PUBLIC HEALTH AND THE RHETORIC OF PERSONAL RESPONSIBILITY

by

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ABSTRACT

My dissertation examines the significance of public health messaging to perceptions of responsibility and risk. Central to this research is my view of public health campaigns as rhetorical texts—rhetoric being the art and study of persuasion—that employ discursive strategies of various kinds to achieve their aims. As rhetorical texts, public health campaigns provide a means of involving individuals in health promotion and disease prevention, which makes them a valuable resource amid growing concerns about rising healthcare costs worldwide. In four case studies, on hand hygiene, vaccination, antibiotic use, and “epidemic” obesity, I illuminate the persuasive means through which public health comes to be understood as, in the first instance, a matter of personal responsibility.

Given that the rhetoric of personal responsibility places more of the onus for health on individuals than on systems, this rhetoric has long been criticized in health contexts as a form of “victim blaming.” Appeals to personal responsibility, for example, ignore the influence of context on health status. These appeals also induce cooperation among individuals by triggering feelings of anxiety, stigma, and blame. Some public health scholars celebrate these effects as essential to public health; I stress their potential to impede a society’s capacity to cope with infection. Throughout, I examine the relationship of the rhetoric of personal responsibility to neoliberalization—especially its advantages for the private sector, some of which come at the expense of public health. A political-economic theory, neoliberalism prioritizes privatization, deregulation, reduced spending on social welfare, and minimal government interference in the private sector.
In each of my chapters, I critique public health’s neoliberalization by documenting consequences or conflicts of interest arising from the rhetoric of personal responsibility. One such conflict is the opportunity to profit from altered perceptions of risk and responsibility, an effect I demonstrate most emphatically in my chapters on hand hygiene and “epidemic” obesity. A rhetoric of personal responsibility also distracts from the reality that some problems—for example, antibiotic-resistant infections (ARIs) and declining vaccination rates—necessitate both societal and individual change.
LAY SUMMARY

My dissertation examines the use of public health messaging to involve individuals in maintaining public health. In it, I ask, “How does public health become a matter of personal responsibility? What are the consequences of premising public health on personal responsibility?” In four case studies, on hand hygiene, vaccination, antibiotic-use, and “epidemic” obesity, I illuminate the strategies used within public health to prioritize behaviour change over government regulation or support. While personal responsibility is seen as both necessary and beneficial to the work of preventing infection, I underscore its limits as an approach to public health. The emphasis on personal responsibility, for example, introduces into public health potential conflicts of interest, such as the increased opportunity to profit from altered perceptions of risk. A model of public health premised on personal responsibility is also too limited to address problems that necessitate both societal and individual change.
PREFACE

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LIST OF ACRONYMS

AIDS  Acquired Immune Deficiency Syndrome
ALSEIB  State Employees’ Insurance Board of Alabama
ARI  Antibiotic-Resistant Infection
AMA  The American Medical Association
ASM  American Society for Microbiology
BCCDC  British Columbia Centre for Disease Control
BMI  Body Mass Index
CBC  Canadian Broadcasting Corporation
CDC  The United States Centers for Disease Control and Prevention
DPT  Diphtheria, Pertussis, and Tetanus
DTCA  Direct-to-Consumer Advertising
PPP  Public-Private Partnership
PPPHW  Public-Private Partnership for Handwashing with Soap
HAI  Healthcare-Associated Infection
HBO  Home Box Office
HHS  The United States Department of Health and Human Services
HIV  Human Immunodeficiency Virus
ILI  Influenza-Like Illness
IOM  Institute of Medicine
JAMA  Journal of the American Medical Association
MMR  Measles, Mumps, and Rubella
MRSA  Methicillin-Resistant \textit{Staphylococcus Aureus}
NAMCS  National Ambulatory Medical Care Survey
NIH  National Institutes of Health
NVIC  National Vaccine Information Center
PAwS  Public Awareness of Science
PEST  Public Engagement with Science and Technology
PSA  Public Service Announcement
PUS  Public Understanding of Science
SAGE  Strategic Advisory Group of Experts
SARS  Severe Acute Respiratory Syndrome
STI  Sexually-Transmitted Infection
STS  Science and Technology Studies
WHO  The World Health Organization
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INTRODUCTION

Now, in a period of fiscal crisis and cost control, . . . higher morbidity rates and demands for more access through comprehensive national health insurance are met with a barrage of statements about the limits of medicine and the lack of appropriate health behavior. Several commentators now link overuse by the poor with their faulty health habits, and the latter are linked with ignorance. Again, education is seen as the solution.

Robert Crawford, “You are Dangerous to Your Health” (1977)

“Public Health and the Rhetoric of Personal Responsibility” examines the significance of public health messaging to perceptions of responsibility and risk. Central to this research is my view of public health campaigns as rhetorical texts, employing various strategies of persuasion to achieve their aims. In a 2015 Canadian Medical Association Journal essay, rhetorician Judy Segal explains:

Rhetoric is a regular part of medicine: in the absence of positive diagnostic tests, patients may have to persuade physicians that they are ill and in need of care; physicians must sometimes persuade patients to adhere to courses of treatment; illness anxiety, perhaps fuelled by the Internet, may lead people to persuade themselves that they are ill; and multiple forces converge to persuade us that some conditions count as disease states, while others do not. (915)

Rhetoric is, I argue, also a regular part of public health, and professional definitions indeed frequently characterize public health campaigns as mainly persuasive endeavours. “A public health campaign,” for example, according to the Encyclopedia of Public Relations, “is an effort to persuade a defined public to engage in behaviors that improve health or refrain from behaviors that are unhealthy” (Springston 713, emphasis added). In four case studies, on hand hygiene, vaccination, antibiotic use, and “epidemic” obesity, I illuminate the persuasive means through which public health comes to be understood as, in the first instance, a matter of personal responsibility. In each of these cases, I ask what Segal, in the introduction to
Health and the Rhetoric of Medicine, identifies as the central questions of rhetorical criticism: “‘Who is persuading whom of what?’ and ‘What are the means of persuasion?’” (2). My analysis underscores the increasing use, within public health, of a rhetoric of personal responsibility to prioritize individual behaviour change over structural intervention or government regulation.

A rhetoric that places the onus for health on individuals has long been described in critical health studies as a form of “victim blaming.”¹ Appeals to personal responsibility, for example, partly overlook the influence of context on health status. These appeals also induce the cooperation of individuals by triggering feelings of fear, anxiety, and even disgust. Whereas some public health scholars celebrate these effects as essential to public health,² I stress their potential to impede a society’s capacity to cope with crisis. Throughout, I assert a connection between the rhetoric of personal responsibility and neoliberalization, especially with respect to advantages for the private sector. A political-economic theory, neoliberalism prioritizes privatization, deregulation, reduced spending on social welfare, and minimal government interference in the private sphere.³ Under neoliberalism, the rhetoric of personal responsibility has helped to justify policies that often work against the very individuals they supposedly empower. Historian David Harvey, for example, deems “increasing social inequality . . . a persistent feature of neoliberalization” (16). Within public health specifically, the potential economic benefits of a rhetoric of personal responsibility typically

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¹ Critiques of personal responsibility as victim blaming include Becker, “The Tyranny of Health Promotion” (1986); Marantz, “Blaming the Victim” (1990); and Brownell, “Personal Responsibility and Control Over Our Bodies” (1991).
² See, for example, Curtis, “Why Disgust Matters” (2011); and Morales, Wu, and Fitzsimons, “How Disgust Enhances the Effectiveness of Fear Appeals” (2012).
³ For an overview of neoliberalism, and specifically its relationship to the rhetoric of personal responsibility, see Chomsky, Profit Over People (1999); Harvey, A Brief History of Neoliberalism (2005); Steger and Roy, Neoliberalism (2010); Nguyen, Rhetoric in Neoliberalism (2016); Springer, Birch, and MacLeavy, The Handbook of Neoliberalism (2016); and Wilson, Neoliberalism (2017).
come at the expense of recognizing the influence of governmental support on health outcomes.

My study contributes to a growing body of rhetorical scholarship on neoliberalization. The essays in the 2017 anthology, *Rhetoric in Neoliberalism*, for example, examine both the rhetorical practices that “make up neoliberalism” (9), as editor Kim Nguyen reports, and rhetorical means used to resist neoliberalization. “While rhetorical studies is uniquely equipped to analyze neoliberalism as the rationality of modern-day capitalism,” Nguyen argues, “the study of rhetoric in its more quotidian forms and among marginalized subjects is long overdue but necessary in order to understand how rhetoric organizes everyday life in the neoliberal era” (8). For example, I illuminate the health-related work increasingly expected of individuals in various contexts—in particular, the workplace, but also within their families and communities. In each of my case studies, I also critique public health’s neoliberalization by documenting consequences or conflicts of interest within public health arising from its rhetoric. One such conflict is the opportunity to profit from altered perceptions of risk and responsibility, an effect I demonstrate most emphatically in my chapters on hand hygiene and “epidemic” obesity. A rhetoric of personal responsibility also distracts from the reality that some problems—for example, antibiotic-resistant infections (ARIs) and declining vaccination rates—necessitate both individual and societal change.

**Neoliberalism, “Self-Imposed Risks,” and the Rhetoric of Personal Responsibility**

One of the earliest critiques of the increasing emphasis on personal responsibility for public health is Robert Crawford’s 1977 essay, “You are Dangerous to Your Health.” Crawford documents the evolution, from the early 1970s onward, of a rhetoric of personal responsibility for public health. Using health policy statements to substantiate his claims,
Crawford deems this rhetoric a response to concerns about rising healthcare costs and emerging research highlighting environmental and industrial causes of epidemic diseases, most notably, cancer. Under such conditions, the maintenance of public health necessitated potentially costly interventions, including stricter regulations of industry. High medical costs in the 1970s, coupled with the view, common among Americans, of medical care as a right also justified the move toward personal responsibility for public health. High medical costs, for example, “became a direct threat to the corporate sector, adding significantly to the costs of production through increases in health benefit settlements with labor, aggravating inflation, and diverting private and governmental resources” (665). To deal with these issues, health policy needed “to be redirected away from the extension of social programs which characterized the 1960s” (665). Crawford’s analysis identifies a distinct shift in policy “toward a health promotion strategy which calls upon the individual to become more responsible for [their] own health rather than to rely only on . . . medical services” (665).

This strategy, which employs a rhetoric of personal responsibility as a substitute for costlier interventions, has since the 1970s formed the basis of the “new public health,” or “neoliberal public health.”

The Canadian case is an important one here. Crawford attributes increasing U.S. investment in personal responsibility for public health to the 1974 publication of a report written by Canadian Minister of National Health and Welfare, Marc Lalonde—and I concur. Known as the “Lalonde Report,” *A New Perspective on the Health of Canadians* sought to

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4 In *The New Public Health* (1996), Alan Petersen and Deborah Lupton first propose the use of “new public health” to describe the emergence of a model of public health premised largely on personal responsibility. However, much recent scholarship—for example, Derkatch and Spoel, “Public Health Promotion of ‘Local Food’” (2017)—terms this model “neoliberal public health” to highlight its relationship to neoliberalization. Derkatch and Spoel observe, for example, of the tendency for public health messaging developed to promote healthy eating to constitute individuals as “neoliberal consumers who have a responsibility to support their regional economies by spending their money within the local food marketplace” (162).
redefine public health in Canada in the face of rising healthcare costs. To reduce the demand for health care, Lalonde proposed the more intensive use of health education and promotion. Rather than relying only on government-funded treatment and care, individuals needed to become actively engaged in the prevention of disease. Support for Lalonde’s proposal came from population-level data produced by Statistics Canada on the etiology of disease. Some of the factors linked to individual health status included environmental factors, such as pollution. Lalonde, however, also used data from Statistics Canada to argue that “self-imposed risks” that could usually be avoided made Canadians more vulnerable to death and disease. These “habits of indolence”—for example, smoking, alcohol use, and diet—threatened to “undo progress in raising the health status of Canadians” that had been made through governmental investments in medicine and public health (5). Individual health thus needed to be understood not only as an effect of access to health care, but also as shaped by biology, environment, and above all, lifestyle. Healthcare costs, Lalonde concluded, might be dramatically reduced through investment in health education and promotion, to reshape understandings of individual health.

To diminish healthcare costs, for example, Canadians had to be persuaded to see prevention as on par with, if not surpassing, medical treatment in attaining and maintaining health. Here, again, existing attitudes and beliefs posed a significant obstacle. “Most Canadians by far prefer good health to illness, and a long life to a short one,” Lalonde wrote, “but, while individuals are prepared to sacrifice a certain amount of immediate pleasure . . . to stay healthy, they are not prepared to forego all self-indulgence nor to tolerate all inconvenience in the interest of preventing illness” (8). Instead, Canadians acted in ways that implied “their individual belief that statistical probability, when it is bad, applies only to
others” (8). When illness struck, they also expected “rapid, quality care; all available resources must be marshaled on [their] behalf with little regard for cost” (8).\(^5\) Parts of Lalonde’s report emphasize the need to pair the focus on self-imposed risk with measures that targeted population-level health status. Personal responsibility was not his only concern. The report’s concluding objectives, for example, stress the need to limit the impact of health hazards on “high-risk” Canadians and improve access to health care among low-income populations, Aboriginal peoples, and rural Canadians. Not all illnesses and diseases could be prevented through personal responsibility, but the potential to prevent some of them strengthened the case for increased investment in health education and promotion.

Lalonde’s endorsement of rhetorical solutions to problems of health and disease took hold mainly because of the economic advantages of a model of public health premised on personal responsibility. Governments could diminish reliance on health care by underlining other factors besides medical treatment and care that influenced health status, like the “self-imposed risks” (5) that made Canadians more vulnerable to death and disease. Even environmental or industrial factors might be managed through the encouragement of personal responsibility, a point Crawford highlights in his writing on “healthism,” his term for the tendency, from the 1970s onward, to “situate the problem of disease at the level of the individual” (“Healthism” 365). Healthism, as Crawford observes, is the preoccupation with personal health as a primary—often the primary—focus for the definition and achievement of well-being; a goal which is to be attained primarily through the modification of life styles [sic], with or without therapeutic help. The etiology of disease may be seen as complex, but healthism treats individual behavior,

\(^5\) Crawford observes that in the U.S. “access to medical services [was, as in Canada, seen as] an essential component of personal and family security” (668). In the 1979 “Healthy People” report, which I discuss below, U.S. Surgeon General Dr. Julius Richmond argued that public health might be improved “not alone through increased medical care and greater health expenditures,” but rather by involving Americans directly in efforts to promote health and prevent disease (1).
attitudes, and emotions as the relevant symptoms needing attention. Healthists will acknowledge, in other words, that health problems may originate outside the individual, e.g. in the American diet, but since these problems are also behavioral, solutions are seen to lie within the realm of individual choice. Hence, they require about all else the assumption of individual responsibility. (“Healthism” 368, emphasis in original)

The moral implications of healthism reinforced the rhetoric of personal responsibility. Those who were healthy, this rhetoric held, were so because they adopted healthy habits. Those who became ill either failed in their responsibility for health or engaged in one of the “habits of indolence” linked in the Lalonde Report to the onset of disease and to untimely death.

Within Canada, writes public health historian Heather MacDougall, the Lalonde Report met with “severe criticism, particularly for its propensity to blame individuals for ‘risk-taking’” (957). However, as MacDougall observes, “[a]s neo-liberal economics came to dominate, funding for both preventive and curative systems was constrained. Health inequalities were identified and new programmes to deal with child poverty, HIV/AIDS and other issues were introduced but not effectively funded. Rhetoric was far less expensive than effective central, state, provincial and local action” (958). In Canada and beyond, the Lalonde Report radically altered approaches to public health. Worldwide, public health officials began to establish programs of health education and promotion aimed specifically at shifting perceptions of entitlement to health care—and thus of responsibility. In 1976, for example, officials in Scotland, Wales, and Northern Ireland released “Prevention and Health: Everybody’s Business,” a joint report that in many respects replicated the Lalonde Report in content and form. In 1979, U.S. Surgeon General Dr. Julius Richmond released “Healthy People: The Surgeon-General’s Report on Health Promotion and Disease Prevention,” which attributed most U.S. deaths “to unhealthy behavior or lifestyle” (958). In “Healthy People,”
Richmond credits Lalonde for establishing a new view of public health, one premised more on the value of personal responsibility and the use of public health messaging to induce it.

Since the mid-1970s, particularly with the publication of the Lalonde Report, the notion of responsibility that defines public health has changed appreciably. The years following the report’s publication, as sociologist Alan Petersen observes in 1996, were marked by a distinct shift away from the “notion that the state should protect the health of individuals” (“Risk and the Regulated Self” 49). Petersen makes these observations in the context of a Foucauldian analysis that uses notions of governance and risk to describe the subject constituted by the rhetoric of personal responsibility. Although the Lalonde Report supplied a model for inducing this shift, the imperative of personal responsibility gained further momentum from the emergence in the late 1970s of the human immunodeficiency virus (HIV), the retrovirus linked to acquired immune deficiency syndrome (AIDS). The fear, anxiety, and uncertainty generated by the AIDS epidemic dramatically intensified perceptions of responsibility and risk. Susan Sontag documents some of these shifts in her essay, *AIDS and Its Metaphors*. As Sontag writes there, responses belied a “premodern” understanding of AIDS as “incurred by people both as individuals and as members of a ‘risk group’—that neutral sounding, bureaucratic category which also revives the archaic idea of a tainted community that illness has judged” (46). As HIV/AIDS exacerbated infection-risk anxieties, a program of health education and promotion emerged to stress the need for individuals to personally manage their risk of exposure. Efforts to address the AIDS epidemic also became an outlet for broader anxieties about infection risk, and these too made their way both into public health campaigns and into public discourse. AIDS became a metaphor, among other things, “for contamination and mutation” (67), observes Sontag, and
this moralizing and stigmatizing of both the disease and infection risk more generally became a defining feature of contemporary public health—again, in Canada and beyond.

As an approach to public health, personal responsibility may seem empowering. When encouraged to take health matters into their own hands, as Petersen writes, individuals are “no longer the passive recipients of health information, but rather active citizens who are to be supported in their efforts to reach their self-defined health objectives” (“Risk and the Regulated Self” 44-45). However, he adds, even in its empowering of individuals, the rhetoric of personal responsibility imposes “a far more subtle and effective mode of population regulation … [and introduces] new possibilities for intervention into private lives” (“Risk” 49). Critics, in documenting the discursive strategies used to encourage personal responsibility, often point to this rhetoric’s more problematic effects. Flis Henwood, Roma Harris, and Philippa Spoel examine the use of discourses of empowerment and choice to encourage “healthy living.” Within neoliberal public health messaging, these discourses work to discipline individuals by provoking feelings of “uncertainty, anxiety, and self-doubt” (2031). Choice and empowerment discourses, however, also complicate the engagement of individuals in the maintenance of public health. In interviews with UK and Canadian citizens, for example, Henwood, Harris, and Spoel document sharp increases in anxiety among those tasked with exercising personal responsibility.

Personal responsibility for public health maintains a foothold because it appears to be essential to the well-being of both individuals and societies. “Lifestyle,” as bioethicist David Resnik explains in a 2007 essay from the Journal of Medical Ethics, continues to play “a major role in most of the illnesses in industrialised nations. Six of the 10 leading factors contributing to the global burden of disease are lifestyle related: unsafe sex, high blood
pressure, tobacco use, alcohol use, high cholesterol and obesity. Lifestyle-related illnesses also contribute to the rising costs of healthcare” (444). Holding individuals responsible for their health outcomes makes economic and moral sense—and, for this reason, the rhetoric of personal responsibility has considerable appeal. Yet even as an approach to lifestyle-related illnesses, this rhetoric is limited, for example, as Resnik observes, by the difficulty of implementing a “system that holds individuals responsible for their own health” (444). Further, as Nadine Wathen, Roma Harris, and Sally Wyatt argue, the work demanded of individuals by the rhetoric of personal responsibility is often more difficult to quantify than lifestyle-related healthcare costs. This work is also often just as difficult to sustain. In four case studies, I thus aim to clarify both what kind of work is demanded of individuals and what consequences arise from approaching certain public health issues as matters of personal responsibility.

Public Health Messaging: Risk, Responsibility, and Constitutive Rhetoric

Despite its appeal, the expectation of personal responsibility has economic, social, cultural, and material effects that tend not to be sufficiently considered. Rhetorical study is thus invaluable to ongoing critiques of what Wathen, Wyatt, and Harris term the “imperative” of personal responsibility because it has the capacity to reveal the persuasive means through which this model of public health takes hold. In A Rhetoric of Motives, Kenneth Burke defines rhetoric as “a means of inducing cooperation in beings that by nature respond to symbols” (43). Burke’s definition aptly describes rhetoric’s function in the context of public health. As the study of persuasive discourse, rhetoric provides insight into how individuals come to see personal responsibility as essential to health status—both their

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Wathen, Harris, and Wyatt make this point about the work expected of individuals by the rhetoric of personal responsibility in the introduction to their 2010 anthology, Configuring Health Consumers.
own and that of others. To rhetorical study, public health campaigns in return offer a compelling site in which to study discursive negotiations of responsibility and risk.

The campaigns I examine in the following chapters function as constitutive texts. “Constitutive rhetoric” is James White’s term for the persuasive means “by which culture and community are established, maintained, and transformed” (28). Taking up White’s term, rhetorician Maurice Charland illustrates how appeals to subjectivity help to induce cooperation with political or ideological objectives. As Charland argues, “the position one embodies as a subject is a rhetorical effect” (148). The theory of constitutive rhetoric holds that interpellation into a given subjectivity provides a powerful means of influencing action. Indeed, in the campaigns I examine, the encouragement of personal responsibility depends upon the shaping of subjectivity. Public health scholars typically describe the subjectivity constituted in health education and promotion as that of the “health citizen.” As I demonstrate, public health campaigns often persuade by emphasizing belonging, or “fitness,” as an effect of compliance with recommended practices.

