(RE)CONCEPTUALIZING NEOLIBERAL HEALTH DISCOURSES AS CONSTITUTIVE RELATIONSHIPS

A Dissertation

by

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ABSTRACT

Over the last several decades, a neoliberal shift in medical practice from institutional treatment to self-care and prevention has moved many engagements with medical authority figures out of the clinic and into society more broadly. In this context, medical authority has become more complex and difficult to locate as Western medical knowledges and practices have dispersed and intermingled with a range of other health informations and forms of healthcare. As a result, this dissertation uses a constitutive rhetorical approach to locate and examine contemporary forms of medical authority by interrogating the relationship between health subjects and medical authority in neoliberal health discourses. Rather than treat health discourses as fixed asymmetrical texts by which health subjects are either disciplined or empowered, I argue that analyzing these discourses as constitutive relationships by interrogating how health subjects and various forms of medical authority interact with and constitute each other through these texts reveals a more nuanced understanding of how both authority and subjectivity are negotiated and sustained in these contemporary neoliberal sites of engagement.

The three case studies in this dissertation explore diverse ways health subjectivity and medical authority are interactively constituted through various health discourses. In analyzing American Girl's *The Care & Keeping of You* advice books, the daytime talk show *The Dr. Oz Show*, and user engagement with Fitbit activity trackers as constitutive relationships, this dissertation illustrates the emergence of a complex understanding of the relationship between subjectivity and authority. I suggest that a relational approach

allows us to move beyond analyzing how health subjects are constituted as they align themselves with health discourses, to examine how health subjects also participate in constituting medical authority as they engage in various forms of interaction. Indeed, reconceptualizing how medical authority emerges from and participates in various interactions with health subjects both expands our understanding of neoliberal health discourses as well as develops a more nuanced approach to critiquing health subject's sustained engagement with these increasingly ubiquitous texts.

I dedicate this work to my beautiful wife Stephanie and my soon-to-be son Emmett. I owe my success and efficiency in completing this project to you.

Emmett, I cannot wait to meet you.

I love you both.

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CHAPTER I

INTRODUCTION

Seven years ago I decided that I needed to do something about my health. After years of sedentary living with three college roommates who played video games continually and ate fast food for every meal, like many Americans,[1] I found myself increasingly unhappy with my body and concerned with the threat that obesity, diabetes, heart disease, and other health related issues posed to my lifespan and well-being. As a result, I substantially changed my diet and started exercising regularly as part of my new quest to lose weight and feel better. In this process I extensively researched healthy recipes and workout routines, began tracking all of the food I ate in order to monitor my eating habits, shopped at nutrition stores to stock up on protein powder and other supplements designed to help me lose weight and gain muscle, spent hours at the gym lifting weights and exercising, and a wide variety of other practices I believed would help me achieve my individual health goals. Over the course of the next year I lost close to 100 pounds and started feeling in control of my health for the first time in a decade.

At the time I took pride in my personal success; however, looking back, my health kick was hardly an individual accomplishment. Since the choice to change my behavior seemed to be a personal decision and the physical transformation from unhealthy to healthy (or at least healthier) took place upon and within my body, it was easy to disconnect myself and my behaviors from the network of resources I used and relied on in this process. In addition to perseverance and self-control, a more accurate

narrative account of this journey would include my continual engagement with a wide range of health informations, technologies, and individuals that facilitated (and perhaps more importantly, encouraged) this change. From this perspective, this narrative might instead read: "Seven years ago I decided to abandon the lifestyle guidelines and behaviors that my roommates promoted and practiced to align myself more closely with the practices of preventative health care that I picked up from various sources in order to avoid risky behaviors and potential medical problems." Rather than emerging from some self-revelation, getting healthy involved learning about what it meant to be healthy, finding out how to achieve this goal, and actively choosing to avoid risky behaviors by engaging in practices that were consistent with this goal. Consequently, the perceived control and empowerment I enjoyed in the original narrative is complicated through recognition of how my choices were constrained and modified by a sustained use of, and reliance on, various health discourses (including the internet, television, friends, health experts, family members, etc.). This narrative shift raises questions not only about my freedom and empowerment in this process, but also about the authority and influence of the many sources that participated in monitoring and managing my health.

Growing out of this personal experience, over the last half of a decade my interest in the relationship between health subjectivity and medical authority has developed through research exploring how health discourses interact with and influence individuals in various contexts. In particular, I have been increasingly interested in how neoliberal forms of self-governance and consumer practices have altered our relationship with and complicated our understanding of medical authority. While the Centers for

Disease Control and Prevention indicate that Americans continue to rely on traditional physician interactions for medical treatment,[2] over the last several decades a shift in medical practice from treatment to prevention has moved many engagements with medical authority out of the hospital/clinic and into society more broadly.[3] In this process, the traditional institutionalized understanding of medical authority through the embodied doctor-patient relationship has become more complex as the knowledges and practices of Western medicine have dispersed and intermingled with a wide range of other health knowledges and "unconventional forms of health care."[4] Discourses of health, medicine, wellness, fitness, and weight-loss, as well as their associated knowledges and practices, have become conflated and negotiated in many sites as they compete for the business of neoliberal health subjects. Although specific definitions of "health" and "medicine" are often differentiated as they are applied in various public and scholarly locations,[5] in a neoliberal society this distinction is regularly blurred. As the traditional connection between medical authority and institutionalized medicine is expanded to include a diverse range of authoritative discourses that normalize various medical/health knowledges and practices and influence the behaviors of health subjects, instead of separating health authority, medical authority, and other descriptive labels we might attach to the authority in this context, I find it more useful to see medical authority along a continuum that includes the various forms this authority can take. Indeed, despite medical authority's association with Western medicine, in this dissertation I use medical authority broadly to account for variations in the authority/subject relationship as they pertain to neoliberal medical/health knowledges and practices. Instead of conflating

dissimilar forms of medical authority, framing medical authority more broadly points to differences and similarities that arise in the relationship between authority and subjectivity as we recognize the diversity involved in the way health and medicine is characterized and practices in a neoliberal society.

As a result, one of the goals of this project is to locate and critically unpack how medical authority is characterized and deployed through various sites of engagement. The case studies in this dissertation trace how this authority is articulated and modified through various health discourses as it participates in the ongoing processes of neoliberal self-governance and health-maintenance practiced by contemporary health subjects. Rather than treating health discourses as fixed authoritative texts by which subjects are either disciplined or empowered (as it is often characterized in academic scholarship), I argue that critically analyzing these discourses by interrogating how health subjects and medical authority interact with and constitute each other through these texts reveals a more nuanced understanding of how subjectivity and authority are negotiated and produced in these neoliberal sites of engagement. Specifically, I approach these health discourses not as discrete texts, but as sustained relational interactions or "constitutive relationships" that participate in constituting both medical authority and health subjectivity. By selecting case studies that make use of different mediums and exemplify varying forms of interaction, this project highlights the complex relational dynamics of authority and subjectivity that emerge within these texts. This approach expands our critical understanding of health discourses as well as points to unique implications that emerge from this perspective.

In the remainder of this introduction I situate this dissertation within existing contextual and theoretical perspectives in order to demonstrate how these analyses will contribute both to contemporary health scholarship and rhetorical theory. I begin by outlining a brief history of the relationship between health subjects and Western medical authority as a means of articulating how this authority has developed and shifted in the United States over the last century and half. Following this section, I position this project in relation to extant scholarship on the rhetoric of health and medicine in order to signal how my project participates in and extends this body of research. As part of this discussion, I include a theoretical overview of subjectivity and constitutive rhetoric to demonstrate how maintaining a more complex understanding of health subjectivity and a broader conceptualization of constitutive discourses enable a unique relational mode of textual analysis. I suggest that exploring how medical authority and health subjectivity are negotiated through ongoing constitutive relationships allows critics to gain new insight into these health discourses. I end by outlining the three case studies I examine in this dissertation that explore different mediums and forms of interaction between health subjects and medical authority as a means of interrogating these constitutive relationships.

Contextualizing Health Subjectivity and Medical Authority

In order to understand how contemporary health subjects engage medical authority through health discourses, I find it useful to trace how this relationship has developed over time. Framing this history in terms of shifts in the relationship between medical authority figures and health subjects[6] is a useful way to conceptualize both the

origins of medical authority in the United States, as well as chart how various changes have modified this relationship. In their discussion of competing characterizations of this relationship, Analee Beisecker and Thomas Beisecker frame their perspective in terms of the controlling metaphors that shape these relationships.[7] They argue that the relationship between health subjects and medical authority figures is typically understood metaphorically as either a *paternal* or *consumer* interaction and that these influence attitudes toward the encounter by both parties involved. While this binary between paternal and consumer relationships is problematically simplistic when looking at the complexity of contemporary medical practice in the United States, these metaphoric perspectives are useful in broadly considering how subjects engage medical authority. Rather than simply summarize these relational metaphors, since these perspectives map onto the historic narrative of Western allopathic medicine's rise in the United States, I will trace the contextual development of these perspectives over the last century and a half. Situating these metaphors in the context in which they emerged reveals how the medical authority figure-health subject relationship has been, and continues to be, negotiated in response to social changes. Using Adele Clarke and colleague's account of the three primary eras of Western medicine's historical development in the United States, characterizations of the medical authority figure-health subject relationship as paternalistic can be roughly linked to the first and second eras in which American allopathic medicine was unified from the 1890s to the mid-1940s and the period of medicalization following World War II up until the mid-1980s.[8]

The biomedicalization era that emerged out of the 1970s and '80s and continues to the present signals a shift from a paternal to a more consumer orientated relationship.

Unification, medicalization, and paternalism

Prior to the rise of Western medicine in the last few decades of the nineteenth century, the knowledges and practices of medical professionals were largely heterogeneous. John Moscop explains that "Western medicine in the eighteenth and nineteenth centuries was characterized by intense competition between different schools of physicians, each claiming to possess the one 'true' theory of medicine, as well as between physicians and other practitioners."[9] Joseph Turow similarly argues that "[b]efore the twentieth century, medicine was a sometimes near-subsistence occupation whose practitioners had to fight fiercely for legitimacy with a spectrum of other contenders for control over human health."[10] The lack of structural unity and clearly defined authority during this period could be seen in the diverse collage of medical practitioners that included barber-surgeons, apothecaries, feldshers, faith healers, midwives, and other medical "professionals."[11] Due to general public distrust in the effectiveness of these professional's therapeutic treatment options and uncertainty associated with competing (and often contradictory) perspectives, the practice of medicine largely failed to capture the esteem of society relegating most medical authority figures to low wages and limited jurisdiction over their patients.

However, attitudes toward medicine shifted substantially during the first era of Western medicine (roughly defined as the period between 1890 and 1945) as the rise of epidemiology and advances in germ theory generated by European medicine led to a

solidification of professionalized American medicine around technological and scientifically based practices and knowledges.[12] The pluralism that had once existed in United States medical practice gave way to a unified authority grounded in a scientific allopathic approach. Alan Peterson and Deborah Lupton explain that

> [p]ublic health and scientific medicine are traditionally archetypal modernist institutions. That is, both projects depend on 'science' as the bulwark of their credibility and social standing, and share a similar belief in the power of rationality and organization to achieve progress in the fight against illness and disease.[13]

As Western medicine solidified its position, standardized scientific medical knowledge became normalized in American society and "routinely employed as 'truths'."[14] Simon Whybrew suggests that the significance of this widespread public acceptance of scientific medical knowledge was that "unlike law and religion, medicine 'is believed to rest on an objective scientific foundation that eschews moral evaluation'."[15] As a result, the unification of medical authority in the United States within a rational scientific approach severely marginalized alternative knowledges and practices. Toby Gelfand explains that "[a]lthough medical professional unification did not eliminate ordinary practitioners suddenly and totally, it did provide a means for their control and systematic reduction in numbers."[16] With other forms of medical practice, and their associated knowledges, receding (and at times forced) into the periphery, the American Medical Association (AMA) capitalized on this opportunity to standardize allopathic medical education and push through "tough state licensing laws around the country that limited medical practices to doctors graduating from those schools."[17] Beyond standardizing education, John Burnham emphasizes that "leaders of the American medical profession

succeeded by the early 20th century in their campaign to persuade the public to want and expect uniformly well-trained, well-paid physicians who themselves set standards of practice."[18] Unlike their predecessors, by positioning physicians as trained professionals with special knowledge and access to changes in patient bodies that were undetectable to the patients themselves, a reliance on Western medical authority figures gradually became situated as a necessary part of American life.

One of the consequences of successfully unifying the American medical profession and encouraging the public to "view extensive medical care as a life necessity" was that medical authority figures within this system began to experience new levels of prestige and significance in society.[19] During the first half of the twentieth century, "as medical discourse, hospitals, and medical education transformed into institutions built on scientific standards," this process simultaneously "elevated the authority and prominence of physicians."[20] Burnham indicates that during this era medicine was seen as the "model profession," and that "up until the late 1950's, American physicians enjoyed social esteem and prestige along with an admiration for their work that was unprecedented in any age."[21] Turow more vividly describes the physician as "a member of a modern elect: a contemporary knight whose painful movement through lists of training had shown that he had the heroic stature necessary to link a compassionate nature to the wonders of healing technology."[22] Turow's depiction is perhaps hyperbolic, yet there is little contention that during this period medical authority figures began to hold an increasingly privileged position in society and were considered "the legitimate authority on what constitutes disease and how it should be

treated."[23] Whybrew contends that "[i]n western society, medicine, its practitioners, and the hospitals in which it is practiced have a special status in that they are given and are perceived to possess the unequivocal authority to define what constitutes an illness and how it may be remedied."[24] It was in this context that the paternalistic view of relationship between health subjects and medical authority figures emerged.

Increased respect for and reliance on Western medical professionals had a significant impact on the health subject's relationship with medical authority. Since medical authority figures provided information and services that their subjects "needed," they assumed control over this interaction forming an "asymmetrical" relationship in which the physician had power over patients who were expected to submit to this expertise.[25] Beisecker and Beisecker explain that "[t]raditionally, physicians…operated paternalistically, like caring fathers, supposedly providing expert judgment and technical skill for the benefit of patients and acting with concern for the well-being of those who sought care."[26] The increasingly esoteric nature of technoscientific medical knowledge forced lay subjects to put their faith in benevolent professional medical authority figures, ultimately submitting to their expertise and skill.[27] Elizabeth Fee stresses that in this relationship "[p]hysicians heal (or do not heal) from a position of power; they relate in either a paternal or an authoritarian manner to their patients."[28] While Fee's view hints at future criticism targeting the domination involved in this relationship that would emerge in later decades, Frank Auton more positively indicates that "[u]ntil almost the closing decades of the 20th century the majority of patients were content to leave health knowledge and medical information to the expert."[29] As advances in scientific and

technical knowledge of disease increased the perceived effectiveness of allopathic treatment and diagnosis, health subject willingness to cooperate and comply with medical authority figure control and situate themselves as submissive in this paternal relationship became the norm in medical practice as well as in popular culture representations for decades.

The paternal relationship that developed between medical authority figures and health subjects during these early years was sustained throughout most of the twentieth century. However, Clarke and colleagues stress that the second era of Western medicine, which emerged in the years following World War II, further influenced this relationship in complex ways.[30] This second era, characterized as the "medicalization era," points to a dramatic expansion of medical jurisdiction. They explain that "medicalization – defined as the processes through which aspects of life previously outside the jurisdiction of medicine come to be construed as medical problems – is one of the most potent social transformations of the last half of the twentieth century in the West."[31] Peter Conrad explains that "[t]he essence of medicalization became the definitional issue: defining a problem in medical terms, usually as an illness or disorder, or using a medical intervention to treat it."[32] While Western medicine traditionally focused on the treatment of disease in individual bodies, the 1940s marked the beginning of medical attention to "non-infectious diseases such as cancer and cardiovascular disease" as well as a wide range of other life experiences that previously fell outside the jurisdiction of medical authority.[33] Nikolas Rose highlights that medicalization encouraged medical authority figures to exercise their authority over a range of experiences including "childbirth,

infertility, sexual mores and practices, aspects of criminal behavior, alcoholism, abnormal behaviour, anxiety, stress, dementia, old age, death, grief, and mourning."[34] Physicians became authority figures "not just in the area of disease diagnosis and treatment but in many other aspects of daily living," allowing the medical establishment to "increase the scope of its power and control."[35] By defining an ever expanding list of life experiences as medical phenomena that required intervention, medical authority figures' paternal influence over health subjects broadened in considerable ways during this period. Public concern with this expanded paternalistic control can be seen as at least partially paving the way for criticism and a shift in the medical authority figure-health subject relationship that emerged in the late twentieth century.

Activism, neoliberalism, and the consumer

In the 1970s and '80s a range of political, economic, and social changes in American society posed a series of challenges to the authority of Western medicine, shifting public perceptions of the relationship between health subjects and medical authority figures away from a paternal orientation toward a more consumer-based conceptualization of this interaction.[36] In this era of "biomedicalization," mounting pressure from social activists advocating for patient rights as well as increasingly neoliberal attitudes toward health significantly deprofessionalized and altered the practice and status of medicine in the United States. Rose clarifies that the barrage of criticism targeting the medical establishment during this period focused primarily on two concerns: First, that "social movements from feminism to disability rights advocates challenged the paternalistic power that doctors exercised over their patients and their

lives," and second, that the medicalization of social problems led to "aggressive medical imperialism based on unrealistic claims about the therapeutic powers of doctors, and that medics were intruding into moral and political matters."[37] Critiques addressing how health subjects both engage and perceive medical authority had lasting effects on this relationship.

Emerging from the American civil rights movement of the 1950s and '60s and increasing cynicism toward and mistrust of the "establishment" by the general public in the late 1960s and early 1970s, [38] the final quarter of the twentieth century saw a rise in social activism as various groups began advocating for rights and challenging oppressive institutions, including Western medicine. While a variety of constituencies representing different interests and identity groups took shape during this period,[39] second wave feminism and the rise of the women's health movement arguably laid the foundation for criticism against institutionalized medicine and traditional medical authority figures. Tasha Dubriwny explains that "[f]eminist women's health activists in the late 1960s through the early 1980s can be best understood as positioning themselves as critics of the medical industry" and that this activism ultimately resulted in a deep skepticism toward mainstream professional medicine.[40] Barbara Barnett more broadly states that "the second wave of the feminist movement challenged notions about responsibility, suggesting that women's role in health care should move from outsider to authority."[41] Critical of patriarchal medical knowledges and practices that often disciplined and forced women into passive roles, feminist advocates pushed for expanded distribution of medical information, recognition and validation of other medical knowledges and

practices, and greater empowerment in managing their health.[42] The disruption of Western medical authority by this movement and other health activist movements shifted more power into the hands of patients. This shift also aligned with the growing presence of neoliberalism in American society.

During roughly the same period as the rise of second wave feminism and the women's health movement, in response to increased criticism targeting the welfare state for intervening too extensively into the lives of citizens, the United States experienced a shift away from direct forms of government toward a new neoliberal commitment to "govern society at a distance."[43] Governing society at a distance led to a decrease in direct governmental control resulting in an increased focus on the responsibilities of individuals.[44] Often framed as a form of Foucauldian "governmentality," a system in which "individuals shape and guide their own conduct," Laurie Ouellette and James Hay stress that in our increasingly neoliberal society individuals are "called upon to play an active role in caring for and governing themselves through a burgeoning culture of entrepreneurship."[45] Instead of controlling subjects, the state relies on the private sector and the free market to shape and produce "good citizens" through discourses of choice and free will.[46] Courtney Bailey frames this individualistic neoliberal approach in terms of the "entrepreneurial self," in which one "behaves in a sensible, mindful way and takes precautions to anticipate and avoid risk" through consumption choices and practices that improve the self.[47] This growing focus on self-governance through individual consumption led to an explosion in non-governmental implemented techniques and

apparatuses designed to provide "self-help" information and products needed by individuals to demonstrate their status as good citizens.[48]

Translated into the arena of health and medicine, a neoliberal health subject is broadly defined as an individual "who recognizes and enacts both his/her rights and duties" in relationship to health.[49] Consistent with neoliberal self-governance, health subjects are encouraged to take personal responsibility and become highly involved and participatory in all aspects of their health including "diet, exercise, emotional wellness and so on."[50] Linked with a self-help shift in medical practice from treatment to prevention, Peterson and Lupton further claim that in contemporary society "[h]ealth is viewed as an unstable property, something to be constantly worked on. It is in the process of working on the self, and of demonstrating the capacity for self-control of the body and its emotions, that one constitutes oneself as a dutiful citizen."[51] Here, health and consumption are conflated to the point where the difference between good and bad health is often framed in terms of individual self-motivation and maintenance best demonstrated through consuming the correct products and services.[52] The body becomes a site of continual work and surveillance as individualized health subjects freely choose to conform to preventative health guidelines. Extending activist interest in patient rights and empowerment, this conceptualization of individuals as self-governed, entrepreneurial, consuming, neoliberal health subjects also influenced how individuals perceive their relationship with traditional medical authority figures.

In contrast to a paternal orientation, the medical authority figure-health subject relationship in a neoliberal society has become frequently characterized as a consumer

encounter where the health subjects/customers gather information in order to make an informed entrepreneurial decision regarding how they want to be treated, or more commonly the preventative behaviors they will adopt to avoid the need for treatment.[53] As individuals are increasingly seen as responsible for their health and seek out information from various sources to manage their well-being, some scholars suggest that self-governing health subjects are becoming more likely to question or even reject Western medicine in favor of non-traditional sources of health information.[54] The relationship between the traditional position of the medical authority figure as a paternalistic expert and the health subject as a submissive recipient is challenged due to broader access and desire for health information.[55] Following Reeder's distinction between the health subject as client and consumer, Beisecker and Beisecker explain that "[t]he client comes to the professional for advice and accepts the professional's opinion; the consumer, in contrast, listens to the thoughts of the provider, or of several providers, but ultimately makes his or her own decision."[56] Instead of situating power in the hands of the seller, "power rests in the buyer who can make the decisions to buy or not to buy as he or she sees fit."[57] As the neoliberal marketplace of health information and treatment options expands beyond the hospital and clinic, the paternal authority of the traditional Western medical authority figure is seemingly sacrificed in the name of freedom and subject choice.

As part of this neoliberal shift from direct governmental intervention to self-governance, rather than relying exclusively on traditional medical authority figures, empowered subjects turn to diverse health "experts" in order to make personalized

decisions about their health.[58] Peterson and Lupton emphasize that health subjects make use of a wide range of traditional and nontraditional experts to assist "in this process of self-governance through the advice they offer and through seeking to promote social institutions that facilitate 'healthy' choices."[59] Katherine Sender similarly explains that "[n]eoliberalism has been characterized as involving a shift from injunction to advice, where the authority hitherto exercised over citizens…gives way to the private…whereby each individual binds themselves to expert advice as a matter of their own freedom."[60] The perceived freedom and choice available to health subjects allows these various forms and embodiments of expertise to be framed as a competitive market of knowledges and services that entrepreneurial citizens can make use of in their ongoing quest for health. Carolina Branson signals that due to the diversity of competing knowledges and advice provided by these different experts, "lay people must constantly question experts political motivations" exercising their freedom as conscious consumers as they navigate this marketplace.[61] Even though health subjects might demonstrate increased autonomy and empowerment in their relationship with medical authority due to their ability to seek, engage, and accept/reject health informations, underlying this empowerment are lingering concerns related to the control experts exert over these interactions by defining the nature of health problems, often through discourses of risk.

Discourses of choice and freedom are frequently articulated in contemporary characterizations of neoliberal health subjectivity, however, these choices are constrained by the options available to consumers. Peterson and Lupton clarify that

> [a]lthough the discourses of neo-liberalism might lead us to believe that private life is inviolable in that we have complete personal 'freedom' in choosing health-

> promoting behaviors, the range and kinds of practices we take up and adapt are, in the final analysis, suggested or imposed by the broader sociocultural and political context.[62]

Entrepreneurial health subjects appear to engage in a diverse marketplace of health informations and practices as free individuals, yet this process masks the normalization of discourses of risk that persuade subjects to voluntarily conform to and internalize the goals of the state and other institutions.[63] Branson explains that "risks emerge from a society that relies heavily on expert knowledge to construct reality, and in which information about risks is in a sense 'manufactured'."[64] Since risk functions as a subjective tool of neoliberal governmentality, Branson further contends that "those who claim to have expert knowledge about varying risks…are able to construct some risks as more meaningful than others as well as set the agenda for how to control and measure risks."[65] Here, health subject empowerment is less grounded in choosing between various (and at times competing) medical knowledges and practices than in choosing preventative behaviors and resources that reduce the embodiment of risk as defined by the institutions that produce this knowledge. Self-governance, often read in terms of risk-avoiding practices of self-surveillance and maintenance, is posed as a form of empowerment, but simultaneously functions as a form of regulatory discipline as subjects internalize and embody these socially accepted standards and practices.[66] Positioning health subjects as entrepreneurial consumers initially seems to challenge the traditional paternal relationship with medical authority, however, state institutions and traditional authorities continue to take a "paternalistic approach to the task of monitoring

and regulating its citizens' health, albeit cloaked in the discourse of individual and community 'voluntary participation'."[67]

While this narrative of American allopathic medicine's rise and fall indicates that since the 1980s the paternalistic metaphor has been substantially challenged and replaced by the empowered consumer metaphor, in contemporary society this relationship remains complex and unsettled as health subjects continue to negotiate their relationship with medical authority figures who are adapting to shifting social conditions. Few argue that the changes brought about by activism and neoliberalism during this biomedicalization era have not influenced public perceptions of Western medicine, yet there is a lack of consensus as to whether these changes have actually decreased the power of medical authority in the lives of health subjects. Scholars suggesting that the prestige and power of Western medicine has deteriorated have been challenged by research exploring how institutional authorities continue to exert paternal control over subjects through alternative forms of governance. The ability for scholars to accurately account for authority and subjectivity in this relationship is complicated as medical expertise and authority increasingly expand beyond the confines of the embodied interactions of the clinic to include a wide range of alternative discursive sites of engagement.[68] It is through these dispersed sites that rhetorical criticism enters as a productive means of evaluating health discourses and the medical authority being articulated in these sites.

Neoliberal Health Discourse and the Rhetoric of Health and Medicine

As a rhetorical critic, I position myself as part of the growing work being done on the rhetoric of health and medicine. Academic interest in the rhetoric of health and medicine largely emerged out of research engaging broader questions about the rhetoric of science that took shape in the final decades of the twentieth century.[69] Scholars have been quick to acknowledge that the rhetoric of health and medicine has broadened and is inescapably interdisciplinary; however, Robin Jensen emphasizes that this research "is not without its own distinct methods, modes of analysis, and contributions."[70] John Lynch and Heather Zollar stress that despite interdisciplinary tendencies, the rhetoric of health and medicine usually emphasizes "the situatedness of discourse, consider stylistic components (i.e., metaphor, trope) as key to persuasion, and culminate with a judgment about the rhetorical practices(s) being considered."[71] Judy Segal argues that in contrast to the field of health communication, the rhetoric of health and medicine has traditionally focused on "criticism of the texts, genres, and discourses of health and medicine."[72] As part of this growing body of work, scholars have engaged a wide range of health discourses both within and outside the confines of institutionalized medicine and have posed a range of unique questions providing valuable insight into how these texts influence and engage audiences. Rather than summarize the content and contributions of this body of research, I find it more useful to position this work in terms of Segal's broad claim that "[p]rojects in rhetoric of health and medicine, in general, aim to be useful. Their usefulness often lies in their ability simply to pose questions that are prior to the questions typically posed by health researchers."[73] More specifically, Blake

Scott, Judy Segal, and Lisa Keranen stress that "its goal is not, in the first instance, to further the aims of medicine as it is, but rather to query medicine's epistemology, culture, principles, practices, and discourses."[74] From this perspective, rhetorical critics situate their usefulness in questioning and interrogating discourse as a means of understanding how texts engage and persuade audiences.

In terms of my specific interest in neoliberal health discourses, rhetorical critics and scholars using rhetorical approaches have productively explored how these discourses participate in, and contribute to, the larger debate regarding authoritative discipline and subject empowerment discussed in the previous section. In contrast to Segal's assertion that literature examining the rhetoric of health and medicine has largely praised neoliberal health discourses function in empowering informed health subjects, there is a growing body of research exploring the problematic effects of self-surveillance and disciplinary regulation that accompany these discourses.[75] While I position my work within this critical scholarship, I extend this conversation by complicating analyses that take a somewhat overly determined position by drawing conclusions based on discourses as static authoritative texts. I make no claim that rhetorical analyses are monolithic in drawing conclusions based on deterministic readings of health discourses. Instead, I suggest that this form of analysis generally interrogates texts as authoritative in their influence over health subjects, rather than considering how health subjects also participate in the formation and maintenance of these texts. Although focusing on authoritative texts allows critics to situate these discourses as either controlling or

empowering as they engage health subjects, Segal warns that drawing these types of conclusions fails to account for audience participation.[76]

In Segal's analysis of contemporary Internet health discourses, she suggests that literature in the rhetoric of health and medicine tends "strongly in the direction of commentary on the speaker/source" at the expense of critically understanding the role of the audience.[77] Segal emphasizes that "the role of patient exists primarily in relation to the role of physician; the patient is also the physician's audience and is for that reason also a construct of the physician."[78] While Segal's research usefully points to the relational nature health discourses that I explore in this project, focusing on how this engagement constitutes health subjects largely fails to acknowledge how these subjects reciprocally participate in constituting medical authority. Treating health subjects as constituted by health discourses sustains a view that these subjects remain apart from the discourses that shape their identities. If the connection between health subjects and medical authority is indeed relational, scholars must consider how this relationship is negotiated not only as health subjects are constituted, but also how these subjects participate in constituting authority within these texts. By critically exploring how health subjects interact with medical authority, rhetoricians can gain insight into how this relationship is managed and constituted through specific discursive engagements.

