recognize the implied message: an ostomy is inherently gross and undesirable, and ostomates don’t get the girl. The negative comments and experiences showcased in these stories succeed rhetorically because they are circulated in a culture of ostomy stigma.

Ostomy stigma, as well as these public ostomy stories, is rhetorically fueled by this social fear regarding leaks and leaking feces. Julia’s narrative, for instance, taps into rampant “social unease” or “collective disturbance” (Turner, 2003, p. 4) regarding bodily fluids and leaks when she reports being unable to leave the house for fear of her ostomy “coming loose” and “smelling” (CDC, 2015a). Further, both characters on Grey’s Anatomy, Clara and Mary, refer, with a tinge of repulsion, to ostomies as “poop” or “poo” bags. Mary also emphasizes disgust at having to wear the “grossest thing ever,” a “poop bag”—a rhetorical move that signals to the audience that ostomies require a disturbing and unnatural proximity to misplaced feces (Cragg & Rimes, 2010). As Mary Douglas (1966) might describe, poop worn in a bag is “matter out of place.” In both Julia’s and Mary’s stories case, emphasis is made on the leaky, out-of-place nature of ostomies, be it the leaky potential of the ostomy bag itself or the leaky nature of a stoma that involuntarily expels human waste into a “poop bag” worn on a person.

Moreover, “that which oozes or secrets from the human body,” Turner (2003) argued, causes “public embarrassment” and is “regarded as dangerous” because of fear of “infection, disease, destruction” (pp. 3–4). These public ostomy stories exemplify this by showcasing experiences with “bodily betrayals” of uncontrolled ostomy-bag leaks and rerouted digestive systems that force people “to shun public spaces” to avoid the threat of embarrassment (Turner, 2003, p. 4). Leaks thus precipitate stigmatization and social isolation. It is not surprising, then, that as Julia and the CDC collaborated to script Julia’s Tips materials, her fears about and experiences with leaks became
a focal point of her story. This makes sense given that her story, alongside the other stories in the campaign, was designed, after all, to show the long-term health risks of smoking as imminent threats that can be mitigated by giving up tobacco. Similarly, the other public ostomy stories in this chapter rhetorically exploit stigma surrounding ostomies vis-à-vis leaks to advance other goals.

Disability Stereotypes

Additionally, experiences with disfigurement and disability appear frequently in these public ostomy stories, particularly in Clara’s story and the Cincinnati PD comments. Just as leakiness incites concerns over bodily boundaries and autonomy, disability is an “attribution of corporeal deviance” that is perceived as dangerous and perverse (Garland-Thomson, 1997, p. 6). Consequently, stigmatizing ostomy stories commonly draw on disability stereotypes and the personal tragedy model. For instance, the Cincinnati PD visualizes the fictional ostomate “limping down Warsaw Avenue.” To be sure, undergoing ostomy surgery does not typically impact the long-term ability to walk, yet the ostomy experience imagined by the Cincinnati PD threatens the abilities of the entire body. Put another way, the ostomy’s disabling effect is diffuse. According to the Cincinnati police, an ostomy doesn’t just refigure your GI tract; it refigures your entire embodiment and all its capabilities. Such rhetoric stigmatizes by “cast[ing] disability as [a] burden” that is not easily accommodated individually or socially (Wilson, 2002, p. 73). In addition to the physical disability portrayed via limping, the ostomate in the Cincinnati PD’s story is socially disabled because, as was argued, limping down the street with an ostomy is no way to gain attention or attraction. This connection established between disability, stigma, and attractiveness aligns with Coleman’s (1986) contention that “stigmatized people are not expected to be intelligent, attractive, or upper class” (p. 220). Ostomates, as disabled and stigmatized, are not expected to be, nor perhaps even capable of being, attractive, according to the Cincinnati PD’s story.

Moreover, Clara’s storyline in Grey’s Anatomy also taps into disability stereotypes when Clara assumes that ostomies are only for older people and thus deploys that assumption as a reason to reject a surgery that could result in an ostomy. Specifically, Clara expresses confusion about how an ostomy, or what she repeatedly calls “a poo bag,” could be her worst-case scenario because her “granddad had one of those” (Vernoff & D’Elia, 2009). This dialogue indicates a disconnect in logic for Clara—how could an ostomy be a possibility for
her as a young person? Although she also indicates concern about undergoing another surgery (remember, her character had previously endured several surgeries related to a boating accident), a primary reason Clara rejects the surgery is her understanding that ostomies are poo bags, only necessary for older people. For Clara, the stereotype that ostomies are only for elderly people echoes the “common stereotypes about old age,” including beliefs that “older people” are “sick” and “disabled” (Sheets, 2005, p. 38). “Aging is disabling” because it is marked by a decrease in control, namely a decrease in the ability to prevent embodied decline that inevitably comes with age (Wendell, 1989, p. 108. Clara’s story underscores this connection between age and disability. Not only does Clara express fear and confusion; her refusal to undergo the surgery suggests that she fully rejects the possibility that she could become like her granddad, disabled prematurely by an ostomy.