Another essential feature of the rhetoric of personal responsibility is its emphasis on risk. For example, writing about HIV/AIDS, rhetorician J. Blake Scott stresses the identification of “high-risk” and “at-risk” populations as essential to the work of inducing cooperation with measures such as HIV testing. Risk constructions such as these may have a basis in epidemiological data, but as Scott argues, they have “also been shaped by cultural notions . . . that stigmatize certain individuals and communities” (“Extending” 360). Risk discourse helps to situate the problem of infection at the level of the individual. However, the

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7 For an extensive discussion of this concept, see Porter, Health Citizenship (2011). Recent studies of the use of public health messaging to constitute health citizens include Spoel, Harris, and Henwood, “Rhetorics of Health Citizenship” (2014); and Derkatch and Spoel, “Public Health Promotion of ‘Local Foods’” (2017).
rhetoric of personal responsibility is a “risky” rhetoric, as Scott calls it, because it also
distracts attention from the influence of context on infection’s spread.

To address public health’s transformation into a matter of personal responsibility, I
thus adopt the rhetorical-cultural methodology that Scott applies in his writing on risk
discourse and HIV/AIDS. Scott widens the scope of a textual rhetorical analysis to include a
focus on the “larger cultural arguments and movements” underlying much public health
messaging (Risky Rhetoric 24). The “basic moves of a rhetorical-cultural approach,” Scott
writes, “are accounting for science’s broader conditions of possibility, mapping the shifting
intertext of science in action, evaluating science according to its effects, and targeting
opportunities to intervene in harmful effects” (Risky Rhetoric 21). Scott’s notion of a
“shifting intertext” is crucial here, since a rhetorical-cultural methodology does not limit its
observations to only the text of a single campaign; nor does it only consider the rhetorical
features of a campaign to be the effect of a straightforward relationship between speaker and
audience. Adopting this approach, I pair traditional rhetorical analysis with a consideration of
additional forces that may influence both the production and reception of public health
messaging.

While the rhetoric of personal responsibility is by no means limited to one context, I
focus on public health messaging directed at audiences in Canada and the U.S. My main
reason for choosing these locations is my interest in the legacy of Lalonde’s report in both
countries. I developed my insights about these campaigns by collecting and reviewing local
and state or provincial public health campaigns related to hand hygiene, vaccination,
antibiotic use, and obesity, focusing mainly on web-based texts. Some of these campaigns are
discussed in what follows. I reviewed dozens of scientific and medical studies to deepen my
understanding of the science that informs each of these four areas of health education and promotion. To document the impetus for public health campaigns that endorse the assumption of personal responsibility, I consulted numerous policy documents, white papers, and technical reports. I also reviewed hundreds of news stories and blog posts discussing the merits of everything from the value of hand hygiene promotion to the severity of “epidemic” obesity. More broadly, I noted that the necessity of personal responsibility for public health increasingly feature prominently in television and film. My observations throughout are thus also informed by my study of the popular culture and public debates surrounding each of my cases.

Outline of Chapters

My investigation begins with a case study on handwashing campaigns. Increasingly common in North America since the outbreak of severe acute respiratory syndrome (SARS) in Toronto in 2003, these campaigns endorse personal responsibility by stressing the risks—and dangers—of human contact. In this first chapter, I describe how expert and societal anxieties about emerging infectious diseases created the impetus for a rhetoric of personal responsibility aimed at involving individuals in infection control. This rhetoric, I argue, is defined in this context by its emphasis on the potential for individual bodies not only to spread infection, but to initiate outbreak. Conversely, according to a slogan developed by the U.S. Centers for Disease Control and Prevention (CDC), “Clean hands save lives.” To illustrate, I describe a U.S. state-level campaign to enforce hand hygiene and other forms of illness etiquette within the workplace. Handwashing campaigns such as the one I examine emphasize the capacity for personal habits to diminish risk. In considering this campaign, I

8 This slogan appears throughout the U.S. CDC’s web-based campaign. See, e.g., “Handwashing: Clean Hands Save Lives.”
note the potential for the rhetoric of personal responsibility to engender a culture of stigma and blame that may work against the need for cooperation in infection control. I characterize hand hygiene promotion as both a “constitutive rhetoric” and a “stigmatizing rhetoric.” Whereas a constitutive rhetoric encourages action by cultivating subjectivity, a stigmatizing rhetoric stresses culpability to motivate behavior change. Partly a response to societal anxieties about infection’s spread from person to person, handwashing campaigns help to normalize a model of public health that prioritizes behaviour change over structural intervention.

My next chapter takes up vaccine messaging. Vaccination is by its very nature a public health initiative that requires participation. “Herd,” or “community,” immunity, for example, describes the indirect protection accorded to those who have not been, or cannot be, vaccinated. Immunity of this kind is achieved only once a high proportion of the community’s members have been vaccinated against a disease. During H1N1, amid concerns about low vaccination rates, public health officials began to promote flu vaccine by stressing the boundary between vaccine science and non-science. Many campaigns continue to encourage vaccination by depicting certain anxieties or concerns as “fictions,” “misconceptions,” or “myths,” to be remedied by improved knowledge of facts. In this chapter, I examine the ways in which these efforts to increase knowledge of vaccine science encourage personal responsibility for public health. I also describe pro-vaccination campaigns as, in part, a response to concerns about the publication of a now-discredited study that posited a link between autism and the measles, mumps, and rubella (MMR) vaccine. Here, the use of a rhetoric of personal responsibility to increase vaccination rates comes at the expense of a more nuanced understanding of the actual sources of “vaccine
hesitancy.” In this chapter, I stress the consequences of addressing low vaccination rates—and, by extension, vaccine hesitancy—as symptomatic of a knowledge crisis rather than as, among other things, a crisis of confidence or trust. Indeed, as I argue, the rhetoric of personal responsibility works against the increasing recognition of vaccine hesitancy as “complex and context specific” (SAGE Report 7).

My third chapter explores a similar predicament—that is, the ways in which the encouragement of personal responsibility may interfere with understandings of a public health problem and efforts to resolve them. In this chapter, I document some of the rhetorical means used to encourage personal responsibility for antibiotic use amid concerns about the evolution and spread of antibiotic-resistant infections such as methicillin-resistant Staphylococcus aureus (MRSA). The costs and dangers of these infections have generated support for the development of public health messaging to transform patterns of antibiotic use and prescription in ways that would limit the evolution of resistance. In my analysis, for example, I highlight the invocation of discourses of antibiotic dependency and demand to moralize the evolution of antibiotic resistance in ways that benefit the emphasis on personal responsibility. By underscoring how patterns of antibiotic use among individuals exacerbate the evolution of ARIs, both discourses enhance impressions of personal responsibility as an adequate solution to the crisis of antibiotic resistance. Drawing on Kenneth Burke’s notion of “terministic screens,” and Robert Proctor and Londa Scheibinger’s notion of “agnotology,” I point to how the framing of antibiotic resistance in terms of personal responsibility may impede efforts to address it. Messages about personal responsibility, for example, compete with the marketing of broad-spectrum antibiotics, often in ways that invite individuals to request these drugs by name. In this context, the discourses of dependency and demand
deflect attention from the pharmaceutical industry’s influence on current patterns of antibiotic use and prescription and the potential need for regulation of direct-to-consumer advertising (DTCA).

Chapter Four examines the sense of urgency surrounding current levels of “overweight” and “obesity,” terms used by public health officials to describe weight “that is higher than what is considered as a healthy weight.” Obesity becomes a public health priority partly because of an epidemic framing: it is, in other words, a metaphoric epidemic. Throughout this chapter, I use the term “epidemic obesity,” rather than “obesity epidemic,” to signal the increasing pervasiveness of concerns about the putative health risks of overweight and obesity. The discourse of epidemic obesity is, I argue, an epideictic rhetoric, a rhetoric that both praises individual efforts as crucial to public health and blames individuals for the spread of “epidemic” obesity. This discourse is also a constitutive rhetoric, a means of cultivating self-governing health subjects, here again defined as those who regard public health as predominantly arising from individual actions and choices. My examination of epidemic obesity underscores some of the ways in which, despite its appeal, the rhetoric of personal responsibility has the potential to work against the aims of public health. Much of the scholarship on this discourse, for example, deems it an effect of societal anxieties about labour productivity. Drawing on this scholarship, I stress the stigmatization of overweight and obesity as both an effect of this discourse and significant to its rhetorical work within the context of neoliberalism. My analysis of key texts from a U.S. federal campaign created by the CDC, for example, highlights its endorsement of practices of self-governance as critical to epidemic obesity’s containment. I also explore the rhetorical

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9 This definition appears on “Defining Adult Overweight and Obesity,” a page of the U.S. CDC’s website.
dimension of a public-private partnership developed to address “epidemic” obesity, including the appropriation of public health ethos to depict media consumption as a meaningful form of agency.

Undoubtedly, public health’s preservation demands the assumption of personal responsibility: there is no getting around the need to involve individuals in disease prevention. It is therefore essential to understand clearly when a rhetoric of personal responsibility works against public health. My goal, in the following case studies, is thus to stress the limits, and problems, of the neoliberal model of public health this rhetoric supports.
Cultivating Personal Responsibility by Promoting Hand Hygiene

*The interactions that make us sick also constitute us as a community.*


On April 29, 2009, to mark the 100th day of his first term in office, U.S. President Barack Obama gave a nationwide press briefing. A tradition of the U.S. presidency, the 100th-day press conference gave Obama an opportunity to chart his administration’s progress in resolving some of the nation’s most pressing problems. That day, prior to Obama’s address, the Emergency Committee of the World Health Organization (WHO) had raised its pandemic alert to a Phase 5. Its second highest ranking, the WHO’s Phase 5 alert sent a “strong signal that a pandemic [was] imminent.” So, the 100th day’s headlining issues of economic recovery, job creation, and the wars in Afghanistan and Iraq came second to Obama’s discussion of H1N1, the pandemic strain of the influenza virus. Obama opened his remarks, for example, by outlining the steps that his government had taken to protect the American people from a pandemic.10

Measures adopted to fend off H1N1 included carefully monitoring the spread of the novel strain and stockpiling medical supplies and drug treatments. On the advice of public health experts, the U.S. government had also considered closing public schools in response to suspected or confirmed cases. Obama urged parents and employers to develop contingency plans if the spread of H1N1 led to massive workplace and school closures. “And finally,” Obama concluded, “I’ve asked every American to take the same steps you would to prevent any other flu: keep your hands washed, cover your mouth when you cough, stay home from

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10 For the full text of President Obama’s remarks, see “Transcript: President Obama’s 100th-Day Press Briefing.”
work if you’re sick, and keep your children home from school if they’re sick.” Practicing these various forms of illness etiquette, Obama implied, demonstrated one’s assumption of personal responsibility in response to the heightened risk of infection.

This chapter contributes to ongoing investigations among rhetoricians of health and medicine of constructions of responsibility and risk.\textsuperscript{11} A rhetorical perspective, as Lisa Keränen explains in a 2014 essay, illuminates “how specific symbolic patterns structure meaning and action” in health and public-health contexts (37). Health humanities scholars and rhetoricians of health and medicine share a common concern for the ethical issues that arise from risk-management exercises undertaken in the name of public health. Keränen also stresses a common interest in the formation of publics, not just through the “official texts of biomedicine,” but also through the practices adopted in response to these texts (104). To healthcare providers, rhetorical study offers insight into how patients understand risk and responsibility and what these understandings mean for healthcare delivery amid crisis. Rhetorical study also helps to identify the consequences of discourses of risk and responsibility, including the ways in which these discourses may work against their stated aims. Writing in the \textit{Journal of Medical Humanities}, for example, Huiling Ding uses rhetorical analysis to demonstrate the economic and sociocultural consequences of media portrayals of “at risk” populations during severe acute respiratory syndrome (SARS).

Here, I examine the use of public health messaging that stresses the risks—and dangers—of human contact to motivate the assumption of personal responsibility. This messaging, I argue, in transforming infection risk into a matter of personal responsibility, normalizes a model of public health that prioritizes behaviour change over structural

\textsuperscript{11} See, for example, Keränen, “Concocting Viral Apocalypse” (2011); Angeli, “Metaphors in the Rhetoric of Pandemic Flu” (2012); Ding, \textit{Rhetoric of a Global Epidemic} (2014a); and Ding, “Transnational Quarantine Rhetorics” (2014b).
intervention. Some scholars—for example, sociologists Alan Peterson and Deborah Lupton—term this neoliberal model the “new public health.” Personal responsibility serves essential functions in response to infection risk: it may be reassuring to know, for example, that one might protect oneself and others from sickness. However, the mandating of personal responsibility also potentially engenders a culture of stigma and blame. Wald, for example, proposes the “outbreak narrative” to describe how media and popular-cultural portrayals shape responses to infectious disease. Her primary concern in documenting the influence of particular outbreak narratives is their tendency to stigmatize individuals by deeming them culpable for the spread of the infections to which they have succumbed. For example, as Wald argues of “superspreaders,” a term coined in media coverage of severe acute respiratory syndrome (SARS), “even the most determined superspreaders could not do the work of infection without a conducive environment” (4). Here, I argue that a rhetoric of personal responsibility may blunt perceptions of both the distribution of risk and of the conditions required to reduce risk, even among individuals. During H1N1, for example, partly in response to this rhetoric, universal paid sick leave became a topic of debate, illustrating that managing risk demands an environment that supports personal responsibility.

In this chapter, I characterize hand hygiene promotion as both a “constitutive rhetoric” and a “stigmatizing rhetoric.” Whereas a constitutive rhetoric encourages action by cultivating subjectivity, a stigmatizing rhetoric uses stigma to motivate behavior change. In what follows, I underscore how expert anxieties about emerging infectious diseases created the impetus for the evolution of a rhetoric of personal responsibility. This rhetoric, I stress, is defined by its emphasis on the potential for individual bodies to spread infection. Drawing on the insights of scholars of rhetoric of health and medicine, I highlight the constitutive and
stigmatizing rhetoric employed in a U.S. state-level campaign to enforce illness etiquette within the workplace. My analysis both illuminates the centrality of stigma and blame to the mandating of personal responsibility via hand hygiene promotion and argues against their use to prioritize individual behavior change over other interventions.

A drawback of critiquing hand hygiene promotion is appearing to be against hand washing and other expressions of illness etiquette. Hand hygiene is a vital form of infection control, and as such, it is also an ethical practice, particularly during an outbreak. Rather than argue against hand hygiene, I explore hand hygiene promotion’s limits as well as its implications for perception of risk and responsibility. In this respect, my analysis draws its inspiration from the work of sociologist Jonathan Metzl, who, in the introduction to his co-edited multidisciplinary anthology Against Health writes that health is a “desired state, but it is also a prescribed state and an ideological position” (2). The same argument applies to public health, which broadly speaking entails the strategic, organized effort to “persuade a defined public to engage in behaviors that will improve health or refrain from behaviors that are unhealthy” (Springston 713). Hand hygiene promotion especially invites further scrutiny because its prescriptive, ideological qualities far too often go unnoticed. Hence, I focus my attention here on describing how handwashing campaigns benefit the ongoing enforcement of personal responsibility.

Research on hand hygiene promotion finds that this messaging has an impact on health behaviors and thus, by extension, on health outcomes. So, why might we who have been exposed to these campaigns concern ourselves, perhaps unnecessarily, with their implications for societal understandings of responsibility and risk? My conclusion is that the rhetorical means used to encourage personal responsibility have the potential to skew

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12 See, e.g., Rajamaran et al., “Implementing Effective Hygiene Promotion” (2014).
perceptions of both the distribution of infection risk and the need for adequate structural supports to address it. Certainly, handwashing campaigns benefit the need for cost-effective, comprehensive responses to infection risk—but these same texts also create opportunities to profit from the stigma and blame used to motivate the assumption of personal responsibility. My aim, in this first chapter, is thus to underscore the limits of personal responsibility, both as a discursive means of managing infection risk and, more generally, as a cornerstone of the new public health.

The Turn to Hand Hygiene Promotion in the Era of Emerging Diseases

To understand how hand hygiene promotion became a vehicle for encouraging personal responsibility, it helps to first explore how infection risk became a defining feature of life in the twenty-first century. As philosopher Ian Hacking observes, every culture has its own “portfolio” of risks that shifts and changes over time. No single theory can account for why certain risks are included in a society’s portfolio. Nevertheless, Hacking argues, we might seek “an understanding of necessary conditions under which a collective risk should become high priority, part of the communal risk portfolio of causes to work for (or against), or at least to worry about” (22). Below I describe some of the conditions under which, from the 1990s onward, the threat of outbreak became a preoccupation among medical experts and public health officials. This preoccupation necessitated a change in our orientations, as societies, toward infection risk, and it also created a sense of urgency surrounding infection’s spread via individual bodies. This latter preoccupation, I argue, helped to justify increasing emphasis in public health messaging on personal responsibility.

In discussing the evolution of a rhetoric of personal responsibility for infection risk, my point of departure is the emerging-infectious-diseases framework. In the introductory (1995)
issue of *Emerging Infectious Diseases*, a peer-reviewed medical journal published by the U.S. Centers for Disease Control and Prevention (CDC), epidemiologist Stephen Morse defines emerging infectious diseases as “infections that have newly appeared in the population, or have existed but are rapidly increasing in incidence or geographic range” (7). Morse posits that, because of emerging infectious diseases, the twenty-first century will be defined by the elevated risk of outbreak. Morse cites several factors that contribute to this elevated risk. These factors include microbial adaption; climate change; shifts in human susceptibility; poverty and social inequality; the breakdown of public health; war and famine; economic development; bioterrorism; and shifts in human demographics and trade (10). The work of other scholars suggests that shifts in human demographics and trade constituted the strongest explanations for the heightened risk of outbreak.

At the end of the twentieth century, bioethicist Nicholas King argues, the notion that “disease knows no borders” gained currency. This notion took hold through widespread emphasis, in media and popular culture, on globalization’s impact on microbial activity. “With increasing international commerce and travel,” King explains, “emerging diseases could be rapidly transmitted from one country to another, constituting a global threat that demanded immediate response” (63). Globalization’s amplifying of the risk of outbreak justified massive investment in the formation of a global system of epidemiological surveillance capable of tracking and monitoring the spread of novel and re-emerging diseases.\(^\text{13}\) Documents such as *Emerging Infectious Diseases from the Global to the Local Perspective*, a report of a two-day conference hosted in Washington, D.C. in 1996, defended

\(^{13}\) A “re-emerging” disease is one that had previously decreased in incidence, but has begun to re-occur, owing to either changes in the health status of the susceptible population or the evolution of the causative agent. For example, some argue that “whooping cough” has re-emerged because of diminishing vaccination rates in certain places (see, e.g., Cardeñosa et al.).
such global surveillance as necessary to the detection and containment of emerging microbial threats. The report argued for the implementation of a “well-designed, well-implemented surveillance program that can detect unusual clusters of disease, document the geographic and demographic spread of an outbreak, and estimate the magnitude of the problem” (2). Co-authored by Nobel prize-winning molecular biologist Joshua Lederberg with Jonathan Davis, *Emerging Infectious Diseases* held that a global epidemiological surveillance system might have limited the impact of human immunodeficiency virus (HIV).14

Throughout the globe, however, and especially in developing countries, infectious diseases were neither emerging nor re-emerging. Clinician and medical anthropologist Paul Farmer makes this point in his writing against the emerging-infectious-disease framework. The central rhetorical aim of this framework, Farmer argues, was to generate funding for infectious-disease research and in doing so to marshal “a sense of urgency, notoriously difficult to arouse in large bureaucracies” (39). Through their emphasis on heightened risk, proponents of the emerging infectious disease framework sought to renew investment in research programs and outbreak-management plans that had languished following the development of modern antibiotics and vaccines.15 King similarly views the notion that “disease knows no borders”—which he calls a “scalar narrative”—as partly a rhetorical means of securing research funding. Broadly defined, scalar narratives “invoke places and spaces at different geographic scales to explain events, enlist allies, and attract attention and

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14 The significance of HIV/AIDS to the emerging infectious diseases framework must be acknowledged. While globalization justified the argument that, it not carefully monitored and contained, a local epidemic could become a global pandemic, the AIDS crisis both proved the risks of global trade and travel and foregrounded the role individuals play in spreading contagion. For a critique of the moralizing quality of public discourse about HIV/AIDS, see Susan Sontag’s *AIDS and Its Metaphors*. Cindy Patton has also critiqued the moralizing discourse of the AIDS epidemic, most recently in *Globalizing AIDS*.

15 Binder, Levitt, Sacks, and Hughes discuss the implications of mid-twentieth-century innovations in sanitation, vaccines, and antimicrobial agents for public health funding.
funding” (63). As a persuasive resource in debates over emerging diseases, scale helped to shape risk perceptions in ways that served different political and professional agendas and that generated revenue for programs such as the global surveillance system endorsed by Lederberg and colleagues.17

Scale also featured in popular culture’s portrayal of outbreak risk as increasing in tandem with the globalization of trade. Blockbuster films such as Wolfgang Petersen’s Outbreak and books like Richard Preston’s bestselling epidemiological drama, The Hot Zone, popularized the notion that globalized networks of travel and trade aided the spread of infection. One of the most influential analyses of the impact of globalization on the risk of outbreak is The Coming Plague. Written by science journalist Laurie Garrett and first published in 1994, the book presents a world thrown “out of balance” by “dramatic increases in [the] worldwide movement of people, goods, and ideas,” which Garrett describes as “the driving force behind the globalization of disease” (3). Fueled by media coverage and a popular culture swelling with images of outbreak, unease about how globalization facilitates the transmission of harmful pathogens lent considerable weight to the claim that local outbreaks could quickly escalate into global pandemics. By contributing to public perceptions of elevated risk, images of outbreak in popular culture reinforced support for investing in epidemiological surveillance to address infection risk. Stakeholders in debates about emerging diseases, for example, invoked imagery typical of popular representations of infection risk, such as Outbreak and The Hot Zone, to create new economic and political opportunities. King notes, for example, that the program of epidemiological surveillance

16 King’s notion of scale as a persuasive resource rather than “an ontologically given geographic territory or a priori unit of analysis” derives from the writings of critical geographers Erik Swyngedouw (“Neither Global Nor Local”) and Neil Smith (“Geography, Difference, and the Politics of Scale”)
17 Obama’s commitment of $1.5 billion to “monitor and track” H1N1 is a powerful indication of the lasting economic legacy of the emerging infectious diseases framework.
defended as the single most effective means of forestalling a global pandemic entailed passing most investigations of microbial activity through American laboratories. This move generated significant revenue in the form of increased funding for, and investment in, U.S.-based “Big Science.”