Relationally constituting medical authority and health subjectivity

I situate this dissertation as part of a growing body of work interested in critically engaging how health discourses influence and govern what Rebecca de Souza and other scholars characterize as "health citizens."[79] While the terminological use of "citizen" is

useful to scholars interested in emphasizing larger public health questions of rights and obligations as they relate to policy and governmental apparatuses, I wish to avoid the broad connotative associations and loaded nature of "citizen" by focusing instead on what I characterize as health "subjects." This terministic choice is due to my specific interest in the relationship between individual health subjects and medical authority. My understanding of subject and subjectivity is informed by Jeffery Nealon and Susan Giroux who argue that "subjects are cultural readers and thereby are not merely passive receptors of preexisting meanings, but, just as important, no meaning or readings can take place outside of a cultural and historical context – and the reading subject is himself of herself subjected to the constraints and possibilities of that context."[80] Rather than understanding subjects as inherently submissive and shaped by authoritative discourses or free to interpret these discourses as they please, subjectivity from this perspective looks to how situated individuals both make meaning and are acted upon by meaning. The complex interactive nature of subjectivity is emphasized as readers are defined both as "subject to" contextual and discursive constraints as well as "subjects as" individuals with the freedom to interpret meaning as they engage these discourses.

Nealon and Giroux's conceptualization of the subjectivity draws on Louis Althusser's work on interpellation. Interpellation is traditionally understood as a "hailing" process in which individuals are passively recruited or transformed into subjects through cultural or institutional acts.[81] However, Nealon and Giroux emphasize that interpellation also involves freedom as subjects "willfully" choose to be hailed.[82] It is in this process, "the line between the supposedly free individual or self and the

supposedly constrained subject is most effectively blurred."[83] I situate this project within this blurred area of subjectivity and interpellation in which constraint and freedom are negotiated, specifically within the discursive interactions in which these subjectivities emerge. Critiquing these interactions from a rhetorical perspective allows for an analysis of context and text as a means of identifying how the authority behind these discourses empower and constrain subjects, as well as how interpellated subjects are encouraged to engage health discourses. I do not suggest that rhetorical analysis is the only or best way to understand these texts, yet by looking at health discourses in this way we gain unique insight into the dynamics of authority and subjectivity that emerge in these sites.

An affinity between Althusser's theorization of interpellation/subjectivity and rhetorical analysis can be found in communication scholarship examining the constitutive function of discourse. Building on the work of Althusser, Kenneth Burke, Edwin Black, James Boyd White, and others, Maurice Charland's foundational approach to constitutive rhetorical criticism emphasizes the significance of audience members recognizing that they are being addressed by a discursive act.[84] Charland explains that "the acknowledgment of an address entails an acceptance of an imputed self-understanding which can form the basis for an appeal."[85] As a rhetorical form of interpellation, when an audience member accepts that they are the subject of a text they implicitly submit to being a member of the community that they simultaneously help constitute, ultimately making themselves susceptible to identification and persuasion. The ability for constitutive discourse to "convert" individuals into subjects is significant since identification arguably positions subjects toward actions in the material world.[86]

Charland emphasizes that ongoing rhetorical "performances" are required by constituted subjects who believe that they are acting of their own free will to "affirm their subject position."[87] However, despite the perceived freedom that comes with accepting one's self-determined position as a constituted subject, the ability to respond is constrained to meet the expectations of the community established by the discourse. Here, critical analysis not only attempts to unpack the subject position with which audience members are encouraged to identify, but also reveals the underlying motivation for the actions of subjects oriented by discourse.

Following Charland's analysis of the constitutive role that The White Paper played in establishing a "peuple quebecois" subject position as part of the nationalist movement in Quebec, a growing number of rhetorical scholars have examined the constitutive function of a wide range of texts.[88] In looking at this body of research, it is worth noting that although Charland's theorization of constitutive rhetoric emphasizes the importance of subject responses to discursive acts through the ongoing performative process of interpellation, a majority of this work (including Charland's own analysis) is limited to the initial text itself and consequently stops short of critically engaging the sustained practices and discourses involved in this process.[89] James Jasinski and Jennifer Mercieca stress that constitutive criticism has been largely based on interpretations of textual "interiors" that make claims regarding presumed discursive effect, emphasizing identity construction over sustained constitutive processes.[90] To move critics beyond looking exclusively at the interiority of the text, Jasinski and Mercieca encourage scholars to explore what they refer to as constitutive "exteriors" or the discursive

reception, circulation, and articulations formed in response to a text.[91] While they provide some preliminary suggestions to direct future research, their brief comments lack a coherent theoretical approach to engage in this type of critique and their call for increased attention to exteriors has gone largely unanswered.

Although I am sympathetic to Jasinski and Mercieca's interest in conceptualizing constitutive rhetoric more broadly (particularly in terms of the interactive potential that emerges through deeper critical attention to subject responses), their focus on Presidential public address maintains a relatively stable perspective on institutional textual authority that becomes less clear in other types of constitutive interactions. As a result, in this project I extend this perspective in an attempt to theorize what I conceive of as a "constitutive relationship."[92] Rather than limit my reading of texts to the discourse of medical authority figures as the exclusive means by which conclusions about the subject position of health conscious individuals can be examined, I contend that the complex negotiation of authority and subjectivity found in health discourses is better understood through an analysis of how health subjects and medical authority are constituted through their interactions. This approach alleviates concerns with producing overly determined critical readings of texts that fail to account for the participation of health subjects in these ongoing relationships. I suggest that by reading health discourses as relational interactions, critics can better unpack how authority and subjectivity are constituted and sustained.

Evaluating the types of constitutive relationships I address in this project, I recognize that interrogating authoritative texts and subject responses as discrete

discourses is problematic.[93] Traditional representations of the medical authority figure-health subject relationship might suggest that these participants can be easily differentiated. Yet as neoliberal health practices have moved medical authority out of institutional environments and expanded health subject empowerment in this relationship, the shape and voice of these participants has become more varied and nuanced. For example, recognizing that in a neoliberal society, physicians can act as both medical authorities figures (dispensing information) and as health subjects (as they monitor their own health) blurs the lines between authoritative text and response. This is further complicated by the presence of other health subjects that participate in these texts. As a result, rather than approach these case studies by evaluating taken-for-granted authoritative texts and audience responses to these texts as separate discursive acts, I am interested in critiquing how health subjects are interactively constituted through these texts and how this interaction participates in constituting medical authority more broadly.[94] I contend that the constitution of health subjectivity and authority is always in relation to each other and that this approach signals both constraints and possibilities for this relationship. While this approach draws on textual interiors, I complicate how we conceive of interiors by examining texts that introduce exterior elements into these discourses and consequently challenge how we conceive of constitutive rhetoric.

Case Studies

This dissertation consists of three case studies, each interrogating a neoliberal health discourse involving an interactive constitutive relationship between health subjects and medical authority. In Chapter II, I examine the gendered transition from

child to adult health subject through an analysis of American Girl's (AG) best-selling series of children's books on maturation for girls, *The Care & Keeping of You*. In this case study I argue that although these books are broadly framed as a discursive resource offering health information and advice for girls during a challenging period in childhood development, AG's interactive relationship with the American girl in these texts constitutes a neoliberal/postfeminist health subjectivity that is grounded in the medicalization of appearance. Further, in conflating self-care and appearance, AG's authority is branded as the medical voice in these texts is situated firmly within the AG franchise. Here, we not only see the early constitution of a particular gendered health subjectivity, but the development of the American girl's long term relationship with both the AG brand and medical authority figures more broadly.

In Chapter III, I turn to television health discourses as I analyze the relationship between Dr. Oz and the various participants that appear on his daytime talk show *The Dr. Oz Show*. In contrast to critics that condemn Dr. Oz for a lack of commitment to Western medicine and his professional background as a physician, I argue that Dr. Oz's position as a medical authority figure emerges less through his association with medicine than through his engagements with the audience, other health experts, and the various health knowledges that accompany these interactions. Dr. Oz's position as a medical authority figure is characterized by flexibility and fluidity as he shifts and adapts his role in these diverse interactions. Dr. Oz's flexibility also facilitates the constitution of an expansive medical authority as these varied interactions allow Dr. Oz to draw on and validate health information and practices from a broad range of sources for his audience.

By examining health discourses that situate medical authority in celebrity health experts we can see how the relationship between health subjects and medical authority is constituted over time through varied interactions.

Finally, in Chapter IV, I analyze user engagement with Fitbit activity trackers as a health discourse. Rather than frame Fitbit simply as a device that collects and visualizes user data, I read user engagement with Fitbit as a health discourse that functions through a constellation of interactions between health subjects and medical authority. I argue that the constellation of diverse interactions between users and Fitbit constitute a sustained relationship with medical authority that permeates the lives of health subjects. By examining different types of interaction, I illustrate various ways that medical authority emerges and participates in these forms of engagement as Fitbit continually intervenes into and directs users' performative generation of data and embodiment of health. Interrogating medical authority's emergence through diverse user interactions complicates our understanding of activity trackers by reading them not as a form of neoliberal self-surveillance, but as an ongoing relationship with medical authority. This case study expands our conceptualization of how the relationship between medical authority and health subjectivity is constituted in neoliberal health discourses as this relationship moves beyond textual forms that health subjects read or watch, to something that health subjects wear.

Together, the three case studies at the heart of this dissertation illustrate a complex understanding of the relationship between health subjects and medical authority as they explore diverse ways subjectivity and authority are interactively constituted. By

interrogating different textual mediums and forms of interaction between health subjects and medical authority, these case studies point to a more nuanced and sustained understanding of the relationships constituted in these texts. I cannot possibly account for all of the ways health subjects and medical authority are relationally constituted in contemporary neoliberal health discourses. However, I hope that the broad spectrum of forms of engagement interrogated in these case studies will provoke further scholarly attention to how health subjectivity and medical authority are constituted and navigated in these increasingly ubiquitous interactive health discourses.

CHAPTER II

THE CARE & KEEPING OF YOU

If you browse Amazon's listing of books on children's health, you find hundreds, if not thousands, of titles offering information and advice for parents on how to ensure that their kids grow up happy and healthy. From general titles like *The Mommy MD Guide* and *The Baby Manual*, to more specific topics including *Raising a Healthy, Happy Eater* and a wide range of texts on how to manage particular medical conditions, there is seemingly no end to the resources parents can turn to in their quest to raise healthy children. And these books are just the tip of the iceberg. Today, healthy parenting television shows, magazines, books, podcasts, internet blogs, websites, and a variety of other resources have become go-to choices for parents seeking the latest and greatest expert knowledge and advice. When parents choose to venture outside the confines of clinical medicine and turn to these health discourses, they are likely to face an overwhelming barrage of children's health information competing for their attention.

In these discourses, the relationship between child and parent is assumed to be one of dependence, as already empowered and autonomous adult health subjects take it upon themselves to care for the child. Since children are arguably unable to monitor and care for themselves, we might conclude that children are not true health subjects. However, situating children as helpless individuals who are dependent on their parents for information and care fails to fully account for the diverse ways children engage health discourses. Overlooking health discourses that directly target children misses the

opportunity to examine how these texts help constitute these developing individuals as health subjects. Despite the fact that there are points in which children are dependent on their parents or other caregivers, since childhood is such a complex and long-term process, it would be a mistake to overlook moments in which these discourses circumvent this dependence. When considering childhood health subjectivity more broadly, we would be well served to attend to discourses that occupy the liminal space in which children become fully functioning health subjects. Rather than focus on a specific age group, I contend that it is more productive to look to specific texts themselves as a means of understanding how this transition is articulated. This approach will not only uncover a more nuanced understanding of children's development into autonomous health subjects, but more importantly, it will also point to how the relationship between health subjects and medical authority is constituted.

Much like the wide range of children's health texts offered to parents, there is a growing number of health discourses available for children to engage. Due to my interest in the development of children as they transition from dependents to autonomous health subjects, I am primarily interested in children's health discourses that address maturation and puberty. Instead of offering general health information, these texts position themselves as resources designed to help children navigate the challenges involved in growing up into adulthood. Books such as *The Boy's Body Book*, *The Period Book*, and *Growing Up: It's A Girl Thing*, are designed to help boys *or* girls in their path toward adulthood, and unlike the many gender-neutral health discourses that target children prior to puberty, these texts frame healthy maturation and development as gendered.

Recognizing these gendered differences in the constitution of children as health subjects is important because "[t]o a much greater extent than men, women are required to work on and transform the self, to regulate every aspect of their conduct."[95] In other words, if society places a disproportionate focus on how adult women manage their health, analyzing the gendered constitution of girl health subjects in these texts can point to broader implications regarding the development of girls' long term relationship with both themselves and medical authority.

In this chapter, I will analyze American Girl's (AG) perennial best-selling set of children's books on maturation for girls, *The Care & Keeping of You,* as a means of exploring some initial insights and implications that can be drawn from this type of resource. I argue that although *The Care & Keeping of You* books are framed as a resource expanding girl's health literacy and guiding them through the challenging transition from childhood to adulthood, AG's relationship with the American girl in these texts constitutes a neoliberal/postfeminist health subjectivity grounded in the medicalization of appearance. Further, in conflating self-care and appearance, medical authority is distinctly branded as the medical voice in these texts is fully imbricated with the AG franchise. I begin with an overview of current research on the relationship between neoliberalism and postfeminism in order to contextualize how these subjectivities relate to AG and the specific texts under consideration. Following this discussion, my analysis will first address the unique ways the girl health subject/reader is encouraged to identify with the "American girl" in these texts. Second, I will turn to examine how AG's medicalization of appearance in *The Care & Keeping of You*

influences the constitution of the American girl health subject as well as AG's position as a branded medical authority figure in this relationship. Finally, I conclude by pointing to implications that can be drawn from this analysis, revealing a more nuanced understanding of how this health discourse participates in the development and constitution of the relationship between health subjects and medical authority.

Neoliberalism, Postfeminism, and the Medicalization of Appearance

Scholars from a variety of academic fields have examined the relationship between girls, subjectivity, and health through a variety of media including television, magazines, books, online environments, movies, music, and toys.[96] Within this body of research, interest in girl's health has been dominated by studies somewhat narrowly concerned with issues of sexuality and body image.[97] Although sexuality and body image are always already linked with gendered health subjectivity, a significant portion of this research on girlhood has focused on the sexualization and objectification of girls in the media as it relates to postfeminist subjectivity. However valuable, this research has neglected to draw connections as to how sexualization and body image can be extended to broader understandings of health and the neoliberal health discourses in which they circulate. One area of this scholarship that has addressed the connection between girls' sexuality and health is research examining adolescent girls' experiences with puberty discourses. Of interest is Elina Oinas' analysis in which she argues that when female puberty is linked with medical authority in the media, these discourses often participate in familiar neoliberal processes of gendered medicalization.[98] Unfortunately, Oinas' focus on medicalization rooted in specific mediated interactions

between girls and representatives of Western medicine fails to extend this discussion to address how these engagements also participate in the constitution of neoliberal and postfeminist subjectivities. Although neoliberal and postfeminist subjectivities underlie much of the ways girlhood is characterized in this body of research, it is perhaps neoliberalism's implicit association with the perceived autonomy of adulthood that has limited many girlhood scholars from drawing these larger connections that have emerged in feminist scholarship.

Feminist scholars have long recognized that "[p]ostfeminism is inextricably linked with neoliberalism."[99] Tasha Dubriwny explains that "postfeminism revolves around the economically independent woman (the consumer), a subject made possible through a neoliberal emphasis on individuality, the free market, and the consumer citizen."[100] Claire Moran similarly emphasizes the link between postfeminism and neoliberalism stating that

> individualism is central to both, at the expense of any recognition of the social or political context, so that there is a striking similarity between the autonomous self-regulating neoliberal subject and the 'freely choosing' postfeminist subject; and both discourses are strongly gendered, with women specifically called upon both 'to regulate every aspect of their conduct and to present all their actions as freely chosen.'[101]

Much like the autonomous neoliberal health subjects who is called upon to actively monitor and discipline their bodies by freely conforming to expert understandings of health, the empowered postfeminist subject is also expected to demonstrate her freedom and femininity through extensive self-surveillance and choosing to comply with normative standards of beauty.[102] We see similar inherent contradictions as "notions of autonomy, choice and self-improvement sit side-by-side with surveillance, discipline and

the vilification of those who make the 'wrong' 'choices'."[103] Freedom and choice are simultaneously encouraged and constrained by discourses that guide autonomous individuals toward particular subjectivities.

Neoliberal health and postfeminist subjectivities are also often linked by a common focus on appearance. Moran indicates that much like Rosalind Gill's conceptualization of the postfeminist "makeover paradigm," neoliberalism "pressurizes women to be dissatisfied with every aspect of themselves…and experience perpetual anxiety or 'normative discontent' about their appearance."[104] This connection between neoliberal health and postfeminism, grounded in the self-maintenance of appearance, is perhaps best articulated in scholarship interested in the "medicalization of appearance." Moran emphasizes that the medicalization of appearance is most recognizable in "the cultural value placed on the attainment of a particular type of feminine body through continual self-improvement and transformation."[105] I contend that the medicalization of appearance emerges in the way neoliberal/postfeminist health discourses' fetishize the "young, able-bodied, 'fit' (understood as both healthy, and in its more contemporary sense as 'attractive') female body."[106] Health and femininity are conflated as empowered subjects engage experts who normalize specific gendered performances of self-surveillance and health maintenance grounded in appearance. Interrogating the way medical authority figures articulate and normalize appearance in gender specific health discourses serves as a productive means of unpacking the complex constitution of an intersecting neoliberal/postfeminist subjectivity. I suggest that it is this broader understanding of subjectivity that is missing in much of the current scholarship on

girlhood and health. Again, while this research regularly emphasizes that girls are barraged by the message that "[t]heir appearance is what matters, and looking sexy is what counts," this work often emphasizes body image and sexuality at the expense of developing a more complete understanding of how appearance influences girls' negotiation of empowerment and discipline within health discourses and their relationship with medical authority figures that participate in this process.[107]

In this case study, I extend this conceptualization of the medicalization of appearance to health discourses targeting girl health subjects as a means of gaining insight into how the relationship between health and femininity is articulated at this early developmental stage. This approach reveals a more nuanced understanding of how girl health subjects are constituted in their relationship to medical authority figures as they engage in neoliberal/postfeminist forms of regulated self-care situated in their appearance. Further, interrogating the medicalization of appearance and the associated empowerment of girl health subjects points to how the AG brand is constituted as a medical authority figure in this text. Examining the relationship between girls and medical authority figures not only expands our understanding of how girls are constituted as gendered health subjects, but also addresses the unique constitution of a branded medical authority shaped through this interaction. Before moving to examine this text, I will turn to the history of AG in order to contextualize how both girls and health relate to *The Care and Keeping of You*.

American Girl and *The Care & Keeping of You*

The story goes that in 1985, Pleasant T. Rowland, a former schoolteacher and textbook writer, came up with the idea for AG on a fateful trip to colonial Williamsburg.[108] During her visit, Rowland came to the realization that in a world of baby dolls and Barbies, there was a void in the doll market; there were no realistic age-appropriate dolls for girls between 8- and 12-years-old to play with. Inspired by her historical setting, she decided that a line of dolls connected with a series of books based on the lives of girls from a variety of historical periods would be the ideal way to fill this void. Subsequently, the following year Rowland formed the Pleasant Company and began using mail order catalogues to sell AG dolls and books to girls across the country. Since its inception, the Pleasant Company, and their ever-growing catalogue of AG products, has been very successful.[109] Although initially focused on historical dolls and the books that told their story, since 1986 AG has expanded its brand, not only adding to the line of historic dolls, but also introducing more contemporary "Girl of the Year" dolls as well as the more recent "Truly Me" dolls designed to look like their buyers. Additionally, just prior to Mattel's acquisition of the Pleasant Company in 1998, AG expanded beyond dolls and historical fiction to include a bimonthly magazine, advice books, various events for girls and their AG dolls (e.g. ice cream socials, fashion shows, books clubs), and several multistory AG Place shopping complexes that function as "a pilgrimage site for girl consumers."[110] Together, this vast empire of AG products "has become part of the cultural universe of young girls in the United States."[111] Despite AG's sustained success and popularity, the company has also faced criticism from a

variety of sources. In their attempt to capture authentic historical and contemporary "American girls," both the dolls and books have been the target of criticism concerned with a lack of diversity and problematic ethnic representations.[112] Further, the high cost of AG dolls and other products has also been a recurring source of concern.[113] These critiques of the Pleasant Company have shed light on issues that deserve attention. However, one area of products that has gone unnoticed, and consequently unexamined in academic literature, is the AG line of advice books.

Scholarship examining the AG brand has focused primarily on AG dolls, historical fiction books, and to a lesser extent, stores.[114] Despite the fact these analyses often note the presence of advice books in their lists of products offered to girls by the Pleasant Company, this growing catalogue of self-help content has yet to be sufficiently addressed. If we take Carolina Acosta-Alzura and Elizabeth Roushanzamir's broad assertion that the "Pleasant Company's products constitute an important site in which to scrutinize the construction of girlhood, the role played by the media in this construction, and its lasting influence in women's lives" seriously, then this lack of attention to AG advice books is a missed opportunity to more fully engage AG as a cultural institution.[115] Further, examining these advice books as part of the complex network of AG consumer goods becomes even more valuable when they are seen in the context of the company's explicit interest in fostering particular values in its customers. For Rowland and the Pleasant Company, age-appropriateness was not the only motivation behind the development of these products. Linking the dolls with values articulated in historical fiction narratives also positioned AG as "an explicit alternative to dolls and girl culture

deemed lacking in values."[116] Nina Diamond and colleagues stress that "[f]rom the beginning, Pleasant Rowland, who markets herself as carefully as Walt Disney did himself, represented the American Girl brand as moral salve for a culture whose conception of girlhood was often painfully at odds with girls' - and mothers' - day-to-day experience."[117] In contrast to Barbie and other products linked with the sexualization of girls, AG continues to appeal to its customer base by emphasizing the positive principles and image their products instill in young girls.[118] Indeed, scholars are quick to note the value-laden and ideological nature of AG's historical fiction.[119] Yet these values become much more explicit in their 34 advice manuals designed to intentionally influence and direct reader behavior.[120]

Around the time the Pleasant Company was acquired by Mattel in 1998, AG released an advice book titled, *The Care & Keeping of You: The Body Book for Girls*. Written be Valorie Lee Schaefer and extensively illustrated by Norm Bendell, *The Care & Keeping of You* was designed to provide girls with "answers to their questions about their changing bodies, from hair care to healthy eating, bad breath to bras, periods to pimples, and everything in between."[121] Despite the original book's popularity, in 2012, AG revised *The Care & Keeping of You* breaking it up into two separate books targeting more defined age groups. Much of the original book's text was moved into *The Care & Keeping of You: The Body Book for Younger Girls* (a book for girls 8 and up) and an additional book, *The Care & Keeping of You 2: The Body Book for Older Girls*, was added featuring new content for older girls (10 and up), turning the original single text into a series. In these new editions, not only was the content revised and pictures updated

for contemporary American girls, but pediatrician Dr. Cara Natterson also joined Schaefer as a medical consultant author.

Early in the first book the text states, "When you were little, your parents took care of you. Now that you're older, you're taking over a lot of that responsibility, and it's not always easy to know what to do or how to ask for help…So what can you do? For starters, you need to get information."[122] Beyond guiding "tween girls through this wonderful and sometimes challenging time in their lives," providing girls with the advice and information they need to navigate puberty is linked with taking responsibility for their own care.[123] This explicit emphasis on pursuing a reduction in dependence on others by taking personal responsibility for your own care situates the reader among the complexities involved in defining the transition from child to adult. In the context of a neoliberal shift in health practice, issues of responsibility and self-maintenance also point to larger questions about medicalization and how girls are constituted as health subjects. Although a majority of the feedback regarding *The Care & Keeping of You* praises the books' value in educating and motivating girls as a modern day *Our Bodies, Ourselves* for a younger generation,[124] I suggest that we delay such judgment until we examine how both girls and the medical authority they engage in these texts participate in shaping this relationship.

Constituting the Health Subject/Reader

The Care & Keeping of You opens with a letter to AG that reads, "Dear American Girl, I am a preteen and all of a sudden growing up is becoming a big and important issue. I don't feel comfortable talking to my parents about it. I feel like it's too

personal to talk to an adult about. Please help me. [Signed] *Growing Up.*"[125] This initial framing of the book's content implies a lack of knowledge on the part of the health subject. This lack of knowledge is made explicit in the authors' response to this letter: "It's a struggle for any girl to ask questions when she's dying of embarrassment and digging for the right words to use. So what can you do? For starters, you need to get *information*. The more you know about your body, the less confusing and embarrassing growing up will seem – and the easier it will be to talk about."[126] Although the extensive advice AG presents in these books goes far beyond this emphasis on giving girls the "words to start a conversation," focusing on a lack of information, rather than poor performance, constitutes this concerned girl as having the ability to engage others and care for herself if only she had the necessary knowledge.

It is worth pausing to point out that despite the fact that this initial letter is written as a direct response to the girl who wrote the note visualized on the opposing page, AG's reply and the subsequent content found in these books is not exclusively targeting this girl ambiguously named "Growing Up." Although the framing of the book's letter correspondence on these pages suggests that the "you" language used in AG's response is addressing the "you" of the letter writer, "you" also functions as a second-person address to the reader as well. This choice establishes a connection between the letter writer and the reader. Jarmila Mildorf argues that when an author uses second-person language they are simultaneously addressing "both a protagonist in the story as well as the reader," further emphasizing that "identification with the you-protagonist is…especially likely if our experiences or circumstances resemble those of

the protagonist."[127] When the young girl reader encounters "you," rather than throwing the book across the room because AG is talking to someone else, instead, they are primed to identify with the subject and recognize that they are also the "you" of the text. In this context, "you" is understood by the reader *as* the reader, establishing a singular referent that continually reinforces consubstantiality between the reader and the constituted subjectivity of the various girls who appear throughout this discourse. Beyond establishing grounds for identification, this use of the second-person also becomes significant as it conjures mental visual representations of dyadic "communication" between AG and reader.[128] The relationship between the health subject and medical authority figure in *The Care & Keeping of You* is not simply an interaction that takes place within the text, but, more importantly, a form of engagement that includes the girl health subject/reader as well.

In addition to the use of the second-person, visual identification with the various illustrated girls that appear in these texts is also fundamental to the constitution of the American girl health subject/reader in *The Care & Keeping of You*. Throughout these books, hundreds of colorful illustrations depict girls engaged in a wide range of practices communicated to readers in the accompanying text. Working in conjunction with the linguistic use of a second-person perspective, these visual representations of girl health subjects reinforce this consubstantiality. The use of illustrations over more realistic photographic images or medical diagrams establishes a diverse range of visual characteristics that facilitate broad identification, while simultaneously avoiding contextual references to specific individuals that could distance readers from being able

to relate.[129] For example, AG primarily represents girl health subjects through the repeated visualization of three American girls. On the cover we see a short White girl with long brunette hair, a taller Asian girl with close-cropped black hair, and a tall Black girl with long natural dark hair. These initial variations in skin tone, height, hair color, and style, all positioned under a large second-person "YOU" in the title, signal diverse characteristics readers are encouraged to identify with. In addition to these three girls who dominate most of the images in the books, there are also depictions of other girls with varying skin tones, hair color, freckles, glasses, and even a few girls with braces. Although we should be wary of gendered, racial, and classed stereotypes that emerge in these illustrations, this assortment of images that highlights diversity in American girl visual composition provides a broad range of characteristics that facilitate identification for a diverse group of health subject/readers.

However much these representations constitute American girls as diverse, these illustrations simultaneously flatten this diversity by removing context and normalizing specific visual representations and performances of health. We could view the girls illustrated in these texts as separate individuals. However, I suggest that when a reader views these girls, rather than recognize their association with a diverse collection of discrete individual health subjects, they are encouraged to see themselves. All of the American girls that appear in these pages *are* the girl reading the book. Rather than celebrating diversity rooted in the lived experiences and lives of a community of individual girls, the reader is primed to erase difference by emphasizing their similarities as American girls. From this perspective, rather than functioning as a contemporary *Our*

Bodies, Ourselves for younger girls, a text originally grounded in the multiple and provisional contexts and embodied experiences of individual women,[130] *The Care & Keeping of You* distances girls from their lived contexts and narratives as they are constituted as a particular type of health subject. A health subject we might appropriately label the "American girl."

This erasure of difference in the process of visual identification is hardly new to girls familiar with the AG brand. Although AG's original historical fiction novels and dolls were intended to establish identification between girls and the values imbedded in these products, Amy Schiller argues that the recent development of customizable "Truly Me" dolls and other products disconnected from discursive narratives has shifted attention away from character development to appearance as girls are primed to seek out doll models that look like them.[131] Schiller laments that "[w]ith a greater focus on appearance, increasingly mild character development, and innocuous political topics, a former character-building toy has become more like a stylish accessory."[132] Adrienne Raphel further suggests that today AG has "turned the dolls into commodities instead of personalities," emphasizing that "[i]nstead of you becoming your doll," allowing girls to dive into other worlds and learn values from these characters, now "your doll becomes you."[133] With over "40 different combinations of eye color, hair color and style, and skin color" to choose from, American girls are trained to notice diversity in appearance while they are simultaneously encouraged to ignore differences in life experience and context since underneath these visual variations all American girls are the same, they are you.[134] In this context, much like girls' consumer engagement with AG's Truly Me dolls,

identification in *The Care & Keeping of You* is grounded in recognizing visual similarities that position the girl health subject/reader as an American girl while erasing any meaningful differences that could fracture this consubstantiality.