These disability stereotypes are rhetorically dependent on enthymematic arguments that position life with a disability as, without exception, negative and automatically tragic. In Clara’s story, in particular, death is suggested to be better than the disabled life that is assumed to certainly accompany an ostomy. The rhetorical conflation of ostomy, disability, and death is highly effective with a visceral public audience that is (problematically) incited and motivated by negative feelings toward all three.

**Fear as a Motivator**

While fear ripples through all these public ostomy stories, its rhetorical work as a motivator is particularly significant and helps explain why the single public ostomy story is especially powerful in seemingly unrelated rhetorical contexts like antismoking or anti-gun-violence campaigns. As I outlined in earlier sections of this chapter, Johnson (2016) has demonstrated that fear as a visceral feeling can be used to rationalize action. Similarly, Sara Ahmed (2013) has argued that fear motivates action, specifically as it is directed at other bodies to help us establish and reinforce separation from what we fear. In this way, fear is rooted in a primal response in which a fight-or-flight reaction kicks in to create literal distance from a perceived threat. In the case of ostomies and public stories (and potentially other stigmatized entities), fear is manifested through portrayals of both perceived physical (i.e., becoming physically disabled) and social threats (i.e., being rendered an unattractive social outcast who is stuck at home). These perceived threats and their potential to invoke fear and motivate action are perhaps precisely why the CDC and the Cincinnati PD selected ostomies as part of their campaigns. The stories
presented in this chapter demonstrate that collective visceral feelings, particularly fear, can be rhetorically used to motivate behavioral change and intensify dramatic effect.

Importantly, it is not my intention to suggest that the rhetorical use of fear is inherently negative or unethical. Millions of people in the US smoke despite the well-documented and serious health consequences, and a 200 percent increase in juvenile shooting victims motivated the Cincinnati PD’s campaign (Warren, 2013). These campaigns attempted to use fear to motivate audiences to quit smoking and to avoid gun violence. Goals that, decontextualized, are worthwhile, no doubt. However, as Guttman and Salmon (2004) have posed:

How does one reconcile the use of persuasive appeals that on the one hand scare people regarding potential hazards, and thus raise motivation to avoid it, but may, on the other hand, present a negative image of those who have the disease? (p. 547)

Although I endorse efforts to reduce smoking and gun violence, given the public retaliation each of these public stories received, primarily from the ostomy and IBD communities, it seems critical to question the motivation and decision to rhetorically leverage ostomies in these stories and to examine the (unintended) consequences of sharing these particular ostomy stories as part of these campaigns.

Upon its release, Julia’s story joined the ranks of the highly successful Tips campaign. That is, by the time Julia joined the campaign, nearly three years after its original launch, Tips had been deemed a massive success. Between 2012 and 2015 the campaign reportedly resulted in “approximately 522,000 sustained quits” among US adult smokers (Murphy-Hoefer et al., 2018). This success, as the CDC itself points out, can largely be attributed to the (rhetorical) use of fear within the campaign. In the CDC’s (2020a) words:

Hard-hitting media campaigns have been proven to raise awareness about the dangers of smoking and to motivate smokers to quit. Many studies have shown that ads carrying strong graphic and emotional messages about health consequences are more effective than other forms of advertising, such as humorous or emotionally neutral advertisements. Given the large scientific evidence base supporting this approach, CDC uses graphic and emotional advertisements in its Tips from Former Smokers (Tips) campaign.