Popular representations of the catastrophic risks of outbreak also generated societal anxiety about the role of individuals in the spread of infection, renewing fixation on the figure of the human carrier of disease. Wald provides an extensive account of contemporary iterations of the human carrier of disease in her book, *Contagious*. During the AIDS epidemic, for example, the human carrier appears as “patient zero,” the disease’s purported epidemiological index case; similarly, during the outbreak of severe acute respiratory syndrome (SARS), the human carrier became the superspreader, a disputed term for a person who infects many more secondary cases than others infected with the same pathogen. She was also designated as “patient zero,” a phrase evocative of what rhetorician Judy Segal calls the “figure of the patient as pariah” (“Interdisciplinarity” 20). Working against the depiction of “patient zero” as “pariah,” Segal observes, was the Canadian Broadcasting Corporation’s (CBC) airing of an interview with “Patient Three” the adult daughter of the woman believed to be the index case of the disease in Toronto:

> Because ‘Patient Three’ told a story—the story of her own mother’s illness and death, her brother’s illness and death, and her own efforts, in the course of her grieving and her own grave illness, to protect others from exposure to infection—the anonymous, always racially identified, and often vilified person, known only for being a body in which the [SARS] virus was imported from Hong Kong, became an innocent individual—someone’s mother—who suffered and died. (“Interdisciplinarity” 20)

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18 Keränen makes a similar claim, that the framing of bioterrorism as a catastrophic risk exacerbated by globalization justified the formation of the contemporary biodefense industry, which is worth billions of dollars annually. The use of scale to advance political, economic, and disciplinary agendas explains why some outbreaks (e.g., the 2001 anthrax attacks) attract attention, while others (e.g., multidrug-resistant tuberculosis in developing countries) are ignored.
Characterizations of patient zero as pariah, which are common to both epidemiological and popular accounts, helped to heighten perceptions of culpability in the transmission of infectious diseases.

Negative representations of patient zero, in stressing culpability for the transmission of infection from person to person, also had implications for the evolution of a rhetoric of personal responsibility for infection risk. For example, just as concerns about globalization’s implications for outbreak generated interest in funding for epidemiological surveillance, concerns about the spread of disease from person to person increased investment in hand hygiene as a potential safeguard against emerging and re-emerging diseases. A search for studies of hand hygiene reveals its increasing prominence in professional literature from the nineties onward. For example, a Google Scholar search for the term “hand hygiene” between 1980 and 1995 produces fewer than three hundred results. A search for articles published between 1995 and 2014, in the years ensuing the introduction of the emerging infectious diseases framework, yields over 20,000 results. While many studies discuss the importance of hand hygiene in healthcare settings, others endorse the use of hand hygiene among individuals, to reduce infection risk.

Rhetorical conceptions of disease transmission underlying the emerging infectious diseases framework offer insight into how certain dangers win high priority in a society’s portfolio of risks. Risks become something “at least to worry about,” to quote Hacking, because certain ways of attending to emerging diseases produce some value to the society, or societies, in question. The measures adopted in response to the framework of emerging

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19 See Bud, who in “Antibiotics: The Epitome of a Wonder Drug” argues that the rise of antibiotic-resistant infections may also herald “the revival of the hygienic and perhaps even the moral disciplines that predated the antibiotic revolution” (n. p.). I describe the rhetoric of personal responsibility for antibiotic resistance in Chapter Three.
infectious diseases may appear to be justified by the putative heightened risk of outbreak. However, the motivations for the selection of certain measures over others must be examined to understand fully the implications of different programs of managing infection risk. The potential opportunities involved in establishing that an outbreak poses an overwhelming risk are relevant for a critical reading of the turn to hand hygiene promotion in what has been called the “era of emerging diseases.” As an extension of the emerging infectious diseases framework, handwashing campaigns help to distribute both the economic and symbolic burdens of outbreak among members of the public. Even when public health agencies supply their constituents with hand hygiene products such as hand sanitizer, an entire industry has developed to encourage individuals to supply themselves with an arsenal of these products as well.

Handwashing campaigns also recruit citizens into active participation in infection-control measures, as these campaigns situate the risk of infection within individual bodies. Indeed, as implied by “clean hands save lives,” a slogan used by both the U.S. CDC and the WHO, lives lost to infection may be understood in part as failures of personal responsibility. The emerging infectious diseases framework, which yokes together the local and global, also informs the rhetoric of personal responsibility. Handwashing campaigns enhance impressions of the need for personal responsibility by implicating individual bodies in global outbreaks of infectious disease. Steven Soderburgh’s 2011 medical thriller, *Contagion*, for example, belabours these connections between personal hygiene and global pandemic. As the film ends, audiences learn that poor hand hygiene—and hand-to-hand contact—was the cause of the film’s catastrophic outbreak. The same associations also frequently appear in public health messaging—for example, in a WHO campaign directed at healthcare professionals,
according to which hand hygiene has the capacity to “change the world” (“Save Lives: Clean Your Hands”). In the era of emerging diseases, personal hygiene—and lack thereof—can have global effects.

Handwashing campaigns developed by public health agencies may appear to be a practical and even inevitable response to infection risk. Yet, as with investments in epidemiological surveillance and the biodefense industry, these campaigns also serve a range of interests, while asking individuals to see themselves—and their bodies—as always already the sources of the spread of infection. A kind of interpellation, as I discuss below, this narrative of disease transmission has been taken for granted as a necessary response to the elevated risk of outbreak. Support of the turn to hand hygiene promotion is especially pronounced in studies of hand hygiene compliance, both in healthcare settings and among the public. Hand hygiene is lauded as the most effective form of infection control, and it is also celebrated as the most cost-effective, more valuable than increased investment in water quality and sanitation. Media accounts also characterize the spread of infectious diseases as a personal failing—a failure to adapt our personal habits to the globalized culture of risk that defines the era of emerging diseases. Many reports discuss varying hand hygiene levels as reflections of our shortcomings when it comes to our duty to maintain public health, portraying the spread of infection as a personal failing. Indeed, as I explain next,

20 See, e.g., Helms et al., which concerns hand hygiene compliance in healthcare settings. For a study of hand hygiene compliance among members of the public, see Borchgrevink, Cha, and Kim, “Hand Washing Practices.”

21 The main source of this latter claim is “Talking Dirty: How to Save a Million Lives,” in which Valerie Curtis, Director of the London School of Hygiene and Tropical Medicine, reports on the results of a meta-analysis (Curtis and Cairncross) conducted in rural Ghana and India.

22 For example, news coverage of the study conducted by Borchgrevink, Cha, and Kim stressed the finding that individuals often fail to adhere to the standards of public health, such as the CDC’s guidelines, which specify that “proper” hand hygiene involves washing for a minimum of 15 to 20 seconds. See Bakalar; “Proper Hand-Washing.”
handwashing campaigns often enforce the assumption of personal responsibility by emphasizing our culpability, as individuals, for infection’s spread.

**Handwashing Campaigns and the Rhetoric of Personal Responsibility**

Personal responsibility is a cornerstone of neoliberal public health, but hand hygiene promotion is an especially persuasive vehicle for popularizing an individualistic conception of infection risk. By “hand hygiene promotion,” I mean efforts to instruct a broad, lay public in hygiene practices typically used to reduce the transmission of disease-causing pathogens, especially in hospitals and clinics. In this section, I use “handwashing campaigns” and “hand hygiene promotion” interchangeably to describe the discursive encouragement of this habit. I also focus mainly on hand hygiene promotion within North America, where amid H1N1, handwashing campaigns and hand hygiene products alike became endemic. Commenting on this trend in a *New Yorker* essay, David Owen attributes the phenomenal success of Gojo Industry’s blockbuster hand sanitizer, Purell, to anxieties about infection risk. In fact, as Owen explains, for a decade prior to SARS, Purell languished in obscurity. Today, hand sanitizer is a product category worth millions of dollars. While worldwide sales figures vary, a CNN story reports that shipments of hand sanitizer tripled during H1N1, from 1 million kilograms to 3 million kilograms.\(^{23}\) A more recent report states that U.S. sales of hand sanitizer reached $300 million in 2009, and have since averaged nearly $200 million per year.\(^ {24}\) The steep increase in hand-sanitizer sales has been regarded critically as both indicative of and responsible for a problematic shift in societal perceptions of infection risk.\(^ {25}\) Purell’s unprecedented sales figures are also inextricably tied both to the increased promotion

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\(^{23}\) This figure is quoted in Rooney, “Hand Sanitizer in Short Supply as Swine Flu Hits.”

\(^{24}\) See Fottrell, “Hand Sanitizer Spread Faster than the Flu.”

\(^{25}\) In Sadler, “Do You Really Need Hand Sanitizer?” health historians Jacalyn Duffin and Nancy Tomes critique anxiety about infection risk as the source of hand sanitizer’s popularity.
of hand hygiene in recent years and to the neoliberalization of public health. Hand sanitizer and related products help individuals protect themselves from infection—but more importantly, these products enable corporations to profit from that assumption of personal responsibility.

Hand hygiene promotion’s alignment with an axiom of neoliberalism—the emphasis on personal responsibility—is thus worthy of further examination. In *A Brief History of Neoliberalism*, David Harvey describes the typical characteristics of the neoliberal state. As Harvey explains, the “social safety net is reduced to a bare minimum in favour of a system that emphasizes personal responsibility. Personal failure is generally attributed to personal failings, and the victim is all too often blamed” (76). Harvey’s account stresses the economic advantages of the neoliberal emphasis on personal responsibility. Indeed, a neoliberal approach to infection risk has both shifted attention away from costlier programs of outbreak management and accorded private stakeholders unparalleled economic advantages. Arguably, the main benefactors of personal responsibility for infection risk are the corporations that develop and distribute products in support of illness etiquette. Yet the recent popularity of hand sanitizer does more than reflect the successful marketing of hand hygiene as an antidote to both uncertainty and infection. Rather, this shift in consumption patterns also illustrates the tremendous impact of handwashing campaigns on a risk-oriented subjectivity.

Anna Plyushteva argues, for example, that hand hygiene promotion in developing countries is typically motivated by more than the aim of reducing high mortality rates due to infection. Plyushteva documents only the latest stage in a longer arc of handwashing campaigns developed to generate sales for hand soap. Health historian Vincent Vinikas, for example, chronicles the creation by soapmakers of the 1920s and 1930s of the Cleaning
Institute, which worked to increase soap sales by inculcating schoolchildren into personal hygiene habits.26 Just as in North America, hand hygiene promotion directed at individuals in developing countries aims to empower them to protect themselves from the risk of infection. Since 2008, for example, Global Handwashing Day has been celebrated annually on October 5. An initiative of the Global Public-Private Partnership for Handwashing with Soap (Global PPPHW), Global Handwashing Day is “dedicated to increasing awareness and understanding about the importance of handwashing with soap as an effective and affordable way to prevent diseases and save lives” (“About Global Handwashing Day”). The celebration also presents “an opportunity to . . . encourage people to wash their hands”—or, as explained in a Global Handwashing Day press release, to inspire personal responsibility.27 In developing countries, hand hygiene promotion’s emphasis on personal responsibility has implications for perceptions of risk. Indeed, Global Handwashing Day presents infection risk as managed not through the provision of clean water or proper sanitation, but rather through the adoption of appropriate personal measures.

Historian Nancy Tomes has written that in the era of emerging diseases what she calls the “gospel of germs” would take on renewed significance. The gospel of germs describes “the belief that microbes cause disease and can be avoided by certain protective behaviors” (2) such as hand hygiene. A morality of infection that depends for its effect on the cultivation of fear, the gospel of germs is easily exploited by marketers “to sell a wealth of goods and services” (11). Indeed, underwritten by an array of corporate sponsors, Global Handwashing Day also teaches people living in developing countries to become faithful consumers of hand

26 See, also, Vinikas, Soft Soap, Hard Sell, which illuminates the significance to modern advertising of early-twentieth-century efforts to promote personal hygiene.
27 For the full text of this press release, see Royal Society for the Protection of Nature, “Global Handwashing Day observed in Yoeseltse MSS in Samtse.”
sanitizer and soap, just like their counterparts in developed countries. Current sponsors include Colgate-Palmolive, Procter and Gamble, and Unilever, all companies with a massive stake in the global marketplace for personal hygiene products. (Corporate sponsors may also have influenced the naming of the Global Public-Private Partnership for Handwashing with Soap. Much of the scholarship produced by the researchers working for this partnership typically includes this addendum.)

Global Handwashing Day’s instruction in the consumption of personal hygiene products, too, has ties to the overarching emphasis on personal responsibility for public health. Hand hygiene is promoted by the Global PPPHW, for example, as a “do-it-yourself vaccine,” a hedge against infection risk (apparently) even in settings in which this risk often stems from poor sanitation and lack of access to clean water (“Global Handwashing Day”).

Of course, regardless of context, hygiene habits have a proven impact on the transmission of disease-causing pathogens. Hand hygiene limits the spread of diarrheal and respiratory diseases, which are among the leading causes of child mortality in developing countries.28 Children thus comprise a key audience for Global Handwashing Day, which seeks to transform them into “change agents” who have the capacity to “positively influence other people’s health behaviours” (Global PPPHW). However, as Plyushteva observes, Global Handwashing Day’s celebration of the life-saving power of individual behavior change potentially obscures understandings of the structural factors that shape infection risk. In developing countries, for example, the spread of disease stems from lack of access to clean water and adequate waste disposal, and not mainly from a lack of agency per se. In attributing infection risk to the “suboptimal behaviour of the poor” (428), handwashing

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28 For a systematic review of the impact of hand hygiene promotion in developing countries, see Freeman et al. (2014). Many of this study’s researchers have ties to the Global PPPHW.
campaigns in developing countries exacerbate longstanding power imbalances, potentially reinforcing rather than removing obstacles to meaningful change. At the same time, hand hygiene promotion in this context expands the global marketplace for personal hygiene products, forging new opportunities to profit from the complex problem of infectious disease.

Plyushteva’s analysis is helpful to my own because she draws attention to insidious elements of hand hygiene promotion and stresses its consequent potential to serve a range of motives. Some of these motives conflict with the aims of public health, particularly in developing countries. “At first glance,” she argues, “the cause of handwashing appears as apolitical and uncontroversial as can be” (428). So unproblematic is hand hygiene, and so important are efforts to promote it, that the very few criticisms of Global Handwashing Day have largely been ignored. Lalitha Sridhar of the India Resource Center, whom Plyushteva quotes, openly criticizes hand hygiene promotion in Kerala as a poor substitute for structural interventions, such as the improvement of sanitation systems or provision of clean water.29 For her part, Plyushteva takes issue with the celebration’s stigmatizing of people in developing countries “as traditional or backward, or, in a teleological view of development, pre-modern” (424). Hand hygiene’s “uncontroversial façade” (420) also obscures the reality that individual behavior change is only ever a “partial solution” (429) to the spread of disease. Even efforts to quell the spread of disease through behavior change depend on structural interventions, or changes that create an environment that supports personal responsibility. I return to these limitations at the end of this chapter.

I quote Plyushteva at length because hers is a recent scholarly critique of contemporary, globalized efforts to promote hand hygiene promotion. Her writing also

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29 For Sridhar’s remarks, see “Handwash or Eyewash? Selling Soap in the Name of Public Private Partnerships.”
establishes a precedent for my argument that handwashing campaigns may serve other motivations besides seeking to diminish infection risk. Circulated within workplaces, schools, transit hubs, airports, community centers, grocery stores, and shopping malls, handwashing campaigns portray individual bodies, and body parts, as dangerous vectors of infectious disease. What makes these bodies, and parts, dangerous is both that they spread infection, and that the disease-causing pathogens they transmit remain invisible to the individuals who transmit them. As a caption for a handwashing poster created by Yale University’s Emergency Management Department in 2009, in response to H1N1, puts it, “You’ve got a mystery on your hands” (see Fig. 1). Taking the form of pamphlets, posters, transit ads, web infographics, social media campaigns, and public service announcements, these texts caution that the power to prevent (and spread) infection is in our hands. Sales figures for hand sanitizer alone illustrate the impressive new revenue streams generated by this individualization of infection risk. Even in developed countries, where the assumption of personal responsibility is less likely to be impeded by structural issues, hand hygiene promotion may nevertheless skew perceptions of contextual or social determinants of infection risk. Such determinants might include the availability of paid sick leave. According to two studies published in the American Journal of Public Health, for example, the absence of workplace policies such as paid sick leave had a direct impact on levels of influenza-like illness (ILI) during H1N1. Both studies identified race and ethnicity as increasing the risk of exposure to H1N1.30

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Hand hygiene promotion invariably serves two distinct purposes. At one level, as exercises in risk communication, handwashing campaigns satisfy the obligation to inform individuals about how to diminish infection risk. Often posted in public restrooms, infographics illustrating the handwashing procedures practiced by healthcare professionals effectively display hand hygiene promotion’s function as a form of risk communication. These infographics teach handwashing methods, but they also stress the need for personal responsibility in public settings. At another level, handwashing campaigns often work to situate infection risk within individual bodies. This is perhaps best illustrated by the use of hand hygiene promotion to trigger a whole host of negative emotions, from anxiety, distrust, fear, and doubt to nausea and disgust. Some of the most prominent voices behind the turn to
hand hygiene promotion, particularly in developed countries, have emphatically defended the rhetorical utility of public health campaigns that inspire feelings of disgust. \(^{31}\) I focus more on this latter function of handwashing campaign—that is, its use to foster emotional states that may predispose audiences to adopt personal responsibility.

Alongside promoting a habit that may reduce the transmission of disease, handwashing texts heighten awareness of those who fail in their duty to limit infection’s spread. Non-compliance with the dictates of hand hygiene promotion becomes grounds not merely for blame, but also for suspicion about a person’s worth. Contemporary handwashing campaigns thus form a constitutive rhetoric, a mode of rhetorical appeal that calls into existence a shared collective identity. Within hand hygiene promotion, the collectivity identity called into existence is that of the health citizen, for whom participation in containing an outbreak is a personal responsibility. James White describes “constitutive rhetoric” (a term that he coined) as “the central art by which culture and community are established, maintained, and transformed” (28). Scholars use constitutive rhetoric to explain the discursive formation of new social and political subjectivities. In demonstrating how some rhetorics discursively constitute the very subjects they address, many critics follow Charland’s model of constitutive rhetoric. Charland incorporates Burke’s notion of identification and Althusser’s idea of interpellation, or “hailing.” To illustrate, Charland argues that before the 1980 provincial referendum the government of Quebec sought support for Quebec’s separation from Canada by constituting the province’s inhabitants as “a distinct peuple.” By voting in support of separation, inhabitants signaled their interpellation into and identification with the peuple québécois.

\(^{31}\) See, for example, Curtis’s review of the emerging body of scholarship on how in public health messaging disgust may help motivate individual behavior change.
And so, as Charland observes, constitutive appeals produce and reinforce new subject positions. By responding to these appeals, individuals affirm their membership in the community. Constitutive rhetoric has been a useful concept for health humanities scholars and practitioners. Anthropologist Joseph Dumit, for example, argues that strategies employed in pharmaceutical discourse create new opportunities for marketing drugs by constituting the individual as a body at risk of disease. The strategic constitution of bodily risk, Dumit argues, is essential to keeping Americans on “drugs for life.” Segal employs constitutive rhetoric to critique the interpellation of headache patients within clinical encounters. Colleen Derkatch uses constitutive rhetoric to account for the maintenance of professional boundaries in medicine, whereas Karen Kopelson shows how in response to breast cancer, public health organizations constitute citizens as consumer-activists. Zoltan Majdik and Carrie Anne Platt describe the health subject constituted by the marketing campaign for a genetic testing product. Finally, constitutive rhetoric has been a productive means for scholars to describe how public health officials shape perceptions of risk and responsibility in response to outbreak.

Hand hygiene promotion presents an opportunity to examine the constitutive functions of efforts to foster personal responsibility for infection risk. The adoption of illness etiquette in response to hand hygiene promotion, for example, signals at least a partial acceptance of personal responsibility. An example of constitutive rhetoric, a poster created by the U.S. CDC instructs Americans to “Keep Calm and Wash [their] Hands,” implying that in washing their hands, citizens consent to their duty to cooperate in the event of an

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32 A constitutive perspective is also consistent with Foucault’s theory of subjectivity formation. For a discussion of Foucault’s significance to health humanities, see Petersen, “Governmentality, Critical Scholarship, and the Medical Humanities.

33 See, for example, Davis, Stephenson, and Flowers, “Compliant, Complacent, or Panicked?” (2011), and Briggs, “Theorizing Modernity Conspiratorially.”
As Petersen and Lupton explain, under neoliberalism, different forms of health education and promotion provide a means of enjoining individuals qua citizens to participate actively in a range of activities such as risk management, self-surveillance, self-care, and body monitoring. According to rhetorician Philippa Spoel and public health scholars Roma Harris, and Flis Henwood, the emphasis in public health messaging on active participation establishes a “civic-moral imperative of healthy living” (2). They argue that observing this civic-moral imperative increasingly defines what it means to be a good citizen in societies in which health education and promotion have become a priority. Similarly, handwashing campaigns promote compliance by depicting hand hygiene as an expression of the “civic-moral imperative” that Spoel, Harris, and Henwood describe. Those who do not comply with these campaigns not only heighten their risk of infection, but also fail in their citizenship duties.