Together, the use of direct address and appearance-based identification is fundamental to AG's constitution of an individualistic and autonomous neoliberal/postfeminist subject. Although there are a few locations in these books that refer to American girls collectively, almost all of the health information and advice is delivered to and visibly performed by the individual "you." Rather than focus on American girls as lacking knowledge as a group, these books more precisely constitute this lack of knowledge in the individualized "one-of-a-kind original" and "unique" American girl addressed in the text.[135] AG explains that "the more you know about your body, the less surprised you'll be. So get the facts. Reading books like this one is a great start. You'll find answers to questions you may have never even thought of!"[136] In statements like these, the American girl is constituted as *the* (as opposed to a more collective *an*) individual that lacks knowledge. As a result, identification with "you" also establishes identification with having a lack of knowledge, positioning the American girl as needing AG for this information.

American Girl's Medicalization of Appearance

AG addresses the American girl's articulated need for information by providing page after page of self-care knowledge and advice. In the text, "care" becomes a broad umbrella term in this health discourse that includes biological and developmental information, medical terminology, hygiene tips, shopping advice, relationship guidance,

emotional support, and a wide range of other forms of content. The ambiguity of care as a catchall term is useful in allowing AG to address a wide breadth of health topics. However, all of the information that is presented in these texts also becomes conflated and equalized in its necessity for the American girl needing to take control of their "health and well-being."[137] Washing your hair becomes just as important as eating enough vitamin B, exercising 60 minutes a day, or learning to manage your menstrual cycle. Although this extensive content provides the ignorant American girl with a wealth of information, in conflating all of these areas of care, AG simultaneously situates the authority of the author/medical authority figure over this sweeping range of self-care informations and practices. It is here that we can see familiar forms of neoliberal medicalization emerge as the jurisdiction of AG expands to cover all of these areas of care requiring expert knowledge and advice.

This medicalization of self-care constitutes AG's medical authority as quite expansive as it absorbs all of these diverse areas needing expert intervention. What is most concerning is not simply that AG's expanded authority constrains and disciplines the American girl's self-care choices, but how AG's medical authority is used in this discourse to conflate care and appearance. AG's content discusses general issues of development and self-care, yet this information is situated almost exclusively in terms of appearance. In *The Care & Keeping of You*, care for your health becomes care for your appearance as AG emphasizes the visuality of successful self-surveillance and maintenance. AG suggests that you should focus on "all the great things your body can do" more than on what it looks like.[138] However, this reasoning deflects attention away

from the fact that the things your body can do is an inherent component of what your body looks like. A consistent message AG weaves throughout these texts is that "[i]f you feel good about yourself on the inside, you'll sparkle on the outside," or put a different way, "[t]he most attractive girl in the room isn't the girl with the thinnest waist or the fairest face. It's the girl who brims with self-confidence."[139] Again, although these comments seem to deflect the American girl away from familiar gendered appearance related concerns like body image and complexion, sparkling on the outside and brimming with self-confidence are visual characteristics and behaviors that are normalized as markers of good self-care.

In positioning appearance under the medicalized umbrella of self-care, AG's engagement with the American girl in these texts participates in the extensive medicalization of appearance. Here, self-care and appearance are conflated to the point where taking responsibility for and managing your health only has meaning in relationship to the way you visually present yourself to others. In this process, AG's medical authority is not only extended over appearance, but also prioritizes appearance in the life of the American girl who is choosing to rely on AG's expertise to provide the self-care information and advice they need to monitor and manage their health as they develop into adult health subjects. This medicalization of appearance points to a clear link between neoliberal and postfeminist subjectivities as visual performances of self-care mingle with gendered standards of feminine beauty. In contrast to AG's emphasis that you are "beautiful in your own unique way," AG's normalization of appearance-based forms of self-care also normalizes particular moralized gendered beauty standards

in the constitution of the American girl health subject.[140] By diving deeper into the American girl's relationship with AG, we will be able to see how this gendered medicalization of appearance saturates the American girl's negotiation of neoliberal/postfeminist empowerment and discipline.

Appearance and the neoliberal/postfeminist American girl

In line with a neoliberal/postfeminist subjectivity, these texts constitute the American girl as empowered in her self-sufficient ability to manage her care despite possessing limited knowledge about her growing body. AG emphasizes that "[y]ou may feel like you don't have any control over your growing body. Not true! You are the boss."[141] No longer is the American girl dependent on parents or other adults for their care. Instead, they have been transformed into an autonomous self-sufficient subject capable of educating themselves and taking on the responsibilities of adulthood. Although parents do make occasional appearances, in general, the American girl is characterized as independent and self-sufficient, suggesting that they are in fact "the boss" when it comes to self-care. However much an emphasis on self-sufficiency might constitute the American girl as the empowered "boss" when it comes to self-care, in a neoliberal/postfeminist context, being the boss also comes with the underlying expectation that the boss will freely choose to embrace and follow the guidelines outlined by expert authorities that orient them towards specific healthy/gendered forms of self-governance and maintenance.

As the American girl displays self-sufficiency in her autonomous performances of health maintenance, these performances are also constrained by the authority of AG

who controls the information and advice presented in these texts. For example, in the discussion of underarm hair, AG explains that "[s]ome girls don't like it. Others aren't bothered by it one little bit. Whether you want to remove it or leave it there is a very personal decision."[142] Beyond the gendered implications underlying this and other choices the American girl is encouraged to make throughout these texts, comments like these seem to empower the American girl by giving her the freedom to weigh options and select what works best for her. Although the American girl is given the freedom to choose whether or not she wants to shave her armpit hair, ultimately there is little choice in the matter since the images surrounding this text, as well as all of the other illustrations in these books, feature American girls without underarm hair. Despite giving the American girl self-care options, AG's authority simultaneously constrains these options by normalizing a consistent gendered appearance in the visual representation of the American girl. This example illustrates the familiar paradoxical negotiation of freedom and discipline associated with maintaining a neoliberal/postfeminist subjectivity as well as highlights how the care of appearance is situated in the relationship between the American girl and the AG medical authority figure.

The conflation of self-care and appearance in the constitution of the American girl health subject clearly emerges in AG's handling of the self-care practice of shopping. Throughout these texts, illustrations conflate self-care and appearance by situating self-surveillance and maintenance practices in terms of entrepreneurial engagement with a diverse range of consumer goods. For example, in the section on bra

choice, rather than focus on images illustrating the various bra types and sizes emphasized in the text, we see a large two-page illustration featuring American girls at a store trying on bras in a changing room.[143] While it is difficult to distinguish what types of bras are being tried on in this image, the American girls' consumeristic selection of bras, highlighting a variety of colors and styles (all with visible price tags), situates bra shopping as an appearance-based form of self-care. AG indicates that when you go bra shopping "[y]ou'll need to try on lots to find a good fit," suggesting that this form of self-care is about comfort and feel, yet this image reinforces the importance of style and appearance as the American girl performs self-care through the consumeristic choice among bras that "come in oodles of styles, fabrics, and colors."[144] In visualizing the American girl shopping for the right bra, glasses, earrings, and other items, self-care becomes just as much about appearance-based consumer practices as it is about understanding and managing your developing body.

As these texts valorize neoliberal/postfeminist empowerment associated with gendered consumeristic choices in the process of self-care, AG also uses its authority to limit *some* of these choices. In the conclusion to a section on clothing, AG emphasizes that "[i]t is important to respect your body. Your body is yours - it doesn't have to be shared with the world. And style can be cute and sophisticated without showing off too much."[145] Not showing off too much of your body becomes the most empowering choice the American girl can make. Unlike AG's discussion of glasses that maintain a utilitarian function even when situated as a stylistic consumer choice, the sexuality inherently linked with clothing choice/style (showing off too much) seems to require a paternal

intervention by AG who must step in to protect the American girl from making bad (read sexualized) consumer choices. There are similar constraints placed on consumer choice in the section on bra selection. AG explains that "[b]ras can look super cute at the store, especially if they have bright colors or unique patterns. But your body is private, and you don't really want other people to see what you are wearing under your clothes."[146] Again, the sexualization of the American girl that accompanies breast/underwear visibility is framed as such a potentially bad choice that it requires an intervention by AG to curtail this entrepreneurial decision. Although the American girl is empowered by her ability to make consumer choices, AG uses its medical authority to define sexually charged appearance related choices as bad/unempowering forms of self-care, ultimately constituting the American girl as a nonsexual health subject.

On one level this choice to desexualize the American girl's self-care seems strange in relationship to their empowered neoliberal/postfeminist subjectivity. Much of the scholarship critiquing postfeminism has suggested that in this new "girl power" culture there has been a substantial shift in femininity away from domesticity toward empowerment grounded in a hypersexualized identity.[147] However, it is important to remember that AG's expert information and advice not only has to strike a chord with the American girl, but also her parents. AG's choice to use their medical authority to direct the American girl toward desexualized forms of consumer empowerment is perhaps also grounded in a secondary need to let the American girl's parents know that they (read the AG brand) are being responsible in protecting their daughters from the dangers of sex. While AG may claim that the lack of sex in these books is due to their

function as starter materials for girls, I would contend that the advice/warnings AG provides in these discussions of gendered appearance point to an underlying paternal belief that "sex is dangerous" and that "young women are morally virtuous only if they ae sexually pure."[148] In this case, we see a clear connection between neoliberalism and postfeminism as AG's role as medical authority figure expands to include not only preparing the American girl to be a good health subject, but also a good adult woman. As a result, the interaction between the American girl and AG in these discussions of the consumeristic self-care practices of shopping reveal a complex negotiation of neoliberal/postfeminist empowerment and discipline situated firmly within the medicalization of appearance.

Branding the medical authority figure

In order to unpack how AG is constituted as a medical authority figure in *The Care & Keeping of You*, we might start by asking the simple but important question: why are girls turning to AG for health information? Answering this question is difficult without situating AG's medical authority in these texts within the larger AG brand in which this authority circulates. If the AG brand is truly "part of the cultural universe of young girls in the United States," then the American girl's choice to turn to AG for self-care information is likely grounded in this larger network of branded experiences.[149] Further, parents are also complicit in guiding their daughters toward particular health discourses. *The Care & Keeping of You's* branded association with AG is not only important for the American girl who is used to engaging their other products, but also for parents/mothers who have their own relationship with this brand and want to instill AG's

values in their daughters. From this perspective, engagement with *The Care & Keeping of You* primes the American girl to situate AG's medical authority within their broader understanding of the AG brand. Here, AG always already functions as both the brand itself and the authoritative voice that the American girl turns to for self-care information.

If we assume that American girls and their parents turn to AG for self-care information due to their familiarity with the AG brand, the next question we might ask is: who/what exactly is AG? If AG is indeed both a brand and an authoritative communicative participant in these interactions, who or what (if anything) does the American girl picture in their head when they engage this medical authority figure? If we look at these texts for an answer, the quick response to this question might very well be nothing. In contrast to AG's ever-present authoritative voice, there are no visual representations of the AG medical authority figure that the American girl is communicating with. While AG has no problem representing American girls in their decontextualized diversity, visually representing the AG medical authority figure/brand is a much more complex and challenging endeavor. Visualizing AG could include illustrated representations of Schaefer, Natterson, or some other more ambiguous and universalized representation of AG interacting with the various health subjects that appear in the pages of this text. Despite having names and bodies, the interaction between the health subject and medical authority figure is articulated less as an engagement between Schaefer/Natterson and readers, than as an interaction between AG and the American girl. Although Schaefer and Natterson are authoritative voices connected with embodied subjectivities with varying forms of medical expertise and

knowledge, the voice that comes through in these texts constitutes the medical authority figure through the ambiguous voice of AG rather than in the specific visualized individuals responsible for this information and advice. As a result, the medical authority figure constituted in this text conflates the AG brand, Schaefer, Natterson, and all the other subjects that participate in providing this expert knowledge and advice into a single unified AG voice.

Although the constitution of AG as a bodiless voice is important to the AG brand's larger interest in not confining their image to any specific visual representation, I suggest that AG's lack of visual representation is significant to the medicalization of self-care and appearance that takes place in these texts. Since a visual representation of AG as a medical authority figure would form linkages between this representation and the areas of expertise that are associated with this image, AG's authority is not limited to any particular type of self-care. For example, if AG was visualized as a female pediatrician (consistent with Natterson's embodied subjectivity) we would likely see the American girl interacting with a stereotypical image of a physician, perhaps including a lab coat, stethoscope, charts and papers in her hand, short or pulled back hair, and glasses. While this visual representation would solidify AG as a specific form of medical authority, this choice would also position AG as an expert over certain medical informations and practices at the expense of distancing them from other forms of self-care and maintenance. The constitution of the AG medical authority figure as a broad and ambiguous voice allows them to conflate Western medicine, home remedies, relational advice, and gendered standards of beauty under the umbrella of self-care

without drawing attention to whether or not they actually have the authority to provide information and advice on any of these topics. Additionally, this lack of a visual body constitutes AG as the ultimate authority over the American girl's appearance since their extensive verbal self-care knowledge and advice is never contradicted by a visualized AG body containing flaws.

Constitution of the AG medical authority figure as a bodiless voice also helps solidify their authority since separating textual content from the physical speaker arguably makes the words themselves more "objective, and above, criticism."[150] However, in contrast to the traditionally bland and unengaging use of this type of textual authority in textbooks and other reference works, AG's interactive use of a second-person perspective constitutes their authoritative voice as friendly and sympathetic in their paternal support of the empowered American girl health subject. In their analysis of AG catalogues, Acosta-Alzura and Roushanzamir indicate that if AG's extensive use of "'you' equals an individual American girl," then their use of "'we' equals the benign, understanding authority figure who listens and responds to 'your' needs and preferences."[151] Similarly, AG's use of "you" in this health discourse points to the presence of AG as the attentive and caring "I/we" in this relationship. While AG's medical voice maintains its paternalistic authority as it provides information and advice, Aisha Harris stresses that in *The Care & Keeping of You* books, the author's tone is "a mixture of friendliness, warmth, and enlightenment, part patient older sister, part new-agey aunt."[152] Rather than grounding their authority in a more traditional representation of Western medicine, AG's authority in these texts is more accurately characterized as a

friendly and empowering paternal voice whose visual ambiguity allows the health subject to fill in their conceptualization of AG with the image of their choice. A choice that is always already shaped by the American girl's other interactions with the AG brand.

Although it is unsurprising that a health discourse for young girls would not include detailed citations to support the information and advice being provided, this lack of outside support constitutes the AG medical authority figure/brand as the only self-care resource the American girl needs. Without outside support for this content, besides an odd and out of place reference to the USDA in the section on food and nutrition, the American girl is asked to put their full trust in the knowledge and expertise of the AG medical authority figure/brand to guide them into adulthood. The American girl/parent's preexisting relationship with the AG brand developed through their engagement with other products lays a foundation for trust/brand loyalty that is carried over into these texts. In this context, the constitution of AG as a medical authority figure concerned with empowering girls through self-care practices grounded in appearance begins to make more sense as this authority is expanded and conflated with the authority of the AG brand that shares a similar interest in helping the American girl "be her best self."[153] Although turning to a corporation known for dolls and historical fiction books for developmental and health information may be surprising (if not concerning), this choice seems appropriate for the American girl health subject already adept at making appearance-based consumer choices as part of their ongoing relationship with AG.

Conclusion

Although *The Care & Keeping of You* might be framed as a health discourse designed to empower and guide the American girl through a healthy transition into adulthood, this analysis suggests that the relationship between the health subject and medical authority figure constituted in these texts is saturated by the medicalization of appearance. The neoliberal/postfeminist American girl health subject/reader's negotiation of empowerment and discipline is oriented almost exclusively toward self-care grounded in visual performances of health and gender. Normalizing standards of appearance through empowered consumer choices that are constrained by AG's paternal/desexualized advice not only constitutes the American girl as a good neoliberal/postfeminist health subject prepared for a lifetime of ongoing appearance-based self-surveillance and maintenance, but also extends their relationship with the AG brand as familiar appearance-based engagement with AG dolls and other products is mapped onto practices of self-care. In this process, AG's medical authority is conflated with the AG brand as the friendly and paternal medical voice of AG participates in the medicalization of appearance, directing the empowered American girl health subject toward particular healthy/gendered performances of self-care.

This analysis points to a variety of implications that merit attention. Here, I want to specifically address two issues that reflect the unique relationship between health subjects and medical authority figures constituted in this discourse. First, as AG blurs the line between the medical authority figure and their corporate brand, we might ask: what does it mean to turn to a brand for health information? Answering this question is easier

if we consider brands like Beachbody or Nike, which often define themselves in terms of their role in shaping fit/sexy health subjects. However, this question is more complex when posed in relationship to AG, a company known for dolls designed for young girls. Although this analysis points to an affinity between the values and consumer practices that surround both the AG brand and AG medical authority figure in this discourse, this connection is grounded in the medicalization of self-care and appearance that accompany these texts. Identifying as an "American girl" individualizes and decontextualizes the health subject/reader to the point where all they have left is a relationship with the AG brand to guide and shape their health/appearance. In separating these girls from their lived experiences and contexts, as well as from other health subjects, this discourse normalizes a relationship with branded medical authority as the only reasonable means of successfully navigating childhood and taking responsibility for your health. We might expect to soon see AG branded nutrition journals, activity trackers, athletic clothing, as well as an AG "Care & Keeping of You" doll line designed to help the empowered autonomous/isolated American girl be their best self. In aligning themselves with this branded medical authority figure, the process of managing your dolls appearance becomes the process of managing yourself. Perhaps, AG is a definitive example of a neoliberal medical authority as health expertise and consumer branding are conflated in the constitution of girl health subjects oriented toward neoliberal/postfeminist consumer health practices.

Second, this reading points to one such way we can see these texts participating within the larger network of health discourses that these developing girl health subjects

will continue to engage throughout their adult lives. Not only the American girls learning to be responsible for herself as a part of growing up and gaining independence from her parents, but she is also being primed to be good adult neoliberal/postfeminist health subject primed for an ongoing need to govern oneself in contemporary society. Beyond bridging the ill-defined liminal space between childhood and adulthood, these texts also normalize a sustained relationship with medical authority. In fact, much of the information and advice articulated in these texts, if located in an alternative context, would be the same information adult women might seek as health subjects. I suggest that the lack of a visible body characterizing the AG medical authority figure also allows the American girl health subject to move on to a variety of other authoritative discourses in the future. Unlike developing a sustained relationship with an embodied figure (e.g., celebrity health experts or a personal doctor), this constitution of an ambiguous medical authority figure solidifies a relationship with the American girl brand, but also opens room for other authority figures to take their place. In locating medical authority in the conflated AG medical authority figure/brand, *The Care & Keeping of You* allows an emphasis on consumeristic practices of self-care to mask an underlying trust in and relationship with Western medicine. As Natterson and other representatives of Western medicine that participate in the formation of this health discourse are lost in the constitution of an ambiguously defined AG voice, the American girl/parent's trust in AG overlooks how these health subjects also are directed towards a particular relationship with medical authority. As the conflation of medical authority and the AG brand may be concerning as it situates girls within this broader neoliberal/postfeminist consumer

culture, we should be equally wary of the normalization of an underlying relationship with medical authority that is likely to continue long after the independent and empowered adult woman health subject has left AG behind. It is this ongoing relationship between health subjects and medical authority that I turn to in the next chapter.

CHAPTER III

THE DR. OZ SHOW

On June 17, 2014, Dr. Mehmet Oz appeared before a Senate Subcommittee hearing to respond to criticism of his popular television program *The Dr. Oz Show*.[154] During the hearing Dr. Oz was extensively questioned and chastised by Chairwoman Claire McCaskill and the other senators for his endorsement of various weight-loss products on his syndicated daytime talk show. Specifically, the senators criticized Dr. Oz for giving his audience false hope by promoting weight-loss products insufficiently supported by current scientific medical research. The senators also expressed broader concerns about the way Dr. Oz had inappropriately blurred the line between legitimate health information and entertainment. McCaskill explained, "[w]hile I understand that your message is occasionally focused on basics like healthy eating and exercise, I am concerned that you are melding medical advice, news, and entertainment in a way that harms consumers."[155] Recognizing Dr. Oz as one of the more visible and influential voices in the medical community, McCaskill's comments suggested that Dr. Oz had not been responsible with the power that his audience had vested in him.

In response to this barrage of criticism, Dr. Oz defended himself and the content of his program by redefining his role as a television host. To counter committee member concerns regarding the lack of scientific support for some of the information he had provided to his audience, he argued, "[m]y job, I feel, on the show is to be a cheerleader for the audience, and when they don't think they have hope…I want to look, and I do

look everywhere, including in alternative healing traditions, for any evidence that might be supportive to them."[156] Instead of apologizing, Dr. Oz shifted the focus of his role from giving medical advice to providing support for his audience. By framing himself as an altruistic and audience-centered motivational coach, Dr. Oz attempted to navigate the complicated position he has played as both a health expert and celebrity television host. As a result, the exchange between Dr. Oz and the senators became not only a discussion of the dangers and benefits of specific health products, but more importantly, the hearing examined the responsibility of those aligned with Western medicine to advocate for particular types of health content in the media.

In a more recent manifestation of Dr. Oz's conflict with Western medicine, in 2015, ten doctors wrote an open letter to Columbia University's Dean of the Faculties of Health Sciences and Medicine calling for Dr. Oz's removal from his position as Vice-Chair of the Department of Surgery.[157] The media attention the letter received, in which the doctors condemned Dr. Oz's "disdain for science and for evidence-based medicine" and promotion of "quack treatments and cures in the interest of personal financial gain," prompted a response from Dr. Oz.[158] In an episode of *The Dr. Oz Show* devoted to defending himself and his program, Dr. Oz stated,

> You may have seen the headlines attacking me this past week…I was surprised since my life's work has been built around one simple message: You have a right and a responsibility to become a world expert on your own body. And the way you do that is to have access to the best current information, multiple points of view, and diverse opinions.[159]

Again, Dr. Oz's defense turned to his audience's needs as a justification for his approach to health and medicine. Rather than distancing himself from Western medicine by

limiting his role to that of a motivational coach, however, Dr. Oz reinforced his image as a physician by bringing on other representatives of Western medicine to legitimate his program and point out the hypocrisy of the doctors who attacked him. Later in the episode, guest Dr. Joel Fuhrman explained that "[w]e have to recognize that half of what doctors do in their regular practices is not supported by randomized control trials. We do it just because we have always done it a certain way. A very narrow portion is very well supported."[160] Instead of differentiating between Western medicine and quack/alternative medicine, this conversation between Oz and Fuhrman defined medicine in a way that legitimized the wide range of health content and opinions his audience needs to manage their health.

These controversies over Dr. Oz's representation of medical authority point to the complexity involved in navigating the boundary between various health knowledges and health subject empowerment in neoliberal health discourses. Despite the millions of daily viewers who attest to *The Dr. Oz Show's* appeal, critics regularly suggest that Dr. Oz dupes and harms his audience by mixing "magic and science."[161] These critics' focus on Western medicine as the exclusive source for legitimate medical knowledge and authority. However, in a neoliberal context, I also find it important to move beyond this privileging of Western medicine by examining how medical authority is constituted as Dr. Oz navigates his position as a health expert and celebrity on the show itself. In doing so, particularly at a moment when health subjects are taking a more active role in seeking diverse health informations and monitoring their own health, we are able to

more fully address not only how health subjects are duped by health discourses, but also how they participate in constituting the medical authority they encounter.

In this chapter, I examine the relationship between Dr. Oz and the various participants that appear on *The Dr. Oz Show* in order to reveal how these interactions participate in constituting medical authority. Rather than characterizing Dr. Oz as a representative of Western medicine who has turned his back on his professional obligations, I argue that Dr. Oz's position as a medical authority figure more accurately emerges out of his ongoing interactions with his audience, other health experts, and the various health knowledges that accompany these interactions. Here, Dr. Oz's position as a medical authority figure is characterized by flexibility and fluidity as he shifts and navigates his position in these relationships. Dr. Oz's flexibility in these interactions facilitates the constitution of an expansive medical authority as these varied relationships allow Dr. Oz to draw on and validate health information and practices from anywhere and everywhere to be presented as bits of content for health subjects to consume. Examining the expansive medical authority that emerges as Dr. Oz flexibly engages other participants provides a more nuanced understanding of how medical authority is constituted in neoliberal health discourses that situate authority in celebritized personas. I begin this case study by situating *The Dr. Oz Show's* unique form of audience engagement as indicative of contemporary daytime talk shows and celebrity health expertise. Following this discussion, I turn to my analysis in which I first, examine Dr. Oz's flexibility as he shifts his position as a medical authority figure in his interaction with various participants and second, interrogate how Dr. Oz's flexibility in these

interactions participates in validating an expansive medical authority grounded in a broad network of health knowledges and practices. I conclude by addressing implications that emerge as we consider how analyzing interactions reconceptualizes our understanding of how medical authority emerges over time in health discourses.

Daytime Talk Shows, Celebrity, and Medical Authority

As part of the growing network of health discourses that health subjects are turning to in their active quest to take charge of their health, television has become a popular medium providing viewers with both information and entertainment on a wide range of health topics.[162] Often focused on the role that television programs play in disciplining audiences through contemporary forms of governmentality, communication scholars have examined a wide range of televised health discourses.[163] This body of research has productively expanded our understanding of television's association with neoliberalism and health subjectivity, arguing that "the impetus to facilitate, improve and makeover people's health, happiness and success through television programming is tied to distinctly neoliberal reasoning about governance and social welfare."[164] In addition to televised content including medical dramas, news reports, reality shows, and commercials, daytime television talk shows have increasingly contributed health related content for these self-governing viewers.

Historically, talk shows situated the studio audience as a passive group of spectators until *Donahue* revolutionized the genre in the 1970s by making the audience full participants able to engage in "direct dialogue with guest experts."[165] Recognizing the value of active audience engagement, *Donahue* became more audience driven and

"issue-oriented" by focusing on content based on "social problems and personal matters."[166] During the final decades of the twentieth century, this shift to issue-oriented talk show content aligned with the rise of neoliberalism by presenting information that was "individualized, personalized, and detached from the larger sociocultural and economic environment in which they occur."[167] Confronting and treating individual studio participants rather than broader social problems allowed daytime talk show hosts to help guests by appealing to their desire for autonomous self-governance without needing to address larger social issues.[168] This individualized issue-oriented format gave both studio participants and at-home viewers the opportunity to interact with daytime talk show content in increasingly personal ways.

The specific audience-centered issues that daytime talk shows cover has varied to include "fashion wearing, body shaping, relationship building, home managing, teenager controlling or addiction curbing."[169] In particular, Oprah Winfrey's *Donahue* stylized talk show began to feature segments focused on diverse health issues. Since Winfrey herself was not a healthcare professional, during these segments she often brought guest health experts onto her show to discuss health related content and answer audience questions. One of the regular health experts to appear on *Oprah* was cardiologist Dr. Mehmet Oz, who was frequently featured providing health tips, dispelling myths, and answering questions about a variety of health concerns and issues. As a result of his popularity on *Oprah*, in 2009 *The Dr. Oz Show* was launched as a health focused spin-off talk show series shifting Dr. Oz from guest to host.[170] Since its inception, *The Dr. Oz Show* has proven to be very popular despite recurring public controversy.[171] Further, as

"America's Doctor," a title he picked up during his years on *Oprah*, Dr. Oz himself has attained celebrity status, gracing the cover of magazines, attending public events, and appearing in a wide range of health discourses.[172]

Dr. Oz's status as a celebrity health expert encourages critics to consider how celebritized persona participate in the constitution of health subjectivity and medical authority. Tania Lewis emphasizes that historically, "experts and celebrities have been thought of as existing in markedly different spheres of public life and linked to very different sets of values and logics."[173] More recently, scholars have suggested that changes in technology and social media have facilitated "celebritization."[174] Such changes have resulted in an increasing overlap between experts and celebrities and the view that "expertise today is increasingly caught up in the logic of celebrity."[175] Here, expertise and credibility are negotiated and derived as celebrity experts balance their public persona with institutional connections that participate in shaping their authority and public image. Celebrity experts may influence "consumer's perceptions, behaviors, values, and decisions," but it is important to recognize that their influence is also shaped by their relationships with the various institutions and subjects that give meaning to their persona.[176] This is particularly relevant when approaching health discourses that situate medical authority in embodied celebrity health experts who must manage their relationships with both their audience and the various institutions and knowledges that are associated with their areas of expertise. Interrogating interactions between celebrity health experts and other participants in these health discourses point to how medical authority is managed and constituted through these relationships.

Like other issue-oriented daytime talk shows that "provide a middle ground between private, free-flowing individual conversation and more rigidly structured forms of institutional discourse," *The Dr. Oz Show* uses short segments in which Dr. Oz and various guest health experts share information and advice on a wide range of health related issues with studio audience members and at-home viewers.[177] However, unlike most talk shows in which studio audience members largely remain in their seats, limiting participation to asking questions and commenting on participants that appear on stage, on *The Dr. Oz Show* individual studio audience members continually come on stage to interact with Dr. Oz. Audience members become interactive participants as they learn from and occasionally teach Dr. Oz and other guest experts about health. These extensive interactions not only make *The Dr. Oz Show* unique, but also play an important role in constituting medical authority on the program. In situating medical authority in part in the embodied celebrity health expert figure of Dr. Oz, these interactions between Dr. Oz and the program's participants are fundamental to the constitution of medical authority.