4. Chapter 4 addresses these public criticisms and protests at length. See also Hafner (2009), Rund (2015), and Warren (2013).
The CDC certainly did its homework in designing this campaign. Research across disciplines including marketing, health communication, and public health has demonstrated the effectiveness of scare-tactic strategies in health-related messaging. Since the 1950s fear has been considered a successful strategy for warranting changes in health behavior (Janis & Feshbach, 1953). As one public health researcher wrote, “a large number of health promotion campaigns are based on a simple strategy: get behind people with a big stick (lots of threat and fear) in the hope that this will drive them in the desired direction” (Soames Job, 1988, p. 163). Grounded in the idea that fear is highly persuasive, scare tactics have become a staple in decades of health campaigns. Fear- and disgust-inducing messages are not only more likely to capture the attention of audiences but also more likely to be remembered and, most importantly, to elicit action or to change behavior (Cho & Witte, 2005; Janis & Feshbach, 1953; Leshner et al., 2009). If the goal is to show people why they should stop engaging in a particular behavior—be it smoking, eating processed foods, drinking alcohol, or texting and driving—then highlighting the “terrifying” consequences of such actions appears to be a productive (though not necessarily ethical) way to do it (Leshner et al., 2009). Rhetoricians will easily recognize this as pathos in its prime.

Fear-based health messaging typically looks something like this: a threat or fear appeal is presented to the audience through graphic imagery and/or disgust-inducing messages. These “persuasive” messages are “designed to scare people by describing the terrible things that will happen to them if they do not do what the message recommends” (Witte, 1992, p. 329). Such appeals need to be more than well-crafted marketing messages, though. They must elicit embodied reactions in viewers, making the risk or threat feel real and imminent (Cho & Witte, 2005, p. 483). In other words, for fear appeals to stage a threat or enact risk, the viewer must identify with the threat itself or with another person who has already been affected—that is, the viewer must be able to envision a future version of themselves that is affected by the threat. As Burke (1969) might summarize: “Here is perhaps the simplest case of persuasion. You persuade a man insofar as you can talk his language by speech, gesture, tonality, order, image, attitude, idea, identifying your ways with his” (p. 158). This identification enables the fear appeal to work. The Tips campaign encourages viewers to identify with a variety of threats: COPD, premature birth and pregnancy complications, death—and, in Julia’s case, a colostomy bag. Emery et al. (2014) explained, “The Tips campaign contained high levels of fear appeals, represented by graphic descriptions of health effects such as cancer, facial damage, amputation, and hair loss” (p. 282). By presenting these health effects to viewers, the Tips campaign strategically stages the smoking
body as at risk of such threats and encourages viewers to feel themselves as potentially at risk of such threats too.

No doubt, the CDC wanted to ensure that Tips would successfully produce the desired results (decrease in smoking) and understood that identifying the right strategy was key in actually affecting health-related behavioral change, especially when it comes to a behavior as addicting as smoking. Because fear messaging has been empirically proved to work, the CDC curated a series of “real stories” that would effectively scare viewers to give up smoking and each of these stories, including Julia’s (2020a). And, as a result, the Tips campaign was associated with “a 12% relative increase in quit attempts” in its first year alone (McAfee et al., 2013, p. 2003) and these success rates have been sustained in the years since (Murphy-Hoefer et al., 2018). As the CDC (2020b) summarizes on the “Impacts & Results” page of the Tips campaign website:

Scientific studies have shown that hard-hitting media campaigns are effective in helping people quit smoking. Study results suggest that emotionally evocative tobacco education media campaigns featuring graphic images of the health effects of smoking can increase quitline calls and website visits and that these campaigns’ effects decrease rapidly once they are discontinued.

Indeed, the CDC’s deployment of “emotionally evocative” messages and “graphic images” worked toward a worthwhile goal, considering that smoking takes nearly 480,000 American lives each year and is the leading preventable cause of death and disease in the US. Julia’s message certainly aligned with the overall Tips campaign mission to share the “hard-hitting” realities of smoking.

It seems less likely that the other public stories in this chapter deliberately used fear messaging as a rhetorical strategy in the same way the CDC’s did. However, that isn’t to say that fear wasn’t evoked toward a specific end. In the other stories, the use of fear appears to be more intuitive and intended for heightened emotional and rhetorical impact. The Grey’s Anatomy storylines and the Cincinnati PD’s campaign attempted to rhetorically conjure fear within these ostomy stories when they, like Julia’s story, foreground embodied experiences with leaks, disability, isolation, and social outcasting. Across these stories, viewers are encouraged to see a frightening future—stuck at home, worrying about a leaky, smelly hole in their stomach, covered with an ostomy bag. The ostomy life staged in these stories is grim, which makes sense given their motivations and goals. This is not to say that public health messages of

5. I am deliberately invoking the language used in Julia’s video here, which incorrectly describes ostomy as a “hole in the stomach.”
the Tips campaign and the Cincinnati PD’s efforts, nor the supposedly low-stakes entertainment content of the Grey’s episode, warrant the staging of stigma and fear regarding ostomies. Nonetheless, it is helpful to contextualize these negative public ostomy stories within their broader contexts, intentions, and rationales. This fear messaging ultimately engenders the visceral public audiences that these stories rely on.