Because it singles out the individual bodies—and individual body parts—that spread infection, hand hygiene promotion forms both a constitutive rhetoric and a “stigmatizing rhetoric.” A stigmatizing rhetoric derives its conception of the “healthy” from portrayals of the “unhealthy.” Notions of poor health shore up understandings of good health. Metzl observes, for example, that within a stigmatizing rhetoric, the “affirmation of one’s own health depends on the constant recognition, and indeed the creation, of the spoiled health of others” (5). Taking up Metzl’s refrain, some of the contributors to Against Health, critique the centrality of stigmatizing rhetoric to a neoliberal model of public health. Kathleen LeBesco, for example, argues that U.S. anti-obesity campaigns reinforce the valuing of “good citizens [who] take care of their own health” (78) at the expense of those classified as

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34 See “Health Promotion Materials” (2016).
“overweight” or “obese.” Handwashing campaigns display such a stigmatizing rhetoric whenever their promotion of hand hygiene casts it as a prosocial behavior rather than as merely a method of infection control. According to these stigmatizing texts, the failure to observe hand hygiene has consequences above and beyond the potential for infection. Such consequences, as I will demonstrate, include exclusion from the group.

Hand hygiene promotion thus also serves an epideictic purpose—to admonish one for certain attitudes and behaviours. As rhetorical theorists Chaîm Perelman and Lucie Olbrechts-Tyteca explain, epideictic discourse “sets out to increase the intensity of adherence to certain values” (51), not merely through the celebration of these values, but also through admonishing contrasting ideals. Handwashing campaigns employ epideictic rhetoric to promote “proper” hand hygiene by using infographics and other forms of instruction that demonstrate the purportedly most effective techniques to eliminate disease-causing pathogens from the hands. Frequently posted in public restrooms, handwashing infographics can be a source of anxiety about exposure, increasing impressions of the need for personal responsibility, but these resources can also be a source of anxiety about compliance. These admonitions, which are implicit in campaigns that encourage hand hygiene by explaining how and when to wash one’s hands, lend a different hue to the value of personal responsibility. In conveying the steps necessary for “proper” hand hygiene, public health agencies supply individuals with a yardstick for measuring their culpability in the context of infection. By demonstrating proper hand hygiene, infographics and other instructional displays reinforce associations between the development of sickness and the failure to adhere to illness etiquette.

35 Chapter Four explores stigma’s significance to the rhetoric of personal responsibility for “epidemic” obesity.
Rooted in the formula that clean hands save lives, handwashing campaigns may seem reassuring when compared with the more overtly moralistic cautionary tales that aim to persuade by enjoining audiences to consider what might happen if they failed to follow public health advice. In *Condition of Doubt*, for example, Catherine Belling discusses the use of personal stories in flu-vaccination campaigns to individuals to vaccinate, to avoid the fate of the storytellers, whose inaction has resulted in tragedy. Deployed in the context of public health discourse, stories of personal tragedy function in the way Belling and Metzl describe, as cautionary tales intended to warn the public about the consequences of failing to adhere to campaign advice. As a result, those who seek out vaccination in response to personal narratives of tragedy may feel healthy, not simply because they have some immunity, but also because they have displayed agency where others were only complacent. The same is true of those who practice hand hygiene in response to handwashing campaigns, who may feel both protected and proactive. Conversely, those who fail in their duty may both fear illness and feel ill at ease about their potential role in sickening others. Indeed, as both a constitutive and a stigmatizing rhetoric, hand hygiene promotion constructs a notion of appropriate responses to infection risk primarily by focusing on the inappropriate. Insufficient handwashing risks exposing self and others to harmful pathogens. To be both healthy and dutiful in the era of emerging diseases means to pay close attention to personal habits, to regard oneself as always potentially culpable for the spread of infection. The elaboration of proper handwashing as a series of discrete steps, a standard against which individual efforts to minimize the spread of germs can be measured, similarly implies the recognition of improper hand hygiene—of a failure to adhere to the standard.
Don’t Be the “Fifth Guy”: Risk and Responsibility in Public

Created by the Florida Department of Health in response to H1N1, the “Fifth Guy” campaign illustrates the use of a constitutive, stigmatizing rhetoric to encourage the assumption of personal responsibility for infection risk. I chose this campaign both because it focuses on the workplace and because its messages about risk and responsibility later saw replication in other states (for example, by the Michigan Department of Health). The “Fifth Guy” campaign has also been the subject of social-marketing case studies.\(^{36}\) The campaign includes an interactive website that hosts a series of public service announcements (PSAs). Together, these PSAs underscore the need for personal responsibility by dramatizing the tensions that arise when someone in the workplace ignores their duty to limit the spread of infection. Underlying the “Fifth Guy,” as I argue, is the message that infection risk is exacerbated mainly by the failure to assume personal responsibility. My close reading of the “Fifth Guy” also emphasizes feelings of anxiety, fear, and even self-doubt. As both a constitutive and stigmatizing rhetoric, the “Fifth Guy” foregrounds these negative emotions to shore up the value of personal responsibility—in particular, its role in the maintenance of public health.

The “Fifth Guy” singles out the person who ignores rather than assumes personal responsibility.\(^{37}\) The campaign is based on a study conducted by the American Society for Microbiology (ASM), which found that four out of five people \textit{do} wash their hands after using the restroom. In this campaign, the fifth guy is not only male, but also young, able-bodied, and white. The “Fifth Guy” seeks to “illustrate a simple point—most people respect

\(^{37}\) My references to the “Fifth Guy” describe the campaign, whereas discussions of the “fifth guy” refer to its main character.
certain hygienic norms” (“About the Campaign”). Those who do not observe these norms become “that one person everyone whispers about.” Within the campaign’s configuration of personal responsibility, illness etiquette is as much a measure of moral worth as it is a form of infection control. The “fifth guy” is portrayed as at risk of both sickness and social quarantine—exclusion from the group because he poses a threat to public health.

To stress the value of personal responsibility, video public service announcements (PSAs) both televised and posted online exaggerate as deviant the fifth guy’s ignorance of a workplace’s “hygienic norms” (“About the Campaign”). Played by comedic actor Ben Spring, the fifth guy is, not surprisingly, central to the campaign’s narrative of personal responsibility. Ben coughs and sneezes without covering his mouth and nose with his elbow. The videos “Cougher” and “Sick at Home” dedicate considerable footage to shots of Ben coughing into his hands, onto food in the lunchroom, during meetings, and in the faces of his fellow coworkers. Ben is quite clearly ignorant of his body as potentially—and, in most instances, quite literally—a source of infection risk to the people around him. However, the Fifth Guy is used to emphasize the necessity of his coworker’s efforts to compensate for his ignorance. “How would I describe Ben to you? The next Black Plague,” Ben’s manager tells the camera in one PSA: “They’re gonna say, ‘How did it happen, was it rats?’ No, it was Ben over at Amalgamated, responsible for the death of Europe.” Ben’s violations of the dictates of illness etiquette make him an object both of disgust and of disdain within his workplace. More importantly, when illness arises within a workplace, his coworkers come to regard Ben’s body as its likeliest source.

In the “Fifth Guy,” attention is paid to Ben’s body not as a site of sickness—or, put differently, a site of suffering—but as a site of infection risk. This situating of infection risk
in individual bodies teaches the importance of avoiding certain others as vectors of infectious
disease. Ben’s coworkers leave the lunchroom when he enters, refuse to shake his hand or
give him high fives, and send emails and issue prank calls urging him to go home. Ben is to
be avoided because he embodies the risk of infection in public. So, in avoiding Ben, his
coworkers assume personal responsibility for infection risk. Ben’s failures in this respect in
turn imply that those who succumb to infection have only themselves to blame, perhaps
because they, too, ignored the dictates of illness etiquette.

Avoidance and exclusion, however, are not the only strategies endorsed as both
infection-control measures and displays of personal responsibility. In the “Fifth Guy,” hand
hygiene represents a hedge against infection risk and its absence a violation of the dictum of
personal responsibility. “Just Another Day in the Office” illustrates this dual function. In this
PSA, Ben’s poor hand hygiene habits graphically come to life in the form of a urinal he
carries around the office after leaving the restroom. In one scene, Ben proudly places his
urinal on a coworker’s desk while asking for some paperwork. In other scenes, he dances
along the office’s corridors, embracing his urinal in a mock tango. Depicting poor hand
hygiene as a urinal makes some sense from the perspective of theories of fomite transmission
of infection. These theories explain that, unless properly sanitized, inanimate materials or
objects can become contaminated with infectious agents such as influenza virus. Similarly,
poor hand hygiene increases the likelihood of transmitting pathogens, both from
contaminated surfaces to individuals, and between individuals as well. Yet, the goal of
featuring Ben’s urinal appears not to be to instruct the workers of Florida in the problem of
fomite transmission. Instead, by emphasizing ignorance of illness etiquette as akin to
intentionality, Ben’s out-of-place urinal serves as an object lesson in hand hygiene as an
expression of personal responsibility. Ben is stigmatized—literally marked—to distinguish him from those who observe their obligation to illness etiquette.

Certainly, the “Fifth Guy” teaches hand hygiene as a display of personal responsibility. Yet the campaign also reveals another dimension of personal responsibility, and that is the enforcement of individual behaviour change among the non-compliant. Frequently lacking the ability to confront him directly, Ben’s coworkers make their concerns known to the camera and by extension to those watching the PSAs and absorbing their messages about personal responsibility. “Yes, I’d say he’s a walking pandemic,” the receptionist comments just seconds after Ben has left the restroom with his urinal-germs in tow. “Quite frankly,” says the coworker whose desk has been sullied by Ben’s metaphorical urinal hands, “he scares me.” Acknowledging that it can be difficult to reproach our colleagues, “Just Another Day” ends with the words of a voiceover narrator: “Four out of five people wash their hands in the restroom. Could someone talk to the fifth guy?” Strategies for doing so appear on the page of the “Fifth Guy” website on which “Just Another Day” is posted. Tips include emailing your coworker one of the campaign videos with the comment, “Hey, sure glad you’re nothing like this” or giving them “a new nickname like ‘Big Loogie’ or ‘Thunder Cough’.” These strategies suggest, through humour, that assuming personal responsibility for infection risk also involves participating in its enforcement.

In using stigma to underscore personal responsibility, the Fifth Guy potentially both validates anxieties about infection risk and reassures that risk can always be managed. Those who regularly encounter infection in the workplace or witness hand-hygiene violations in public restrooms may feel vindicated by the campaign’s mockery of Ben. After all, as the campaign implies, only careless people spread disease. With care, infection can be avoided.
The Fifth Guy’s attributions of intentionality may be the campaign’s most problematic feature, and not simply because such attributions may exacerbate interpersonal conflicts within public settings. The use of a constitutive, stigmatizing rhetoric has consequences for shared perceptions of infection risk. It is to these perceptions that I now turn my attention.

**Personal Responsibility and Shared Perceptions of Infection Risk**

Three configurations of infection risk emerge from the “Fifth Guy’s” encouragement of personal responsibility. First, the most serious risk depicted throughout the campaign is exposure to Ben, who is a “walking pandemic,” as his manager explains. In implying that infection risk is determined mainly by exposure to others, this configuration places undue emphasis on the need for hypervigilance in interpersonal interactions. In Ben’s story, the assumption of personal responsibility for infection risk takes the form of a kind of citizen-epidemiology, with everyone working to root out sources of infection. Second, infection risk is determined largely by one’s ability to control and manage certain behaviors. Conversely, failure to change habits increases our risk. Different scenes from the “Fifth Guy” illustrate this formulation of infection risk. Motivated by the threat of Ben’s behavior, his coworkers more than once demonstrate for the camera different practices for limiting infection risk. In displaying their compliance with illness etiquette to the camera rather than to Ben, his colleagues indicate the necessity of habitual and bodily responses to the management of infection risk.

A third assumption is underscored within the numerous texts that together form the campaign’s overarching message about risk and responsibility. In the “Fifth Guy,” a lack of knowledge increases one’s risk of infection. Ben, who displays ignorance of his duty to manage risk, teaches that being knowledgeable reduces the risk of infection (not to mention
the threat of expulsion from the group). Other elements of the campaign reinforce this equation of knowledge with the assumption of responsibility for infection risk. Visitors to the “Fifth Guy” website can, for example, take a quiz that tests their “hygiene IQ.” Their scores to determine “which person” they are in the workplace drama of illness and infection. Yet, as anyone who takes the quiz may quickly realize, it is only possible to either be the “fifth guy” (ignorant) or not the fifth guy (not ignorant). Users who select the incorrect answer to a series of five questions are also goaded to correct their mistakes by the message, “Wrong. Who are you, the fifth guy?” Most of these wrong answers correspond with Ben’s behaviors in different scenes from the campaign PSAs. The didacticism of the campaign’s testing of hygiene IQ raises the question: What knowledge, exactly, do audiences gain through exposure to the “Fifth Guy” and campaigns like it? Perhaps most importantly, the formulation of knowledge as a defense against infection risk teaches a neoliberal model of risk management. Within this conception, the complex problem of emerging infectious diseases is most effectively resolved through personal transformations of our daily habits and our relationships to one another. The focus on behavioral change is frequently regarded mainly as an alternative to the implementation of costlier, more comprehensive forms of protection, treatment, and care. Problematically, however, this encouragement of the personal responsibility ignores the influence of contextual and environmental factors. Complex economic and social factors, from social support networks to gender, ethnicity, race, and culture, shape and determine the health of populations. Instead, even those campaigns that single out the person who (like Ben) does not adhere to the dictates of illness etiquette imply equality in our susceptibility to (or risk of) infection.
The Limits of Personal Responsibility for Infection Risk

Despite its shortcomings, critics have only occasionally spoken out against the emphasis on personal responsibility for infection risk and the neoliberal model of public health it entails. Shortly after President Obama advised Americans to help fend off a global pandemic by washing their hands, for example, Randy Cohen wrote a *New York Times* column about the ethical dimensions of the 100th-day address. Was Obama’s counsel to Americans to do their part by washing their hands and staying home from work “merely good manners,” Cohen wondered. Or, should his comments instead be understood as a moral injunction, with serious implications for how the nation would cope with the outbreak? Put simply, is hand hygiene a matter of etiquette—or is it a matter of ethics? While etiquette may “have a trivial impact on others,” Cohen deemed Obama’s H1N1 advisory a matter of ethics “because it concerns the effect of our actions on other people.” Washing one’s hands removes harmful, disease-causing pathogens, making the endorsement of the act an “ethical imperative, meant to mitigate the harm we might do to others.” That hand hygiene has a personal benefit does not make the habit any more ethical—just more desirable, perhaps, because self-care for the most part overlaps with care of others.

Yet in defending hand hygiene as an ethical imperative, Cohen claimed that even this commonsense health habit has its limits. A program of risk management that depends for its success on the assumption of personal responsibility may similarly be too limited an approach to the problem of infection. As Cohen put it, the dictates of illness etiquette, although “fundamentally ethical, are not universally applicable.” Efforts to mobilize citizens against infection risk require an environment supportive of their participation. Adequate
supports must exist to ensure that citizens can “do the right thing.” To illustrate the limits of personal responsibility, Cohen discussed the example of labour law:

Some employees, particularly low-wage workers, risk losing pay or even getting fired if they stay home from work to avoid infecting their coworkers. If we expect individuals to act ethically, we have a societal obligation to protect them when they do—for instance, by guaranteeing paid sick days to all.

During H1N1, concern about the ability of individuals to behave according to the dictates of public health led to the introduction in the U.S. Congress of a bill that would require most employers to provide workers sent home with infections such as influenza a minimum of five paid sick days. Paid sick leave, supporters argued, could even be a benefit to the economy, since the policy could both increase productivity and reduce the spread of illness and infection around the workplace.

Cohen was one of few critics to publicly speak out about the ethical issues that arise from the increasing encouragement of personal responsibility. Even Owen, in describing in detail the “rise of Purell,” shies away from too staunch a critique of the implications of the turn to hand hygiene promotion. Despite the appeal of the argument that infection risk can be managed mainly through individual behavior change, most exercises in risk management depend for their success on an environment supportive of these changes. In implying that infection risk may be equally distributed across populations, handwashing campaigns exclude the insights of decades of research on the social determinants of health and diseases. In this context, rhetoricians of health and medicine and health humanities scholars contribute meaningful investigations of the rhetoric of personal responsibility, and specifically its emphasis on fear, anxiety, distrust, stigma, and blame. Such analyses are sure to deepen conversations among scholars and practitioners about the long-term implications of a seemingly uncontroversial enterprise—the promotion of hand hygiene.
As mentioned at this chapter’s outset, I do not wish to question hand hygiene’s efficacy as a form of infection control. Myriad studies report on the impact of hand washing on the risk of infection, with the majority suggesting that the habit significantly limits the transmission of communicable diseases.\textsuperscript{38} To abandon hand hygiene because of concerns about the rhetoric used to promote it makes no sense. Far from opposing handwashing campaigns, I have illuminated their broader implication in the ongoing individualization and responsibilization of public health, which is also in essence a neoliberalization of public health. Hand hygiene promotion moralizes the spread of infection, making its publics more sensitive to their capacity to sicken, and be sickened, by others. In the context of outbreak, such a perception both potentially lessens expectations of various kinds of support, for example in the form of employment or health benefits. This perception also creates new opportunities for those who stand to profit from the negative emotions often highlighted in messaging about personal responsibility for infection risk.

Despite its seemingly neutral objective as a form of risk communication, hand hygiene promotion engenders a culture of stigma, blame, and distrust in response to the threat of infection. To what extent might these effects in fact inhibit the need for cooperation in the face of a catastrophic outbreak? Handwashing campaigns transform perceptions of infection risk, casting illness as a personal failing. This is not to say that infection is not partly a consequence of poor hand hygiene, but the reality is just that. Poor hand hygiene is only a contributing factor and not the root cause of the heightened risk of outbreak. It may thus be time to consider alternatives, or complements, to a neoliberal model of public health. Personal responsibility has its advantages—that much is clear—but a more expansive

\textsuperscript{38} Some of the most frequently-cited references to studies in support of hand hygiene appear on “Show Me the Science,” a page of the U.S. Centers for Disease Control and Prevention’s (CDC) federal handwashing campaign.
approach might better facilitate the cooperation, and compassion, that infectious-disease outbreaks demand. In my next chapter, I relate the significance of the rhetoric of personal responsibility to expert anxieties about the impact of anti-vaccination messaging on declining vaccination rates in recent years.
CHAPTER TWO
“Separating Fact from Myth”: Defending Vaccine Science Against Anti-Vaccination

Our fears are informed by history and economics, by social power and stigma, by myths and nightmares. And as with other strongly held beliefs, our fears are dear to us. When we encounter information that contradicts our beliefs . . . we tend to doubt the information, not ourselves.

On Immunity, Eula Biss (2014)

The flu is a good example of how medical myths can get in the way of good medical care. When it’s flu season, take the necessary steps to stay healthy. That includes separating fact from myth.


At the outset of flu season in the Northern hemisphere in 2009, the New York Times published an opinion piece about the importance of vaccination against the pandemic strain, H1N1. In “Nothing to Fear but the Flu Itself,” vaccine inventor and proponent Paul Offit urged individuals to seek out flu vaccine. Getting that year’s flu shot, Offit explained, potentially limited H1N1’s impact on those most vulnerable to complications, a demographic that included pregnant women, immunocompromised individuals, people over 65, and children under five. High vaccination rates also boosted levels of herd, or “community,” immunity, protecting those with pre-existing conditions that prohibited them from receiving H1N1 vaccine. Yet despite news of millions of cases of H1N1 and nearly a thousand U.S. deaths, many Americans had not gotten the vaccine and had no plans to do so either. According to a study conducted through the Harvard School of Public Health, fewer than half of U.S. adults felt “absolutely certain” about H1N1 vaccine (“Survey Finds”).

Those who refused vaccines or remained undecided reported concerns about possible side effects. As Harvard’s study confirmed, only a third of Americans believed in the safety
of H1N1 vaccine. Their safety concerns posed a significant obstacle to efforts to contain the first influenza pandemic of the twenty-first century. Offit thus warned Americans not to be persuaded by “unfounded fears” about the H1N1 vaccine. Such fears were “myths,” widely held but false ideas that undermined confidence in vaccines. Because of their implications for vaccine uptake, lay anxieties about the safety and effectiveness of H1N1 vaccine factored significantly into the public health messaging. Some messaging sought to overturn the belief that flu vaccine might cause the flu, a common reason for refusing H1N1 vaccine, as rhetorician Heidi Lawrence found in her interviews with U.S. college students.

Characterizations of vaccine anxieties as “myths,” “fictions,” and “misconceptions” also became key to the encouragement of personal responsibility during H1N1. The U.S. Centers for Disease Control and Prevention (CDC) has, since H1N1, positioned itself as “a great source of information about the serious risks of flu illness and the benefits of flu vaccination, as well as information to correct myths about the flu vaccine” (“Everyone Can Be a Flu Vaccine Advocate”). A week after the publication of Offit’s essay, the New York Times produced a publication for its online teaching and learning forum. “Shot in the Dark? Debunking Myths About Swine Flu Vaccine” sought to teach students how to use “scientific evidence and facts” to identify “the myths that deter people from the [H1N1] vaccine.”

During H1N1, even mainstream media used the difference between myths and facts to underscore the need for vaccination.