As scholars examine audience engagement with televised health discourses, they often situate medical authority as a relatively static feature of the discourse, existing prior to the televised text. Although this perspective is useful in pointing to problematic ways health discourses influence and discipline health subjects, it neglects to consider the influence of the interactional nature of the daytime talk show genre on medical authority itself. In fact, a closer look that these programs reveal that rather than static, medical authority is fluid and flexible, a feature that relies as much on celebrity and

expertise as it does on mediated interactions among medical practitioners and health subjects. Indeed, as television programs situate medical authority in embodied celebrity health experts that engage both at-home viewers and show participants, we ought to interrogate how these medical authority figures simultaneously constitute health subjects and are constituted through these interactions. I will now turn to examine the complex and extensive network of interactions that take place on *The Dr. Oz Show* which point to the emergence of an expansive medical authority through the flexible celebritized persona of Dr. Oz, expanding our understanding of how medical authority can be constituted in contemporary health discourses.

Dr. Oz, the Flexible Medical Authority Figure

As a medical professional and celebrity host of the television program, Dr. Oz is positioned as the primary medical authority figure on *The Dr. Oz Show*. Although other health experts appear on the show and contribute to the audience's understandings of health and medicine, medical authority remains grounded in Dr. Oz's celebritized persona. However, rather than solidify authority exclusively in his role as a physician, Dr. Oz's position as a medical authority figure continually shifts through his interactions with various audience members and guest health experts. In these interactions we can see Dr. Oz shift his role from physician, to entertainer, to health educator, to motivational coach, to engaged learner, and back again. This fluidity suggests that Dr. Oz's position as a medical authority figure is shaped by these interactions that allow his authority to emerge. An extended look Dr. Oz's endorsement of the practice of meditation illustrates the flexibility of medical authority on his show.

Throughout the show's nine-year run, Dr. Oz has repeatedly indicated that he is a firm believer in the benefits of and personally practices transcendental meditation in his own life. In a segment in which Dr. Oz explains to the audience why he is so passionate about meditation and encourages his staff to engage in meditative practices at work, he emphasizes that in addition to his own successful experiences meditating and use of meditation as a form of medical treatment for his patients, scientific studies have repeatedly shown that meditation has a variety of medical benefits including lowering blood pressure, lowering cholesterol, lowering risk of stroke, lowering stress, and improving creativity.[178] In this interaction, Dr. Oz is positioned as a credible physician/health educator as he informs his audience and grounds the validity of meditation in his own personal and professional experiences as well as trusted outside research that reinforces his claims. Dr. Oz's role as a physician is also reinforced in segments in which Dr. Oz interacts with and aligns himself with doctors and other representatives of Western medicine. In a segment on meditation and back pain, Dr. Oz brings on neurologist Dr. Fahad Khan to discuss a series of MRI scans to educate the audience about how meditation can reduce pain.[179] By including allusions to both his own knowledge and experience as a physician and to scientific medical research that supports the information he provides, these interactions between Dr. Oz and the audience are constituted as highly paternal as he educates passive viewers about meditation.

Dr. Oz also regularly shifts his role in these interactions from paternal health educator to celebrity entertainer as he uses dramatic props and visual graphics to engage

audience members as he visualizes the processes and benefits of meditation. Like segments in which Dr. Oz presents medical concepts to his audience by simplifying them into entertaining visual models or experiments, employing a variety of liquids, confetti, balloons, balls, boxes, fabric, and other props to illustrate specific observable processes, Dr. Oz's discussion of meditation also incorporates this form of amusing and often interactive audience engagement. In a segment on Himalayan fire meditation, Dr. Oz starts by putting on surgical gloves to show audience members an actual human brain as he describes the effects meditation can have on memory and brain health.[180] He then shifts the discussion and talks about how monks practicing this type of meditation claim that they can raise their body temperature through these practices. Rather than just explain this process, Dr. Oz makes use of infrared cameras to track the skin temperature of Diane and Eric engaged in meditation and expresses shock when their temperature begins to rise. In these segments, Dr. Oz flexibly shifts his role to entertainer as he uses these dramatic and playful forms of interaction to both inform and engage his audience.

In other segments, Dr. Oz changes his role to health subject/patient as he allows other health experts to teach about and guide him and the audience through meditative practices. For example, in a segment on using meditation for weight-loss, Dr. Oz brings on "world-renowned alternative health guru," Dr. Deepak Chopra, to explain how meditation can be used to expand bodily awareness and facilitate weight-loss.[181] This segment also includes an uncomfortably long scene in which Dr. Chopra walks Dr. Oz and the audience through a full five minutes of guided meditation. In a segment on "mindfulness" meditation, Cory Muscara, an integrative health expert, leads Dr. Oz and

the audience through a series of meditation practices and attempts to alleviate concerns that you need to be a Buddhist or subscribe to particular religious philosophies to meditate.[182] Segments featuring guest health experts educating and guiding Dr. Oz and the audience through various forms of meditation are common. Here, Dr. Oz shifts his position from health expert to eager health subject/patient as he, along with the rest of the audience, learn from and engage in these practices with guest health experts.

Dr. Oz's fluid ability to take on the role of health subject/patient in these interactions also importantly allows audience members and other non-experts to shift their position to health expert in this relationship as they provide information and advice on how to effectively integrate meditation into their lives. Although talk show interview stylized forms of engagement with audience members is common on *The Dr. Oz Show*, as Dr. Oz encourages health subjects to self-disclosure information about themselves, provide feedback on the shows content, and ask questions, these interactions also provide opportunities for audience members to actively contribute to show's health content. For example, as part of a segment on mindfulness meditation, Dr. Oz asks several audience members who practice meditation to explain how they have been able to integrate meditation practices into their busy lives, prompting a variety of tips and advice.[183] In a different segment, Zoey explains to Dr. Oz how meditation allowed her to move on from tragedy in her life.[184] Similarly, ABC News anchor Dan Harris appears in a segment in which he talks about the value of meditation in terms of personally managing stress and achieving success at work.[185] In this segment, Harris' position as a celebrity health subject allows him to act as a health expert as he explains how these

practices have helped him focus and reduce stress. Together, segments like this blur the boundary between health subject and health expert as Dr. Oz flexibly shifts his position in these interactions to submit to the expertise and knowledge of health subjects.

The interactions described above are not representative of all the ways Dr. Oz flexibly shifts and adapts his position as a medical authority figure; however, these examples illustrate the fluidity involved in his enactment of medical authority as he becomes both participant and host on *The Dr. Oz Show*. Indeed, Dr. Oz's medical authority relies not only on his professional background and credentials, but on his participation in multiple roles and varied interactions on the show. Almost every segment of *The Dr. Oz Show* features some form of interaction between Dr. Oz, the audience, and health experts that provide information, advice, and model behaviors for the audience. Beyond supplementing and structuring the show's health content, Dr. Oz's shifting engagement with these participants illustrates medical authority as interactional, flexible, and fluid, not static and simply grounded in his professional credentials. Recognizing Dr. Oz's flexibility not only provides insight into Dr. Oz's management of his complex celebritized position as a medical expert/motivational coach/talk show host, but, more importantly, also points to the constitution of an expansive medical authority as these diverse forms of engagement explore and validate various health knowledges and practices. Put simply, medical authority comes from anywhere and everywhere because Dr. Oz tells us so. In examining these interactions we can see Dr. Oz make good on his promise to "look everywhere, including in alternative healing traditions, for any evidence that might be supportive."[186]

Expanding Medical Authority

In a 2015 interview, when confronted about *The Dr. Oz Show's* medical content, Dr. Oz explained, "I want people to realize that I am a doctor and I am coming into their lives to be supportive of them, but it is not a medical show."[187] He went on to clarify that "[t]he purpose is not to throw you at you the biggest articles published by doctors that week. Frankly it's not very much fun to listen to, either. It's to have a conversation with people who may be feeling the way you feel right now and maybe got better."[188] Much of the content on *The Dr. Oz Show* appears to fit this supportive and entertaining conversational focus, yet a lack of references to "the biggest articles" in medicine does not disassociate Dr. Oz and the content of the show from medical authority. In fact, the choice to include "doctor" in the title of the show and in reference to himself as a celebrity talk show host establishes a clear link with medicine. Be that as it may, on *The Dr. Oz Show* the doctor title expands as other health experts including naturopaths and other practitioners of alternative medicine are also positioned as doctors. Despite "doctor's" implied medicalization of the health content on this show, Dr. Oz's position as a medical authority figure is not exclusively tied to Western medicine or any other specific medical knowledge. Instead, Dr. Oz's authority is grounded in his interactions with the various participants that appear on the show, allowing an expansive medical authority to emerge as he explores and endorses various health knowledges and practices through these relationships. Dr. Oz's interactions range from establishing solidarity with guests as peers who reinforce his credibility to expanding and redefining medical knowledge by validating or questioning alternative sources of health information.

Examining several examples will illustrate how an expansive medical authority emerges through these varied interactions.

Dr. Oz's professional background as a physician might suggest that he need not rely on other medical experts with similar backgrounds to provide health information and advice, especially in light of the team of scientific medical researchers at his disposal to supply him with current health information. However, physicians and other representatives of Western medicine regularly appear on the program. As these representatives provide information and advice, they also participate in positioning Dr. Oz's medical authority in relationship to the institutional knowledges and practices they embody. A good illustration of this process can be seen in Dr. Oz's ongoing relationship with one of his most frequent guests, neurosurgeon and CNN chief medical correspondent, Dr. Sanjay Gupta. As a fellow celebrity health expert, Dr. Gupta regularly appears on *The Dr. Oz Show* to help Dr. Oz provide credible health information. However, Dr. Oz's interactions with Dr. Gupta have significance beyond simply informing the audience of health subjects about various health topics. In the episode on debunking common health myths, Dr. Gupta joins Dr. Oz on stage and they lightheartedly banter about which of their medical specialties is more important.[189] In response to a question from Dr. Oz asking what health myth bothers him the most, Dr. Gupta states, "the myth that bothers me the most is that people believe that cardiothoracic surgeons are better than neurosurgeons. A big big myth," prompting Dr. Oz to playfully retort, "[i]if it wasn't for the heart pumping blood to the brain where would we be?"[190] While this exchange functions as a comical set-up for the segment, this

interaction also illustrates how medical authority emerges out of this interaction as references to their shared association with Western medicine reinforce Dr. Oz's credibility. The humorous nature of this conversation and the similarity between their specialties let the audience know that there is no loser in this conflict since they are both on the same team.

Additionally, as Dr. Gupta's specialized knowledge regarding brain health serves as a justification for his discussion of specific issues, both Dr. Gupta and Dr. Oz often overstep the borders of their occupational specialties as they supplement each other's content and address health issues that extend beyond heart and brain health. Later in the same episode, when talking about the myth that humans only use 10% of their brain, Dr. Oz appeals to Dr. Gupta's specialized knowledge indicating that he is the one most qualified to inform the audience about the brain. However, as Dr. Gupta and Dr. Oz walk through the process of what happens in the brain while doing something as simple as drinking a cup of tea with audience member Britany, Dr. Oz participates in sharing information about the brain just as much as the neurosurgeon. Further, after discussing a brain specific myth, Dr. Gupta and Dr. Oz go on to talk about various health issues like whether or not potatoes are fattening, what happens when you feel butterflies in your stomach, how allergies effect your nose, and how astronauts go to the bathroom. Here, we can see the emergence of an expansive medical authority as Dr. Oz's interaction with Dr. Gupta aligns their credentials and expertise as well as uses this exchange to enlarge their medical jurisdiction over these various areas of health.

The expansion of medical authority on *The Dr. Oz Show* is perhaps most clear in Dr. Oz's interaction with health experts that practice or advocate for alternative forms of medicine. As part of his personal approach to medicine, Dr. Oz has long been a supporter of complementary medical practices throughout his career. In addition to ties to Eastern medicine associated with his Turkish and Muslim heritage,[191] Dr. Oz has frequently indicated that his wife is responsible for encouraging him to expand his understanding of medicine by exploring the potential benefits of alternative medicine and Eastern mysticism.[192] Frank Bruni suggests that Dr. Oz's interest in these alternative medical knowledges and practices is significant because they allow him to "indulge his own personal obsession with how best to treat the body and wring optimal performance from it."[193] Rather than reading Dr. Oz's choice to bring on alternative health experts as an abandonment of Western medicine or an excuse to expand the jurisdiction of Western medicine, from this perspective, it is more accurate to see these interactions as opportunities for Dr. Oz to participate in constituting a more expansive medical authority willing to seek out any source that might aid his audience. Using these interactions to deliver and validate a wide range of health options for his audience seems to supersede a need to privilege or limit himself to any one source of medical knowledge. In an episode exploring Ayurvedic medicine, Dr. Oz explains that even though the information on Ayurveda comes from an ancient Indian form of holistic medicine, his guest Dr. Trupti Gokani is a board certified neurologist and Ayurvedic medicine is increasingly being "embraced by modern medicine."[194] Rather than personally deliver this information to the audience, we see Dr. Oz's desire to seek out new and unfamiliar health solutions

intersect with his relationship with scientific medicine as he frames this content for his audience and then encourages his guest to educate both himself and his viewers. Fluidity is particularly important in these interactions with alternative health experts as Dr. Oz's role as an eager health subject allows him establish distance from more controversial health practices even as these interactions also point to expansiveness in medical authority as Dr. Oz's position as a credible medical expert validates these alternative perspectives growing his audience's understanding of health and medicine.

In contrast to segments in which Dr. Oz's interaction with health experts expands health and medicine, interactions also serve as an opportunity to question or even challenge certain health practices. In an episode looking at the high fat ketogenic diet, although Dr. Oz explains that "ketosis" has a long history with Western medicine in the treatment of seizures and diabetes, he warns that using this medical process for weight-loss is much more controversial.[195] Acknowledging the controversiality of health solutions that appear on the show even as he supports these practices as potential options for his audience is a common occurrence on *The Dr. Oz Show*. However, in this example, after discussing the potential benefits of a ketogenic diet, Dr. Oz comes close to outright condemning this particular health solution. After talking with Dr. Josh Axe (a doctor of natural medicine) and fitness trainer Drew Manning, Dr. Oz pauses and states, "So you know what I do for a living? I am a heart surgeon. So I spend my day opening people's chest with a band saw to pull out stuff that looks like this from arteries. This makes me a little nervous" and later goes on to emphasize that he believes there has not been enough research done on this topic to make it a long-term solution for anyone.[196]

Despite the fact that segments in which Dr. Oz voices legitimate concern with a health solution being presented to him and his audience are somewhat rare, we can see Dr. Oz's position shift as he transitions from demonstrating openness in seeking information about this perspective to using his paternal authority to direct his audience away from this specific choice. The ability for these interactions to participate in expanding medical authority also facilitates opportunities to set boundaries on health solutions that fail to meet Dr. Oz's guidelines. Segments like this point to a boundary between *dangerous* and *safe* medical practices, establishing a need for Dr. Oz's broad expertise to sort through and validate health content for his audience.

The emergence of an expansive medical authority may be clear in interactions in which Dr. Oz engages guest health experts that inform and guide Dr. Oz and audience members from a position of authority grounded in their diverse areas of expertise. Yet, as we saw in the previous section, health subjects and other non-experts also participate in expanding medical authority on *The Dr. Oz Show*. In contrast to segments in which Dr. Oz presents health information to the audience, Dr. Oz often interviews audience members by asking questions and seeking feedback. In these exchanges, Dr. Oz shifts his position from paternal educator to knowledge seeker as he learns about and expands his understanding of health apart from his own personal background in medicine and more clearly defined health experts. In these interactions, audience members provide Dr. Oz and other audience members with various health informations including eating plans, recipes, practical tips, and a wide range of other content. For example, towards the end of an episode on dieting, audience member Theresa teaches Dr. Oz how to make a

delicious and healthy smoothie for the audience.[197] In an episode on extreme weight-loss, Dr. Oz appeals to health subject Jenny (who lost over 300 pounds) for strategies and suggestions on how to lose weight and overcome challenges that inhibit success.[198] In these segments, audience members are positioned as health experts in their interaction with Dr. Oz as he is now the one to ask questions and submit to their knowledge and authority. These interactions between Dr. Oz and health subjects not only expand health knowledge, but also the sources from which legitimate health information can emerge. Dr. Oz's flexibility in turning to his audience for health information and advice validates the active involvement of these health subjects in collecting information and managing their health. By positioning health subjects as health experts, Dr. Oz's position as a medical authority figure sustains a more fluid relationship with medicine and other health knowledges as these interactions participate in expanding how medical authority is constituted on this television program.

These examples illustrate just a few of the many types of interaction that participate in expanding medical authority on *The Dr. Oz Show*. Here, focusing on Dr. Oz's engagement with any one health expert or source of health information is less important than broadly recognizing how medical authority is expanded though Dr. Oz's ongoing flexible navigation of these various relationships. Rather than situating Dr. Oz's medical authority in Western medicine or any other system of medical knowledge, implying that medical authority is static and solidified prior to these interactions, we see that Dr. Oz's flexible position as a medical authority figure enables these interactions to

expand medical authority by both exploring and validating a broad array of health knowledges and practices for his audience.

Conclusion

Critics of *The Dr. Oz Show* tend to dismiss the show's content based on a perceived lack of commitment to evidence-based medicine or by attacking Dr. Oz for misleading his audience and abandoning his relationship with Western medicine. My analysis suggests that these criticisms either fail to understand or refuse to accept how medical authority functions in neoliberal health discourses. Rather than situate medical authority exclusively within Western medicine or any other form of medical knowledge, Dr. Oz's position as a medical authority figure emerges from his flexible navigation of the complex and ongoing network of interactions that take place on this television program. As he educates, entertains, and is informed by various audience members and health experts, Dr. Oz's authority as a celebrity health expert is continually shaped through his ever changing position in these interactions. This flexibility also facilitates the emergence of an expansive medical authority as these varied interactions allow Dr. Oz to seek out and validate a wide range of health knowledges and practices for his audience of health subjects. As Dr. Oz moves from segment to segment and from episode to episode, medical authority is continually expanded and shaped as it emerges out of these diverse interactions. Ultimately, these interactions allow Dr. Oz to leverage and vary his relational position as a medical authority figure in order to bridge the gap between diverse medical knowledges as he draws from anywhere and everywhere for health information and practices to help his audience.

Three implications that arise from this analysis point to the significance of *The Dr. Oz Show's* constitution of medical authority to our understanding of neoliberal health discourses. First, the constitution of an expansive medical authority suggests that medical authority is no longer necessarily tied to any specific institution or medical knowledge. Instead of preexisting this discourse in some underlying institutional source, medical authority emerges from the interactions between the embodied celebrity health expert persona of Dr. Oz and the various participants that appear on the show as they negotiate and shape the validity of various health knowledges and practices. Rather than limiting medical authority to Dr. Oz's institutional affiliations and credentials, Dr. Oz's flexibility in these interactions demonstrates that medical authority can emerge from any source offering health information that can be of use to health subjects interested in improving and maintaining their health. In a neoliberal context in which entrepreneurial health subjects are no longer satisfied with limiting themselves as they search for health information, expansive medical authority becomes quite appealing as it not only bridges the divide between various health knowledges and practices, but also continually shifts in its positionality. Further, as this medical authority expands health and medicine, Dr. Oz's flexibility as a medical authority figure also somewhat masks his paternal ability to direct health subjects toward particular options. Dr. Oz's ability to flexibly transition back and forth between paternal health educator, celebrity entertainer, and knowledge seeking health subject allows him to draw on the credibility and authority rooted in various institutions and health knowledges in order to validate other informations and practices without distancing audience members not interested in simply being educated

by a physician. Dr. Oz himself may be everything at various points in these interactions, yet in being everything he sustains his ability to strategically shift his position in order to direct and discipline health subjects. From this perspective, we might argue that Dr. Oz's participation in the constitution of an expansive medical authority through his celebritized position as a flexible medical authority figure allows him to gain even greater authority than he would if he was limited to any one source of medical knowledge or type of interaction.

Second, in addition to providing insight into how medical authority is relationally constituted in this discourse through interactions, this understanding of medical authority also tells us something about how health subjects are constituted in their interaction with celebrity health experts. As these interactions signal Dr. Oz's flexibility as a medical authority figure, the health subjects that participate in these interactions are simultaneously constituted as flexible as they are forced to adapt to diverse forms of engagement. Instead of seeing Dr. Oz's audience as passive spectators or empowered participants, health subjects are constituted through both of these positions and more as they shift and navigate their relationship with Dr. Oz and other health experts. Not only is the audience member an audience member, at times they are also a patient, a lab assistant, an instructor, a prop, and anything else they need to be in this relationship. This relationship can be constraining as Dr. Oz and his guest health experts educate and guide health subjects toward particular health practices. At other times there are opportunities for direct and active engagement with these medical authority figures as they ask questions and add their own health knowledge to the shows expansive body of

content. I am hesitant to overstate health subject empowerment in these segments, however, in reading *The Dr. Oz Show* as a series of relationships that continue to evolve and take shape over time, I believe there is room to consider how the active participation of health subjects introduces room for expanded involvement and empowerment.

Finally, the constitution of an expansive medical authority that emerges through Dr. Oz's celebritized position as a flexible medical authority figure points to one such means by which televised neoliberal health discourses can encourage health subjects to continue to turn to them for health information. An expansive medical authority suggests that Dr. Oz is willing to look everywhere and turn to any reasonable source for information to help his audience, but we might also read this process as bringing these diverse health informations to his audience to discourage them from turning to other health discourses. Instead of situating *The Dr. Oz Show* as one of many options that health subjects can choose from, Dr. Oz position himself as the as the only resource health subjects need in managing their health. The episodic nature of daytime television talk shows becomes important in sustaining this relationship by offering ongoing opportunities for interaction as Dr. Oz continues to bring the newest and best health experts and information to his audience. Rather than move on to other health discourses, the audience is encouraged to maintain their relationship with Dr. Oz who promises to be there for them for an hour each day with new health information and advice. Unlike most health subject's limited engagement with their personal healthcare providers, Dr. Oz is regularly available and seemingly unconstrained by institutional obligations to advocate for one perspective. Expanding health and medicine to include a variety of

perspectives both provides a diverse range of health content appealing neoliberal health subjects' entrepreneurial need to freely choose what options works best for the while also allowing Dr. Oz to paternally guide them toward particular choices. This process not only gives health subjects a variety of health informations to choose from, but also facilitates a sustained and disciplined relationship with Dr. Oz as he points them towards the best options. Although flexibility in this relationship may offer expanded opportunities for more consistent and active engagement, this relationship also comes with the added expectation that health subjects will increase the amount of time that they invest in both this relationship and their own health as this expansive medical authority continues to take shape. It is this increase in relational investment that I turn to in the next chapter as we consider health subjects' sustained interaction with activity trackers.

CHAPTER IV

FITBIT

On January 5th, 2016, Jeff Bravo checked into Our Lady of Lourdes Medical Center in Camden, New Jersey.[199] While the man initially arrived at the hospital in response to a seizure he experienced earlier in the day (thought to be linked to a missed dose of medication), the doctors treating him soon discovered a sustained irregular spike in heart rate that pointed to atrial fibrillation, a more serious medical condition. Unfortunately, without knowing when his irregular heart rate began, the doctors had trouble determining the specific cause of this anomaly and subsequently how to best treat their patient. It was then that Dr. Carol McDougall noticed that the man was wearing a Fitbit Charge HR activity tracker on his wrist. Knowing that these devices continually record heart rate data and send this information to a smartphone application, the doctor asked the patient if they could look at the information that had been collected that day. After reviewing the Fitbit's heart rate data, the doctors learned that the increase in heart rate had occurred less than 48 hours previously. This new data suggested that he was an ideal candidate for a cardiovert rather than more invasive and time-consuming testing and treatment. This event, which has become widely regarded as "the first documented case of medical personnel consulting a patient's wearable activity tracker to help them make a diagnosis," points to a growing affinity between wearable activity trackers and medicine.[200]

Incidents like the above narrative are encouraging to patients and medical professionals interested in wearable biosensing technologies' potential as medical devices. Here, wearable activity trackers take on medical authority as physicians and other trusted medical professionals validate the data and other information being gathered by these devices as a valuable component of healthcare. However, focusing on medical professional use of this data in clinical settings fails to account for how medical authority always already participates in the user's interactions with self-tracking devices. The ability for users to make sense of and use the data they generate through activity tracking technology is grounded in multiple forms of interaction with sources of medical authority that analyze, visualize, and direct user performance. Indeed, user engagement with activity trackers includes a broad network of interactions that go far beyond counting steps or logging heart rate. In a neoliberal context in which technological advances and social changes have moved many areas of health management and maintenance out of traditional medical institutions, rather than limit our understanding of activity trackers by framing them simply as a form of biosensing technology that collects and visualizes user data, I read user engagement with activity trackers as a health discourse that functions through a constellation of interactions with medical authority that extends beyond the clinic and into every facet of the health subject's life. By approaching the relationship between users and activity trackers as a health discourse, we gain insight into how both medical authority and health subjectivity are constituted through diverse forms of engagement.

In this chapter, I argue that the constellation of interactions between users and Fitbit constitute a sustained relationship with medical authority that saturates the lives of health subjects. By examining different types of interaction, I illustrate various ways that medical authority emerges and participates in these forms of engagement as Fitbit continually intervenes into and directs users' performative generation of data and embodiment of health. Interrogating medical authority's emergence through diverse user interactions complicates our understanding of user engagement with activity tracking technologies by reading them not simply as a form of self-surveillance, but as an ongoing relationship with medical authority. From this approach, we can see that even traditionally understood neoliberal self-help practices are imbricated with interactions with medical authority. This approach expands our conceptualization of how the relationship between medical authority and health subjectivity is constituted in neoliberal health discourses as this relationship moves beyond textual forms that health subjects read or watch, to something that health subjects wear. I begin with an overview of current scholarship on wearable technologies and health subjectivity in order to articulate how interactivity and medical authority are situated in user engagement with activity trackers. After outlining some underlying forms of medical authority that appear in Fitbit's discourse, I then move to explore three types of interaction between users and Fitbit that point to various ways medical authority emerges and participates in constituting health subjects. Examining interactions associated with goals and notifications, virtual trainers, and contextualized wearing reveals how these varied performances contribute to and constitute the relationship between health subjects and

medical authority. I conclude by looking at implications that emerge from this case study as we consider how wearing a relationship with medical authority broadens our understanding of neoliberal health discourse.

The Rise of Wearables

Within the last five years, wearable data collecting technologies, or "wearables," have proliferated in the arenas of healthcare and fitness. Isabel Pedersen defines wearables as technologies situated "midway between media that you carry (e.g., laptops, BlackBerrys, memory sticks) and media that you become (e.g., devices implanted in the body, future nanotechnological manipulation, prostheses)."[201] These wearables, which include an ever expanding network of medical and consumer goods (such as Google Glass, smartphones, smartwatches, and a variety of health sensors and activity trackers), are designed to "naturally integrate advanced computing functionality into the user's (normally) nonmediated experiences."[202] Melanie Swan notes that recently the biggest growth in the wearables market has been in "measuring individual health metrics through self-tracking gadgets, clinical remote monitoring, wearable sensor patches, Wi-Fi scales, and a myriad of other biosensing applications."[203] Among these diverse products, personal activity trackers have emerged as one of the most popular and ubiquitous forms of wearable technology as millions of users have turned to these devices as a means of surveilling and improving their health. Growing out of the popularity of the original Fitbit (released in 2009), the wearable activity tracker market has expanded to include a range of products by Fitbit, Garmin, Jawbone, Nike, Samsung, Apple, and "various mobile phone applications that track activity."[204] With a market

projected to be worth more than $50 billion by 2018 fueled by the sale of individual tracking units, Alex Hutchinson humorously notes that based on current trends, the wearable activity tracker has "completed its 10,000-step march to ubiquity."[205]

In a neoliberal society in which health subjects are increasingly taking responsibility for monitoring their health, the continuous and personalized collection and interpretation of data as well as the associated sense of "empowerment-through-self-discipline" offered by activity trackers has become increasingly desirable.[206] Emerging as part of what Brad Millington describes as the "second fitness boom," characterized by neoliberal practices of socio-technical interactivity grounded in customizable data collection, activity trackers "allow users to measure, visualize, and share their physical activity throughout the day."[207] Catherine Gouge and John Jones explain that these devices function as "a class of wearables that harvest data from multiple sensors (accelerometers, Global Positioning System [GPS] chips, and heart rate monitors) to track a range of bodily metrics related to exercise, like steps taken or calories burned."[208] It is implied that by self-tracking, "individuals are able to identify patterns that need to be modified or reinforced…and act on them," pointing to an underlying belief that if health subjects continue to gather enough data they will ultimately gain "a means of avoiding illness and disease."[209] While Eric Topol suggests that the neoliberal empowerment offered by activity trackers positively represents "a serious challenge to medical paternalism," particularly as patients can now produce and use their own medical data apart from traditional clinical settings, Mark Andrejevic emphasizes his concern that the disciplinary work of "information gathering and comprehensive

monitoring" that accompanies self-surveilling technologies "is being offloaded onto consumers in the name of their empowerment."[210] Here, issues of empowerment and discipline emerge as scholars address the influence of activity tracking on health subjectivity.