Credibility Enhanced through Stigma

These four rhetorical elements—omissions, leaks, disability stereotypes, and fear—whether used in isolation or in combination throughout these stories, work to effect particular outcomes (i.e., don’t smoke; don’t mess with guns) and responses (i.e., be afraid of ostomies, smoking, guns, disabilities). Importantly, too, each rhetorical move is tied to specific practices or experiences, whether it be what an ostomy is (definitions of ostomies), what an ostomy does (leaks, isolates), or what kinds of emotional or embodied responses ostomies invoke for those who have them (fear, disgust, disability). Together, these rhetorical moves and their intended goals both engage and configure visceral public audiences, which sheds light on the rhetoricity of stigma. Specifically, stigmatization is enacted in and through the consistently negative practices that are invoked in each of these stories, which build on the single ostomy-story template that figures ostomies as negative, undesirable surgeries, technologies, and ways to live. Praxiographic analysis of these stories that focuses on these practices tells us important things not only about the rhetoricity of ostomies within the public sphere but also about the larger rhetorical implications of stigma itself. In particular, stigma has been theorized as a rhetorical black mark. To be stigmatized is to be deemed arhetorical at worst, untrustworthy and uncredible at best. However, these individual ostomies stories and the broader single ostomy story complicate stigma’s relationship to credibility in a few key ways.

First, the staging of ostomies as worst-case scenarios through these stories is made powerful by the credibility of the sources advancing their negative ostomy messages. The Centers for Disease Control and Prevention. A police department. A highly revered TV show. These are the rhetors that promoted negative ostomy stories. Overall, these are credible, reliable authorities. Each source was advantaged by pre-established credibility. The CDC, after all, is one of the US’s top health agencies. It’s no surprise that viewers would trust

6. For a complete discussion on arhetoricity, see Yergeau (2018).
information branded under its umbrella. With stigma as part of the rhetorical context, the visceral public audiences of each of these stories were prepared to believe and agree with the negative ostomy stories presented. Making these cases all the more powerful is their public and, in two of the cases, mass media, impact.

For example, by 2010 and long before the end of its sixth season, *Grey’s Anatomy* had solidified its place in American popular culture. *Grey’s* has boasted a steady average of over fifteen million viewers per episode since its start in 2005. Known for its dramatic storylines and love triangles, the show provides a fictional window into the world of medicine. Though the show is based in real Western medicine, *Grey’s* is not intended to teach audiences the intricacies of neonatal surgery or the diagnostic criteria for fungal infections. Regardless of its intended entertainment purposes, research has found that viewers often consume the show as a form of “infotainment”—information + entertainment—rather than as purely fictional content. In fact, research has demonstrated that viewers tend to trust the show as realistic, perceive the doctors as credible, and absorb what they believe to be factual medical information presented in the show (Chung, 2014; Quick, 2009; Quick et al., 2014). “The more people watched the show,” one study found, “the more realistic they perceived” it to be (Quick, 2009, p. 50).

For these reasons, when the show included Clara’s and Mary’s stories, there was a lot on the line. Millions of viewers saw Clara’s episode, many of whom probably had little prior exposure to ostomies. If, as research has suggested, these viewers took Clara’s storyline seriously and trusted the credibility of the doctors who treated her, what would they have learned? For starters, they would have heard an ostomy described as a “poo bag” several times, and as something elderly people need. They might have learned that doctors, or at least the ones they trust on *Grey’s*, think that ostomies are a “worst-case scenario.” And, based on the exchange between Dr. Bailey and the resident, they might have walked away thinking that just talking about an ostomy with a patient is an attempt “to kill” the patient (Dr. Bailey’s words) because an ostomy is so horrifying that the mere thought would dissuade a patient from lifesaving surgery. These takeaways, of course, require some logical leaps, though leaps that *Grey’s* audiences have been shown likely to make.