Worldwide, numerous public health jurisdictions reported H1N1 vaccination rates well below the level of uptake needed to achieve community immunity.39 Varying professional assessments of the annual flu shot’s effectiveness had, prior to H1N1, been

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39 For a discussion of the vaccination rates achieved in the U.S. and Europe during H1N1, see Plans-Rubió, “The Vaccination Coverage Required to Establish Herd Immunity Against Influenza Viruses.”
known to affect vaccination uptake. Several surveys conducted during H1N1 found that many doctors and other healthcare providers intended to decline vaccination once the H1N1 flu shot became available.\textsuperscript{40} By 2009, vaccination rates had also more broadly been affected by a now-discredited study, published in the \textit{Lancet} in 1998, that hypothesized associations between autism and the measles, mumps, and rubella (MMR) vaccine.\textsuperscript{41} Led by British former medical researcher and gastroenterologist Andrew Wakefield, this study was discredited after numerous researchers failed to reproduce Wakefield’s results. In 2010, the \textit{Lancet} officially retracted the 1998 publication, not long after United Kingdom General Medical Council laid charges against Wakefield for professional misconduct.\textsuperscript{42} By that time, the study’s ties to increases in anti-vaccination activism had begun to influence the rhetoric used in public health messaging both about MMR vaccine and about vaccination more generally. To effectively promote H1N1 vaccine, many campaigns sought both to improve lay understandings of vaccine science and to equip individuals to defend this science in conversations with family and friends.

In this chapter, I examine the ways in which efforts to increase knowledge of vaccine science serve the encouragement of personal responsibility. Here, the rhetoric of personal responsibility aims to increase vaccination rates by improving science knowledge. For example, by stressing the difference between vaccine facts, and fictions, misconceptions, or myths, public health officials instructed individuals in the boundary between vaccine science and “non-science.” The persuasive use of this demarcation stems from the sense that personal failings hamper the achievement of community immunity, a point Offit makes quite

\textsuperscript{40} See Boseley, “Doctors May Refuse Swine Flu Vaccine.”
\textsuperscript{41} The full title of Wakefield’s 1998 \textit{Lancet} publication is “Ileal-Lymphoid-Nodular Hyperplasia, Non-Specific Colitis, and Pervasive Developmental Disorder in Children.”
\textsuperscript{42} Dyer, “\textit{Lancet} Retracts Wakefield’s MMR Paper,” describes the charges laid against Wakefield.
emphatically in his opinion piece. Deficits in knowledge of vaccine science, officials and experts reason, not only hinder efforts to administer vaccine. These knowledge gaps also make individuals more susceptible to the anti-vaccination claims that have circulated more widely since the publication of Wakefield’s now-discredited study.

As a rhetorical approach, distinguishing science from non-science benefits the mandating of personal responsibility largely because it places the onus for low vaccination rates on individuals: improved understanding means increased vaccination rates. Under this view, the maintenance both of one’s own health and of public health depends on one’s capacity to separate fact from myth. Vaccine messaging premised on this distinction thus appears to empower individuals, here by equipping them with knowledge, while enforcing the need for compliance with flu vaccination campaigns. However, these potential advantages of “boundary work,” sociologist Thomas Gieryn’s term for demarcating science from non-science, come at the expense of a more comprehensive approach to low vaccination rates—not just during H1N1, but since then, and for all vaccines.43 Vaccine scholars from numerous disciplines argue, increasingly, that ensuring high vaccination rates requires understanding the actual sources of what is now called “vaccine hesitancy.” The SAGE Working Group, which the World Health Organization (WHO) convened in 2011 to study this problem, proposes the following definition: “Vaccine hesitancy refers to delay in acceptance or refusal of vaccines despite availability of vaccination services. Vaccine hesitancy is complex and context specific, varying across time, place and vaccines. It includes factors such as complacency, convenience and confidence” (SAGE Report 7). In

43 As Gieryn explains, boundary work entails the “attribution of selected characteristics to the institution of science (i.e., to its practitioners, methods, stock of knowledge, values, and work organization) for purposes of constructing a social boundary that distinguishes some intellectual activities as ‘non-science’” (782).
addressing vaccine hesitancy as symptomatic only of deficits in knowledge of vaccine
science, boundary work potentially undermines emerging efforts to understand the actual
factors behind the refusal of H1N1 and other vaccines.

Vaccine messaging premised on science knowledge alone exemplifies a “public
understanding of science” (PUS) approach to health education and promotion. A policy
movement originating from the Royal Society’s publication, in 1985, of the “Bodmer
Report,” PUS supplies a framework for structuring relations between individuals and experts
in contexts of science and medicine. Vaccination provides an opportune site for structuring
such relations because its success depends on lay participation and trust in expertise. PUS
involves a communication-based approach to lay-expert relations. The goal of PUS-based
communication is to improve public participation—for example, in vaccination efforts—by
remedying deficits in lay understandings of science. Through what rhetorician Alan Gross
calls a “rhetoric of accommodation,” PUS-based communication aims to “accommodate the
facts and methods of science to the public’s limited experience and cognitive capacities” (6).
Rhetoricians and STS scholars have argued against the deficit model because this approach
enforces a perception of individuals as passive recipients of scientific knowledge.44 As Gross
remarks, “it is a mistake to locate the problem of public understanding in public ignorance,”
because it “isolates science from the contexts that give it public significance” (7). PUS also
ignores opportunities to advance scientific knowledge through the incorporation of lay
expertise. Instead, as Gross argues, a deficit model assumes the need for a rhetoric of
accommodation, “one that adjusts the facts of science to public needs and limitations” (6):

44 Other critiques of the deficit model and PUS include Miller, “Public Understanding of Science at the
Properly employed, a responsible rhetoric of accommodation can certainly be helpful. . . But even a rhetoric of accommodation grounded in cognitive psychology and demonstrated need for public health and safety cannot overcome the final and most telling defect of the deficit model: its inability to turn a critical eye on the fact and facts of science. Of necessity, all rhetorics of accommodation deflect attention from the ethical and political issues science raises, or ought to raise. . . . In fact, as we shall see, the situation is worse: in many cases, rhetorics of accommodation actually mask ethical problems. (9)

PUS has in recent years been replaced by “public awareness of science” (PAwS) and “public engagement with science and technology” (PEST). Both approaches more openly recognize the contribution and active participation of publics in the advancement of science.

Much public health messaging on vaccination works against the recent move beyond PUS because it so clearly locates the problem of low vaccination rates in knowledge deficits. Several recent studies also find that efforts to correct deficits in knowledge of vaccine science do not improve vaccination rates. I discuss these findings in more detail at this chapter’s end. Given its failure to improve vaccination rates, why does messaging premised on reinforcing the divide between vaccine science and non-science remain a prominent feature of flu-shot campaigns? This strategy persists, I argue, partly because it benefits the overarching investment in personal responsibility. When understood as a knowledge crisis—rather than, for instance, as a crisis of innovation or crisis of care—low vaccination rates do not appear to demand more comprehensive interventions. Such interventions might be costlier than vaccine messaging, and they might entail recognizing the problem of trust, not of knowledge, that underlies vaccine hesitancy.

In what follows, I make connections between concerns about anti-vaccination messaging and the increasing emphasis on science knowledge as a matter of personal responsibility. I also attribute the adoption of a boundary-work approach to vaccine
messaging to concerns about the circulation of anti-vaccination messaging. One such concern surrounds the problem of “false balance” in coverage of anti-vaccination in the years ensuing the publication of Wakefield’s now-retracted study. My analysis underscores the rhetorical use, in messaging about flu vaccine, of distinctions between myths, misconceptions, or fictions and facts. Some vaccine messaging premised on these distinctions, as I show, aims to equip individuals to argue against anti-vaccination, in doing so encouraging such work as an expression of personal responsibility. Such an approach both benefits the interest in potentially cost-effective alternatives to public health interventions and at the same time defends vaccine science against attacks on its integrity. The emphasis on science and non-science, however, runs counter to recent efforts to address the actual sources of vaccine hesitancy. Rhetorical study can contribute to efforts to improve vaccination messaging because it begins by recognizing vaccine hesitancy, as does the WHO, as complex and context specific.

**Anti-Vaccination Activism, Vaccine Hesitancy, and the Rhetoric of Personal Responsibility**

Researchers working in multiple disciplines, ranging from anthropology to epidemiology, have sought to explain why, in recent decades, worldwide vaccination rates have stagnated. As recently as 2016, according to the WHO, uptake had improved for new and underused vaccines, but worldwide coverage had “stalled at 86%, with no significant changes during the past year” (“Immunization Coverage”). The WHO’s move to recognize vaccine hesitancy as complex and context specific represents the organization’s investment in identifying the myriad factors driving vaccination’s stagnation in recent years. The SAGE Working Group on Vaccine Hesitancy identifies convenience and complacency as
significantly affecting vaccination decisions; neither issue has ties to lay knowledge of science. Even so, anti-vaccination activism’s impact on perceptions of the safety, efficacy, and science of vaccines remains a common explanation for stalled vaccination rates worldwide. This section highlights the ways in which researchers studying the problem of low vaccination rates have characterized the threat posed by anti-vaccination rhetoric.

Numerous studies of contemporary anti-vaccination activism identify the internet as the primary site of the spread of information that goes against the scientific consensus on vaccines. Paul Davies, Simon Chapman, and Julie Leask argue, for example, that the internet affords anti-vaccination activism “unprecedented opportunity for exposure” (22). One in three Americans, according to a survey conducted in 2013 by the Pew Research Center, report having gone online to try and diagnose a medical condition, either for themselves or for another. Eight of ten searches for health information online, Pew reports, begin at a search engine, where searches for vaccine information may produce results from anti-vaccination websites. According to a study published in a 2017 issue of Human Vaccines & Immunotherapies, “the interest for vaccines [sic] is increasing through time: in particular, users seek information about possible vaccine-related side effects” (Bragazzi et al. 466). The authors of this study also find that the most frequently researched vaccine is the flu shot.45

Anti-vaccination’s influence, however, is attributed not only to increased exposure, but also to the internet’s impact on perceptions of empowerment and expertise in health contexts. This, too, has implications for the use of public health messaging to defend vaccine

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45 In 2012, Vaccine produced a special issue exploring how online anti-vaccination rhetoric affects both risk perceptions and the intention to vaccinate. Betsch and Sachse discuss significant findings in their editorial, “Dr. Jekyll or Mr. Hyde?” See, also, Betsch, Renkewitz, Betsch, and Ulshöfer, “The Influence of Vaccine-Critical Websites on Perceiving Vaccination Risks” and Betsch, “Innovations in Communication: The Internet and the Psychology of Vaccination Decisions.”
science. “[A] new postmodern paradigm of healthcare has emerged,” medical anthropologist Anna Kata explains, “where power has shifted from doctors to patients, the legitimacy of science is questioned, and expertise is redefined” (“Anti-Vaccine Activists” 3778).

Conducted between 2010-2012 and published in the journal Vaccine, Kata’s research on web-based anti-vaccination activity updates several studies conducted in the early 2000s. Her study illuminates the deployment, on anti-vaccination websites, of discourses of individual rights, activism, and health empowerment. These discourses, Kata argues, appeal to individuals as experts in matters of their own health and present anti-vaccination activists as against pharmaceutical-industry influence and paternalism in medicine. Anti-vaccination rhetoric also persuades, as Kata observes, by directly challenging scientific and medical expertise. Many anti-vaccination websites even depict patients and parents as better equipped than experts to make vaccination decisions on behalf of themselves and their loved ones.

Rhetoricians Judy Segal and Karen Kopelson have, respectively, critiqued the notion that the use of the web to share information produces an empowered, expert patient. Segal uses the term “internet health” to describe “the public use of information Web sites to facilitate decision making on matters of health and illness” (351). In writing about the internet-health user, Segal aims to “argue that the Internet-health user is not simply empowered by the Web but rather remade by it, and she is remade in a way that does not necessarily render her an especially good health consumer or decision maker.” Internet health, as Segal observes, “is a complex rhetorical situation, and its effect is likewise


complex” (352). Kopelson’s essay similarly acknowledges both the complexity of Internet health and issues arising from the ideology of the empowered, expert patient. Certainly, the belief that internet health empowers individuals has been advantageous to the rhetorical work of anti-vaccination activists. An example from the National Vaccine Information Center (NVIC) helps to illustrate how anti-vaccination messaging incorporates notions of empowerment and expertise. Founded in 1982 by Barbara Loe Fisher, the NVIC is considered an anti-vaccination organization although it claims not to “advocate for or against the use of vaccines” (“About National Vaccine Information Center”). Central to the organization’s rhetoric is its emphasis on the questioning of experts, and specifically one’s physician, as part of being “fully informed about the risks and complications of diseases and vaccines.” To empower individuals in interactions with healthcare providers, the NVIC has developed a set of questions, “If you Vaccinate, Ask 8!” In their challenging of scientific and medical expertise, organizations such as the NVIC frequently adopt the same rhetoric of personal responsibility used to involve individuals in the maintenance of public health. Here, this rhetoric positions individuals, against medical and scientific experts, as experts in matters of their own health rather than as benefactors of community immunity.

Efforts to defend vaccine science, for example by stressing the difference between myths and facts, in part respond to the threat posed by anti-vaccination. The NVIC characterizes this questioning as a defense of individual rights, such as the right to informed consent, which entails the right to refuse medical interventions. Some organizations encourage parents to exercise their right to refuse vaccines on their children’s behalf. As early as the nineteenth century, governments introduced vaccine exemptions in response to anti-vaccination activism. In the late nineteenth century, the British government introduced a
“conscience clause” that allowed parents to refuse smallpox vaccine for their children because of concerns about effectiveness or safety.48 “Every [U.S.] state,” as historian Mark Largent explains, “has a list of vaccines that it compels all children to receive,” usually before they enter daycare or public school. “All states,” Largent adds, “allow parents to secure from their doctors an exemption from any particular vaccine for medical reasons” (3), but even today many states also permit exemptions for philosophical or religious reasons. Similarly, Canada permits vaccine exemptions both for medical and religious reasons.

Vaccine exemptions create an opportunity for anti-vaccination organizations to urge individuals, and parents, to exercise their rights. As explained on the NVIC’s website,

Many parents, who support our work, are not philosophically opposed to the concept of vaccination and do not object to every vaccine. However, they are philosophically opposed to government health officials having the power to intimidate, threaten, and coerce them into violating their deeply held conscientious beliefs in the event they conclude that either vaccination in general, or, more commonly, a particular vaccine is not appropriate for their children. (“The Moral Right”)

Anti-vaccination organizations such as the NVIC, as Kata observes, in depicting the questioning of scientific and medical expertise as a display of personal responsibility, also stress it as “more important than the eventual vaccination decision” (1714). Anti-vaccination’s use of a rhetoric of personal responsibility, which has ties not only to notions of empowerment and expertise but also to the maintenance of individual health, is illustrated by the NVIC’s slogan: “Your health. Your family. Your choice.”

Much commentary on anti-vaccination activism deems it not only an attack on vaccine science, but also an expression of a broader trend toward “denialism.” Denialism entails the

48 Historian Nadja Durbach discusses the history of conscientious objection—a term first used to describe vaccine refusal—in a chapter of her 2005 book, Bodily Matters.
rejection of scientific consensus—in particular, on issues such as climate change and evolution. Published in 2010, science journalist Michael Specter’s Denialism includes a chapter on contemporary anti-vaccination activism in which he observes the tendency for denialists to persuade by adopting the appearance of medical and scientific authority. “Denialist arguments,” Specter writes, “are often bolstered by accurate information taken wildly out of context, wielded selectively, and supported by fake experts who often don’t seem fake at all” (6). Specter elaborates:

Type the word ‘vaccination’ into Google and one of the first of fifteen million or so listings that pops up, after the Centers for Disease Control, is the National Vaccine Information Center, an organization that, based on its name, certainly sounds like a federal agency. Actually, it’s just the opposite: the NVIC is the most powerful anti-vaccine organization in America, and its relationship with the U.S. government consists almost entirely of opposing federal efforts aimed at vaccinating children” (7-8).

Denialists also, as historians of science Naomi Oreskes and Erik Conway observe, persuade by positioning themselves as defenders of free speech rather than as opponents of scientific consensus. Anti-vaccination activists describe themselves only as advocating for “safer vaccines and further research” (“Anti-Vaccine Activists” 3781). Below, I describe the rhetorical work of actress and vaccine opponent Jenny McCarthy to position anti-vaccination as not “anti-vaccine,” but rather as “pro-safe vaccine.” On anti-vaccination websites, credibility appeals further reinforce the sense of vaccine opposition as a defense of individual rights—and even, in some sense, as a defense of vaccine science.

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49 Oreskes and Conway discuss the significance to denialists of claims of free speech in “Free Speech and Free Markets,” a chapter from their 2010 book, Merchants of Doubt.

50 For McCarthy, to be “pro-safe vaccine” means to demand the development of vaccines without toxins. In June 2008, McCarthy and actor James Carrey hosted a rally in Washington, D.C. McCarthy and Carrey used “Green Our Vaccines” to advocate for the removal of purportedly toxic substances from vaccines and demand a reduced vaccination schedule for children.
Anti-vaccination rhetoric engages the emotions of people who rely primarily on the internet for their decision-making on vaccination. Multiple researchers have thus commented on the need to counter the emotional appeal of anti-vaccination rhetoric, for example by developing messaging with more emphasis on affect.\textsuperscript{51} However, the overarching strategy, even amid efforts to identify the actual sources of vaccine hesitancy, remains the defense of vaccine science. Philosopher of science Maya Goldenberg underlines the persisting concern with anti-vaccination’s “anti-science” in an opinion piece published in the \textit{Toronto Star} at the outset of the Northern hemisphere’s 2017 flu season. As Goldenberg argues, “When members of the public challenge the consensus view, they do not reject science but, rather, challenge the integrity of the statement. They do not trust the source, and thereby question the content of the consensus statement.” Trust is gained only through meaningful engagement, an aim that public health messaging developed to improve knowledge of vaccine science fails to accomplish. Next, I examine the influence on vaccine messaging of the publication of Wakefield’s 1998 study on autism and MMR vaccine.

\textbf{MMR-Autism: False Balance and the Need to Defend Vaccine Science}

Both the publication of Wakefield’s study and its reception partly explain how a deficit model became a common approach to vaccine messaging in recent years despite criticisms of this model. In 1998, the esteemed medical journal, the \textit{Lancet}, published a scientific study that posited a link between the measles, mumps, and rubella (MMR) vaccine and the onset of autism. The \textit{Lancet} publication had an almost immediate impact on perceptions of the safety of the MMR vaccine and vaccination in general. As researchers

\textsuperscript{51} See, e.g., Chapman and Coups, “Emotions and Preventive Health Behavior,” which finds that in the context of flu vaccine, “interventions that appeal to emotions are more likely to change health behavior than are interventions related to risk statistics” (89).
sought to substantiate a possible link between autism and MMR vaccine, critics documented what they saw as increases in anti-vaccination activism. In the paragraphs that follow, I do not give a detailed overview of the MMR vaccine controversy, which other authors have described at length. Instead, my account highlights how experts’ anxieties about the impact of Wakefield’s hypothesis came to justify the prominent focus on science knowledge within vaccine messaging, even for flu vaccines. Messaging premised on defending vaccine science, as I argue, evolves partly from concerns about “false balance”—that is, when media coverage implies more balance between opposing views than scientific evidence supports.

The MMR-autism hypothesis made its way into public discourse in early 1998, with the publication of Wakefield’s study. To mark the occasion of the Lancet publication, a press conference was held to announce the news of important findings about the cause of autism. The press conference took place on February 26, 1998 at the Royal Free Hospital, where Wakefield worked as a surgeon and medical researcher specializing in gastrointestinal disorders. Because of the tentativeness of Wakefield’s MMR-autism hypothesis, the plan for the Royal Free Hospital press conference had been to emphasize the need for further research. Once the press conference began, however, Wakefield become outspoken about his study’s implications for the continued use of MMR vaccine. As Wakefield explained to reporters, “I cannot support the continued use of the three vaccines given together. … My concerns are that one more case of this is too many and that we put children at no greater risk if we dissociated those vaccines into three, but we may be averting the possibility of this problem.” Wakefield’s stance against MMR vaccine made a noticeable impression on

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members of the British public. Within a few weeks of the press conference, for example, parents began to demand that their children be given separate vaccinations for measles, mumps, and rubella rather than the combined dose.\textsuperscript{53} News of the study also made its way to other parts of the world, sparking worry among parents and affecting levels of MMR vaccination in countries such as the U.S. and Canada.

In the period between the 1998 \textit{Lancet} publication and the 2010 retraction of Wakefield’s study, researchers failed to replicate his results. Many parents, however, remained wary of MMR vaccine. The MMR-autism hypothesis also had an impact on anti-vaccination activism. Prior to the publication of Wakefield’s study, anti-vaccination activism had been directed mainly at diphtheria, pertussis, and tetanus (DPT) vaccine, after allegations arose that “36 children suffered neurological conditions” following immunization (“History of Anti-Vaccination Movements”).\textsuperscript{54} These allegations led to the formation of anti-vaccination organizations, including the Association of Parents of Vaccine Damaged Children and the National Vaccine Information Center (NVIC). Wakefield’s \textit{Lancet} publication lent anti-vaccination activism the appearance of scientific credibility. Organizations such as the NVIC entreated parents to support their demand for further scientific investigation into the possible risks and harms of MMR and other childhood vaccines.