Much of the current scholarship on wearables has focused on interrogating how increased use of these technologies participates in reshaping the identity of health subjects.[211] In this body of work, the most common characterization of this new self-tracking and datacentric identity is the "quantified self." Swan defines the "quantified self" as "any individual engaged in the self-tracking of any kind of biological, physical, behavioral, or environmental information."[212] Further, Swan goes on to emphasize that the quantified self is grounded in neoliberal self-tracking technologies, which allow the individual to become a "knowable, calculable, and administrable object."[213] James Gilmore stresses that the significance of the quantified self lies in its ability to cause us to "rethink our bodies as collections of data."[214] He explains that while activity trackers provide "structures of motivation for users to lose weight, be more active, and improve their overall health…this motivation also reshapes how users think about their bodies as both computational and organic, adding increasingly quantifiable means of accounting for one's being in the world."[215] Deborah Lupton similarly argues that the data produced by activity trackers "not only configure the body and health states into visual displays…based on quantification," but also, more importantly, "contribute to a new way of conceptualizing one's body and one's health status."[216] The quantified self not

only describes individuals who collect data on themselves, but also points to new ways health subjects are constituted through their use of wearable tracking technologies.

In addition to this growing body of work on the quantified self, some scholars have also examined the significance of wearing itself as an embodied and performative act. Molly Kessler explains that "current scholarly focus on quantification and materialization represents an important area of inquiry…however, a more comprehensive notion of wearable technologies might focus on the act of wearing, or wearability, not quantification as the critical aspect of such technologies."[217] Rather than focus on how data collection and representation impact the way health subjects come to understand themselves, Kessler and others have looked to the importance of interrogating forms of embodiment that produce and are produced by these devices.[218] Jordynn Jack emphasizes that in developing a framework for analyzing wearable technologies, it is important to recognize wearables as "embodied rhetorics used by real people, and in doing, carefully consider how use of those technologies depends on performances of status and gender, policy frameworks, space-time arrangements, and the material design of technologies themselves."[219] Jack situates wearables within a broader network of embodiments of health by asking how individuals use and talk about their use of wearables in the real world. These analyses by Kessler and Jack provide a useful starting point in which we can begin to understand how embodiment intersects with wearable technologies. However, I suggest that their specific interest in ostomy pouches and breast pumps do not fully account for how embodiment relates to the quantification of the self that emerges through user interaction with wearable activity trackers that

involve more diverse and explicit interaction with medical authority.[220] I suggest that approaching activity trackers as a health discourse that functions through a constellation of interactions, rather than simply as a wearable technological device, allows us to interrogate user performance and interaction as a means of revealing how embodiment and quantification both participate in an ongoing relationship with medical authority.[221] Instead of focusing on quantification or embodiment, examining the relationship between health subjects and medical authority that emerges through multiple forms of engagement reveals how these competing perspectives work together and are negotiated.

One of the constraints holding back research on wearable activity trackers is a limited conceptualization of the text under examination. Much of the current scholarship looking at activity trackers is focused almost exclusively on data generation through the device itself and situationally on applications that visualize the information collected and interpreted by the device. Scholars are within their right to limit their work to this specific conceptualization of wearable technologies. However, this specificity also misses the opportunity to interrogate the complexity involved in user engagement with these fragmented texts that include various forms of engagement with devices and applications, as well as with websites, online stores, advertisements, community forums, and a range of other sites.[222] Indeed, a more complete examination of wearable activity trackers should take into account the multiple ways users engage these technologies. From this perspective, I approach activity trackers as a health discourse made up of a constellation of interactions between users and medical authority in order to take into account the diverse ways users interact with these fragmented texts. Interrogating these

multiple forms of interaction allows us to more fully examine how the relationship between users and activity trackers as well as the medical authority that participates in and emerges through these interactions is constituted.

Academic interest in medical authority's relationship with wearable activity trackers has primarily focused on medical provider's analysis and use of voluntary data sent from patients in the treatment of various conditions.[223] Recently, however, scholars have begun highlighting the more direct involvement of institutionalized medicine in the use of activity trackers. Suneel Jethani asserts that "self-trackers cannot be said to exist independently of these infrastructural and institutional structures."[224] Christa Teston similarly emphasizes that "focusing only on translating, collaborating, and analyzing wearable data…neglects other institutional and technological actants."[225] As activity trackers collect data on a range of health indicators, these scholars suggest that authoritative institutions participate in this process by working behind the scenes to interpret and visualize data for users and other sources. Rather than characterizing health subject use of wearable technologies and institutional engagement of this data as discrete interactions, these studies situate medical authority in the institutions that are an inherent part of activity tracking technology. While this body of research has expanded our understanding of medical authority's relationship with activity trackers, focusing on medical institutions role in data analysis has constrained our ability to examine other ways medical authority emerges and participates in this relationship with users. I suggest that by examining the constellation of interactions the surround activity trackers we can see users engage medical authority in ways that are not limited to medical institutions

and data interpretation.[226] Here, in addition to looking for medical authority in specific institutions or individuals that work behind the scenes, we should also look to various user interactions with activity trackers to see how medical authority is constituted as it emerges in the lives of health subjects.

Fitbit, the Sum of Your Life[227]

In 2007, James Park and Eric Friedman founded Healthy Metrics Research, Inc., a startup company interested in generating buzz and funding for their idea to market wearable biosensor technologies as fitness and activity tracking consumer goods.[228] After recovering from several setbacks in development, the company (which they renamed Fitbit) released its first self-titled tracker in 2009, which allowed users to track steps, movement, sleep, and calories burned through a small clip-on device. As part of a series of technological improvements in Fitbit devices that broadened the range of health metrics that could be tracked and opportunities for device connectivity, Fitbit notably moved from wearable clip-ons to wristband styled devices with the Fitbit Flex in 2013. These wrist activity trackers proved to be very popular with consumers, especially as they began incorporating various traditional wristwatch technologies that expanded their usability. In 2014, reports of allergic reactions to the materials used in the Flex led to a mass recall. Despite this setback, Fitbit soon introduced the Fitbit Charge and Charge HR made from safer materials and the added ability to continually monitor heart rate. Since this time, although the introduction of other activity trackers and various controversies have somewhat encroached on Fitbit's dominance, Fitbit's ever-expanding range of products and services has continued to claim over 70% of the wearables market

share as recently as 2016. Widely recognized as the world leader in activity tracking technology, Fitbit offers the opportunity to interrogate how user engagement with these devices participates in contemporary neoliberal health practices.

Although Joshua Rudner and colleagues indicate that "activity trackers have been used medically only to encourage or monitor patient activity, particularly in conjunction with weight loss programs," as the story from the introduction illustrates, the boundary between these wearable technologies and healthcare has become increasingly blurred.[229] In fact, Fitbit founder James Park recently emphasized this relationship between activity tracker data and medical science, stressing that in the future Fitbit needs to "tie into more detailed clinical research" and focus on the ability to make "'lightweight" medical diagnosis."[230] Fitbit may not be currently recognized as an official medical device by the FDA and many practitioners of Western medicine, yet Park signals a growing affinity between the sustained biometric data produced by activity-tracking devices and health experts who are increasingly turning to data as an important means of improving patient health. Despite the contention that Fitbit still has a ways to go in developing its affiliation with clinical medicine, I suggest that it is important to recognize how Fitbit already structures the relationship between users and medical authority. Fitbit's website states:

> Somewhere between first tries and finish lines. Pillow fights and pushing the limits. That's where you find fitness. Every moment matters and every bit makes a big impact. Because fitness is the sum of your life. That's the idea Fitbit was built on – that fitness is not just about gym time. It's all the time. How you spend your day determines when you reach your goals. And seeing your progress helps you see what's possible.[231]

With this statement, Fitbit embeds itself within the network of neoliberal health discourses and practices that encourage and facilitate continued self-monitoring. Although sustained self-tracking of every part of your day is framed as a way to help users "stay motivated, and see how small steps make a big impact," this personalized data collection not only motivates users to increase their physical activity, but also constitutes the way users see themselves and their relationship with medical authority.[232] It is to this relationship that I now turn.

Underlying Medical Authority

I want to first briefly address Fitbit's association with medicine in order to point to how this underlying medical authority is always already situated within user engagement with Fitbit. Amy McDonough, vice president of Fitbit Group Health, explains that although "Fitbit trackers are designed to provide meaningful data to our users to help them reach their health and fitness goals," they are "not intended to be scientific or medical devices."[233] Fitbit's products may not be recognized as a FDA approved medical devices, yet Fitbit's discourse repeatedly blurs the line between activity tracking and medical tracking. For example, Fitbit regularly attempts to lend credibility to their various technological advances by explicitly positioning its products and features as advancements on medical processes and technologies. In describing their PurePulse heart rate sensor technology, Fitbit suggests that while medical research regularly emphasizes that tracking your heart rate has many health and fitness benefits, historically this information has been expensive, uncomfortable, and challenging to attain. Fitbit explains that "[i]n clinical settings, researchers were using

electrocardiograms (EKGs), which cost around $5000, Athletes and weight loss hopefuls were using chest straps, but those could irritate the skin when worn for long periods of time."[234] The website's section on sleep tracking technology similarly explains that "[s]leep can have a huge impact on your overall health. But in 2007, the only way to measure it was with bulky, portable equipment or through overnight clinical assessments. Sleep tracking was time-intensive, highly expensive or just plain uncomfortable."[235] These various statements are framed as a justification for Fitbit's desire to make this technology both wearable and affordable, however, these statements also situate Fitbit technology as an extension of and improvement on medical technologies.

In addition to this medical framing of its products, Fitbit's user-friendly descriptions of how these technologies work mix medical and technological understandings of this technology. In describing PurePulse technology, Fitbit indicates that the advanced optical sensors that sense and record heart rate data in its trackers are based on photoplethysmography. Fitbit goes on to describe this process, elaborating that

> [w]hen your heart beats, blood flows, and the volume of the blood in your wrist changes. Blood - interestingly enough - absorbs green light. The higher your blood volume is, the more green light is absorbed. To calculate blood flow, PurePulse shines a green light onto the skin and uses light detectors called photodiodes to measure how much light is being absorbed. This measurement is used to determine how many times your heart beats per minute.[236]

Although it might be difficult to describe this process without talking about the heart, blood flow and volume, skin, and other biological components, this detailed explanation of a seemingly complex biotechnological process positions Fitbit technology within the realm of scientific medical knowledge and practice. Having established that these

various technological developments emerged out of clinical medical practices, these descriptions further participate in reinforcing Fitbit's underlying medical authority.

In the few cases when Fitbit does not take the time to describe in detail how a particular biotechnological process works, there are often detailed references to the health and medical experts who participate in creating and verifying the credibility of these technologies or at minimum, citations that support the particular claims being made. As part of a discussion on how to care for Fitbit products, Fitbit explains, "We have created a Scientific Advisory Board of leading, certified dermatologists who meet with Fitbit executives to review our testing protocols, ensure our products meet the highest possible standards, and to help us better communicate with our customers."[237] Following this statement there are photographs and biographies for the members that make up this advisory board. Additionally, throughout Fitbit's discourse there are many references to the American Medical Association, the American Heart Association, the Centers for Disease Control and Prevention, the Mayo Clinic, and other sources that ground Fitbit in familiar institutions associated with Western medicine. Even information less-grounded in technical medical knowledge is supported by outside research and often includes detailed information about the contributor of that specific content. In an article discussing Fitbit's choice to set 10,000 steps as a user goal, there are references to the CDC and The Academy of Nutrition and Dietetics, as well as detailed information on the article's author, writer and fitness trainer, Lisa Rosenbaum.[238] As Rosenbaum is not be a traditional representative of Western medicine, Fitbit goes out of its way to be transparent by emphasizing her credibility as a health

expert. Together, Fitbit's choice to position its technologies as an extension of medical practices, medicalize the discursive framing of its processes, and emphasize the individuals and institutions supporting its devices ground Fitbit's medical authority. However, in order to fully understand how Fitbit's medical authority engages health subjects, we must also examine how user interactions with Fitbit participate in constituting medical authority.

Numbers and Notifications

I felt the vibration. Groggily I opened my eyes to look down at the Fitbit on my wrist that was silently ringing letting me know it was time to get up. I must have been restless during the night since my Fitbit informed me that I had already taken 22 steps that day. I felt the vibration. I looked down at my wrist and saw that it was almost 10 am and I had not logged 250 steps in the last hour. I closed my laptop and walked downstairs to take a jog around the building to hit my goal. I felt the vibration. I looked down at my wrist and noticed that my dad sent me a text message. I made a note to respond later since the kickboxing class I was taking was about to start. I felt the vibration. I looked down at my wrist and saw that I had just received a "Hot Air Balloon" badge for reaching a new lifetime goal of 2,000 total floors climbed. I thought about how convenient it was that I lived in a two-story apartment and that my office on campus is on the second floor. I felt the vibration. I looked down at my wrist and happily noted that I had hit my 10,000 step daily goal early that day. I thought about how my choice to ride my bike to campus that morning added nearly 2,200 steps to my total. I felt the vibration. I looked down at my wrist and observed that it was almost 7 pm and I

had not logged 250 steps in the last hour. Even though I knew I would be frustrated when I checked the app later and saw that I did not hit all of my hourly goals, I decided not to stand up and awkwardly walk around the restaurant since I was out to dinner with my wife. I felt the vibration. I looked down at my wrist and saw that my brother was calling. I ignored the call and continued getting ready for bed. I would call him back this weekend when I knew I would have time to catch up.

In this narrative we can see medical authority emerge in my relationship with Fitbit as numbers and notifications intervene into my lived experiences. My performance as a health subject is linked to medical authority as my bodily movements prompt Fitbit to provide me with interpreted and visualized statistical information quantifying my actions. Simultaneously, medical authority emerges in these interactions as Fitbit's notifications interrupt my movement through the world and orient/discipline me toward particular performances of health. While medical authority may be imbedded in the development and framing of Fitbit technologies, we can see that medical authority is also constituted through the performative act of wearing. Indeed, algorithms and advice in Fitbit's discourse mean little without an ongoing relationship with users who participate in these interactions allowing medical authority to emerge and take on meaning in the life of the individual health subject. Due to Fitbit's roots in step counting technology, a good place to start interrogating user's relationship with medical authority is through interactions that involve the generation and interpretation of user data.

Medical authority emerges in user's relationship with Fitbit through goals and gamified systems of rewards that direct health subjects toward particular quantifiable

forms of data production and performance. One of the primary ways user data is given meaning is by setting various goals and rewarding users for achieving these goals. As users reach daily, weekly, and even lifetime goals, they receive notifications from Fitbit congratulating them for their progress as well as various digital badges that highlight the user's current "best" in that area. For example, rather than simply reporting back the number of floors you have climbed that day, users are given the goal of climbing 10 floors and if that goal is reached users are immediately alerted. Further, if the total number of floors climbed that day is a new personal record they will receive a new badge like Lighthouse (50 floors) or Skyscraper (100 floors). These floors are also carried over to cumulative lifetime badges like Spaceship (14,000 floors) and Satellite (35,000 floors). Although these goals and badges mean relatively little beyond the satisfaction of achieving short and long-term goals and comparing these results with other users, this gamified process allows Fitbit's medical authority to direct health subjects toward particular performances of health.

Setting and achieving personal goals may provide users with a sense of personal accomplishment and serve as a great way to "track your weekly routine and stay motivated;" however, these goals are shaped and normalized by medical authority that defines what type of performances are reasonable and preferred.[239] Fitbit statistics prioritize and privilege certain types of data generating performances. The specific quantifiable goals offered to users in this relationship are often grounded in medical authority. Fitbit explains that "everybody has a starting goal of 2000 calories, 10,000 steps and 30 active minutes a day based on the Center for Disease Control's

recommendation."[240] Even though health subjects have the option to modify and change their goals, this justification, grounded in the CDC's medical authority, normalizes these numeric thresholds as healthy. Further, the goal/badge system not only positions specific data as important, but also encourages users to exceed these normalized goals, sometimes to extreme levels. While 10,000 steps might be the base recommendation for "healthy" individuals, gamifying this process also rewards users for exceeding these goals. There are no studies that suggest walking 50,000 or 100,000 steps a day should be required or even appropriate in the maintenance of health, yet gamifying data collection normalizes the perception that more is better/fitter. In this process we see Fitbit's medical authority emerge as "healthy" goal recommendations and badge rewards constitute health subjects with a sustained need for improving individual performances of health. Fitness becomes less about health maintenance and more about increased performance as numeric measures become the markers of the constituted health subject's level of fitness in this relationship.

A high step count and a "Ruby Slippers" badge may satisfy the Fitbit user's gamified need for positive behavioral reinforcement. The numeric goals offered by Fitbit's medical authority also direct and discipline health subjects toward particular normalized performances of health in the world. Walking from my car to my office or eating lunch with my friends may have always been part of my day, yet my continual relationship with Fitbit in these contexts defines this experience as an interactive performance of health as my body movements generate data. Even if my physical movement through space during these activities never changes, this relationship

influences the way my body moves through the world by allowing Fitbit's medical authority to give my movement new performative meaning. This relationship is designed to not only passively collect data, but encourage the user to be hyperaware of previously taken-for-granted movement through the world as a means of altering embodied practices to generate data to meet previously defined goals. Having a Fitbit may not alter my need to physically travel to my office on campus, but the awareness of my ongoing interaction with Fitbit may encourage me to park a little farther away so I can log more steps or even ride my bike from home to increase my activity time for the day altering my movement through the world. If all of my life is fitness, now all my movements become performances of fitness requiring continual self-discipline and engagement with the medical authority that guides this interaction.

Perhaps the most extreme manifestation of how user interaction with Fitbit's medical authority influences and directs the way health subjects move through the world is through notifications. In the story above, as numeric goals oriented me toward certain performances, periodic notifications (in the form of distracting vibrations) directly intervened into my life by interrupting my movements and/or thoughts and redirecting them toward various performances. For example, basing the recommendation to move 250 steps an hour on scientific medical research justifies Fitbit's notifications which regularly remind me to be continually aware of my movements in order to meet the guidelines established by medical authority.[241] The choice to receive these notifications may be optional, yet Fitbit's overarching medical authority positions this form of interaction as the optimal way to improve the user's health. Consequently, choosing to

opt out of certain "interactions" in this relationship suggests that the user is not willing to perform health in line with the medical authority that is always watching and willing to remind the user to move more frequently. Further, these notifications are indistinguishable from notifications for other types of interaction. Fitbit's notifications about phone calls or text messages are no different or less distracting than notifications to move more or congratulating users for meeting my daily goals. Each of these interactive moments ultimately force attention back to one's relationship with Fitbit, expanding the ubiquity and jurisdiction of this medical authority in the user's life.

Virtual Trainers

I am no stranger to the gym and aerobics classes. In the last decade I have spent countless hours lifting weights, taking fitness classes, and following along with home workout videos. So when I came across Fitbit's guided video workout program, Fitstar, I decided to try and incorporate this feature into my personal fitness routine. I began the program (which is integrated into the Fitbit app) with a "fit test," a short series of exercises designed to set a base level of difficulty for future workouts. At the beginning of this test I was introduced to fitness trainers, Adrian (a tall muscular black man) and Lea (a short trim white woman) who start the program with a short interactive video that asks the user to "tell us about your current fitness level and we will get you started on the right track" prompting me to self-disclose various demographic information by manually entering my gender, age, and other content into the application. I was then asked to pick my preferred personal trainer and then my selection (Adrian) both verbally and visually guided me through a series of seven exercises requiring manual feedback

after each exercise. This process felt frantic since there was little time to learn how to do each new move and several times new exercises began while I was entering feedback on how many repetitions I performed and my perceived difficulty with the previous movement. At the end of this test, Adrian suggested several workout options (some free and others requiring a premium account) based on my current fitness level calculated by my manual feedback and the Fitbit data I generated during this experience. Although some moments of this guided workout program were odd (notably the loud interjected vocal tips evenly distributed throughout the video based on the length of my workout), I was pleasantly surprised by the level of personalization afforded by this system that clearly modified itself based on my feedback and performance.

In this example we can see that beyond using numbers and notifications to direct Fitbit users toward particular performances of health, features like Fitstar offer interactive forms of engagement that directly guide the user's body movements. Fitstar's workout videos make the relationship between health subjects and medical authority both sustained and embodied as users watch and follow along with fitness trainers as they demonstrate and coach them through various routines. In addition to expert tips and demonstrations, Fitstar workouts are tailored for each user as the app takes into account generated numeric data through the Fitbit, previous workouts and activities, as well as manual feedback provided by users throughout each session as they interact with the fitness instructor on the screen. Fitstar's interactive workouts blur the line between the quantified self and embodiment as directed bodily movements performed in the world produce data used to calculate both the user's level of health as well as suggestions for

future workouts. Although health subjects and medical authority interact in the process of recording steps and celebrating met goals, Fitstar's choice to provide users with an authoritative behavioral model to emulate as they work together to generate these numbers points to a different manifestation of this relationship. Here, embodied fitness instructors visually represent Fitbit's medical authority as their actively engagement participates in directing user performances of health. Beyond facilitating quantitative improvement, this interaction encourages us to consider how this relationship with Fitbit's medical authority directly influences the way health subjects engage the world around them.

Direct and sustained interaction between users and discursive representations of Fitbit's medical authority also emerges in Fitbit's "Relax" guided breathing sessions. With this feature, health subjects can engage in 2 or 5 minute sessions in which the Fitbit draws on the user's current heart rate to determine a comfortable breathing rate and then uses text, vibrations, and animations to guide users as they inhale and exhale. Like Fitbit's other technologies and features, the benefits of Relax sessions are explicitly situated within current medical research. Fitbit explains that although we breathe all of the time, "[w]hen a bit more mindfulness is added to that simple in-and-out, deep breathing has been shown to lower blood pressure, reduce stress, and lessen anxiety."[242] Each of these benefits is linked directly to source material that verifies the credibility of these claims, including the AHA, Harvard Medical Publications, and the journal Teaching and Learning in Medicine. What makes this feature unique is not an underlying association with various medical institutions, but that this interaction

involves sustained participation by both the user and a disembodied communicative representative of medical authority as they work together to discipline the user's breathing. Rather than providing statistical information on user breathe rate or sending notifications to make sure the user is taking time to slowly breathe each hour, Relax involves several minutes of continuous interaction as the Fitbit textually and visually guides each of the user's movements. Beyond simple messages to "inhale" and "exhale" associated with shrinking and expanding animated concentric circles that help align the users breath with Fitbit's recommended rhythm, this interaction becomes even more conversational through textual messages including "be still, take slow deep breaths," "sensing your breathing," and "all done…you're perfecting the art of calm." Despite little variation in these textual comments, this process requires careful and sustained attention to Fitbit throughout the duration of this interaction. By participating in this interaction health subjects are constituted as unable to monitor their own deep breathing and consequently require a relationship with Fitbit to effectively perform this process.

Fitstar and Relax offer the clearest examples of direct and active user interaction with representative figures that become stand-ins for Fitbit's overarching medical authority, but it is worth noting that there are also other moments in which users are expected to directly interact with Fitbit. For example, Fitbit's ability to provide users with their estimated calories burned requires participation by both users and medical authority. While the passive activity recorded on the health subject's tracker contributes to this calculation, Fitbit also requires health subjects to manually input various other information to produce a more accurate reading. Since calories burned is partially based

on the health subject's basal metabolic rate (BMR), users are encouraged to manually disclose personal information by inputting data including their age, gender, height, and weight into the Fitbit application to improve the accuracy of Fitbit's calculation.[243] Additionally, Fitbit offer's various log features including a food journal, sleep information, and the ability to manually record specific activities not automatically tracked by Fitbit. Manually entering this information is voluntary, however, recording detailed information on food contributes to Fitbit's ability to accurately calculate your BMR and other statistics like approximate weight lost. As a result, this type of manual interaction is constituted as an important part of the health subject's effective performance of health. Although these calculations are seemingly instantaneous and automated as algorithms continually analyze and update information based on incoming data, medical authority continues to engage users as they seek out and give meaning to this data. Together, these examples illustrate that the Fitbit user's relationship with medical authority emerges through more direct forms of interaction as sustained textual and, in the case of Fitstar, embodied engagement move health subjects toward particular performances of health.

Fashion in Fitness

Last year I was the best man in my brother's wedding. Unlike my typical casual Oregonian-in-Texas dress including t-shirts, shorts, and flip-flops, for this event I was required to wear a tuxedo. On the big day, after carefully grooming myself and putting on my formalwear, I was lovingly informed by my ever style-conscious wife that the Fitbit Charge on my wrist did not go with my outfit. I tried several times to assure my

wife that the black band matched my black shoes and belt and was therefore an appropriate addition to my attire, but no amount of clarification or whining could change my wife's mind. In the end, my Fitbit did not join me during the wedding ceremony nor during the reception (I still contend that dancing would have been an excellent way to generate enough steps for my daily goal). In this context involving specific expectations and constraints regarding appearance, my interest in generating health data seemed to conflict with the need to appropriately embody my position as best man. In retrospect I might have gotten away with hiding my Fitbit in my pocket or putting it around my ankle to generate some data. Nevertheless, this experience signaled that there may be some places that (my relationship with) Fitbit should not go.[244]

This example illustrates the challenge involved in managing the visibility and invisibility of activity trackers. In Jack's analysis of wearable technologies she explains that "on the one hand, they are meant to fit seamlessly into our lives…At the same time, they are never completely invisible, but advertise themselves as status symbols."[245] Wearing a Fitbit may serve as a status symbol,[246] but this visibility also poses questions about the relationship between Fitbit use and embodiments of health that are somewhat removed from data generation and interpretation. For example, Fitbit's biosensing technology can tell the difference between when I go for a run or take a bike ride. However, tracking my activity becomes much more difficult when quantifying the difference between sitting in my office at work, sitting at home, or sitting at restaurant with friends. Looking at my data, there is little statistical variation in these activities, yet these contexts involve very different performative embodiments of health. Since my

relationship with Fitbit is situated as something that I am supposed to sustain throughout my day regardless of company or environment, these shifting contexts become important in my ongoing performance of health despite a lack of quantifiable interest in these specific movements. A lack of data generated during these activities may suggest that this type of interaction with Fitbit involves little medical authority. On the other hand, I contend that medical authority continues to emerge in this relationship as Fitbit normalizes its appearance as a part of these various embodiments of health. Fitbit users are not just wearing a device, but wearing a relationship with medical authority.

Rather than ignore appearance related social norms that accompany Fitbit user's changing contextual environments, Fitbit offers a variety of product styles and colors that allow a relationship with medical authority to more seamlessly and continually integrate into the life/body of the wearer.[247] For example, in a commercial introducing Fitbit's new customizable and interchangeable wristbands, we see a top down shot of the Fitbit on a woman's wrist as she walks around engaging in different activities throughout her day.[248] In each of the changing scenes we see her wristband change color/style along with her clothing to match her environment. The black band we see as she sits at home becomes a yellow band during her jog, a pink band in the shower, a shiny gold band at work, and a chrome band later that night at a party. Just in case we missed the visual argument, the commercial ends with text initially stating that "Fitness is now in Fashion" before flipping to read "Fashion is now in Fitness." Data is almost completely removed as the focus of this interaction with Fitbit becomes making sure you are being mindful of your visible embodiment of health as a Fitbit wearer. Changing wristbands may suggest

that users are empowered in their ability to manipulate Fitbit to meet their contextual needs, but, at the same time, Fitbit's authority over the lives of users is sustained and expanded as successfully embodying and wearing a relationship with medical authority now requires a variety of consumer goods unrelated to quantifiable fitness data.

Beyond choosing an activity tracker based on the specific data you want recorded and analyzed, all of Fitbit's products are also linked with a "Lookbook" page that highlights variations in the visible ways you can customize your tracker so you can "find the style that moves you."[249] Fitbit users can choose from a wide range of wristband colors and styles. In addition to traditional wristband color options, users can now choose from active sport bands that are breathable with a perforated design, leisure khaki and olive nylon bands, stylish deluxe genuine leather and stainless steel bands (with optional gold plating and a hand-polished mirror finish), and a variety of special edition bands by fashion designers including Vera Wang, Tory Burch, Public School, and others. Here, fashion designers contribute to the constitution of medical authority as their expertise participates in improving the health of users by facilitating their ability to engage in an appropriate and sustained relationship with medical authority regardless of their location. Wearing a leather Fitbit band with my suit may not have any effect on my quantifiable data, yet successful visual integration of Fitbit into my performance of health is normalized as an important part of my relationship with medical authority. Instead of embarrassingly wearing an unsightly traditional black Fitbit wristband to work or hiding the tracker in some discrete location, changing your band to match your clothing/environment is normalized as a way for affluent users to show that they are

mindful of their health, but also respectful of appearance-based social norms.[250] Here, appropriate wearing signals particular qualities of the user as their adorned relationship with medical authority is privileged through sustained visual presence in the life of the health subject. Although this emphasis on the importance of the health subject's visual embodiment of health associated with the visual style of their Fitbit never completely dismisses the value and authority associated with data collection and analysis, here we see a more complex relationship with Fitbit emerge as medical authority continues to intervene and participate in the lives of users and direct them toward particular performances of health.

Conclusion

In approaching user engagement with Fitbit as a health discourse that functions through a constellation of interactions, this case study examines how medical authority and health subjectivity emerge through user performances of health in their ongoing relationship with Fitbit. I do not suggest that the specific forms of engagement I have analyzed here represent all of the ways users interact with Fitbit. Instead, these examples are meant to broadly illustrate how the relationship between health subjects and medical authority is constituted through varied interactive performances. Rather than limit our understanding of medical authority in this relationship to clinical use of biosensing technologies or in the medical institutions that work behind the scenes to develop these devices, in looking at specific forms of interaction we can see medical authority emerge as goals and notifications, periods of guided interaction, and normalized forms of embodiment intervene into and direct the lives of the health subjects who participate in

this relationship. As a result, this analysis prompts us to move beyond simply asking what it means to wear an activity tracking device to consider what it means to wear a relationship with medical authority.