Similarly, the Tips and Cincinnati PD campaigns were designed to reach broader public audiences. Obviously, the Cincinnati police case did not reach nearly the national scale of the Tips campaign or *Grey’s Anatomy* episodes, but it was part of a citywide effort. The PD’s efforts were thwarted by public backlash that occurred too early to show whether the campaign itself was successful. However, the choice to use a negative ostomy story in a citywide public
health campaign suggests that the Cincinnati PD believed in its potential to be highly effective. The Tips campaign, on the other hand, has reached millions, if not billions, of viewers. Its success rates alone demonstrate this. According to the CDC’s (2020b) own research, between 2012 and 2018 “more than 16.4 million people who smoke have attempted to quit and approximately one million have successfully quit because of the Tips campaign.” These success rates point to the campaign's wide-reaching effect.

It wasn’t just the CDC that was able to stage the ostomy as a worst-case scenario. Nor did the Cincinnati PD simply make up their ostomy story at random. In both cases these larger, trusted, public sources relied on actual people living with ostomies and their experiences to advance these negative ostomy stories and affiliated campaigns. The CDC strongly emphasize that Tips campaign participants are real people sharing their actual stories and experiences, just as the Cincinnati PD tied their ostomy story to the gunshot-wound victim they met while researching for their antigun campaign. The fact that ostomates—who are at risk themselves of being stigmatized—were perceived as credible sources in these examples is especially important to note.

In fact, Julia’s credibility complicates previous understandings of the rhetorical impact of stigma. Rhetoricians, particularly in RHM, have theorized stigma’s “rhetorically disabling effect” on rhetors (Johnson, 2010; Miller, 2019; Molloy, 2019; Prendergast, 2001). Such work has primarily focused on people with mental illnesses, whose actions and discursive practices are perceived as unintentional or uncontrollable, and therefore as nonrhetorical or arhetorical (Johnson, 2010; Molloy, 2019; Prendergast, 2001; Pryal, 2010). Specifically, this work has demonstrated how stigma surrounding mental illnesses leads to “rhetorical foreclosure . . . that permanently arrest[s] one’s rhetorical ethos at the moment of imprint” (Johnson, 2010, p. 464). Put another way, stigma engenders “ethos deficit, damage, or loss” (Molloy, 2015, p. 160). For example, Molloy’s 2019 book Rhetorical Ethos in Health and Medicine: Patient Credibility, Stigma, and Misdiagnosis richly explores how people living with mental illness are stripped of credibility and rhetorical ability in clinical encounters, as they are repeatedly told that their symptoms are “all in their head.” As I argued in chapter 1, one of stigma’s most profound rhetorical effects is its silencing power that demands stigmatized individuals or groups conform to cultural nomos (Johnson, 2010) or otherwise make themselves invisible.

In contrast, it seems that ostomy stigma actually enables the public stories of some rhetors like Julia. Whereas participants in Molloy’s (2019) research needed to “recuperate” their credibility and agency, Julia, despite having a stigmatized condition, is deemed highly credible from the start. She expends little rhetorical effort to establish her credibility other than to self-identify as
an insider of the smoking community. Notably, she does not self-identify as a part of the ostomy community, which not only helps separate her from her ostomy and ostomy experiences but encourages further aversion to ostomies. Mostly, Julia establishes her ethos by telling a familiar ostomy story, one that, as I’ve already pointed out, audiences are prepared to accept through previous cultural knowledge, assumptions, and stereotypes. Similar moves are made in the Cincinnati PD example, though on a much smaller scale.

Rather than be rhetorically foreclosed, Julia is granted credibility because she does not stray from the negative ostomy story that audiences and the CDC presumed to be the only ostomy story. If alternative ostomy experiences were considered, even momentarily, it seems they were deemed so rare that Julia’s experience could speak universally of the ostomy experience. The ostomy as a worst-case scenario aligns readily with the stories, beliefs, and cultural conditions that enable ostomy stigma in the first place. Exploring public ostomy stories like Julia’s suggests that, in some cases, stigma can rhetorically enable stigmatized rhetors, so long as the rhetor plays into the stigma. In this way, public ostomy stories like Julia’s or the Cincinnati PD’s not only depend on but reinforce ostomy stigma as they lean into ostomy stereotypes and present ostomy experience as categorically negative.