\textsuperscript{53} Offit describes the MMR-autism’s impact on vaccination rates in Britain in “The Implosion,” a chapter of his 2008 book, \textit{Autism’s False Prophets}. By 2003, according to Offit, “immunization rates . . . had dropped below the level required to prevent measles from once again becoming a common childhood infection” (24). See, also, Jansen et al., “Measles Outbreak in a Population with Declining Vaccine Uptake,” from a 2003 issue of \textit{Science}.\textsuperscript{54} For a discussion of the emergence of contemporary anti-vaccination activism, see Dubé, Vivion, and MacDonald, “Vaccine Hesitancy, Vaccine Refusal, and the Anti-Vaccine Movement,” from a 2015 issue of \textit{Vaccines}. 
A few celebrities also rallied in support of Wakefield’s hypothesis—most notably Jenny McCarthy, who alleges toxins contained in MMR vaccine caused her son’s autism. On the topic of her son’s autism, McCarthy has published several books, including *Louder than Words: A Mother’s Journey in Healing Autism* (2008), *Mother Warriors: A Nation of Parents Healing Autism Against All Odds* (2009), and *Healing and Preventing Autism: A Complete Guide* (2010). Positioning herself as an expert in her child’s care, McCarthy inspired a movement of parents who sought alternatives to MMR and other childhood vaccines. McCarthy’s involvement raised the ire of critics, who targeted her as a prominent source of misinformation and a significant cause of diminishing vaccination rates. When, in 2013, McCarthy became a co-host of the popular daytime television show, *The View*, vaccine proponents took to news and social media to voice their objections. Many commenters took issue with McCarthy’s advocacy of a link between autism and MMR vaccine, a line of reasoning that pitted McCarthy’s “non-science” and “anti-science” against scientific consensus. Commenters also emphasized that those who subscribed to McCarthy’s vaccine dictums displayed a lack of knowledge of vaccine science that needed to be corrected. In defense of her stance, McCarthy entreated vaccine proponents to “[s]it down with our side, with our doctors and scientists, to take a look at what we’re talking about” (“Jenny McCarthy: ‘We’re Not an Anti-Vaccine Movement’”). Even once Wakefield’s study had been both discredited and retracted, anti-vaccination activists continued to demand that their stance on vaccines be considered.

In 2011, science journalist Seth Mnookin published *The Panic Virus*, which explores the effects of the MMR-autism hypothesis on anti-vaccination activism in North America and

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beyond. Mnookin’s account stresses the impact of Wakefield’s hypothesis on the growth of an industry of vaccine alternatives that profits from anxieties about MMR vaccine’s safety and efficacy. Mnookin also describes the impact of media coverage on perceptions of vaccine science. As Mnookin argues, coverage of both the MMR-autism hypothesis and of anti-vaccination views more generally stemmed from journalistic efforts “to be fair to those on ‘both sides’ of an issue about which there was nothing up for debate” (43). To frame Wakefield’s hypothesis as both a “debate” and a “controversy,” as news coverage often did in the years ensuing the *Lancet* publication, implied that the scientific community had not yet achieved consensus on MMR vaccine’s safety. Indeed, rhetorician Leah Ceccarelli proposes that the commitment to balance in media coverage is often used, as McCarthy uses it above, to manufacture controversy and undermine confidence in scientific consensus. Such controversy is typically manufactured to generate profit, influence public policy, or block government regulation. It works by producing the sense “that there are two equally strong sides on the matter within the scientific community” (198). To manufacture controversy, Ceccarelli explains, “an arguer announces that there is ongoing scientific debate in the technical sphere about a matter for which there is actually an overwhelming scientific consensus” (196). Because of its commitment to fairness, and balance, mainstream media is vulnerable to exploitation by those who wish to manufacture controversy. After Wakefield, for example, anti-vaccination activists frequently used what Ceccarelli calls the “fairness appeal” to demand representation for those with opposing views on vaccination.

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56 Oreskes and Conway, in *Merchants of Doubt*, describe the significance of media coverage to the erosion of confidence in the scientific consensus on issues such as tobacco smoking and climate change. Efforts to spur doubt about the science of these issues, they argue, often involve the exploitation of journalistic conventions. As Oreskes and Conway conclude of the tobacco case, “Balance was interpreted, it seems, as giving equal weight to both sides, rather than giving accurate weight to both sides” (39). Those who seek to manufacture doubt about a complex issue often exploit the journalistic commitment to presenting “both sides” of it, just as McCarthy and others have done in the context of vaccination.
The fairness demanded by anti-vaccination activists such as Jenny McCarthy, for example, had implications for perceptions of vaccine science. “When journalists showcase marginal, extreme, or even thoroughly discredited views and people,” sociolinguist Deborah Tannen argued in *The Argument Culture*, “they give them more weight than they deserve and bestow upon them the credibility of the press” (40). The focus “on balancing two sides” moves news coverage “away from the investigative role for which it is so singularly well equipped” (37). News becomes less informative, and members of the public become more confused about complex issues. Efforts to represent “both sides” in reporting on climate change has, as Jules Boykoff and Maxwell Boykoff find, led to biased coverage of the issue. Media outlets that seek to present more than one perspective on climate change fail to accurately (and adequately) represent climate change as “a serious problem that has anthropogenic influences” (125).\(^5^7\) Graham Dixon and Christopher Clarke find similarly that false balance in representations of MMR-autism intensifies the belief both that MMR vaccine causes autism and that experts remain divided on the vaccine’s efficacy (358). Dixon and Graham conclude that false balance heightens uncertainty among readers surrounding MMR’s safety and efficacy. The finding that false balance affects perceptions of vaccine science also sheds insight into how messages about the difference between science and “non-science” became the focus for vaccine messaging. The goal of messaging that stresses this difference, it seems, is to correct these perceptions and in doing so improve knowledge of vaccine science.

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\(^{57}\) Indeed, in 2014, in a segment on *Last Week Tonight*, host John Oliver illustrated the problem of false balance by hosting a debate in which 97 scientists appeared in defense of scientific consensus on climate change and three spoke out against it (“Climate Change Debate”).
Another problem of false balance is its failure to adequately account for the views of most individuals. Rhetorician Celeste Condit uses media representations of abortion to illustrate this consequence of coverage that highlights “two sides” of a complex issue. Whereas, for example, most individuals tend to “middle-ground options” for abortion (328), news coverage premised on “both sides … work[s] to polarize a debate, thereby obscuring the possibility of a middle ground” (327). False balance in news coverage has similar implications for approaches to vaccine messaging. The focus in mainstream media on there being “two sides” to the debate about MMR’s efficacy and safety not only undermined confidence in scientific consensus. Just as Condit observes of news coverage on abortion, false balance also failed to adequately represent the views of the vaccine hesitant, a demographic that significantly outnumbers those opposed to either specific vaccines or vaccination more generally. Above all, in distorting perceptions of the predominance of anti-vaccination, false balance in media coverage supplied a rationale for messaging aimed at defending vaccine science against threats to its integrity.

In the years ensuing Wakefield’s *Lancet* publication, the motivation to defend vaccine science against the “non-science” of anti-vaccination became a widespread imperative. As recently as 2017, for example, *Science* writer Lindzi Wessel sought to dispel “four vaccine myths” stemming from Wakefield’s 1998 publication. According to Wessel, these myths had taken on renewed significance when the release of *Vaxxed*, a documentary directed by Wakefield, again led to media coverage of the MMR-autism hypothesis. While it exists both for other vaccines—and for vaccine more generally58—boundary work became a common approach to messaging about flu vaccine during H1N1, when the media’s amplification of

58 The WHO has, since H1N1, promoted vaccination using messaging developed by the U.S. CDC, by targeting “six common misconceptions.
“unfounded fears” about vaccine science and safety threatened to undermine efforts to forestall the pandemic. In his 2009 opinion essay, for example, Offit identifies a need, in response to such coverage, for messaging that teaches individuals to distinguish facts from “misconceptions” and “myths”:

Distributing [H1N1] vaccine to those who need it most . . . will be difficult enough. But the task is made harder by the various myths, spread on TV talk shows and Web sites, suggesting that Americans have more to fear from the vaccine than from the deadly disease it prevents.

[.. .]

New myths will inevitably arise as some of the millions of people who are inoculated against H1N1 flu suffer unrelated illnesses. Health officials will keep a close eye out for any real problems. One can only hope that the American public will understand that subsequence isn’t necessarily consequence, and not be scared away from a vaccine that can save lives.

Next, I describe some of the means since H1N1 to defend against the “various myths” that, according to Offit and many others, interfere with the administration of flu vaccine. In this section, I also highlight some of the ways in which messaging developed to defend vaccine science benefits the mandating of personal responsibility.

**Boundary Work in Vaccine Messaging: Distinguishing Fact from “Misconception” and “Myth”**

The U.S. CDC has since H1N1 used demarcations between facts and “myths” or “misconceptions” to increase acceptance of flu vaccine. A web-based initiative, the CDC’s annual flu campaign includes information about the symptoms, diagnosis, prevention, and treatment of flu. My interest is in the rhetorical work of “Misconceptions about Seasonal Influenza and Influenza Vaccines,” an information page that uses a question-and-answer format to promote flu vaccine as part of its emphasis on prevention. Throughout the agency’s
flu-shot campaign, the boundary between science and non-science is enforced by stressing the difference between “misconceptions” and credible scientific facts. The CDC also portrays as non-science any attitudes, ideas, or beliefs that run counter to the scientific consensus in flu vaccine. As part of the rhetoric of personal responsibility, these distinctions reinforce the sense that vaccine hesitancy stems mainly from deficits in lay knowledge of science. “Misconceptions” for example, characterizes questions about the flu shot not as expressions of concern, but rather as failures of understanding.

While both the CDC and the WHO use “misconception” to signal the failure of understanding, many more campaigns employ the terms “fiction” and “myth” to similar effect. In Canada, for example, multiple provincial health organizations promote flu vaccine by outlining and then dismissing as “myth” certain questions concerning the shot’s efficacy or safety. These efforts to reinforce the boundary between science and non-science often respond directly to the challenges to vaccine science posed by anti-vaccination activism. For example, the CDC’s “Misconceptions” page works to dispel the beliefs, common among anti-vaccination activists, that vaccines cause either disease or harmful side effects. In response to these beliefs, the CDC cites two randomized, blinded scientific studies that compared common side effects of flu vaccine to those of different placebos (e.g. inactivated flu shots, salt-water shots). Neither study documented significant differences in terms of common side effects, including body aches, fever, cough, runny nose, and sore throat. Yet, the discussion of these studies is not meant to assuage concerns so much as defend against attacks on vaccine’s safety. In the context of vaccine decision-making, the CDC implies,

59 The two studies are Nichol et al., “The Effectiveness of Vaccination Against Influenza in Healthy, Working Adults” (1995), and Bridges et al., “Effectiveness and Cost-Benefit of Influenza Vaccination of Healthy Working Adults” (2000).
trustworthy knowledge comes not from personal experience—for example, the experience of side effects—but from credible, peer-reviewed studies of a vaccine’s effects.

Anti-vaccination activists, as I explain above, often persuade by appealing to personal experience as an invaluable form of health expertise. Parents, this rhetoric holds, are experts in the care of their children, and patients hold expertise on matters of their own health. Boundary work in vaccine messaging often seeks to defend against anti-vaccination by challenging the credibility of personal experience. Indeed, whereas organizations such as the NVIC equip individuals to question medical experts, public health officials now seek to equip individuals to defend that expertise in personal conversations about vaccination. ImmunizeBC, a campaign developed as part of the British Columbia Centre for Disease Control’s (BCCDC) provides rhetorical training to support individuals in addressing vaccine “myths” (here, labeled “What they say”) and facts (“What you could say”). Also provided are further resources that might be circulated among family and friends to improve their knowledge, but more importantly, to dispel their misconceptions. Implied by the BCCDC’s rhetorical training is the notion that what others say about flu vaccine cannot always be trusted.

The CDC similarly dismisses anecdote as non-scientific by depicting as misconceptions certain questions—for example, about why “some people [do] not feel well” or experience “flu-like symptoms” after vaccination. While neither misconception is labeled as anecdotal, the phrasing of these questions—the emphasis on “some people,” for example—suggests a second-hand account of another’s experience. The CDC characterizes these effects as “mild reactions,” “common reactions,” and “most likely the result of the body’s early immune response reacting to a foreign substance entering the body.” The
reactions, according to the campaign, may also be signs that a vaccine is working—not evidence of the flu shot’s propensity to cause illness. Finally, by describing flu shot’s “side effects” as “mild and short-lasting, especially compared with the symptoms of seasonal flu infection,” the CDC corrects perceptions of infection risk versus vaccination risk. Flu vaccine does not cause flu, but it may bring on flu-like symptoms—and these effects prove the vaccine is working. The CDC also dismisses the view that flu vaccine causes flu by providing multiple explanations for the appearance of flu-like symptoms in vaccinated people. Some people become sick because the vaccine only protects against a season’s most common or most harmful flu strains. Others may develop flu-like symptoms as the result of exposure to other respiratory viruses, such as the common cold. Sickness may be due to exposure in the two weeks following the administration of flu vaccine, during which the body is still only developing immunity. Finally, people sometimes become sick with flu after vaccination because “unfortunately the flu vaccine doesn’t always provide adequate protection against the flu”—not because the shot causes flu.

What matters with each explanation is the use of scientific evidence to interpret personal experience. The presumption is that personal experience is itself an inadequate form of understanding within the context of vaccination. The CDC’s effort to counter certain beliefs by classifying them as misconceptions thus enforces the value of scientific facts. Within vaccine messaging, scientific facts appear as that which ought to guide the decision to vaccinate, and as that which public health officials provide. Multiple texts included within the CDC’s flu-vaccine campaign characterize scientific fact as more reliable than personal experience, the most prominent being an interactive online quiz. “Flu I.Q. tests knowledge of ‘flu facts,’ and is described by the CDC as “an easy and fun way to learn what’s true about
flu.” As an exercise in boundary work, “Flu I.Q.” also tests the capacity of individuals to distinguish science from non-science. The first question, for example, asks individuals to confirm whether the flu vaccine causes flu. Those who accept vaccination, according to this rhetoric of personal responsibility, understand “what’s true” and have the capacity to separate myth from fact.

Boundary work in vaccine messaging has a basis in inoculation theory, especially when understood as a hedge against the influence of anti-vaccination activism. “At the core of inoculation theory,” write Josh Compton, Ben Jackson, and James Dimmock, “is a biological metaphor . . . [which holds] that attitudes can be inoculated against persuasive attacks in much the same way that one’s immune system can be inoculated against viral attacks” (1). First proposed by social psychologist William McGuire, inoculation is a persuasive strategy for protecting attitudes and beliefs from outside attack. McGuire believed, as communication scholars Erin Szabo and Michael Fau explain, that “people can be stimulated to build up resistance to attacks on attitudes by being exposed to weakened attitude-threatening messages” (“Nuances in Inoculation” 234). Posed in the form of questions, for example, certain ideas or beliefs about flu vaccine might be understood as weakened expressions of anti-vaccination. A two-stage process akin to the immunity-building exposure that prepares the body to resist infection, inoculation includes a second stage called “refutational preemption,” that involves pairing exposure to weakened threats with “specific content that can be used to protect and defend one’s attitudes” (“Inoculation and Resistance to Persuasion” 267). More than fifty years after McGuire published his findings, inoculation remains a common feature of public health messaging. Refutational preemption, for example, is evident in the CDC’s enumerating of “misconceptions” in
question and answer form, as each answer also supplies a refutation that might in turn be
used by individuals to defend against anti-vaccination. Through metaphoric inoculation, the
CDC educates individuals not merely in the “facts” of flu vaccine, but in an appropriate
rhetoric for defending the vaccine itself.

As an approach to vaccine messaging, inoculation supports individuals in their efforts
to promote vaccines within their own communities. More importantly, in supporting
individual efforts to defend vaccine science, inoculation enhances perceptions of opposition
to vaccines as both a non-scientific stance and a threat to public health. Both inoculation and
boundary work, of course, have relevant applications in public health contexts, in which
some knowledge of science may facilitate decision-making about exposure to risk. However,
the presumption of a knowledge deficit that underlies both approaches to vaccination
messaging also has the potential to hamper vaccine’s promotion. In the context of
vaccination, for example, too narrow a focus on the “non-science” of anti-vaccination may
detract attention from the need for vaccine innovation—and, more importantly, from the need
for trust. Messaging informed by a deficit model also has no long-lasting impact on the
intention to vaccinate. In 2005, for example, researchers at the University of Michigan and
the University of Toronto sought to test the effectiveness of using distinctions between
vaccine “myths” and facts to encourage vaccine uptake. This study found that participants
who read a CDC brochure that outlined the “myths” and facts of flu vaccine could
immediately distinguish between the two.

Later, however, most participants became “much more likely to misremember a myth
as a fact than to misremember a fact as a myth.” Further, those who read about myths and
facts were at first just as likely to report an increased intention to vaccinate, but later
displayed no increased intention. This group also reported the “lowest perceived personal risk for catching the flu of any group in the study, including those who read no flyer at all” (Skurnik, Yoon, and Schwarz 5). These findings led researchers to conclude that the emphasis on myths and facts in vaccine messaging might be too cognitively demanding to facilitate clarity in vaccine decision-making. Another issue, however, may be that boundary work depends for its effect on the recirculation of “myths” and “misconceptions,” thus amplifying beliefs that go against the scientific consensus on vaccines. Such amplification has the potential to widen the divide between vaccine proponents and the vaccine hesitant.

STS scholars have already critiqued the deficit model as being too limited an approach to the promotion of public health. A significant shortcoming of the deficit model is the extent to which this model presupposes vaccination to be a subject of debate. Rather than merely adapting existing methods of vaccination promotion, public health agencies must revisit the very assumptions about the cause of opposition to vaccination on which many vaccination campaigns are premised. Indeed, findings that challenge boundary work’s effectiveness imply that it may be too simplistic an approach to the problem of declining vaccination rates. Gross’s critique of the deficit model is rooted in the concern that this model fails to represent the complexity of scientific knowledge. Citing STS scholar Stephen Hilgartner, Gross argues that the very problem with this model is its assumption of a clear distinction between science and non-science. The “concept of purity” implied by this distinction, as Hilgartner explains, “requires one of contamination, and the notion of popularization shores up an idealized view of genuine, objective, scientifically-certified knowledge” (520). While vaccination campaigns that engage in boundary work have implications for perceptions of vaccine science, such campaigns also potentially exacerbate
antagonism between anti-vaccination activists and vaccination proponents. That campaigns may perpetuate rather than resolve antagonisms raises questions about the effectiveness of boundary work given the interest in improving the culture of vaccine acceptance.

Vaccination campaigns by their very nature invite individuals to be personally responsible not only for their own health, but also for the health of the group. For this reason, in her 2014 book, *On Immunity*, essayist Eula Biss describes the community immunity produced by vaccination as akin to a public bank—like a blood bank—on which immunocompromised individuals draw when their conditions make direct immunization too risky. “If we imagine the action of a vaccine not just in terms of how it affects a single body,” she writes, “but also in terms of how it affects the collective body of a community, it is fair to think of vaccination as a kind of banking of immunity. Contributions to this bank are donations to those who cannot or will not be protected by their own immunity” (22). The current rhetoric of personal responsibility, however, invites individuals not only to make contributions to this bank, but also to preserve the bank itself by defending vaccine science.

Vaccine messaging premised on boundary work also expects individuals to assume responsibility for stagnating vaccination rates in recent years. *ImmunizeBC*, for example, both teaches the difference between science and “non-science” and demands that those who possess this understanding defend vaccine science when interacting with those who display either vaccine hesitancy or anti-vaccination. The CDC similarly invites individuals to promote flu vaccine among family and friends, in part by correcting “myths” and addressing “concerns about the influenza vaccine, including side effects, safety, and vaccine effectiveness.” “Everyone,” explains a post on the agency’s “Public Health Matters” blog, “can be a flu vaccine advocate.” This demand that individuals contribute directly to efforts to
improve vaccination rates further implies that lack of scientific knowledge is behind vaccination’s decline.

Boundary work’s simplifications also often have a negative impact on the effectiveness of certain campaigns. A study published in a 2014 issue of the medical journal *Pediatrics* finds, for example, that corrective approaches “do not always work as intended.” Conducted by a team of interdisciplinary researchers, this study sought to test the effectiveness of campaigns that aim to increase MMR vaccination rates by focusing on misperceptions. The study found that even when vaccination campaigns succeed in correcting misperceptions, correctives also “reduced vaccination intent” among participants who had been identified as to varying degrees opposed to MMR vaccine. Rather than reversing opposition, corrective approaches “brought to mind other concerns about vaccines,” which these participants used to “defend their anti-vaccine attitudes” (Nyhan, Reifler, Richey, and Reid e840). The study’s authors conclude that campaigns premised on correctives may be counterproductive, and that what may be needed more is a willingness to explore and test other approaches. These researchers recommend further study of a broader range of approaches to vaccination promotion, including the use of various kinds of health narratives and more direct reference to the role and credibility of primary caregivers.

Certainly, boundary work makes sense as a response to anti-vaccination activism—and it also makes sense amid broader concerns about the “non-science” and “anti-science” that circulates online. Boundary work also aligns with the neoliberalization of public health, in large part because this approach relies on education, a seemingly cost-effective intervention into the problem of low vaccination rates. Rhetorical training provided in various campaigns recruits individuals into doing the work of defending vaccine science. The
study of vaccine hesitancy recognizes the complex sources of the “delay in acceptance or refusal of vaccines.” Rhetorical study, as Barbara Hefferson argues, provides insight into the factors behind low vaccination rates by producing case studies that contextualize, and historicize, instances of vaccine refusal. In “Smallpox: An Epidemic of Words?” Hefferson uses rhetorical analysis to describe how resistance formed in response to nineteenth-century U.S. smallpox vaccination campaigns. In her analysis, Hefferson emphasizes rhetorical study as an aid to developing effective vaccine messaging. She urges rhetoricians to be activists and proponents who appeal directly to journalists and public health officials.