Approaching user engagement with Fitbit as a health discourse expands our understanding of how medical authority and health subjectivity are interactively constituted in at least three ways. First, Fitbit's underlying medical authority may intervene into and direct the lives of constituted health subjects through its varied interactions, yet medical authority is also dependent on the empowered performance of individual health subjects. Beyond Fitbit's extensive attempts to align their products and services with various medical institutions, fundamentally, Fitbit requires a sustained interactive relationship with users who directly participate in constituting Fitbit's medical authority and are simultaneously constituted through their ongoing engagement. Due to the constellation of means by which users interact with Fitbit, when users look away from their wrist or close the application and go back to their lives, their relationship with medical authority is ongoing. Receiving notifications, checking data on the application, following along with personal trainers, and other forms of direct engagement may highlight specific moments in this relationship, however, a relationship with Fitbit does not require continual conscious participation. The health subject's relationship with medical authority is sustained as both conscious and unconscious interactive performances produce data prompting particular responses and as the act of wearing normalizes certain embodiments of health. Although Fitbit's medical authority may guide and discipline user performance, our understanding of neoliberal medical

authority is also complicated as this authority depends on the sustained interactive engagement with health subjects that influence how this relationship is constituted.

Second, if a user's relationship with Fitbit is continuous as they consciously and unconsciously interact with Fitbit throughout their day, this relationship unavoidably also participates in the health subject's relationship with other health discourses and medical authority. In choosing to wear a Fitbit, a relationship with medical authority is sustained to the point where a health subject can read *The Care & Keeping of You* or watch and participate in an entire episode of *The Dr. Oz Show* without pausing or diminishing their relationship with Fitbit. Here we see significance in the act of wearing a relationship with medical authority as this relationship extends into every facet of the user's life and environment, including their engagement with other health discourses. Rather than having to choose between Fitbit and other health discourses (like choosing which book to read or show to watch), the constellation of interactions that accompany this ongoing relationship continue to engage users even as they interact with other discourses that simultaneously constitute their own relationship with medical authority. By approaching Fitbit as a health discourse involving a broad constellation of interactions rather than simply as a wearable device that facilitates self-surveillance, we are able to recognize the possibility for diverse relationships with medical authority to overlap and mingle in the lives of health subjects. Beyond framing neoliberal empowerment in terms of entrepreneurially choosing between various health discourses, this analysis suggests that we should pay also attention to how variations in the

interaction between health subjects and medical authority complicate engagement with these texts.

Finally, by interrogating these varied modes of interaction between health subjects and medical authority we can see how the relationship between users and Fitbit always already involves both quantification and embodiment. The respective importance of data or embodiment may fluctuate in different types of interaction. Yet as users generate data as their bodies move through the world around them, a relationship with Fitbit is constituted by both of these understandings of performance. Although I may see myself as a visualized arrangement of numbers and graphics when I look at the Fitbit application on my phone, when I look in the mirror I see a body continually engaged in embodying health in line with the ever present medical authority wrapped around my wrist. Instead of separating our critical understanding of the quantified self from the embodied self, as is often the case in current scholarship addressing use of wearable technologies, in approaching Fitbit as a health discourse we are able to see how both of these areas work together as users perform health. I suggest that sustaining an awareness of how user performances influence both quantification and embodiment in this ongoing relationship with medical authority provides a more complete and balanced understanding of how interaction participates in constituting health subjects.

CHAPTER V

CONCLUSION

I began this dissertation with a narrative of my personal experiences with neoliberal health discourses like those examined in these chapters as a means of exploring the relationship between health subjectivity and medical authority. Unsurprisingly, throughout the process of developing these case studies I once again found myself eager to make use of the various health discourses examined here in my personal quest for health. In reading about healthy childhood development in *The Care & Keeping of You* I began thinking about how I would personally approach educating and advising my soon-to-be-born son on how to embrace various practices of hood health. In watching episodes of *The Dr. Oz Show* I repeatedly considered how I might incorporate various food options and health practices into my daily routine. In using and learning more about Fitbit products I often caught myself wondering how much easier it would be to get healthy if only I had the new technologies and features available on the Fitbit Charge 2 activity tracker. Through my interaction with the health discourses examined in this dissertation, tension between neoliberal empowerment and discipline emerges as my position as a conscious consumer intersects with medical authority that directs me towards particular health informations and practices. From this perspective, revealing how texts empower and discipline health subjects is crucial to helping individuals (including myself) navigate this expansive marketplace of health discourses. This dissertation serves as a productive step in gaining a more nuanced understanding of

health discourses by examining ways health subjects and medical authority interact through these texts. This approach not only expands our understanding of health subject engagement with neoliberal health discourses, but also points to unique implications that emerge from a rhetorical perspective that takes into account interaction. In the remainder of this conclusion, after reviewing the constitutive relationships that emerge out my case studies, I outline some broad implications and opportunities for future research that can be drawn from this project.

Neoliberal Health Discourses and Constitutive Relationships

In this dissertation I approached health discourses from an interactive perspective in order to locate and understand how the relationship between health subjects and medical authority is constituted through diverse forms of engagement. Critically approaching health discourses as constitutive relationships allows us to move beyond the constraints imposed by reading discourses as fixed and authoritative asymmetrical texts by which health subjects are either disciplined or empowered. In a neoliberal context in which medical authority is not only dispersed beyond the institutional confines of Western clinical medicine, but also intermingles with a wide range of other health knowledges and practices, I find it valuable to sustain a more fluid understanding of how medical authority emerges and participates in the lives of health subjects. While I am sympathetic to scholars who are interested in how health subjects are constituted by health discourses, through these case studies I demonstrate that there is also room to more carefully interrogate how medical authority is simultaneously constituted through interaction.

On the surface, *The Care & Keeping of You* comes across as a relatively static informative resource designed to help young girls navigate their way into adulthood. However, in examining the relationship between health subjects and medical authority in these books I complicate our understanding of the interaction between AG and the American girl health subject/reader by illustrating how both health subjectivity and medical authority are constituted in this relationship. By using a second-person perspective and facilitating decontextualized consubstantiality between the illustrated American girls featured in the text and the American girl reader, engagement with these books is situated as a conversational interaction. Here, the "I/we" disembodied authorial voice of AG informs, listens to, and responds to "you" the health subject. This relationship is highly paternal as AG guides the American girl towards particular normalized neoliberal/postfeminist gendered practices of appearance-based self-care. However, the conversational relationship articulated between the American girl and AG also empowers the American girl by normalizing more active and direct interaction with medical authority. Normalizing the American girl with the freedom to actively engage AG as they seek and evaluate health information apart from parents and traditional medical sources establishes grounds for producing health subjects more likely to ask questions and potentially challenge medical authority as they engage other health discourses in the future.

Interaction between AG and the American girl can also be seen more broadly in the way the American girl's preexisting relationship with the AG brand participates in constituting medical authority in *The Care & Keeping of You*. Here, the American girl's

past experiences and consumeristic relationship with the AG brand constitutes a branded medical authority as the AG brand and AG medical authority figure are conflated into a unified trusted authoritative voice in the text. In situating self-care in terms of appearance, appearance-based consumer practices associated with other AG products become appearance-based practices of self-care. In this process, the American girl is encouraged to participate in constituting the ambiguous and disembodied AG medical authority figure voice in these books in-line with their broader trust in and loyalty to the AG brand. Not only does interaction between the American girl health subject and medical authority normalize this health discourse as part of an ongoing relationship with AG based on appearance and consumerism, but also normalizes a sustained relationship with medical authority. As the AG brand and AG authorial voice are conflated in the constitution of friendly and engaging articulation of medical authority, Western medicine's jurisdiction over self-care and appearance is masked as the authors vanish into this broader constitution of medical authority always already linked with the AG brand. Although *The Care & Keeping of You* may be the most static health discourse in this dissertation, even here we can see the relationship between health subject and medical authority take shape as it is constituted through interaction.

Turning from children's health books to daytime television talk shows, we see how the relationship between health subjects and medical authority is modified and constituted over time on *The Dr. Oz Show*. Rather than situate medical authority in some static or preexisting source, in this case study medical authority emerges segment by segment and episode by episode as Dr. Oz navigates his many ongoing interactions with

the various participants that appear on the program. Although Dr. Oz's institutional affiliations and professional background participate in this discourse, his position as a medical authority figure is not limited to his role as a physician. Indeed, Dr. Oz's position as a medical authority figure is characterized by flexibility as he continually shifts his role from educator, to entertainer, to knowledge seeking health subject, and back again. In this process, we can see health subjects and other health experts directly participate in the constitution of Dr. Oz's position as a medical authority figure and the show's medical authority more broadly as participants shift and orient themselves toward both Dr. Oz and the various health knowledges and practices that accompany these interactions. As Dr. Oz participates in constituting the health subjectivity of his audience by exploring and validating diverse health knowledges and practices, interactions with the audience also participate in constituting medical authority. Dr. Oz may discipline health subjects by directing the audience toward particular health informations, yet health subjects are also empowered in these interactions as they flexibly position themselves in relationship to Dr. Oz. In expanding their forms of participation in this relationship, health subjects are not only recipients of expert health information, but also sources of credible health information, as they contribute content to the show. Here, medical authority is not grounded in medicine, but in the ongoing and shifting interactions in which this authority emerges and takes shape.

Approaching user engagement with Fitbit as a health discourse allows us to expand our understanding of neoliberal health discourses by considering how the relationship between health subjects and medical authority is constituted through the

diverse network of interactions that make up this fragmented text. Rather than looking for medical authority in a singular authorial voice or embodied celebrity health expert, Fitbit's medical authority emerges as individual users directly interact with this health discourse in a variety of ways. Although Fitbit's underlying medical authority, grounded in the institutions and individuals that work behind the scenes interpreting and visualizing user date, appears in many forms of interaction, the diverse constellation of ways users engage Fitbit expands the health subject's relationship with medical authority beyond issues of data analysis. Here, health subjects and medical authority continually constitute each other as varied user performances prompt intervening responses from Fitbit that direct the user toward particular performances of health. This constellation of interactions not only constitutes a relationship in which Fitbit encourages users to generate data, but also normalizes particular modes of wearing a relationship with medical authority that extends into all areas of the user's life. In a user's relationship with Fitbit, medical authority requires sustained individualized interaction with the empowered health subject who chooses to engage in as well as be influenced and disciplined through this relationship. Indeed, examining the diverse constellation of interactions between users and Fitbit is fundamental to understanding how health subjectivity and medical authority emerge and engage each other in this health discourse.

These case studies highlight a broad range of interactions that participate in constituting the relationship between health subjects and medical authority in contemporary neoliberal health discourses. I do not suggest that the forms of interaction examined here are representative of all of the ways this relationship is constituted.

Instead, these case studies illustrate the value in interrogating the various ways medical authority and health subjectivity emerge as they interact through diverse sites of engagement. By approaching health discourses as ongoing constitutive relationships, rather than as asymmetrical and authoritative texts, we see a more complex understanding of health subjectivity and medical authority take shape. A relational approach allows us to move beyond analyzing how health subjects are constituted as they align themselves with health discourses, to examine how health subjects also participate in constituting medical authority as they engage in various forms of interaction. Indeed, reconceptualizing how medical authority emerges from and participates in various interactions with health subjects both expands our understanding of neoliberal health discourses as well as develops a more nuanced approach to critiquing health subject's sustained engagement with these increasingly ubiquitous texts.

The Implications of Critiquing Constitutive Relationships

I want to address three implications that surface as we consider the relationships between health subjects and medical authority that are constituted in neoliberal health discourses. First, throughout these case studies we see that medical authority is no longer exclusively tied to medicine. Although medical institutions and various representatives of these institutions may continue to appear and participate in health discourses, my analyses indicate that medical authority is grounded less in traditional institutional sites of authority than in the interactions in which medical authority emerges. For example, in *The Care & Keeping of You*, rather than locate medical authority exclusively in the

professional background of the authors, an examination of the relationship between AG and the American girl suggests that medical authority is also found in the AG brand that participates in normalizing particular consumeristic and appearance-based understandings of self-care. Similarly, on *The Dr. Oz Show*, while Dr. Oz's background as a physician lends credibility to some of the information he presents to the audience, the diverse forms of interaction between Dr. Oz and the various participants that appear on the show reveal that medical authority more accurately emerges through interaction as various health knowledges and practices are explored and validated expanding medical authority beyond any particular institutional affiliation. Together, these cases studies demonstrate that medicine is just one of many sources from which medical authority emerges as health subjects engage health discourses. Indeed, medical authority can seemingly arise from anywhere and everywhere, including doll companies and fashion designers, as health subjects actively participate in and contribute to their relationship with medical authority. Recognizing that medical authority can emerge from such a broad range of sources and locations through varied interactions is significant to our understanding of health subject's engagement with neoliberal health discourses. As health subjects venture outside the boundaries of clinical and institutionalized medicine and turn to a vast array of health experts and discourses in their quest to monitor and manage their health, my analyses indicate that entrepreneurial consumers must not only be aware of various health informations and practices, but also how their own forms of interaction contribute to the constitution of the medical authority that they engage in this marketplace of health discourses.

Second, approaching health discourses as constitutive relationships signals expanded opportunities for health subject participation and empowerment in their interactions with medical authority. Scholars note the negotiation of health subject empowerment and discipline is common in neoliberal texts in which discourses of freedom and choice regularly intersect with discourses that simultaneously constrain this freedom. As mentioned in the introduction, this body of research typically situates discourses of empowerment and discipline in terms of the authoritative texts that health subjects engage in their ongoing quest for health. As a result, health subject empowerment is often limited to consumerism as health subjects choose among various health knowledges and practices in the marketplace. However, in these case studies, rather than limit our understanding of empowerment to choosing between various health options, approaching texts as constitutive relationships allows us to also locate empowerment in the health subject's active participation in constituting medical authority. While various forms of paternal discipline continue to intervene into and direct the lives of health subjects, there is also room to consider how these interactions facilitate more empowered and direct engagement with medical authority. For example, on *The Dr. Oz Show*, although there are some interactions in which health subjects are paternally disciplined as Dr. Oz educates the audience and validates particular health options, in this relationship there are also opportunities in which health subject empowerment is expanded as audience members not only contribute their own health content to the television program, but also participate in constituting the expansive medical authority that emerges through these interactions. From a different perspective,

although user engagement with Fitbit is highly disciplinary as medical authority directs users toward particular performances of health, in this health discourse medical authority requires sustained interaction with the individual health subject. Health subjects are empowered as they actively choose to constitute medical authority based on their selective participation in the constellation of interactions available to them in their relationship with Fitbit. As health discourses change forms, health subjects become more flexible and complex as they adapt to variations in their relationship with medical authority. In this process, rather than adapting to a fixed text, these interactions facilitate opportunities for continued engagement allowing the relationship between health subjects and medical authority to change over time. Empowerment in this sense is less about the freedom to choose between different health knowledges and practices than about the opportunities for change and modification in power relations that emerge through an awareness that health subjects are able to actively participate in constituting their relationship with medical authority.[251]

Finally, conceptualizing health discourses as constitutive relationships expands our understanding of constitutive rhetoric. Interrogating texts as constitutive relationships rather than as asymmetrical forms of constitutive discourse points to limitation imposed by scholarship that draws overly deterministic conclusions based on texts characterized as static and fixed. While my analyses in this dissertation make use of traditional forms of textual analysis as I examine various features of these discourses, at the same time, I also expand how we approach and read texts by emphasizing the shifting and varied interactions that influence and shape these discourses. I demonstrate

that paying greater attention to the participation of health subjects in the constitution of theses texts allows us to sustain a more fluid understanding of how health discourses are constituted over time based on ongoing interactive relationships between health subjects and medical authority. For example, on *The Dr. Oz Show*, simply reading this television program as a fixed and discrete text that constitutes viewers misses the opportunity to examine how various interactions participate in constituting the relationship between health subjects and medical authority over time. By interrogating the interactions between Dr. Oz and the many participants that appear on this show we see that medical authority and the text itself is continually modified and shaped through these relationships. Further, Dr. Oz regularly blurs the line between exterior interaction with the show and internal interaction with him as a medical authority figure as both at-home viewers and studio audience members are positioned as active participants. In this health discourse, at-home viewers have the ability to not only interact with Dr. Oz through mediated forms of engagement like segments that feature face-to-face video calling, but also through the available option to travel to New York and physically appear in the studio audience. The line between constitutive interiors and exteriors is blurred as health subject interactions with Dr. Oz facilitate the articulation of actual exterior responses as part of the interiority of the show. User engagement with Fitbit similarly expands our understanding of constitutive rhetoric as this health discourse depends on user interactions that continually participate in constituting medical authority and the text itself. If constitutive rhetoric converts and positions subject's towards action in the material world, recognizing the interactive nature of neoliberal health discourses not

only encourages rhetorical critics to examine how health subjects are empowered and disciplined by these texts, but also how the health subject's empowered and disciplined actions participate in constituting ongoing relationships with medical authority both within and outside of health discourses.

Directions for Future Research

Neoliberal health discourses are likely to remain a significant area for future research and investigation by rhetorical scholars as health subjects continue to seek out an ever expanding and changing marketplace of texts for the latest and greatest health informations and practices in their ongoing quest to surveil and manage their health. As mentioned in the introduction, a growing body of academic research has valuably contributed to our critical understanding of the ways health discourses influence neoliberal health subjects. However, this dissertation suggests that this scholarship's limited conceptualization of and approach to analyzing health discourses has constrained both the conclusions that can be drawn, as well as the way medical authority and health subjectivity are situated in these discourses. If communication scholars interested in the rhetoric of health and medicine situate their usefulness in questioning and interrogating discourse as a means of understanding how texts engage and persuade audiences, then critics would be well served to expand their understanding of health discourses in order to take into account the diverse ways health subjects engage and are engaged by these texts in the future.

Rather than simply identify means by which health subjects and paternalistically disciplined or consumeristically empowered, future research should more carefully

examine the ongoing and shifting forms of interaction between health subjects and medical authority that emerge in neoliberal health discourses in order to identify ways in which participants are actively involved in the formation of texts and signal potential ways that health subjects might expand and improve their position in relationships with medical authority. Barbara Biesecker argues that rhetorical critics "operate out of the firm conviction that things can change, be otherwise, different – in fact better."[252] From this perspective, I suggest that interrogating health discourses as constitutive relationships serves as a productive means of not only uncovering how audiences are empowered and disciplined through their engagement with the medical authority that emerges in neoliberal health discourses, but also identifying opportunities in which health subjects can improve and expand their participation in these relationships with medical authority. While my approach may not be the only means of expanding our understanding of health subject textual engagement, future research highlighting the interaction between health subjects and medical authority involved in these health discourses points to relational dynamics in which health subjects can potentially question or challenge the paternal control of medical authority. Here, scholars who examine constitutive relationships should not only use this approach to provoke more complex readings of texts, but also practically signal openings for expanded health subject empowerment in their relationship with medical authority. In a neoliberal context in which health subjects are actively engaged in managing their health, it would be a mistake to underestimate or dismiss the ways that individuals can participate in and contribute to health discourses.

NOTES

[1] Far from alone, in response to rising obesity levels in the United States (The President's Council on Fitness, Sports, and Nutrition emphasizes that over 78 million Americans are obese and roughly 28% are physically inactive), millions of Americans have turned to fitness and diet-related self-help resources. "Facts & Statistics," *President's Council on Fitness, Sports & Nutrition*, accessed May 3, 2016, http://www.fitness.gov/resource-center/facts-and-statistics/. Data gathered by the Physical Activity Council indicates that 212.6 million Americans share an interest in maintaining more active lifestyles. "2016 Participation Report: The Physical Activity Council's Annual Study Tracking Sports, Fitness, and Recreation Participation in the Us," *Physical Activity Council*, accessed May 3, 2016, www.physicalactivitycouncil.com/pdfs/current.pdf. Recent reports also highlight that 77% of people in the United States are actively trying to eat healthier (this includes the 50% of the population, mostly women, that are dieting at any given time), fueling a $64 billion dollar weight-loss industry. Tammy Dray, "Facts & Statistics About Dieting," *Livestrong*, July 1, 2015, www.livestrong.com/article/308667-percentage-of-americans-who-diet-every-year/; John Kell, "Lean Times for the Diet Industry," *Fortune*, May 22, 2015, fortune.com/2015/05/22/lean-times-for-the-diet-industry/. The vast number of Americans participating in these various forms of health maintenance signals the importance of critically evaluating how individuals engage health discourses and practices.

[2] "Ambulatory Care Use and Physician Office Visits," *Centers for Disease Control and Prevention*, accessed May 4, 2016, www.cdc.gov/nchs/fastats/physician-visits.htm.

[3] Leo G. Reeder, "The Patient-Client as a Consumer: Some Observations on the Changing Professional-Client Relationship," *Journal of Health and Social Behavior* 13, no. 4 (1972): 407.

[4] John A. Astin, "Why Patients Use Alternative Medicine," *Journal of the American Medical Association* 279, no. 19 (1998): 1548.

[5] The Harvard School of Public Health suggests that health is focused on disease prevention and health promotion in populations, while medicine emphasizes disease diagnosis and treatment of individuals. "Public Health and Medicine," *Harvard School of Public Health*, accessed May 4, 2016, www.hsph.harvard.edu/about/public-health-medicine/.

[6] One of the challenges in discussing this relationship involves accounting for the various ways these individuals and groups are discussed in academic scholarship. While I am not interested in imprecisely and inaccurately conflating the denotative and connotative differences between various terminological choices referring to medical authority figures (e.g., doctor, physician, clinician, practitioner, provider, expert, caregiver, etc.) or those engaged with these authorities (e.g., health citizen, patient, consumer, client, subject, etc.), unfortunately there is often slippage in how these terms are applied both historically and practically. In this context, although the doctor-patient relationship is perhaps a more common reference in some literatures, I find that this relationship is often rooted in specific embodied forms of institutionalized medical practice that constrain how we might approach this form of engagement in nontraditional discursive forms. Geist-Martin, Ray, and Sharf indicate that the way we refer to health communicators are often "rooted in the world of medicine and do not speak to the broader contexts of health communication." Patricia Geist-Martin, Eileen Berlin Ray, and Barbara F. Sharf, *Communicating Health: Personal, Cultural, and Political Complexities* (Belmont: Wadsworth, 2003), 7-8. Consequently, in this project I will refer to this interaction as a medical authority figure-health subject relationship as a means of maintaining consistency and enabling a broad conceptualization of how this relationship might manifest itself through various health discourses.

[7] Analee E. Beisecker and Thomas D. Beisecker, "Using Metaphors to Characterize Doctor-Patient Relationships: Paternalism Versus Consumerism," *Health Communication* 5, no. 1 (1993).

[8] Adele E. Clarke et al., "Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine," *American Sociological Review* 68 (2003).

[9] John C. Moscop, "The Nature and Limits of the Physician's Authority," in *Doctors, Patients, and Society: Power and Authority in Medical Care*, ed. Martin S. Staum and Donald E. Larson (Ontario: Wilfrid Laurier University Press, 1981), 30.

[10] Joseph Turow, *Playing Doctor: Television, Storytelling, and Medical Power* (Ann Arbor: The University of Michigan Press, 2010), 19.

[11] Toby Gelfand, "The Decline of the Ordinary Practitioner and the Rise of a Modern Medical Profession," in *Doctors, Patients, and Society: Power and Authority in Medical Care*, ed. Martin S. Staum and Donald E. Larson (Ontario: Wilfrid Laurier University Press, 1981), 121.

[12] Clarke et al., 163.

[13] Alan Peterson and Deborah Lupton, *The New Public Health: Health and Self in the Age of Risk* (London: Sage, 1996), 6.

[14] Ibid., 8.

[15] Simon Daniel Whybrew, ""The Ultimate Woman Is a Man": An Analysis of Medical Authority and the (in)Visibility of Intersexuality in House, M.D.," *Aspeers* 8 (2015): 99.

[16] Gelfand, 107.

[17] Turow, 22.

[18] John C. Burnham, "American Medicine's Golden Age: What Happened to It?," *Science* 215 (1982): 1474.

[19] Ibid.

[20] Leigh E. Rich et al., "The Afterbirth of the Clinic: A Foucauldian Perspective on 'House M.D.' And American Medicine in the 21st Century," *Perspectives in Biology and Medicine* 51, no. 2 (2008): 221.

[21] Burnham, 1474.

[22] Turow, 29.

[23] Vikki Entwistle and Trevor Sheldon, "The Picture of Health?: Media Coverage of the Health Service," in *Social Policy, the Media and Misrepresentation*, ed. Bob Franklin (New York: Routledge, 1999), 120.

[24] Whybrew, 98. While on the surface Whybrew's comment describes the authority involved in institutionalized medicine more broadly, it is important to note that the authority being articulated here is not necessarily isolated in practitioners of medicine, but in hospitals and other locations in which this authority is deployed. This characterization of authority is useful in pointing to the ability for medical authority to be grounded in locations that transcend physicians and medical practitioners.

[25] Analee E. Beisecker, "Patient Power in Doctor-Patient Communication: What Do We Know?," *Health Communication* 2, no. 2 (1990): 106.

[26] Analee E. Beisecker and Thomas D. Beisecker, "Using Metaphors to Characterize Doctor-Patient Relationships: Paternalism Versus Consumerism," ibid.5, no. 1 (1993): 42.

[27] Ibid., 46; Gelfand, 122; Sydney A. Halpern, "Medical Authority and the Culture of Rights," *Journal of Health Politics, Policy and Law* 29, no. 4-5 (2004): 841; Moscop, 39.

[28] Elizabeth Fee, *Women and Health: The Politics of Sex in Medicine* (New York: Baywood Publishing Company, 1982), 20.

[29] Frank Auton, "The Advertising of Pharmaceuticals Direct to Consumers: A Critical Review of the Literature and Debate," *International Journal of Advertising* 23 (2004): 31.

[30] Clarke et al., 163.

[31] Ibid., 161.

[32] Peter Conrad, "The Shifting Engines of Medicalization," *Journal of Health and Social Behavior* 46 (2005): 3.

[33] Peterson and Lupton, 2.

[34] Nikolas Rose, "Beyond Medicalisation," *The Lancet* 24 (2007): 701.

[35] Beisecker, 105.

[36] These changes mark what Clarke and colleagues characterize as the shift in Western medicine from medicalization to an era of "biomedicalization." They explain that "[b]iomedicalization is our term for the increasingly complex, multisited, multidirectional processes of medicalization that today are being both extended and reconstituted through the emergent social forms and practices of a highly and increasingly technoscientific biomedicine." Clarke et al., 162. From this perspective, this shift does not mean that the increased medicalization of everyday life has been reduced (in many ways this process has intensified and medical jurisdiction has become even broader). Instead, new social formations and technological advances have led to technoscientific innovations and interventions that have reconstituted how society engages with medicine in new and more complex ways.

[37] Nikolas Rose, *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century* (Princeton: Princeton University Press, 2007), 10. Halpern similarly contends that "physicians have been losing both their monopoly over medical knowledge and their authority with clients" largely due to "organized patient movements, increased skepticism about doctors' commitment to serving client interests, demands for provider accountability, improved lay access to medical information, and a narrowing of the knowledge gap between doctors and patients." Halpern, 843.

[38] Turow, 168.

[39] Halpern suggests that "[h]ealth activism has often coalesced around stigmatized social identities…or has arisen from within already organized constituencies," including feminists, black feminists, disabled persons, AIDS activists, and a variety of other constituencies. Halpern, 837.

[40] Tasha N. Dubriwny, *The Vulnerable Empowered Woman: Feminism, Postfeminism, and Women's Health* (New Brunswick: Rutgers University Press, 2013), 15.

[41] Barbara Barnett, "More Contradictions: A Framing Analysis of Health Agency and Femininity in a Magazine for Women over Forty," in *Women, Wellness, and the Media*, ed. Margaret C. Wiley (Newcastle: Cambridge Scholars Publishing, 2008), 13-14.

[42] While feminist activism during this period took a variety of forms (e.g., radical feminism and liberal feminism), in the context of this project I use Dubriwny's interpretation of a more open-ended approach to feminism that allows for a more general discussion of how this activism influenced engagement with medical authority. Dubriwny, 15.

[43] Andrew Barry, Thomas Osborne, and Nikolas Rose, *Foucault and Political Reason: Liberalism, Neo-Liberalism and Rationalities of Government* (Chicago: University of Chicago Press, 1996), 14.

[44] Peterson and Lupton, 61.

[45] Laurie Ouellette and James Hay, "Makeover Television, Governmentality and the Good Citizen," *Continuum: Journal of Media & Cultural Studies* 22, no. 4 (2008): 472.

[46] Wendy Brown, "Neo-Liberalism and the End of Liberal Democracy," *Theory & Event* 7, no. 1 (2003): 2.

[47] Courtney W. Bailey, "Coming out as Homophobic: Isaiah Washington and the Grey's Anatomy Scandal," *Communication and Critical/Cultural Studies* 8, no. 1 (2011): 3.