Perhaps the most compelling manifestation of the credibility of these public ostomy stories is the responses they received. For each story explored in this chapter, hundreds if not thousands of tweets, Facebook posts, signatures on petitions, blogs, and articles passionately reject it. As I mentioned in chapter 1, Julia’s commercial alone generated a 10,000-plus-signature petition. As one petition against Julia’s commercial put it, “The situation is especially serious precisely because the CDC, a trusted source of important medical information, has spread the message” (Burns et al., 2015). Similarly, the Cincinnati PD story was protested in articles published by HuffPost and Uncover Ostomy, and through a petition garnering over 2,600 signatures. Angered members of the ostomy and chronic GI communities also targeted Grey’s Anatomy for Mary’s and Clara’s episodes. Individual branches of the United Ostomy Association of America support groups wrote letters to Grey’s producers, and a 400-plus-member Facebook group called “Shame on Grey’s Anatomy for Their Negative Views of an Ostomy” was established to monitor the show’s ostomy stories and post educational ostomy information in response.

These various responses, which I explore in more detail in chapter 4, underscore the presumed rhetorical power of these negative public ostomy stories. If these communities felt that the negative public ostomy stories were going to be discredited, then the exigency for protesting dwindles. However,
these communities anticipated the high-impact credibility of these public stories and therefore publicly worked to combat the stigma perpetuated by sharing their own stories that spotlight different experiences, practices, and events with their ostomies and chronic GI conditions.

Conclusion

The stories presented in this chapter not only have high impact in the broader public sphere through their credibility and successful rhetorical strategies; they also have high impact on individual lives and stories, particularly of people living with ostomies, considering elective surgery, or waking up with a new or unexpected ostomy. As I listened to comments about smelly, leaky poop bags in each of these stories, I couldn’t help but be reminded of Seven Charles’s story. Where do ten-year-olds learn to bully a classmate for having an ostomy? Through TV shows or commercials? In language picked up from parents, bus drivers, local police officers, or doctors? From watching their grandparents struggle with an ostomy? It’s hard to trace the specific tendrils, but it’s not hard to see how our larger public discourse impacts our cultural understandings as well as our individual lived experiences and practices.

In following these public ostomy stories, or, better, these variations on a single ostomy story that has created not necessarily “untrue” but certainly “incomplete” stereotypes about life with an ostomy, I’ve worked to understand stigma’s rhetoricity in more complex and concrete ways. Namely, I’ve argued that stigma is rhetorically enacted through repeated discussion of particular practices, lived experiences, and stereotypes—in the case of ostomies: fear, leaks, social isolation, and concerns about becoming disabled. Additionally, it has been my intention to illuminate the reciprocal connections between stigmatization and visceral publics as these two feed off and on each other within complex rhetorical ecologies and histories. These findings help enrich our currently understanding of stigma’s rhetoricity by complicating stigma’s relationship to credibility and by arguing for the ways in which stigma, visceral feelings, and visceral publics do work in the world on people’s lives, bodies, and experiences.

Importantly, I have not intended to suggest that the rhetorical use of fear and the invocation of a visceral public audience is inherently negative, unethical, or stigmatizing. No doubt, the configuration of a visceral public can be essential to advancing necessary public health goals. For example, collec-

tive public fear experienced throughout the COVID-19 pandemic has helped ensure social distancing, masking, and other necessary measures to mitigate the spread of disease. And in the ostomy cases presented in this chapter, fear was similarly provoked to meet important public health goals. These campaigns attempted to use fear to motivate audiences to quit smoking and to avoid gun violence. Goals that, decontextualized, are worthwhile, no doubt. But at what cost?

Threading the needle between appropriate use of fear and stigmatizing use of fear seems like an impossible task. So impossible that, in many ways, it’s hard for me to not vilify the CDC, Cincinnati PD, or Grey’s Anatomy, and honestly, I’m not sure that I haven’t done that at times in this chapter. I’ve done my best to fairly consider the potential intentions alongside the implications as I rhetorically assess each of these stories. However, I acknowledge that my personal identities as a patient muddy these waters significantly.

I’ll admit my personal feelings about Julia’s story have evolved significantly since I first met Julia, heard her story, and began to think through the rhetorical work and implications of the Tips campaign and Julia’s story. Too, with each additional public story I found in researching and writing this chapter, my researcher perspective approached with interest and curiosity, only to be overruled by my personal patient identity, who felt anger, defensiveness, and erasure in each of these stories. I couldn’t help but feel betrayed by the publicity of these stories, but not because I didn’t relate to the challenges presented in each story. Surely, I have felt the fear and dread about the possibility that I might need an ostomy someday myself for the very same reasons that Julia outlines (though I’m not proud to admit it). However, as many in the IBD and ostomy communities historically and continually advocate, we must make space for the diverse, complex, contradictory, expected, and unexpected stories and experiences of those who live with ostomies, because no single story can possibly tell the whole story.