Researchers working in rhetoric of health and medicine have also used case studies to examine the view of vaccine hesitancy as symptomatic of a deficit in lay knowledge of vaccine science. Heidi Lawrence, Bernice Hausman, and Claire Dannenberg adopt such an approach in their study of H1N1 vaccine refusal within a “local public, rather than a globally conceived antivaccination public” (111, emphasis in original). In the context they studied, a rural community in a southeastern U.S. state, public health officials had interpreted H1N1 vaccine refusal in broad terms as an indication both of anti-vaccination and of “illiteracy” (119). Lawrence, Hausman, and Dannenberg instead found in interviews that those who refused vaccination adopted discourses that emphasized a shared value of family health, realized through responsible care of the immune system (whether that means exposing it to or protecting it from encounters with antigens) and enacted through practical, non-scientific behaviors designed to protect the self from needless encounters with disease. (124)

Rhetorical study, according to Lawrence, Hausman, and Dannenberg, better accounts for the complexity of vaccine hesitancy because it focuses on how beliefs form and circulate within local publics. Their own study stresses the significance to vaccination decisions of
“vernacular rhetoric,” Gerard Hauser’s term for discourses that articulate a “common sense of reality” (qtd. on 115). Leah Ceccarelli argues, more broadly, that successful engagement on scientific matters—for example, vaccination—requires approaching them not only as matters of fact, but also as “matters of value and policy” (201). She too offers rhetorical study as a means both for identifying how views that go against scientific consensus take hold, and for determining how to meaningfully engage individuals in discussion and debate about such issues.

In 2009, during H1N1, clinician and essayist Danielle Ofri published a New England Journal of Medicine opinion piece about her experiences with patients seeking H1N1 flu vaccine. As the pandemic unfolded, patients who demanded the vaccine began to refuse the shot once it became available. Ofri vented her frustration, stressing that rapidly changing attitudes could not be explained by the release of new scientific data about the safety and efficacy of H1N1 vaccine. Patients’ changing attitudes toward H1N1 vaccine instead seemed “to reflect a sort of psychological contagion of myth and suspicion” (2594). For this reason, she argued, vaccination promotion needed to shift from addressing certain ideas not as misconceptions in need of correction. Instead, responses to H1N1 and other vaccines could be understood as patterned ways of responding to infection risk that are defined more by emotion than by logic. As Ofri explained, “Just as there are patterns of infection, there seem to be patterns of emotional reaction” to infectious disease that challenge the successful administration of vaccines (2594).

Rhetorical analysis provides a systematic approach to the study of what Ofri calls the “emotional epidemiology” of disease outbreaks, predictable patterns of reaction that may be valuable indicators of vaccine acceptance—and vaccine refusal. Taking seriously these
patterns of reaction also created an opportunity to explore alternatives to the deficit model of vaccine promotion. When understood as part of an effort to restore the integrity of vaccine science, campaigns that target deficits in knowledge of science may appear justified. The need to restore trust, however, will require moving beyond the defense of science. By addressing the current crisis in vaccine uptake as almost exclusively an issue of science knowledge, public health officials both offload responsibility for infection and overestimate the part of individuals. For example, as Ofri points out, even despite their agreement about the necessity of vaccines, scientists and clinicians may differ in their approaches to communicating about the risks and benefits of vaccines. In doing so, experts themselves have an impact on confidence and trust that may be just as detrimental as the claims of the anti-vaccination movement.
CHAPTER THREE

Moralizing Antibiotic Use through Discourses of Dependency and Demand

We can make great strides toward curtailing side effects and curbing antibiotic resistance if we can convince individuals that these drugs are not “cure-alls.”


Convenience and laziness top the list of the causes of antibiotic resistance. That is because those who misuse these drugs mostly do not pay the cost. Antibiotics work against bacteria, not viruses, yet patients who press their doctors to prescribe them for viral infections such as colds or influenza are seldom harmed by their self-indulgence.


This chapter examines efforts, in response to antibiotic-resistant infections (ARIs), to encourage personal responsibility for antibiotic use. A pressing concern across public health jurisdictions worldwide, ARIs are infections that no longer respond to one or more antibiotics. Antibiotic, or antimicrobial, resistance forms through bacteria’s sustained exposure to antibiotics, which initiates microbial evolution. The resulting infections are difficult, costly, and sometimes impossible to treat. Antibiotic resistance poses a serious threat because of the limited means of treating these infections. This threat is especially imminent in hospitals, where ARIs like methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (C. difficile, or “C. diff”) can be deadly, especially to immunocompromised patients. Certain strains of gonorrhea, a sexually-transmitted infection (STI) that globally affects more than one million people each year, have recently

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60 For a detailed explanation of how resistance forms, see World Health Organization (WHO), “Antimicrobial Resistance.”

61 The most recent data available from the U.S. Centers for Disease Control and Prevention (CDC) estimate that ARIs cost $20 billion annually in healthcare expenditures and $35 billion in lost productivity (see “Antibiotic Resistance Threats”).

62 ARIs that spread in healthcare settings are also known as “healthcare-associated infections,” or HAIs.
begun to display resistance to antibiotics. Increasingly, ARIs also circulate in public settings such as gyms and public pools. Their spread beyond hospitals has exacerbated anxieties about their catastrophic potential.

Sharp increases in the incidence of ARIs have also incited debate about what these infections mean for antibiotic use. The prevailing view is that antibiotic use and prescription must be adapted in ways that limit the evolution of antibiotic resistance. Public health officials have, for example, begun to endorse antibiotic stewardship programs among healthcare providers. These programs help to ensure the safe, efficient, and effective administration of antibiotics. Public health messaging has also been developed to educate individuals about the impact on antibiotic resistance of patterns of antibiotic use among individuals. These campaigns represent yet another discursive enforcement of personal responsibility for public health.

My contribution to research on antibiotic resistance is to describe the persuasive means through which a public health issue, the evolution and spread of ARIs, becomes a matter of personal responsibility. In this context, the case for personal responsibility, I argue, relies on the invocation of discourses of antibiotic dependency and demand that moralize the evolution of antibiotic resistance. The discourse of dependency, for example, holds that antibiotic resistance evolves because of overreliance on antibiotics to treat infection and widespread failure to understand and respect their limits. Antibiotic dependency differs from other kinds

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63 This estimate of worldwide rates of gonorrhea infection comes from a WHO press release, “Urgent Action.”
64 Published research on the evolution of antibiotic resistance typically echoes this emphasis on antibiotic use, as exemplified by an article, from a 2010 issue of Microbiology and Molecular Biology Reviews, in which authors Julian Davies and Dorothy Davies explain, “these infections are the direct result of antibiotic use” (421).
65 According to 2016 report produced for the World Health Organization, for example, these broad-based campaigns typically endorse the “judicious / prudent / responsible / appropriate / [or] adequate use of antibiotics” (8). For the full text of this report, see Saam, Huttner, and Harbarth, “Evaluation of Antibiotic Awareness Campaigns.”
of drug dependency—in particular, the dependence on opioids that results in severe withdrawal symptoms when the use of these drugs is interrupted. Here, the “dependency” displayed by individuals surrounds their expectation of antibiotics, including symptom relief but also validation of sickness as well. The discourse of demand also targets individuals as largely responsible for the evolution of antibiotic resistance because they request antibiotic treatment, even for viruses, which do not respond to these drugs. Parents and caregivers tend to be the prime target of this latter discourse, which depicts them as seeking out antibiotics for sick children even when antibiotic treatment may be ineffective and potentially dangerous. By connecting patterns of antibiotic use among individuals to the evolution of ARIs, both discourses enhance impressions of personal responsibility as an adequate solution to the crisis of antibiotic resistance.

My rhetorical account both illuminates the strategies used to encourage personal responsibility and reveals problems that may arise from the invocation of discourses of dependency and demand. Certainly, these discourses have the potential to transform patterns of antibiotic use among individuals, a transformation necessitated by the dangers of antibiotic resistance. Yet because both discourses foreground the individual’s role at the expense of more nuanced understandings, the discourses of dependency and demand potentially work against the prevention of antibiotic resistance. Kenneth Burke’s notion of terministic screens helps to explain how the framing of antibiotic resistance in terms of personal responsibility may impede efforts to address it. Burke first described the rhetorical functions of terministic screens in *Language as Symbolic Action*. “Not only does the nature of our terms affect the nature of our observations,” Burke explains, “in the sense that the terms direct the attention to one field rather than to another. Also, *many of the ‘observations’ are but implications of*
the particular terminology in terms of which the observations are made” (46, emphasis in original). Terministic screens work to limit perspectives, and these more limited perspectives have their advantages. A terministic screen common to health care, for example, frames health outcomes as an effect mainly of choice. While this framing, which Dutch ethnographer Annemarie Mol terms the “logic of choice,” may seem empowering for patients, it also deflects attention from the impact on health outcomes of coordinated, collaborative care. In the absence of such care, patient choice may be limited in its capacity to preserve health.

Similarly, in the context of antibiotic resistance, the more limited focus on personal responsibility may motivate people to be more circumspect about the impact of antibiotic use on antibiotic resistance. This same perspective may also deflect attention both from systemic factors driving the evolution of antibiotic resistance and thus from more meaningful solutions. The risk of antibiotic resistance demands systemic change—for example, as mentioned, the implementation of antibiotic stewardship programs and more careful regulation of antibiotic use in the livestock industry.66 Public health messaging, for example, increasingly depicts the impact on antibiotic resistance of widespread use of antibiotics within the livestock industry. Many campaigns also promote antibiotic stewardship among healthcare providers. Messaging has yet to incorporate an emphasis on the factors driving the demand for and dependence on antibiotics among individuals—most notably, the pharmaceutical industry’s marketing of these drugs. Rather, the evolution of antibiotic resistance has incited calls for the creation of incentives for industry, to motivate the development of new antibiotics. Historians of science Robert Proctor and Londa Scheibinger

66 Indeed, the 2013 report, “Antibiotic Threats in the United States,” the CDC prioritizes improvements to antibiotic use in healthcare settings and within agriculture as essential to the prevention of antibiotic resistance.
use the term “agnotology” to describe the cultural production of ignorance. In “Agnotology: A Missing Term,” Proctor, for example, documents the tobacco industry’s efforts to “manufacture doubt about the hazards of smoking,” both to maintain sales and to forestall industry regulations (11). A subtler example of agnotology, the rhetoric of personal responsibility invoked in antibiotic-use campaigns is certainly less exploitative than industry efforts to manufacture doubt about the health risks of smoking. Even so, this rhetoric is just as likely to generate ignorance about what kinds of interventions, in addition to personal responsibility, might best resolve the crisis of antibiotic resistance. Such changes might include stricter regulations surrounding the marketing and promoting of broad-spectrum antibiotics, often in ways that invite individuals to request these drugs by name.67

In this chapter, I describe the emergence of modern antibiotics, connecting their historically persuasive appeal as “wonder drugs” and “miracle drugs” to the current framing of antibiotic resistance in terms of personal responsibility. The mandating of personal responsibility for antibiotic resistance, I argue, benefits from discourses of dependency and demand because these discourses foreground the individual’s role. My analysis thus highlights their significance to the U.S. Centers for Disease Control and Prevention’s (CDC) Get Smart, a longstanding campaign aimed at altering current patterns of antibiotic use and prescription. This campaign, and campaigns like it, in stressing the need for personal responsibility, raise questions about what motivates dependence on and demand for antibiotics. I argue that a crucial factor—and one not yet prominent to messaging about antibiotic resistance—is the pharmaceutical industry’s investment in the widespread use of broad-spectrum antibiotics for the treatment of infection. My examination of pharmaceutical-

67 A “broad-spectrum” antibiotic describes any antibiotic used to treat a range of different disease-causing bacteria. Penicillin is an example.
industry influence helps to illuminate the limits of a rhetoric of personal responsibility, including its capacity to deflect attention from a significant force shaping patterns of antibiotic dependency and demand. The case of antibiotic resistance also provides further insight into opportunities for the private sector created by the rhetoric of personal responsibility at public health’s expense. In the chapter following this one, on efforts to contain “epidemic” obesity, I elaborate on how corporations benefit from the rhetoric of personal responsibility.

**Antibiotic “Wonder Drugs” and the Problem of the “Ignorant Man”**

To understand the current framing of antibiotic resistance, it helps to consider how the development of modern antibiotics changed perceptions of responsibility and risk in the context of infection. Early antibiotics like penicillin, as historian Robert Bud explains, dramatically reduced perceptions of the risk of infection, transforming it into “a technical problem susceptible to a pharmaceutical solution” (*Penicillin* 98). Antibiotics also created a new role for individuals when infection symptoms arose—to seek out antibiotic prescription—a responsibility that created tensions between patients and healthcare providers. The following account of the emergence of and responses to modern antibiotics highlights anxieties, mainly among healthcare providers, about antibiotic use among individuals brought on by changing perceptions of responsibility and risk. My aim in detailing these anxieties is to emphasize their connection to the more recent mandating of personal responsibility for antibiotic resistance.

My account of the history of modern antibiotics, and specifically the introduction of penicillin, draws on the writings of historians of science and medicine. Bud, for example, provides an abridged version of this history in “Antibiotics: From Germophobia to the
Carefree Life and Back Again." A lengthier, more detailed account appears in his 2007 book, *Penicillin: Triumph and Tragedy*. The history of modern antibiotics begins with the development of penicillin by Scottish biologist and pharmacologist Alexander Fleming in 1928. While examining mold on a discarded Petri dish from a contaminated experiment, Fleming noticed the antibiotic properties of *Penicillium rubens*. Together with pharmacologist Howard Florey and biochemist Ernst Chain, Fleming developed penicillin for medical use and large-scale manufacture.\(^{68}\) Penicillin antibiotics provided effective treatment for a whole host of serious and potentially deadly infections, including infections caused by streptococci and staphylococci.\(^{69}\) Early advertisements also celebrated the use of penicillin to treat infections during World War Two. A 1944 *LIFE* magazine advertisement, for example, advertised the drug by depicting a wounded soldier receiving treatment. The advertisement includes the caption, “Thanks to PENICILLIN . . . He Will Come Home!”\(^{70}\) Because penicillin so radically redefined the risk of infection, *Time* declared it a “wonder drug” in 1943, a label that persists. Subsequent antibiotics—for example, streptomycin, a treatment for tuberculosis first discovered in 1943—came to be understood in similar terms, as “miracle drugs.”\(^{71}\)

Essential to the current framing of antibiotic resistance is that patterns of antibiotic use and prescription accelerate the evolution of ARIs. This notion, however, dates to the decade following the introduction of penicillin. In 1945, Florey, Chain, and Fleming won the

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\(^{68}\) Bud chronicles the process of developing penicillin for wide-scale manufacturing in *Penicillin: Triumph and Tragedy*.

\(^{69}\) Penicillin also provided an effective treatment for sexually-transmitted infections (STIs), including gonorrhea and early syphilis. Alan Brandt’s *No Magic Bullet* details the social implications of the advent of antibiotic treatment for STIs.

\(^{70}\) A reproduction of this *LIFE* advertisement for penicillin appears in a 2013 blog post on the National WWII Museum Website. See “SciTech Tuesday: Thanks to Penicillin!”

\(^{71}\) See, for example, Alan Yoshioka, “Streptomycin in Postwar Britain: A Cultural History of a Miracle Drug,” for an account that stresses the widespread faith invested in this early effective treatment for tuberculosis.
Nobel Prize in Medicine for their role in the discovery of modern antibiotics. Fleming used his Nobel Lecture to “sound one note of warning” about penicillin’s potential dangers. “The time may come,” Fleming predicted, “when penicillin can be bought by anyone in the shops. Then there is the danger that the ignorant man may easily underdose himself and by exposing his microbes to non-lethal quantities of the drug make them resistant” (“Penicillin,” emphasis added).

Fleming foretold of a world in which the widespread availability of antibiotics, combined with a lack of regulation, created the ideal conditions for the evolution of ARIs. Fleming thus saw the prevention of antibiotic resistance as necessitating the careful oversight and administration of these drugs by healthcare providers. To facilitate the administration of antibiotics in ways that minimized the evolution of resistance, Fleming wrote and published *Penicillin: Its Practical Application*, an early guide for physicians and pharmacists.

Over the second half of the twentieth century, as Bud observes, antibiotic use became “a defining quality of societies across the world” (“Antibiotics” 17). Prior to the introduction of antibiotics, prevention had been actively promoted by public health officials as the prime means of avoiding infection. Within a culture of prevention, the development of infection signified the failure of personal responsibility. The introduction of antibiotics not only diminished the risk of infection, but also reduced the stigma associated with the development

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72 Saam, Huttner, and Harbarth observe, in their report to the WHO, the basis of antibiotic-use campaigns in messaging about “misuse” and “overuse.” Underuse—or failing to take antibiotics for the full course of treatment—as described by Fleming is considered by most public health officials to be a misuse of these drugs that accelerates the evolution of resistance. To discourage underuse, for example, the CDC urges individuals to “[t]ake antibiotics exactly as prescribed” and to “[c]omplete the prescribed course of treatment, even when you start feeling better” (“Mission Critical”).

73 The need for oversight by physicians and pharmacists remains a focus of antibiotic-use campaigns, including the U.S. CDC’s *Get Smart*. As I demonstrate, their recruitment into antibiotic-resistance prevention efforts depends on a rhetoric that characterizes ARIs as stemming from failures of personal responsibility. This rhetoric is apparent even in Fleming’s own attribution of antibiotic resistance to faulty antibiotic use by the “ignorant man.”
of certain infections. Personal responsibility became less a matter of preventing infection and more one of seeking out antibiotic treatment when the symptoms of infection arose. This newfound sense of agency among patients, however, came at the expense of a physician’s responsibility for care and treatment. As Bud explains, drawing on the writings of sociologist Talcott Parsons, doctors went from being caregivers to gatekeepers, “more-or-less interchangeable tradesmen whose job it was to prescribe medicines” (“Antibiotics” 26). Patients came to see themselves as responsible mainly for procuring drug treatment.

Antibiotics increased patient agency, and in doing so worked against the authority of their physicians. In exercising the power to request drug treatment, for example, patients gained agency previously lacking in clinical encounters, whereas treating infection mainly by dispensing drugs entailed a more limited role for physicians. By the mid-twentieth century, concerns about the impact of antibiotics on physician-patient relationships began to transform debates about the broader culture of antibiotic use. Fleming had endorsed the need for regulation, to improve oversight and administration of antibiotics. Public health officials and physicians also became invested in the need for education, to influence approaches to antibiotic use among individuals and more importantly to restore to physicians their authority for antibiotic treatment. This investment in education stemmed from the view that individuals lacked the knowledge demanded by their newfound responsibility for infection. Anxieties also arose among clinicians about the implications for patient responsibility of both the status of antibiotics as “wonder drugs” or “miracle drugs” and the industry that had formed to

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75 Parsons describes these shifting responsibilities of doctor and patient in his 1951 book, The Social System, in which he outlines his theory of the “sick role.” According to this theory, a person who falls sick assumes a social role defined by certain rights and obligations. Parsons’ theory helps to illustrate the influence of antibiotics on perceptions of responsibility.
promote their powers. “Doctors have been awed and appalled,” reported a 1946 Time commentary, “by a gusher of argumentative books and reports claiming that . . . penicillin will cure almost anything” (“Fleming on Penicillin”). By 1950, Henry Welch, Director of the Division of Antibiotics of the U.S. Department of Health, Education, and Welfare, observed the following:

The American public is like a huge sponge that absorbs antimicrobial agents like water, always eager to try the new one they have read about in their daily press or latest magazine, one whose miraculous cures emanated from the radio or television. It has reached the point where the physician can tell his patient—but he can not [sic] tell him much! The patient advises the doctor that he does not want antibiotic “A” because he has heard it is dangerous; he wants antibiotic “B” because a friend of his was cured with it. It makes no difference to him that his friend had an entirely unrelated infection. It’s a “miracle drug”—let it perform its miracle. (qtd. in Levy 85)

In his Nobel Lecture, Fleming had supplied two differing yet overlapping perspectives on the prime source of antibiotic resistance. On one level, ARIs arose from improper use by uninformed individuals, as exemplified by the “ignorant man” whose use of antibiotics accelerated the evolution of resistance. On another level, systemic factors—for example, the expansion of an underregulated industry—created the conditions in which dependence on and demand for antibiotics might flourish.

Both the impact of antibiotic use on perceptions of responsibility and risk, and growing concerns about how these drugs altered the physician-patient relationship, tipped the scales toward the perspective that held individuals responsible. Decades later, this targeting of individuals remains a hallmark feature of debates about antibiotic resistance. In The Antibiotic Paradox, for example, microbiologist Stuart Levy, a vocal advocate for the resolution of antibiotic resistance through increased emphasis on personal responsibility, argues,

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76 Microbiologist Stuart Levy incorporates these comments from Welch into his concluding remarks in The Antibiotic Paradox, in which he emphasizes education as a means of defending against antibiotic resistance.
Whatever the means of distribution, the common denominator of antibiotic usage in all countries is the individual consumer. Therefore, any attempt to improve the use of antibiotics must focus on the person who asks for, buys, and takes the antibiotic. We can make great strides toward curtailing side effects and curbing antibiotic resistance if we can convince individuals that these drugs are not “cure-alls.” (226).

Media coverage echoes the targeting of individuals as the prime agents driving the evolution of ARIs. Consider, for example, the following editorial, from the Economist, on the evolution of “superbugs,” or infections that display resistance to multiple antibiotics:

*Convenience* and *laziness* top the list of the causes of antibiotic resistance. That is because those who misuse these drugs mostly do not pay the cost. Antibiotics work against bacteria, not viruses, yet *patients who press their doctors to prescribe them* for viral infections such as colds or influenza are seldom harmed by their *self-indulgence* . . . The hypochondriacs can, though, act as breeding grounds for resistant bacteria that may infect others. Even when the drug has been correctly prescribed, those who fail to finish the course are similarly *guilty* of promoting resistance. (“The Spread of Superbugs,” emphasis added)

Rooted in the history of modern antibiotics, the targeting of individuals—and the moralizing of their patterns of antibiotic use—also supplies the terms used to encourage their assumption of personal responsibility.