[48] For examples of research addressing varying forms of neoliberal governance, see Mark Andrejevic, "The Discipline of Watching: Detection, Risk, and Lateral Surveillance," *Critical Studies in Media Communication* 23, no. 5 (2006); Graham Burchell, "Liberal Government and Techniques of the Self," *Economy and Society* 22, no. 3 (1993); Barbara Cruikshank, "Revolutions Within: Self-Government and Self-Esteem," ibid.; Mitchell Dean, *Governmentality: Power and Rule in Modern Society* (London: Sage, 1999); Micki McGee, *Self-Help, Inc.: Makeover Culture in American Life* (New York: Oxford University Press, 2005); Toby Miller, *The Well-Tempered Self: Citizenship, Culture, and the Postmodern Subject* (Baltimore: John Hopkins University Press, 1993); Ouellette and Hay; Nikolas Rose, "Governing 'Advanced' Liberal Democracies," in *Foucault and Political Reason: Liberalism, Neo-Liberalism and Rationalities of Government*, ed. Andrew Barry, Thomas Osborne, and Nikolas Rose (Chicago: University of Chicago Press, 1996); Katherine Sender, "Queens for a Day: Queer Eye for the Straight Guy and the Neoliberal Project," *Critical Studies in Media Communication* 23, no. 2 (2006); Bradford Vivian, "Neoliberal Epideictic: Rhetorical Form and Commemorative Politics on September 11, 2002," *Quarterly Journal of Speech* 92, no. 1 (2006).

[49] Rebecca de Souza, "Local Perspectives on Empowerment and Responsibility in the New Public Health," *Health Communication* 26 (2011): 26.

[50] Alan Peterson et al., "Healthy Living and Citizenship: An Overview," *Critical Public Health* 20, no. 4 (2010): 391.

[51] Peterson and Lupton, xiv.

[52] For examples of research exploring the relationship between health citizenship and neoliberalism, see de Souza; Carol-Ann Farkas, "Well of Weak?: The Construction of Knowledge, Agency, and Competence in Women's Wellness Magazines," in *Women, Wellness, and the Media*, ed. Margaret C. Wiley (Newcastle: Cambridge Scholars Publishing, 2008); Joelle Kivits, "Researching the 'Informed Patient': The Case of Online Health Information," *Information, Communication & Society* 7, no. 4 (2004); Glenn Laverack, *Health Promotion Practice: Power and Empowerment* (Thousand Oaks: Sage, 2004); Jo Lindsay, "Healthy Living Guidelines and the Disconnect with Everyday Life," *Critical Public Health* 20, no. 4

(2010); Deborah Lupton, "Discourse Analysis: A New Methodology for Understanding the Ideologies of Health and Illness," *Australian Journal of Public Health* 16, no. 2 (1992); Ouellette and Hay; Peterson et al; Peterson and Lupton; Christine M. Quail, Kathalene A. Razzano, and Loubna H. Skalli, *Vulture Culture: The Politics and Pedagogy of Daytime Television Talk Shows*, vol. 152 (New York: Peter Lang, 2005); Michael L. Silk, Jessica Francombe, and Faye Bachelor, "The Biggest Loser: The Discursive Constitution of Fatness," *Interactions: Studies in Communication and Culture* 1, no. 3 (2009); Heather M. Zoller and Tracy Worrell, "Television Illness Depictions, Identity, and Social Experience: Responses to Multiple Sclerosis on the West Wing among People with Ms," *Health Communication* 20, no. 1 (2006).

[53] Analee E. Beisecker and Thomas D. Beisecker, "Using Metaphors to Characterize Doctor-Patient Relationships: Paternalism Versus Consumerism," ibid.5 (1993).

[54] See Tae Hyun Baek and Hyunjae Yu, "Online Health Promotion Strategies and Appeals in the USA and South Korea: A Content Analysis of Weight-Loss Websites," *Asian Journal of Communication* 19, no. 1 (2009); Carma L. Bylund et al., "Exploration of the Construct of Reliance among Patients Who Talk with Their Providers About Internet Information," *Journal of Health Communication* 12 (2007); de Souza; Kivits; Xiaoli Nan, Xiaoquan Zhao, and Rowena Briones, "Parental Cancer Beliefs and Trust in Health Information from Medical Authorities as Predictors of Hpv Vaccine Acceptability," *Journal of Health Communication* 19 (2014); Hedy S. Wald, Catherine E. Dube, and David C. Anthony, "Untangling the Web - the Impact of Internet Use on Health Care and the Physician-Patient Relationship," *Patient Education and Counseling* 68 (2007).

[55] Entwistle and Sheldon, 120.

[56] Beisecker and Beisecker, 49.

[57] Ibid., 50.

[58] While traditional Western medical authorities are often included in this group, expertise in this case is broadened to include a wider range of competing perspectives facilitated by the free market. The self-help consumer market has extended this conceptualization of expertise as fitness, wellness, and other approaches to preventative health intermingle with traditional sources of health information.

[59] Peterson and Lupton, xiii.

[60] Sender, 137.

[61] Carolina Fernandez Branson, "The Discursive Construction of Complementary and Alternative Medicine (Cam) in Women's Popular Health Media and Medical Journals" (Dissertation, University of Minnesota, 2014), 19.

[62] Peterson and Lupton, xiv.

[63] Peterson and Lupton stress that despite perceptions of freedom and choice, individuals often unquestioningly rely on traditional institutionalized knowledges and practices due to widespread normalization of their discourses of risk. Ibid., 12.

[64] Branson, 9.

[65] Ibid. Dubriwny further clarifies that "[t]he identification of risk comes with certain expectations about risk-avoiding behavior" Dubriwny, 28.

[66] Annandale's explains that in a neoliberal society, "[i]ndividualism becomes a fate, rather than a choice freely entered into." Ellen Annandale, *Women's Health and Social Change* (New York: Routledge, 2009), 103.

[67] Peterson and Lupton, 71.

[68] Geist-Martin, Ray, and Sharf emphasize that in contemporary society, as health communication increasingly varies in form, there is value in "considering health in other sites and relationship beyond the medical milieu." Geist-Martin, Ray, and Sharf, 9.

[69] Barbara Heifferon and Stuart C. Brown, *Rhetoric of Healthcare: Essays toward a New Disciplinary Inquiry* (Cresskill: Hampton Press, 2008), 3; Judy Segal, *Health and the Rhetoric of Medicine* (Carbondale: Southern Illinois University Press, 2005), 10.

[70] Robin E. Jensen, "An Ecological Turn in Rhetoric of Health Scholarship: Attending to the Historical Flow and Percolation of Ideas, Assumption, and Arguments," *Communication Quarterly* 63, no. 5 (2015): 534.

[71] John A. Lynch and Heather Zoller, "Recognizing Differences and Commonalities: The Rhetoric of Health and Medicine and Critical-Interpretive Health Communication," ibid.: 500.

[72] Judy Segal, "Rhetoric of Health and Medicine," in *The Sage Handbook of Rhetorical Studies*, ed. Andrea A. Lunsford, Kirt H. Wilson, and Rosa A. Eberly (Thousand Oaks: Sage, 2009), 228. Segal argues that "[h]ealth communication is a field that share interests with, but is separate from, rhetoric of health and medicine. Research in health communication is typically more applied and more empirical than most rhetorical research, and it is performed by, for examples, experts in professional communication, as well as nurses and other health professionals." Ibid., 237.

[73] Ibid., 228.

[74] Blake Scott, Judy Segal, and Lisa Keranen, "The Rhetorics of Health and Medicine: Inventional Possibilities for Scholarship and Engaged Practice," *Poroi* 9, no. 1 (2013): 2.

[75] Judy Segal, "Internet Health and the 21st-Century Patient: A Rhetorical View," *Written Communication* 26, no. 4 (2009): 357. See Dubriwny; Kivits; Laverack; Lindsay; Lupton; Ouellette and Hay; Peterson and Lupton; Peterson et al; Quail, Razzano, and Skalli, 152; Sender; Helene A. Shugart, "Shifting the Balance: The Contemporary Narrative of Obesity," *Health Communication* 26, no. 1 (2011); Silk, Francombe, and Bachelor; Zoller and Worrell.

[76] Segal, "Internet Health and the 21st-Century Patient: A Rhetorical View."

[77] Ibid., 355.

[78] *Health and the Rhetoric of Medicine*, 37.

[79] de Souza, 25.

[80] Jeffery Nealon and Susan Searls Giroux, *The Theory Toolbox: Critical Concepts for the Humanities, Arts, and Social Sciences*, 2 ed. (Lanham: Rowman & Littlefield Publishing, 2012), 48.

[81] Louis Althusser, *Lenin and Philosophy and Other Essays*, trans. Ben Brewster (London: Monthly Review Press, 1971), 174.

[82] Nealon and Giroux, 44.

[83] Ibid., 46.

[84] Maurice Charland, "Constitutive Rhetoric: The Case of the Peuple Quebecois," *Quarterly Journal of Speech* 73, no. 2 (1987).

[85] Ibid., 138.

[86] Ibid., 142.

[87] Ibid., 141.

[88] For examples of constitutive rhetorical scholarship, see Vanessa B. Beasley, *You, the People: American National Identity in Presidential Rhetoric* (College Station: Texas A&M University Press, 2004); Peter Cramer, "Sick Stuff: A Case Study of Controversy in a Constitutive Attitude," *Rhetoric Society Quarterly* 43, no. 2 (2013); Nathaniel I. Cordova, "The Constitutive Force of the Catecismo Del Pueblo in Puerto Rico's Popular Democratic Party Campaign," *Quarterly Journal of Speech* 90 (2004); Timothy D. Dougherty, "Lost in Transnation: The Limits to Constitutive Nationalism in the Fenian Movement," *Rhetoric Society Quarterly* 45, no. 4 (2015); Bonnie J. Dow, "Aids, Perspective by Incongruity, and Gay Identity in Larry Kramer's '1,112 and Counting'," *Communication Studies* 45, no. 3-4 (1994); Dexter B. Gordon, *Black Identity: Rhetoric, Ideology, and Nineteenth-Century Black Nationalism* (Carbondale: Southern Illinois University Press, 2003); Ronald Walter Greene, "Social Argumentation and the Aporias of State Formation: The Palestinian Declaration of Independence," *Argumentation and Advocacy* 29 (1993); Michael C. Leff and Ebony A. Utley, "Instrumentalism and Constitutive Rhetoric in Martin Luther King Jr.'s 'Letter from Birmingham Jail'," *Rhetoric & Public Affairs* 7, no. 1 (2004); Kristy Maddux, "Playing the Victim: Violence, Suffering, and Feminine Submission in the Passion of the Christ," *Journal of Media and Religion* 7, no. 3 (2008); Helen Tate, "The Ideological Effects of a Failed Constitutive Rhetoric: The Co-Option of the Rhetoric of White Lesbian Feminism," *Women's Studies in Communication* 28, no. 1 (2005); Robert E. Terrill, "Colonizing the Borderlands: Shifting Circumference in the Rhetoric of Malcolm X," *Quarterly Journal of Speech* 86, no. 1 (2000); Kenneth S. Zagacki, "Constitutive Rhetoric Reconsidered: Constitutive Paradoxes in G.W. Bush's Iraq War Speeches," *Western Journal of Communication* 71, no. 4 (2007).

[89] Jasinski and Mercieca assert that "[d]espite claims to the contrary, Charland's analysis concentrates on narrative form, making no effort to trace the White Paper's circulation or to disclose the way Quebec citizens used it to shape their 'practices' of their understanding of social reality." James Jasinski and Jennifer R. Mercieca, "Analyzing Constitutive Rhetorics," in *The Handbook of Rhetoric and Public Address*, ed. Shawn J. Parry-Giles and J. Michael Hogan (Malden: Wiley-Blackwell, 2010), 316.

[90] Ibid., 317.

[91] Ibid., 318.

[92] In their analysis of Martin Luther King, Jr.'s rhetoric, Leff and Utley productively stress the importance of constitutive rhetoric's role in shaping the relationship developed between the rhetor and the audience. They argue that "the agency of the rhetor refers not just to the use of character appeals but also to the way that rhetors place themselves within a network of communicative relationships." Leff and Utley, 40. They argue that this relationship is established through the rhetors' construction of both themselves and the intended audience which consequently facilitates both identification and persuasion. However, while this analysis emphasizes relational qualities that emerge in constitutive rhetoric, Leff and Utley's approach remains tied to the interiors of King's text as a means of defining the relationship. While I appreciate the authors' concern with these relational elements, I suggest that constitutive relationships are not exclusively

tied to or defined by the authoritative rhetor, but are shaped through an ongoing exchange as textual authorities interpellate subjects that respond in turn as members of the community encouraging sustained rhetorical engagement.

[93] While Jasinski and Mercieca's suggestion that constitutive rhetorical criticism should pay more attention to audience responses and subsequent articulation of these texts is useful when rhetors are clearly defined, in these case studies the interaction that takes place between medical authority and health subjects within the text, as well as between the text and broader audiences makes this type of distinction difficult to identify and sustain. The various ways empowerment and discipline emerge through the relationships articulated in through these discourses blurs the boundaries of subjectivity and authority.

[94] Although I recognize that visualized representations of health subjects unavoidably participate in shaping the broader texts being critiqued in these case studies, it is valuable to critically engage the empowerment that these health subjects embody both as a means of reinforcing institutional authority as well as demonstrating their autonomy in a neoliberal landscape. Evaluating these performances is useful in unpacking how health subjects participate in constituting themselves through interactions with authority in these texts, in addition to constituting those engaging this texts as a cohesive authoritative text.

[95] Rosalind Gill and Christina Scharff, *New Femininities: Postfeminism, Neoliberalism and Subjectivity* (London: Palgrave Macmillan, 2013), 7.

[96] See Jennifer Stevens Aubrey, Elizabeth Behm-Morawitz, and Kyungbo Kim, "Understanding the Effects of MTV's 16 and Pregnant on Adolescent Girls' Beliefs, Attitudes, and Behavioral Intentions toward Teen Pregnancy," *Journal of Health Communication* 19 (2014); Sarah Baker, "Rock on, Baby!: Pre-Teen Girls and Popular Music," *Continuum: Journal of Media & Cultural Studies* 15, no. 3 (2001); Renee A. Botta, "Television Images and Adolescent Girls' Body Image Disturbance," *Journal of Communication* 49, no. 2 (1999); Laura M. Carpenter, "From Girls into Women: Scripts for Sexuality and Romance in Seventeen Magazine, 1974-1994," *Journal of Sex Research* 35, no. 2 (1998); Kara Chan, Yu Leung Ng, and Russell B. Williams, "Adolescent Girls' Interpretation of Sexuality Found in Media Images," *Intercultural Communication Studies* 221, no. 3 (2012); Levina Clark and Marika Tiggemann, "Appearance Culture in Nine- to 12-Year-Old Girls: Media and Peer Influences on Body Dissatisfaction," *Social Development* 15, no. 4 (2006); Dawn Currie, *Girl Talk: Adolescent Magazines and Their Readers* (Toronto: University of Toronto Press, 1999); Dubriwny; Lisa Duke, "Get Real!: Cultural Relevance and Resistance to the Mediated Feminine Ideal," *Psychology & Marketing* 19, no. 2 (2002); Lisa Duke and Peggy J. Kreshel, "Negotiating Femininity: Girls in Early Adolescence Read Teen Magazines," *Journal of Communication Inquiry* 22, no. 1 (1998); Rita J. Freedman, "Reflections on Beauty as It Relates to Health in Adolescent Females," *Women & Health* 9, no. 2/3 (1984); Kamille A. Gentles and Kristen Harrison, "Television and Perceived Peer Expectations of Body Size among African American Adolescent Girls," *The Howard Journal of Communications* 17 (2006); Esther Blank Greif and Kathleen J. Ulman, "The Psychological Impact of Menarche on Early Adolescent Females: A Review of the Literature," *Child Development* 53 (1982); Stacey J. T. Hust, Jane D. Brown, and Kelly Ladin L'Engle, "Boys Will Be Boys and Girls Better Be Prepared: An Analysis of the Rare Sexual Health Messages in Young Adolescents' Media," *Mass Communication & Society* 11 (2008); Sue Jackson, "Dear Girlfriend...: Constructions of Sexual Health Problems and Sexual Identities in Letters to a Teenage Magazine," *Sexualities* 8, no. 3 (2005); Catherine Lumby, "Watching Them Watching Us: The Trouble with Teenage Girls," *Journal of Media & Cultural Studies* 15, no. 1 (2001); Marie-Louise Mares and Maichael T. Braun, "Effects of Conflict in Tween Sitcoms on Us Students' Moral Reasoning About Social Exclusion," *Journal of Children and Media* 7, no. 4 (2013); Maghboeba Mosavel and Nadia El-Shaarawi, "I Have Never Heard That One: Young Girls' Knowledge and Perception of Cervical Cancer," *Journal of Health Communication* 12 (2007); Phillip N. Myers and Frank A. Biocca, "The Elastic Body Image: The Effects of Television Advertising and Programming on Body Image Distortions in Young Women," *Journal of Communication* 42, no. 3 (1992); Elina Oinas, "Medicalization by Whom? Accounts of Menstruation Conveyed by Young Women and Medical Experts in Medical Advisory Columns," *Sociology of Health &*

Illness 20, no. 1 (1998); Ana Cristina Ostermann and Deborah Keller-Cohen, "Good Girls Go to Heaven; Bad Girls...Learn to Be Good: Quizzes in American and Brazilian Teenage Girls' Magazines," *Discourse & Society* 9, no. 4 (1998); Bruce E. Pinkleton et al., "The Role of Media Literacy in Shaping Adolescents' Understanding of and Responses to Sexual Portrayals in Mass Media," *Journal of Health Communication* 17 (2012); Deborah L. Tolman, "Doing Desire: Adolescent Girls' Struggles for/with Sexuality," *Gender & Society* 8 (1994); Jennifer Vardeman-Winter, "Medicalization and Teen Girls' Bodies in the Gardasil Cervical Cancer Vaccine Campaign," *Feminist Media Studies* 12, no. 2 (2012); Tiina Vares, Sue Jackson, and Rosalind Gill, "Preteen Girls Read 'Tween' Popular Culture: Diversity, Complexity and Contradiction," *International Journal of Media and Cultural Politics* 7, no. 2 (2011).

[97] See Charles Ashbach, "Media Influences and Personality Development: The Inner Image and the Outer World," in *Media, Children, and the Family: Social Scientific, Psychodynamic and Clinical Perspectives*, ed. Dolf Zillmann, Jennings Bryant, and Aletha C. Huston (Hillsdale: Lawrence Erlbaum, 1994); Aubrey, Behm-Morawitz, and Kim; Botta; Carpenter; Chan, Ng, and Williams; Clark and Tiggemann; Currie; Dubriwny; Duke; Michelle Fine, "Sexuality, Schooling, and Adolescent Females: The Missing Discourse of Desire," in *Disruptive Voices: The Possibilities of Feminist Research*, ed. Michelle Fine (Ann Arbor: University of Michigan Press, 1992); Freedman; Ana Garner, Helen M. Sterk, and Shawn Adams, "Narrative Analysis of Sexual Etiquette in Teenage Magazines," *Journal of Communication* 48, no. 4 (1998); Gentles and Harrison; Hust, Brown, and L'Engle; Jackson; Sharon R. Mazzarella, "Coming of Age Too Soon: Journalistic Practice in U.S. Newspaper Coverage of 'Early Puberty' in Girls, "*Communication Quarterly* 58, no. 1 (2010); Myers and Biocca; Oinas; Ostermann and Keller-Cohen; Pinkleton et al; Tolman; Vares, Jackson, and Gill.

[98] Oinas, 59.

[99] Tasha N. Dubriwny and Vandhana Ramadurai, "Framing Birth: Postfeminism in the Delivery Room," *Women's Studies in Communication* 36 (2013): 247.

[100] Dubriwny, 24.

[101] Claire Moran, "Re-Positioning Female Heterosexuality within Postfeminist and Neoliberal Culture," *Sexualities* 20, no. 1 (2017): 124.

[102] Ibid., 128.

[103] Rosalind Gill, "Culture and Subjectivity in Neoliberal and Postfeminist Times," *Subjectivity* 25 (2008): 442.

[104] Moran, 125.

[105] Ibid., 129. Much of the academic work examining the medicalization of appearance has focused on Western medicine's participation in elective cosmetic surgery. See Helen S. Edelman, "Why Is Dolly Crying?: An Analysis of Silicone Breast Implants in American as an Example of Medicalization," *The Journal of Popular Culture* 28, no. 3 (1994); Debra L. Gimlin, "Too Good to Be Read: The Obviously Augmented Breast in Women's Narratives of Cosmetic Surgery," *Gender & Society* 27, no. 6 (2013); Ashley L. Merianos, Rebecca A. Vidourek, and Keith K. King, "Medicalization of Female Beauty: A Content Analysis of Cosmetic Procedures," *The Qualitative Report* 18, no. 46 (2013); Paulo Poli Neto and Sandra N. C. Caponi, "The Medicalization of Beauty," *Interface* 3 (2007).

[106] Rosalind Gill, "Postfeminist Media Culture: Elements of a Sensibility," *European Journal of Cultural Studies* 10, no. 2 (2007): 163.

[107] Deborah L. Tolman, "Female Adolescents, Sexual Empowerment and Desire: A Missing Discourse of Gender Inequality," *Sex Roles* 66 (2012): 746.

[108] While iterations of this story appear in almost every article featuring American Girl, my account here draws primarily on Acosta-Alzura and Kreshal's interpretation of this narrative. Carolina Acosta-Alzura and Peggy J. Kreshel, "I'm an American Girl...Whatever That Means: Girls Consuming Pleasant Company's American Girl Identity," *Journal of Communication* 52, no. 1 (2002): 139-40.

[109] According to the American Girl website, since 1986, over 153 million American Girl books and 29 million American Girl dolls have been sold. "Fast Facts," *American Girl*, accessed December 1, 2016, www.americangirl.com/corporate/fast-facts.

[110] Nina Diamond et al., "American Girl and the Brand Gestalt: Closing the Loop on Sociocultural Branding Research," *Journal of Marketing* 73 (2009): 119.

[111] Carolina Acosta-Alzura and Elizabeth P. Lester Roushanzamir, "Everything We Do Is a Celebration of You!: Pleasant Company Constructs American Girlhood," *The Communication Review* 6, no. 1 (2003): 45.

[112] See ibid.; Diane Clehane, "Why Is American Girl Rebranding Their Historical Line without an Asian Doll?," *Forbes*, July 8, 2014, www.forbes.com/sites/dianeclehane/2014/07/08/why-is-american-girl-rebranding-their-historical-line-without-an-asian-doll/#cc39d825c743; Aisha Harris, "The Making of an American Girl," *Slate*, September 21, 2016, www.slate.com/articles/arts/culturebox/2016/09/the_making_of_addy_walker_american_girl_s_first_black_doll.html; Katie Kindelan, "American Girl Rebuts Critics after Dropping Minority Dolls," *ABC News*, May 28, 2014, abcnews.go.com/blogs/headlines/2014/05/american-girl-rebuts-critics-after-dropping-minority-dolls/; Heidi Zimmerman, "American Girl as a Technology of Racialized Girl-Citizenship" (paper presented at the International Communication Association, Phoenix, 2012).

[113] While journalists and academics alike regularly point to problems associated with the $100+ cost of American Girl dolls, recently the introduction of a homeless girl character sparked controversy due to perceptions that this doll normalized homelessness as appropriate for some girls as well as the hypocrisy in selling a homeless girl for costs over $95 Eric Noll, "Meet Gwen Thompson, the 'Homeless' American Girl," *ABC News*, September 26, 2009, abcnews.go.com/GMA/Weekend/homeless-american-girl-doll-sparks-controversy/story?id=8676579.

[114] Acosta-Alzura and several other authors have addressed the influence of American Girl dolls and the historical fiction books on representations of girlhood and identity formation, particularly in relationship to race, class, and gender norms. See Acosta-Alzura and Kreshel; Acosta-Alzura and Roushanzamir; Emilie Zaslow and Judy Schoenberg, "Stumping to Girls through Pop Culture: Feminist Interventions to Shape Future Political Leaders," *Women & Language* 35, no. 1 (2012); Zimmerman. American Girl's relationship with consumerism and branding have also become an interest in marketing scholarship. See Diamond et al; Diane Carver Sekeres, "The Market Child and Branded Fiction: A Synergism of Children's Literature, Consumer Culture, and New Literacies," *Reading Research Quarterly* 44, no. 4 (2009).

[115] Acosta-Alzura and Roushanzamir, 65.

[116] Zimmerman, 11.

[117] Diamond et al., 122-3.

[118] Diamond and colleagues suggest that "American Girl may be perceived as a protective shield for little girls against the precocious sexualization that is often blamed on consumer culture and, in particular, brand marketers." Ibid., 123. The American Girl website claims that "[s]ince the first catalogue debuted in

1986, American Girl has ignited the strength inherent in all girls by developing products and experiences that help them reach their full potential." "Our Company," *American Girl*, accessed December 1, 2016, www.americangirl.com/corporate/our-company.

[119] Acosta-Alzura and Kreshel emphasize that American Girl dolls, books, and catalogs, though "seemingly innocent…can be deeply ideological." Acosta-Alzura and Kreshel, 114.

[120] American Girl advice books include *The Care & Keeping of You 1: The Body Book for Younger Girls*, *The Care & Keeping of You 2: The Body Book for Older Girls*, *The Care & Keeping of Us* (a journal for girls and their mothers with talking points), *Is This Normal?* (a sequel to The Care & Keeping of You with more questions answered), *The Feelings Book: The Care & Keeping of Your Emotions*, *Stand Up for Yourself & Your Friends*, *The Sister Book: A Guide to Good Times with Your Family*, *Friends: Making Them and Keeping Them*, and a wide range of titles in their "A Smart Girl's Guide" series.

[121] "Advice Library," *American Girl*, accessed December 1, 2016, www.americangirl.com/shop/bookstore/advice-library.

[122] Valorie Lee Schaefer and Cara Natterson, *The Care & Keeping of You: The Body Book for Younger Girls* (Middleton: American Girl Publishing, 2012), 3.

[123] "Our Brand," *American Girl*, accessed December 1, 2016, www.americangirl.com/corporate/our-brand.

[124] Harris claims that "[i]n the same way that *Our Bodies, Ourselves* touched a nerve with the generation before us, *The Care and Keeping of You* provided us with accessible and nutritious comfort food to help us through the most awkward and anxiety-ridden periods of youth." Aisha Harris, "How American Girl's Puberty Books Shaped a Generation of Tweens," *Slate*, August 8, 2016, www.slate.com/blogs/nightlight/2016/08/08/how_american_girl_puberty_books_shaped_a_generation_of_tweens.html.

[125] Schaefer and Natterson, 2.

[126] Ibid., 3.

[127] Jarmila Mildorf, "Reconsidering Second-Person Narration and Involvement," *Language and Literature* 25, no. 2 (2016): 145, 53.

[128] Mildorf emphasizes that the use of second-person "employs direct address and thus creates a quasi-communicational set-up with real readers." ibid., 146.

[129] While photographs may be read as more trustworthy than illustrations since they are grounded in a literal reality, Goff emphasizes that younger people are often more receptive to ambiguity of illustrations. Brian Goff, "Photos Vs. Illustrations: When to Use Which Format," *Big Stock*, June 6, 2013, www.bigstockphoto.com/blog/photos-vs-illustrations-when-to-use-which-format. Fang argues that due to children's familiarity with picture books, illustrations "represent relatively concrete, familiar experience, something young readers can easily identify with." Zhihui Fang, "Illustrations, Text, and the Child Reader: What Are Pictures in Children's Storybooks For?," *Reading Horizons* 37, no. 2 (1996): 138.

[130] Wells emphasizes that in *Our Bodies, Ourselves* that "[m]embers developed ways of speaking their own embodied experience and of bracketing that experience as partial and local." Susan Wells, "Our Bodies, Ourselves: Reading the Written Body," *Signs: Journal of Women in Culture and Society* 33, no. 3 (2008): 698. Hayden similarly emphasizes that this foundational feminist text grounded its discourses in "an epistemology that privileges personal experience" apart from institutionalized sources of knowledge. Sara Hayden, "Re-Claiming Bodies of Knowledge: An Exploration of the Relationship between Feminist

Theorizing and Feminine Style in the Rhetoric of the Boston Women's Health Book Collective," *Western Journal of Communication* 61, no. 2 (1997): 137.

[131] Amy Schiller, "American Girls Aren't Radical Anymore," *The Atlantic*, April 23, 2013, www.theatlantic.com/sexes/archive/2013/04/american-girls-arent-radical-anymore/275199/.
[132] Ibid.

[133] Adrienne Raphel, "Our Dolls, Ourselves?," *The New Yorker*, October 9, 2013, www.newyorker.com/business/currency/our-dolls-ourselves.

[134] "Our Brand."

[135] Schaefer and Natterson, 12.

[136] Ibid., 8.

[137] Ibid., 7.

[138] Ibid., 9.

[139] Ibid., 12.

[140] Ibid.

[141] Ibid., 10.

[142] Ibid., 42.

[143] Ibid., 48-9.

[144] Ibid., 48.

[145] Cara Natterson, *The Care & Keeping of You 2: The Body Book for Older Girls* (Middleton: American Girl Publishing, 2012), 92.

[146] Ibid., 35.

[147] Moran emphasizes that a postfeminist sensibility "sees a radical departure from a traditional femininity which was characterized by caring and domesticity, to a modern femininity that is marked by a focus on being beautiful, sexy and empowered." Moran, 124. Kissling similarly stresses that postfeminism "demonstrates femininity through possession and presentation of a 'sexy body' in an increasingly sexualized culture," further emphasizing that "[t]his marks a shift from previous media characterizations of femininity arising from psychological traits or behavior, such a nurturing or motherhood. This sexy female body requires constant discipline and surveillance to adhere to (ever narrower) standards for feminine appearance." Elizabeth Arveda Kissling, "Pill, Periods, and Postfeminism: The New Politics of Marketing Birth Control," *Feminist Media Studies* 13, no. 3 (2013): 492.

[148] Dubriwny, 141.

[149] Acosta-Alzura and Roushanzamir, 45.

[150] David Olson, "On the Language and Authority of Textbooks," *Journal of Communication* 30 (1980).

[151] Acosta-Alzura and Roushanzamir, 53.

[152] Harris, "How American Girl's Puberty Books Shaped a Generation of Tweens."

[153] "Our Company."

[154] "Hearings," *U.S. Senate Committee on Commerce, Science, & Transportation*, accessed July 8, 2015, www.commerce.senate.gov/public/index.cfm/hearings?ID=C1698871-3625-4F67-B0E5-A06D3BAB6CA1.

[155] Ibid.

[156] Ibid.

[157] Paula Cohen, "Group of Doctors Calls on Columbia Univ. To Oust Dr. Oz," *CBS News*, April 16, 2015, www.cbsnews.com/news/group-of-doctors-call-for-dr-oz-to-be-ousted-from-columbia-university/.

[158] Ibid.

[159] "Dr. Oz Fights Back: His Exclusive Reaction to His Critics," *The Dr. Oz Show*, NBC, College Station, TX: KAGS, April 23, 2015.

[160] Ibid.

[161] Julia Belluz, "The Making of Dr. Oz: How an Award-Winning Doctor Turned Away from Science and Embraced Fame," *Vox*, August 30, 2015, www.vox.com/2015/4/16/8412427/dr-oz-health-claims. For other criticism of Dr. Oz's relationship with Western medicine, see Associated Press, "Dr. Oz Slammed over Apple Juice Arsenic Warning," *CBS News*, September 16, 2011, www.cbsnews.com/news/dr-oz-slammed-over-apple-juice-arsenic-warning/; Belluz; Adam S. Cifu, "Why Dr. Oz Makes Us Crazy," *Journal of General Internal Medicine* 29, no. 2 (2013); Maki Inoue-Choi, Sarah J. Oppeneer, and Kim Robien, "Reality Check: There Is No Such Thing as a Miracle Food," *Nutrition and Cancer* 65, no. 2 (2013); Christina Korownyk et al., "Televised Medical Talk Shows - What They Recommend and the Evidence to Support Their Recommendations: A Prospective Observational Study," *British Medical Journal* 349 (2014); Henry I. Miller and Kavin Senapathy, "Low-Hanging Fruit: Dr. Oz Sows Seeds of Mistrust on Genetic Engineering," *Slate*, April 10, 2015, www.slate.com/articles/technology/future_tense/2015/04/arctic_apple_safety_dr_oz_sows_seeds_of_mistrust_on_gmos.html; Michael Specter, "The Operator," *The New Yorker*, February 4, 2013, www.newyorker.com/magazine/2013/02/04/the-operator.

[162] Tania Lewis emphasizes that "[o]ver the past decade, television around the globe has been marked by a growing focus on teaching audiences, both men and women, how to manage and optimize their everyday lives through a seamless focus on food, home decoration, health, style, grooming and more recently (as evidenced in globally popular formats like *Queer Eye for the Straight Guy*, *The Biggest Loser* and *Supernanny*) through making over the self and the family." Tania Lewis, "Branding, Celebritization and the Lifestyle Expert," *Cultural Studies* 24, no. 4 (2010): 580.

[163] Reality television programs have arguably received the most attention by scholars interested in the effects of neoliberalism on consumer health practices. See Lori A. Klos et al., "Losing Weight on Reality TV: A Content Analysis of the Weight Loss Behaviors and Practices Portrayed on the Biggest Loser," *Journal of Health Communication* 20, no. 6 (2015); Katherine Sender and Margaret Sullivan, "Epidemics of Will, Failures of Self-Esteem: Responding to Fat Bodies in the Biggest Loser and What Not to Wear," *Continuum: Journal of Media & Cultural Studies* 22, no. 4 (2008); Shugart; Silk, Francombe, and Bachelor; Yan Tian and Jina H. Yoo, "Connecting with the Biggest Loser: An Extended Model of

Parasocial Interaction and Identification in Health-Related Reality TV Shows," *Health Communication* 30 (2015); Jill Yamasaki, "Age Accomplished, Performed, and Failed: Liz Young as Old on the Biggest Loser," *Text and Performance Quarterly* 34, no. 4 (2014); Jina H. Yoo, "No Clear Winner: Effects of the Biggest Loser on the Stigmatization of Obese Persons," *Health Communication* 28, no. 3 (2013). Beyond reality television, medical dramas, television news coverage, and commercials have also examined the influence of these programs on health subjects. See Christina S. Beck et al., "Blurring Personal Health and Public Priorities: An Analysis of Celebrity Health Narratives in the Public Sphere," ibid.29 (2014); Christina S. Beck et al., *Celebrity Health Narratives and the Public Health* (Jefferson: McFarland & Company, 2015); Carolina Fernandez Branson, "I Want to Be One Less: The Rhetoric of Choice in Gardasil Ads," *Communication Review* 15, no. 2 (2012); Susan J. Douglas and Meredith Michaels, *The Mommy Myth: The Idealization of Mother-Hood and How It Has Undermined Women* (New York: Free Press, 2004); Tasha N. Dubriwny, "Television News Coverage of Postpartum Disorders and the Politics of Medicalization," *Feminist Media Studies* 10, no. 3 (2010); *The Vulnerable Empowered Woman: Feminism, Postfeminism, and Women's Health*; Parul Jain and Michael D. Slater, "Provider Portrayals and Patient-Provider Communication in Drama and Reality Medical Entertainment Television Shows," *Journal of Health Communication* 18 (2013); Tania Lewis, "Changing Rooms, Biggest Losers and Backyard Blitzes: A History of Makeover Television in the United Kingdom, United States and Australia," *Continuum: Journal of Media & Cultural Studies* 22, no. 4 (2008); "Branding, Celebritization and the Lifestyle Expert."; Susan E. Morgan et al., "Entertainment (Mis)Education: The Framing of Organ Donation in Entertainment Television," *Health Communication* 22, no. 2 (2007); Susan E. Morgan, Mauren Movius, and Michael J. Cody, "The Power of Narratives: The Effect of Entertainment Television Organ Donation Storylines on the Attitudes, Knowledge, and Behaviors of Donors and Nondonors," *Journal of Communication* 59, no. 1 (2009); Michael D. Slater and Parul Jain, "Teens' Attention to Crime and Emergency Programs on Television as a Predictor and Mediator of Increased Risk Perceptions Regarding Alcohol-Related Injuries," *Health Communication* 26, no. 1 (2011); Michael D. Slater et al., "News Coverage of Cancer in the United States: A National Sample of Newspapers, Television, and Magazines," ibid.13, no. 6 (2008); Turow; Zoller and Worrell.

[164] Ouellette and Hay, 471.

[165] Bernard M. Timberg and Bob Erler, *Television Talk: A History of the TV Talk Show* (Austin: University of Texas Press, 2002), 7.

[166] Jane M. Shattuc, *The Talking Cure: TV Talk Shows and Women* (New York: Routledge, 1997), 3.
[167] Quail, Razzano, and Skalli, 152, 58.

[168] Bonnie Dow argues that "television programming does not deal well with complex social issues; it prefers the trials and tribulations of the individual." Bonnie Dow, *Prime-Time Feminism: Television, Media Culture, and the Women's Movements since 1970* (Philadelphia: University of Pennsylvania Press, 1996), xxi.

[169] Quail, Razzano, and Skalli, 152, 49.

[170] A variety of daytime talk shows occasionally feature health related content, but *The Dr. Oz Show* stands out as one of only two daytime talk shows devoted to this subject matter. *The Doctors*, the only other talk show that communicates health information in a similar format, typically receives about half of *The Dr. Oz Show's* viewers. Sara Bibel, "Syndicated TV Ratings," *Screener*, January 26, 2014, tvbythenumbers.zap2it.com/.

[171] The Dr. Oz Show has won 6 Daytime Emmy Awards for Outstanding Talk Show Host (2010, 2011, 2016) and Outstanding Talk Show Informative (2011, 2012, 2013), including the 2016 Daytime Emmy for Outstanding Informative Talk Show Host indicating the show's continued success despite public controversies. Additionally, ratings show that the syndicated talk show, currently broadcast in 118

countries, continues to receive over four million daily viewers helping the program maintain a spot in the top five syndicated daytime talk shows. See "Oz Media," *The Dr. Oz Show*, accessed September 1, 2016, www.drozmedia.com/.

[172] Specter.

[173] Lewis, "Branding, Celebritization and the Lifestyle Expert," 581.

[174] Lewis defines celebritization as "the process whereby growing numbers of public figures today, including experts, are increasingly framed in ways that make them more accessible, media-friendly and crucially more 'ordinary'." Ibid., 584.

[175] Ibid., 583.

[176] Jasmina Ilicic and Cynthia M. Webster, "Being True to Oneself: Investigating Celebrity Brand Authenticity," *Psychology & Marketing* 33, no. 6 (2016): 410.

[177] Carroll J. Glynn et al., "When Oprah Intervenes: Political Correlates of Daytime Talk Show Viewing," *Journal of Broadcasting & Electronic Media* 51, no. 2 (2007): 229.

[178] "Oz on Transcendental Meditation," *The Dr. Oz Show*, NBC, College Station, TX: KAGS, April 26, 2012.

[179] "The Drug-Free Way to Relieve Back Pain," *The Dr. Oz Show*, NBC, College Station, TX: KAGS, November 8, 2016.

[180] "How to Practice Fire Meditation," *The Dr. Oz Show*, NBC, College Station, TX: KAGS, December 18, 2015.

[181] "Meditate to Lose Weight," *The Dr. Oz Show*, NBC, College Station, TX: KAGS, January 4, 2011.

[182] "The Benefits of a Daily 5-Minute Meditation," *The Dr. Oz Show*, NBC, College Station, TX: KAGS, December 18, 2015.

[183] "Dr. Oz's Best Tips for Meditation," *The Dr. Oz Show*, NBC, College Station, TX: KAGS, December 18, 2015.

[184] "Lauren Scruggs: The Model Who Survived Disaster," *The Dr. Oz Show*, NBC, College Station, TX: KAGS, October 1, 2014.

[185] "Last-Minute, Easy Homemade Health Gifts," *The Dr. Oz Show*, NBC, College Station, TX: KAGS, December 18, 2015.

[186] "Hearings."

[187] Bill Briggs, "Dr. Oz Responds to Critics: 'It's Not a Medical Show'," *NBC News*, April 23, 2015, www.nbcnews.com/health/health-news/dr-oz-responds-critics-its-not-medical-show-n347101.

[188] Ibid.

[189] "The Biggest Health Myths Americans Still Believe," *The Dr. Oz Show*, NBC, College Station, TX: KAGS, April 12, 2016.

[190] Ibid.

[191] Due to his darker complexion, Dr. Oz is able to visually embody Eastern medicine just as easily as he can embody Western medicine. Although his heritage and religious background is not a common topic of discussion on the show, Dr. Oz's visible racial associations enable him to more easily navigate back and forth between these divergent forms of medical practice.

[192] Frank Bruni reports that when Dr. Oz married Lasa Lemole in 1985, "their relationship opened him up to the worlds of alternative medicine and Eastern mysticism, which he integrated into his thinking and career early on." Frank Bruni, "Dr. Does-It-All," *The New York Times*, April 16, 2010, www.nytimes.com/2010/04/18/magazine/18Oz-t.html.

[193] Ibid.

[194] "Ayurvedic Solutions for Your Biggest Health Complaints," *The Dr. Oz Show*, NBC, College Station, TX: KAGS, January 7, 2014.

[195] "Can You Trick Your Body into Burning Stored Fat? Why You Need to Know About the Ketogenic Diet," *The Dr. Oz Show*, NBC, College Station, TX: KAGS, May 18, 2016.

[196] Ibid.

[197] "Dr. Oz's Two-Week Rapid Weight-Loss Diet," *The Dr. Oz Show*, NBC, College Station, TX: KAGS, January 6, 2014.

[198] "Secrets to Losing Half Your Body Size," *The Dr. Oz Show*, NBC, College Station, TX: KAGS, July 13, 2016.

[199] This narrative is based on Bratskeir and Lee's versions of this incident. Kate Bratskeir, "Doctors Diagnosed a Patient's Life-Threatening Condition through His Fitbit," *The Huffington Post*, April 7, 2016, www.huffingtonpost.com/entry/fitness-trackers-in-emergency-room_us_57052d37e4b0537661885157; Stephanie M. Lee, "This Man's Fitbit Data Got Him the Medical Care He Needed," *BuzzFeed*, April 11, 2016, www.buzzfeed.com/stephaniemlee/fitbit-in-the-hospital?utm_term=.xfWlNZRr8#.xc3AywDE2.

[200] Kim Mulford, "South Jersey Man's Fitbit Solved His Heart Mystery," *Courier-Post*, April 13, 2016, www.courierpostonline.com/story/news/health/2016/04/13/south-jersey-mans-fitbit-solved-his-heart-mystery/82949102/.

[201] Isabel Pedersen, *Ready to Wear: A Rhetoric of Wearable Computers and Reality-Shifting Media* (Anderson: Parlor Press, 2013), 1.

[202] Nicholas Bowman, Jaime Banks, and David Westerman, "Through the Looking Glass (Self): The Impact of Wearable Technology on Perceptions of Face-to-Face Interaction," *Communication Research Reports* 33, no. 4 (2016): 332.

[203] Melanie Swan, "Sensor Mania! The Internet of Things, Wearable Computing, Objective Metrics, and the Quantified Self 2.0," *Journal of Sensor and Actuator Networks* 1 (2012): 218.

[204] James N. Gilmore, "Everywear: The Quantified Self and Wearable Fitness Technologies," *New Media & Society* 18, no. 11 (2016): 2525.

[205] Alex Hutchinson, "How a Fitbit May Make You a Bit Fit," *The New York Times*, March 19, 2016, www.nytimes.com/2016/03/20/opinion/sunday/how-a-fitbit-may-make-you-a-bit-fit.html.

[206] Brad Millington, "Smartphone Apps and the Mobile Privitization of Health and Fitness," *Critical Studies in Media Communication* 31, no. 5 (2014): 482. Gouge and Jones explain that "[f]rom consumers to technology professionals to medical practitioners, a rapidly growing segment of Americans believe that wearable technologies such as these will soon support dramatic changes to our everyday lives." Catherine Gouge and John Jones, "Wearables, Wearing, and the Rhetorics That Attend to Them," *Rhetoric Society Quarterly* 46, no. 3 (2016): 200.

[207] Brad Millington, "Fit for Prosumption: Interactivity and the Second Fitness Boom," *Media, Culture & Society* 38, no. 8 (2016): 1185; Daniel St. Clair Kreitzberg et al., "What Is Your Fitness Tracker Communicating?: Exploring Messages and Effects of Wearable Fitness Devices," *Qualitative Research Reports in Communication* 17, no. 1 (2016): 94.

[208] Gouge and Jones, 200.

[209] Eulalia Puig Abril, "Tracking Myself: Assessing the Contribution of Mobile Technologies for Self-Trackers of Weight, Diet, or Exercise," *Journal of Health Communication* 21 (2016): 638; Deborah Lupton, "Quantifying the Body: Monitoring and Measuring Health in the Age of Mhealth Technologies," *Critical Public Health* 23, no. 4 (2013): 397.

[210] Eric Topol, *The Patient Will See You Now: The Future of Medicine Is in Your Hands* (Boulder: Basic Books, 2015), 12; Andrejevic, 393.

[211] See Abril; Bowman, Banks, and Westerman; Casey Boyle, "Pervasive Citizenship through #Sensecommons," *Rhetoric Society Quarterly* 46, no. 3 (2016); Arul Chib, Michelle Helena van Velthoven, and Josip Car, "Mhealth Adoption in Low-Resource Environments: A Review of the Use of Mobile Healthcare in Developing Countries," *Journal of Health Communication* 20 (2015); Anne Cranny-Francis and Cathy Hawkins, "Wearable Technology," *Visual Communication* 7, no. 3 (2008); Gilmore; Gouge and Jones; Linda F. Hogle, "Enhancement Technologies and the Body," *Annual Review of Anthropology* 34 (2005); Jordynn Jack, "Leviathan and the Breast Pump: Toward an Embodied Rhetoric of Wearable Technology," *Rhetoric Society Quarterly* 46, no. 3 (2016); Suneel Jethani, "Mediating the Body: Technology, Politics and Epistemologies of Self," *Communication, Politics & Culture* 47, no. 3 (2015); Jason Kalin and Jordan Frith, "Wearing the City: Memory P(a)Laces, Smartphones, and the Rhetorical Invention of Embodied Space," *Rhetoric Society Quarterly* 46, no. 3 (2016); Molly Margaret Kessler, "Wearing an Ostomy Pouch and Becoming an Ostomate: A Kairological Approach to Wearability," ibid.; Jeongeun Kim, "Analysis of Health Consumers' Behavior Using Self-Tracker for Activity, Sleep, and Diet," *Telemedicine and e-Health* 20, no. 6 (2014); Kreitzberg et al; Stine Lomborg and Kirsten Frandsen, "Self-Tracking as Communication," *Information, Communication & Society* 19, no. 7 (2016); Lupton, "Quantifying the Body: Monitoring and Measuring Health in the Age of Mhealth Technologies."; Richard MacManus, *Health Trackers: How Technology Is Helping Us Monitor and Improve Our Health* (Lanham: Rowman & Littlefield, 2015); Millington, "Fit for Prosumption: Interactivity and the Second Fitness Boom."; Phoebe Moore and Andrew Robinson, "The Quantified Self: What Counts in the Neoliberal Workplace," *New Media & Society* 18, no. 11 (2016); Mitesh S. Patel, David A. Asch, and Kevin V. Volpp, "Wearable Devices as Facilitators, Not Drivers, of Health Behavior Change," *Journal of the American Medical Association* 313, no. 5 (2015); Jill Walker Rettberg, *Seeing Ourselves through Technology: How We Use Selfies, Blogs and Wearable Devices to See and Shape Ourselves* (New York: Palgrave Macmillan, 2014); Minna Ruckenstein, "Visualized and Interacted Life: Personal Analytics and Engagements with Data Doubles," *Societies* 4 (2014); Julian Schweitzer and Christina Synowiec, "The Economics of Ehealth and Mhealth," *Journal of Health Communication* 17 (2012); Nabil Sultan, "Reflective Thoughts on the Potential and Challenges of Wearable Technology for Healthcare Provision and Medical Education," *International Journal of Information Mangagement* 35 (2015); Swan; "The Quantified Self: Fundamental Disruption in Big Data Science and Biological

Discovery," *Big Data* 1, no. 2 (2013); Christa Teston, "Rhetoric, Precarity, and Mhealth Technologies," *Rhetoric Society Quarterly* 46, no. 3 (2016); Topol.

[212] Swan, "The Quantified Self: Fundamental Disruption in Big Data Science and Biological Discovery," 85.

[213] Ibid., 96.

[214] Gilmore, 2526.

[215] Ibid.

[216] Lupton, "Quantifying the Body: Monitoring and Measuring Health in the Age of Mhealth Technologies," 399.

[217] Kessler, 237.

[218] Cranny-Francis and Hawkins stress that "we often do not recognize ourselves as part of the wearable technologies with which we live, although we are changing and changed by our interactions with them." Cranny-Francis and Hawkins, 268. Here, use of wearables is less rooted in data than in continual embodied interaction with our technological environment. Although the quantified self's interest in the visualization of data can be material in form, this perspective lacks the materiality of the bodily practices and technologies that produce it.

[219] Jack, 208.

[220] Much of the current scholarship on wearables has focused either on the quantified self or embodiment. While drawing a distinction between these two perspectives has been useful in pointing to alternative and arguably neglected approaches to engaging activity trackers and other wearables, these often competing characterizations are not always distinguishable. In the case of activity trackers, user relationship with the medical authority that emerges through these interactions simultaneously engages data and embodiment.

[221] In conceptualizing Fitbit as a constellation of interactions, I draw on Lomborg and Frandsen understanding of that the act of using activity trackers as a ritualized communicative process. They suggest that the use of activity trackers should be conceptualized as a "social and cultural practice that is fundamentally communicative: it mirrors and molds the user towards an audience comprising to the very least the user herself, but often other users of a given service as well." Lomborg and Frandsen, 1015. While Lomborg and Frandsen's focus on user response to activity trackers and communication through social media does not address medical authority, their ritualistic view of communication highlights a more complex and interactive understanding of user engagement with wearables.

[222] Here, I draw on Michael Calvin McGee's understanding of the rhetorical critic's inventive process in creating and defining "a text suitable for criticism" out of various fragments. Michael Calvin McGee, "Text, Context, and the Fragmentation of Contemporary Culture," *Western Journal of Speech Communication* 54 (1990): 288. McGee explains that "[c]ritical rhetoric does not begin with a finished text in need of interpretation; rather, texts are understood to be larger than the apparently finished discourse that presents itself as transparent." Ibid., 279. Raymie McKerrow similarly indicates that rhetorical criticism is grounded in the "'pulling together' of disparate scraps of discourse which, when constructed as an argument, serve to illuminate otherwise hidden or taken for granted social practices." Raymie E. McKerrow, "Critical Rhetoric: Theory and Praxis," *Communication Monographs* 56, no. 2 (1989): 101.

[223] Due to scholar's interest in examining the influence of these technologies on clinical medicine, this research often characterizes this relationship in terms of traditional doctor-patient interactions rooted in Western medicine. See Kim; Patel, Asch, and Volpp; Sultan.

[224] Jethani, 39.

[225] Teston, 262.

[226] Computer programmers and algorithms, visualization software, fitness experts, medical consultants, fashion designers, marketers, and a range of other people and processes collectively participate in forming an underlying network of medical authority. Unfortunately, this varied network of sources of authority are often ill-defined and overlap in actual user experiences.

[227] "Why Fitbit," *Fitbit*, accessed January 14, 2017, www.fitbit.com/whyfitbit.

[228] Background on Fitbit is taken from Jonah Comstock, "Eight Years of Fitbit News Leading up to Its Planned Ipo," *Mobihealthnews*, May 11, 2015, www.mobihealthnews.com/43423/eight-years-of-fitbit-news-leading-up-to-its-planned-ipo; Gary Marshall, "The Story of Fitbit: How a Wooden Box Became a $4 Billion Company," *Wearable*, September 9, 2016, www.wareable.com/fitbit/youre-fitbit-and-you-know-it-how-a-wooden-box-became-a-dollar-4-billion-company.

[229] Joshua Rudner et al., "Interrogation of Patient Smartphone Activity Trackers to Assist Arrhythmia Management," *Annals of Emergency Medicine* 68, no. 3 (2016).

[230] Marshall.

[231] "Why Fitbit."

[232] Ibid.

[233] Daniel Coughlin, "Why Researchers Are Flocking to Fitbit in the Fight against Disease," *Wearable*, June 17, 2016, www.wareable.com/fitbit/fitbit-clinical-studies-researchers-887.

[234] "Our Technology," *Fitbit*, accessed March 8, 2017, www.fitbit.com/technology.

[235] Ibid.

[236] "Purepulse," *Fitbit*, accessed March 8, 2017, www.fitbit.com/purepulse.

[237] "Wear & Care," *Fitbit*, accessed March 8, 2017, www.fitbit.com/product-care.

[238] Lara Rosenbaum, "Should You Really Take 10,000 Steps a Day?," *Fitbit*, March 1, 2016, blog.fitbit.com/should-you-really-take-10000-steps-a-day/.

[239] "Why Fitbit."

[240] "Fitscience," *Fitbit*, accessed March 8, 2017, www.fitbit.com/fitscience.

[241] We can see Fitbit's underlying medical authority emerge as Fitbit's discourse justifies these hourly notifications encouraging users to move by explaining that "[r]esearch shows that prolonged sitting is associated with a significantly higher risk of heart disease, diabetes, obesity, cancer, and depression, as well as muscle and joint problems. Even if you meet typical exercise guidelines, sitting for long periods of time can still compromise your health. Fortunately, moving even a few minutes every hour reduces the

negative effects of sitting" . Further, imbedded in this statement there are multiple citation linked to medical studies roughly verifying that 250 steps is a healthy choice.

[242] "What Should I Know About the Relax Feature?," *Fitbit*, accessed March 17, 2017, help.fitbit.com/articles/en_US/Help_article/2077.

[243] Fitbit's underlying medical authority participates in shaping this interaction by requiring information from users to calculate their basal metabolic rate (BMR) as a meaningful and normalized component of health in their relationship with Fitbit. Fitbit explains that the BMR is "the rate at which you burn calories at rest just to maintain vital body functions like breathing, heartbeat, and brain activity." "Our Technology." The Harris-Benedict equation that serves as the basis for calculating BMR is not a computer calculation or algorithm developed by Fitbit, but a formula associated with the medical authority of Harris and Benedict who established this calculation as part of their research on human and animal biology. J. Arthur Harris and Francis G. Benedict, "A Biometric Study of Human Basal Metabolism," *Proceedings of the National Academy of Sciences of the United States of American* 4, no. 12 (1918). Further, this equation has been developed and refined several times by studies in *The American Journal of Clinical Nutrition*. See Mark D. Mifflin et al., "A New Predictive Equation for Resting Energy Expenditure in Healthy Individuals," *The American Journal of Clinical Nutrition* 51, no. 2 (1990); Allan M. Roza and Harry M. Shizgal, "The Harris Benedict Equation Reevaluated: Resting Energy Requirements and the Body Cell Mass," ibid.40, no. 1 (1984). The use of BMR to calculate calories burned highlights Fitbit's medical authority as these medical knowledges underlie Fitbit user's manual engagement with this technology.

[244] Fitbit would likely argue with my wife that a relationship should be sustained even in this context since they have produced a commercial in which a father in a tuxedo checks his Fitbit on his wrist before walking his daughter down the aisle.

[245] Jack, 217.

[246] Status in the case of Fitbit is grounded in the socioeconomic privileged associated not only with the ability to purchase a Fitbit, but also with the ability to advertise that you are mindful of your health. Indeed, the ability to wear activity trackers on your wrist, as opposed to older models that were discretely clipped to clothing, turns the Fitbit into a visual marker of affluence. Bee argues that the appeal of activity trackers as a marker of status is strong enough that even young children are increasingly turning to these devices, leading many schools to ban them due to the distraction they cause in these environments. Peta Bee, "The Latest Status Symbol for Children: The Fitbit," *The Times*, September 3, 2016, www.thetimes.co.uk/article/the-latest-status-symbol-for-children-the-fitbit-znx26lddn.

[247] In contrast to Jack's association with seamless integration and invisibility, in the case of Fitbit, seamless integration can be read more appropriately as aesthetically and visibly appropriate. Interestingly, this need to visibly integrate Fitbit into the lives of users first became an issue in 2013 with the introduction of the Fitbit Flex. This device was the first activity tracker to shift from the more traditional clip on pedometer style to a device worn on the wrist. This new functionality and ease of access also led to challenges as these devices intended to be worn at all times became more noticeable and out of place in certain contexts.

[248] "Fashion and Fitness," *iSpot.tv*, accessed March 17, 2017, www.ispot.tv/ad/AHex/fitbit-flex-2-fashion-and-fitness.

[249] "Lookbook," *Fitbit*, accessed March 14, 2017, www.fitbit.com/lookbook.

[250] If wearing a Fitbit on your wrist serves as a status symbol as it visually communicates your commitment to health (read relationship with medical authority) to those around you, status becomes even more of an issue as the cost of a relationship with Fitbit expands to account for the need to vary your

embodiment of health by visually matching your activity tracker to your environment. Sustaining a relationship with Fitbit is a substantial financial investment. With costs ranging from $60 to $250 just to purchase your initial Fitbit device and additional bands ranging from $30 to $300 (not to mention a monthly subscription to Fitstar or a Premium Fitbit account), it quickly becomes clear that this relationship is not meant for everyone. For example, in order to successfully embody health like the woman in the above commercial, users would have to spend over $450 to be able enjoy that type of customization. Unlike relationships with medical authority that are available in inexpensive children's books or a relatively accessible television program, a relationship with Fitbit is a privileged experience not available to many entrepreneurial health subjects interested in managing their health.

[251] Unlike the social movements of the late twentieth-century, empowerment here is not located in some health revolution designed to broadly challenge or revolt medical authority. In fact, in a neoliberal context in which individualized health subjects engage a wide range of health discourses involving varying relationships with medical authority, this type of broad and collective challenge to medical authority would be difficult if not impossible. Instead, critically unpacking the way individuals engage medical authority in these texts points to interactive opportunities of "gaps" that may allow for expanded empowerment by modifying the power relations in this relationship. Here, I draw on Kendall Phillips conceptualization of discursive "gaps" or "spaces from which resistant acts emerge to disturb power relations." Kendall R. Phillips, "Spaces of Invention: Dissension, Freedom, and Thought in Foucault," *Philosophy and Rhetoric* 35, no. 4 (2002): 331. Grounded in Foucault's understanding of power and power relations, Phillips argues that discursive empowerment is made possible through gaps or points of resistance in which these relationships can be replaced or modified. From this perspective, what we might conceive of as neoliberal freedom is positioned at the stasis point between relations of power and resistance that facilitates moments of possibility and expanded empowerment in these relationships.

[252] Barbara Biesecker, "Michel Foucault and the Question of Rhetoric," ibid.25 (1992): 351.

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