“No Antibiotics Please”: Discourses of Dependency and Demand

First launched in 1995 as the *National Campaign for Appropriate Antibiotic Use in the Community*, the U.S. CDC’s federal antibiotic-use campaign become known in 2003 as *Get Smart: Know When Antibiotics Work*. *Get Smart* remains one of the most comprehensive efforts to involve individuals in preventing antibiotic resistance, and it also addresses the need for altered approaches to antibiotic prescription among healthcare providers. Key to the campaign’s rhetoric of personal responsibility is the message that individuals have as much a role to play in limiting the evolution and spread of antibiotic resistance as do healthcare providers. An overarching goal, for example, is for individuals to rethink what it means to be responsible in the context of infection. The introduction of penicillin and subsequent
antibiotics meant that individuals became responsible for securing treatment when the symptoms of infection arose. Now, it has become important for individuals to see that not requesting antibiotic treatment—and not expecting so much of antibiotics—can potentially forestall the evolution of ARIs.

In what follows, I highlight the rhetorical work of the discourses of dependency and demand, both of which supply a rationale for the assumption of personal responsibility for antibiotic use—and antibiotic misuse. Antibiotic dependency, for example, is depicted as both a factor driving antibiotic resistance and a personal failing that requires correcting individuals’ understanding of and expectations surrounding antibiotic use. This discourse reinforces the need for personal responsibility by deeming ignorance the prime source of antibiotic misuse. Antibiotic demand, or the demand for antibiotic prescription for infection, previously a patient’s responsibility, is also depicted as accelerating the evolution of antibiotic resistance. Compliance with healthcare providers, an expression of personal responsibility, becomes a potential antidote to resistance’s evolution.

As Burke explains of terministic screens more generally, the framing of antibiotic resistance in terms of dependency and demand works to direct attention, here to the need for personal responsibility. Underlying the encouragement of personal responsibility is the presumption that patterns of antibiotic use among individuals have the most significant impact on the evolution of antibiotic resistance. The foregrounding of dependency and demand also deflects attention, for example from a systemic factor driving patterns of use—the marketing and promoting of broad-spectrum antibiotics directly to individuals. Burke’s notion of terministic screens supplies a rationale for rethinking the goals of a rhetoric of personal responsibility within the context of antibiotic resistance, as does Proctor and
Schiebinger’s theory of agnotology. Additional support comes from French philosopher Jacques Derrida, who in a 1989 interview with literary critic Michael Israel proposed a “rhetoric of drugs.” “[T]he concept of drugs,” Derrida argues, “is not a scientific concept, but is rather instituted on the basis of moral or political evaluations: it carries in itself both norm and prohibition” (n.p.). According to Derrida, what counts as a drug, for example, is closely tied to dictates surrounding what it means to be a contributing member of one’s society.

Antibiotics differ significantly from the illicit drugs that Derrida discusses, but the rhetoric of personal responsibility that is characteristic of antibiotic-use campaigns has much in common with his “rhetoric” of drugs. Public health messaging presents antibiotic use not, in the first instance, as curative but rather as potentially dangerous, and it is through such presentations that a more limited view of antibiotic resistance takes hold. This more limited view includes the notion that dependence on antibiotics significantly accelerates the evolution of antibiotic resistance. The early emergence, among physicians, of concerns about faith in antibiotics as “wonder drugs” and “miracle drugs” set a precedent for the use in public health messaging of the discourse of dependency. This discourse asserts a relationship between the rise of antibiotic resistance and widespread failure among individuals to understand antibiotics properly and use them accordingly.

Accompanying this stressing of dependency, mainly among parents and caregivers, is an overarching emphasis on demand. According to the discourse of demand, antibiotic resistance emerges because individuals ignore the advice of healthcare providers and thus interfere with the safe and effective administration of antibiotics. The discourse of demand commonly finds expression in messaging that invites individuals to refuse rather than ask for antibiotics—for example, through the Get Smart slogan, “Snort. Sniffle. Sneeze. No
Antibiotics Please!” Materials developed for the CDC’s annual Get Smart About Antibiotics Week encourage individuals to “not demand antibiotics when your healthcare professional says they are not needed” (“Antibiotics Aren’t Always the Answer”). This advice is paired with the observation that because of demand for antibiotics, healthcare providers administer “47 million unnecessary antibiotic prescriptions.” The idea that patients might refuse rather than demand antibiotics appears paradoxical except when understood as an effect of the rhetoric of drugs. Just as, for example, the notion of a “natural body” takes hold through the admonition of performance-enhancing drugs, the notion that individual demand accelerates resistance takes hold through the admonition of requests for antibiotic treatment.

A prime focus of Get Smart is the potential dangers of dependency and demand among parents and caregivers and their consequent need for personal responsibility. Throughout the campaign, images of sick children and their caregivers use pathos to illustrate a common situation in which antibiotic dependency and demand interfere with the safe administration of antibiotics. Multiple campaign texts admonish parents and caregivers for depending on and demanding antibiotics and in doing so encourage both compliance with healthcare providers and the adoption of alternative expressions of care and treatment. Research on antibiotic-use trends provides some context for the CDC’s targeting of dependency and demand, for example among parents and caregivers. Published in the Journal of the American Medical Association (JAMA), a 1995 study finds that U.S. children younger than 15 years of age take more antibiotics than any other age group. Subsequent

77 In 2017, the CDC renamed their week-long observance “Antibiotic Awareness Week.”
78 See McCaig and Hughes, “Trends in Antimicrobial Drug Prescribing.”
studies attribute elevated levels of antibiotic use among children to dependency and demand among parents and caregivers.\textsuperscript{79}

The most prominent texts attending to the need for personal responsibility among parents and caregivers include a series of video public service announcements (PSAs). Posted on \textit{Get Smart} and hosted on a CDC YouTube channel, the PSAs portray dependency and demand as stemming primarily from a sense of responsibility for the care and treatment of a dependent. The PSAs avoid blaming individuals and at the same time holding them accountable for the use of antibiotics in ways that accelerate the evolution of ARIs. For example, the PSA “Parents Want to Do What’s Best” acknowledges parents and caregivers as personally responsible for the safety and well-being of the children in their care. A stop-motion animation, the PSA features images of children at play, superimposed over which appear objects that might protect them from harm. In one scene, for example, a mattress and a parachute appear under a boy climbing a tree.

As the video’s narrator explains, “As a parent, of course you want to protect your kids. Sometimes, you know just what to do. Sometimes, you just try your best. But when your child is sick, antibiotics may not be the answer.” After the images of children at play, a sick child is shown. In this scene, an ice pack and thermometer appear to reinforce the CDC’s message that “antibiotics may not be the answer.” “Parents Want to Do What’s Best” encourages parents and caregivers to rethink their dependence on and demand for antibiotics while acknowledging that both tendencies may stem from a parent’s sense of responsibility. “Sometimes,” the narrator acknowledges, “you just try your best.” As the narrator speaks these words, the PSA cuts to a scene in which a child plays in a room filled with plastic balls.

\textsuperscript{79} A study published in \textit{Pediatrics} finds, conversely, that physicians often overestimate parental demand for antibiotics. See Mangione-Smith et al., “The Relationship Between Perceived Parental Expectations and Pediatrician Antimicrobial Prescribing Behavior.”
A hand reaches out to spray down each of the balls with disinfectant, a potentially unsustainable albeit caring response to the risk of infection. The subtext of this scene is that demand for and dependence on antibiotics for sick children may similarly be an unreasonable and even ineffective response to the symptoms of infection. The video ends with an encouragement to parents to “talk with your child’s doctor or nurse and learn how to help your child feel better.” “Parents Want to Do What’s Best” teaches that antibiotic resistance stems from a tendency to rely on antibiotics as expressions of care. Parents who wish to satisfy their responsibility for sick children amid anxieties about antibiotic resistance must be willing to comply with healthcare providers’ authority over antibiotics.

The PSA, “Always Gives Hugs,” similarly stresses the need for compliance with health provider advice by highlighting how a mother who is also a healthcare provider attends to the suffering of her sick child.80 “As a mom,” explains the PSA’s protagonist, “I know what it’s like: you want to be there for them and make them feel better.” After several scenes in which this parent appears caring for a sniffling, sneezing child, the camera pans back to reveal her wearing a white coat and stethoscope. The protagonist continues, “As a pediatrician, I know that the best thing you can do is to make sure that the care you give is the right care for the condition.” “Always Gives Hugs” again questions the demand for and dependence on antibiotics while still respecting that both tendencies may be motivated by the desire to give care. As she explains, when faced with her sick child’s suffering, she prioritizes her healthcare expertise over her emotional response—a response she associates with her parental desire to “be there” for her child and “make them feel better.” Existing research on antibiotic dependency and demand among mothers helps to justify the CDC’s

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80 This video PSA, which the CDC created for Get Smart in 2008, is no longer available online as of 2017. To learn more about the video, see “Get Smart About Antibiotics Week.”
targeting of female caregivers in “Always Give Hugs.” Public health scholar Marianne Kuzujanakis and co-authors identify mothers, for example, as forming “the vast majority of respondents” to their survey of antibiotic use among parents and caregivers (206). Research also deems U.S. mothers the “most fervent online health seekers,” a finding that reflects their heightened sense of responsibility for providing care for sick children. Like “Parents Want to Do What’s Best,” “Always Gives Hugs” seeks to restore to healthcare providers the responsibility for determining the necessity of antibiotic treatment. Caregivers—and mothers in particular—can assume responsibility for antibiotic resistance again by complying with expert recommendations.

A third and final PSA again blurs roles—between adults and children, and children and physicians—to prioritize a healthcare provider’s responsibility for administering antibiotic prescriptions over a caregiver’s demand for them. Called “Snort. Sniffle. Sneeze. No Antibiotics, Please!” and set in a clinic waiting room, this final PSA features adult actors playing the roles of sick children. One adult complains to a stuffed bear, “I don’t feel so good”; another adult resists having his temperature taken; while yet another adult moans, “I wish I’d feel better. My ear.” These dramatizations reiterate the CDC’s assertion of antibiotic dependency and demand as stemming from a parent or caregiver’s sense of responsibility for a child’s infection symptoms. By reversing the roles of adult and child, the PSA implies that a child’s reactions may be an unreliable basis for dependency and demand. Further implied is the possibility that dependency and demand emerge as much from a caregiver’s desire for reprieve as they do from the will to give care. As the video’s narrator, a child, muses, “You know how frustrating it is trying to help your kids when they’re sick. A visit to the doctor’s can be a challenge.” The child narrator then appears on screen in a white lab coat and scrubs.
“As a parent, you want to help make your child feel better as fast as possible,” she continues.

“It’s tempting to think that antibiotics are the answer when your child is sick, but that may not always be the case.”

Another healthcare provider, this time played by an adult, is introduced to corroborate the child-doctor’s caution against antibiotic dependency and demand. A mother, like the protagonist of “Always Give Hugs,” this physician explains,

I’m a doctor, but also the mother of two kids. … She’s right, antibiotics are used too often for things they can’t treat, like colds, flu, or other viral infections. They can stop working effectively against bacteria when you really need them. Antibiotic resistance, when antibiotics can no longer cure bacterial infections, has been a concern for years. Everyday problems can become much worse if we can’t use our first line of defense. Children can need hospitalization for superbugs that don’t respond to common antibiotics. As a parent, you can do something.

With this third PSA, the CDC asserts a direct link between the evolution of antibiotic resistance and the demand for and dependence on antibiotics among parents and caregivers. The assumption of personal responsibility for antibiotic resistance is in turn signaled by deference to healthcare providers.

The use of parents and caregivers to illustrate the problems of antibiotic dependency and demand persuasively shores up the case for personal responsibility because this example diminishes impressions of blame. Indeed, the targeting of parents and caregivers allows for some recognition of the agency associated with dependency and demand—including, for example, the desire to give care. Parents and caregivers may be more responsive to messages that recognize their responsibility for giving care. Those without children may also come to see their demand for and dependence on antibiotics for themselves as similarly limited if justified responses to infection.
More broadly, the assertion that dependency and demand accelerate the evolution of ARIs finds reinforcement in media discourse, which further benefits the mandating of personal responsibility for antibiotic resistance. The following opinion piece, from the *National Post*, illustrates the echoing in news coverage on antibiotic resistance of discourses of dependency and demand:

It is a scenario familiar to many in the medical profession: A patient comes in complaining of an upper respiratory infection—a cough or cold. He wants the doctor to prescribe an antibiotic. The doctor knows the infection is almost certainly viral, and will resolve itself on its own. But even after the doctor explains that, the patient wants the antibiotic ‘just in case.’ Rather than arguing, because she is facing the pressures of time, the doctor gives in to the request. (“Avoiding an ‘Antibiotic Apocalypse’”)

This essay’s author does not absolve healthcare providers of their responsibility. Blame is still directed at individuals—caregivers, patients, and to an extent doctors—rather than at a healthcare context that works against the safe, effective administration of antibiotics. This author concludes, for example, that antibiotic resistance might be quelled by diminishing the demand for antibiotics. A costlier yet potentially more effective intervention might involve relieving the time pressures that healthcare providers face in interactions with patients and caregivers seeking antibiotics. It might also help to understand what motivates requests for antibiotic prescriptions—“just in case.” In my conclusion, I explore the pharmaceutical industry’s efforts to encourage such a culture of antibiotic dependency and demand.

As mentioned at this chapter’s outset, responses to antibiotic resistance have included efforts to equip healthcare providers to prescribe antibiotics in ways that forestall the evolution of ARIs. These efforts also benefit from the discourses of dependency and demand invoked in *Get Smart* to encourage patients and caregivers’ assumption of personal responsibility. The *Get Smart* website, for example, refers to research on the impacts of
dependency and demand on prescribing habits among healthcare providers. One study, published in 2001 and cited on the campaign website, describes the prescription of antibiotics for viral infections as “having as much or more to do with patient and physician expectations as with physicians’ diagnostic skills.” According to this study, individuals exert pressure on healthcare providers in numerous ways—not just through direct request for antibiotics. Indirect pressures include “portraying the severity and inability to shake the illness.” The authors of this study conclude that reducing the use of antibiotics for viral infections requires attending to “the powerful role patients play [in doctor-patient interactions].” Here, the discourses of dependency and demand do appear to absolve healthcare providers of their part in the administration of antibiotics for infections that do not respond to these drugs.

A video posted on Get Smart and directed at physicians exemplifies this absolving of healthcare providers both for current levels of antibiotic use among individuals and for antibiotic prescriptions for viruses. A four-minute video primer narrated by Dr. Lauri Hicks, medical director for the Get Smart campaign, “Don’t Give In and Give Those Antibiotics!” instructs healthcare providers in how to counter the “subtle approaches patients use to pressure them.” Hicks recommends five rhetorical strategies for reducing antibiotic prescriptions, in doing so positioning physicians as rhetorical actors who depend on persuasion to acknowledge a patient’s symptoms while limiting their access to antibiotics. First, physicians should state a “specific diagnosis,” telling a patient that they have “viral bronchitis” rather than “just a virus.” Second, since patients often “request an antibiotic because they think it will help them or their child feel better,” symptomatic relief might be prescribed. Instead of giving antibiotics, for example, healthcare providers can write prescriptions for over-the-counter remedies using the “CDC’s downloadable symptomatic
prescription pad” (a “non-prescription”) or give individuals “cold-care kits to prevent them from leaving . . . empty-handed.”

Third, physicians should “[s]hare normal findings as you go through your exam.” This strategy involves being explicit about the severity of a patient’s symptoms: “For example, let patients know that their lungs sound clear, or that you aren’t seeing inflammation in their child’s ear.” Physicians who outline findings reassure patients about the relative severity of symptoms, a strategy that may make them “more open to the idea that they don’t need an antibiotic.” Fourth, those patients who do not “realize that antibiotics can be harmful” should be engaged in a conversation about the “potential side effects of antibiotic use.” Finally, patients—and caregivers—should be informed about “what to expect over the next few days,” a strategy aimed at helping them “feel reassured and empowered.”

Each strategy, in providing a hedge against dependency and demand, reinforces the individual’s role in accelerating antibiotic resistance and endorses compliance with healthcare providers as a necessary solution.

A growing body of research has emerged in support of limiting antibiotic resistance by supplying healthcare providers with non-antibiotic, and primarily rhetorical, means of validating patient and parental concerns about infection. Much of this research reinforces the notion that patterns of use among individuals are the prime driver of antibiotic resistance. Written by James Avorn and Daniel Solomon, an essay from the Annals of Internal Medicine exemplifies this preoccupation with the individual’s role. According to Avorn and Solomon, patients depend on and demand antibiotics to fulfill their need for support in overcoming infection:

Through the alchemy of the pharmacy, the paper prescription and its inscrutable ritualistic writings are transformed into a container of tablets or capsules. In a real
sense, the drug prescription prolongs the physician-patient encounter by enabling the patient to ingest a “dose of the doctor” several times a day. … This perspective helps to explain the “drug hunger” that many symptomatic patients bring to the physician visit, in which they feel satisfied only by receiving a prescription. (129)

To temper dependency and demand, Avorn and Solomon recommend developing meaningful alternatives to antibiotic prescription—in particular, a “tangible product of the clinical encounter” that provides the validation most patients seek (128). Rhetorical alternatives to drug treatment include “a preprinted prescription recommending simple, safe, over-the-counter remedies for symptomatic relief,” a “kind of un-prescription” (133) like the non-prescription Hicks describes in her appeal to healthcare providers. Rhetorical alternatives to antibiotics potentially satisfy a patient’s emotional or interpersonal needs while limiting their access to antibiotics.

The stated goal of an un-prescription is to acknowledge the presence and potential severity of a viral infection. Physicians who use the CDC’s un-prescription issue a diagnosis—for example, cold, cough, flu, middle ear fluid, or viral sore throat. This diagnosis creates an opportunity for a physician to address a patient’s “incorrect perceptions,” to quote Avorn and Solomon, surrounding the use of antibiotics. Printed beneath the diagnosis checkbox, a warning reads as follows: “You have been diagnosed with an illness caused by a virus. Antibiotics do not cure viral infections. If given when not needed, antibiotics can be harmful. The treatments prescribed below will help you feel better while your body’s own defenses are fighting the virus.” Treatments include drinking water or juice, taking lozenges, or using a vaporizer or saline nasal spray, all mechanisms that relieve the symptoms of viral infection. Doctors can check one of these treatments or even issue to patients an instruction to purchase a specific (presumably over-the-counter) medicine. The non-prescription includes a space where doctors can indicate how long a patient should wait before returning
for a “recheck,” a postponing of further negotiations for antibiotic treatment that reinforces physician authority.

As rhetorical tools, non-prescriptions and un-prescriptions work to treat antibiotic dependency and demand, particularly with respect to viral infections, as symptomatic of other desires and needs. These texts, for example, have been developed to acknowledge an individual’s sense of responsibility for seeking out treatment for infection. So, the writing of an un-prescription, explain Avorn and Solomon,

signifies that the physician has made a diagnosis and that treatment is possible. A prescription officially (and tangibly) assigns the patient to the sick role, with all of its benefits and responsibilities. It can also act as a termination strategy for an office visit, a sign that the visit has been consummated, the encounter complete, and it is time for the patient to move on. (128)

Patients who receive an un-prescription ideally come away feeling validated, reassured that their doctors perceive an illness as a problem—not “just a virus.” The CDC’s non-prescription and texts like it thus have the potential to reframe the doctor-patient dynamic as one of apparent collaboration rather than open conflict.81 Rhetorician Judy Segal describes this strategy of seeking to maintain authority through the appearance of collaboration between patient and physician as one of concordance. For physicians, the advantage of a concordance model for doctor-patient interactions is that it reproduces the ideology of compliance—an important aim of antibiotic-use campaigns—without appearing to do so.

To increase compliance, *Antibiotic Awareness*, an initiative of multiple Canadian federal-level health partners, similarly circulates “un-prescription” sheets for use in clinical encounters. The *Antibiotic Awareness* un-prescription targets those “who have a suspected viral infection,” and includes checklists for a “Working Diagnosis,” “Instructions,” and

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81 See Segal, “‘Compliance’ to ‘Concordance’: A Critical View” (2007).
“Over-the-Counter Medicines.” Accompanying the un-prescription download is a document titled, “‘Script’ for the doctor rather than a ‘script’ for antibiotics.” This script indicates the conditions under which a patient should return to the clinic. This sheet explains to doctors how to administer an un-prescription using the “elicit-provide-elicit method.” A three-stage communicative strategy, this method prescribed the rhetorical moves a doctor might make to counter a patient’s request for antibiotics for suspected viral infections. When antibiotics first came to market, doctors complained that these drugs radically altered the experience of professional caregiving. Treating bacterial infections with antibiotics gave “no credit to the doctor; all credit goes to the drug.” Now, with un-prescriptions, physicians and other healthcare providers assume a newfound responsibility—in this context, for providing validation without giving prescriptions.

Studies have shown that un-prescriptions and other such rhetorical surrogates have an impact on the demand for and dependence on antibiotics. More broadly, antibiotic-use campaigns prescribe to clinicians, patients, parents, and caregivers, roles better adapted to the crisis of ARIs. As exercises in risk communication, these campaigns raise awareness about the impact of antibiotic use on the evolution of antibiotic resistance. The Get Smart website, for example, explains as much to site visitors: “It is important to learn about the potential danger of antibiotic resistance—and what you can do to prevent it. Remember, the power to prevent antibiotic resistance is in your hands!” A key element of efforts to raise awareness, however, is the moralizing of antibiotic resistance as stemming from dependency and

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82 Find the Antibiotic Awareness un-prescription on their website, https://nccid.ca/antibiotic-awareness/.
83 This quotation, which Robert Bud cites in “Antibiotics,” comes from a study conducted in the 1950s by a team of medical sociologists working at Columbia University. For the original source of this quotation, see Coleman, Katz, and Menzel, 12.
demand: ARIs evolve because individuals lack either the knowledge that antibiotics have limits or the power to resist the allure of drug treatment.

It may now be worth asking what shapes the evolution of dependency and demand. Another explanation—and one I examine next—concerns the pharmaceutical industry’s influence on contemporary patterns of antibiotic use. The introduction of antibiotics in the twentieth century significantly expanded the marketplace for drug treatment. In places where the law permits it, direct-to-consumer advertising (DTCA) of pharmaceutical treatment, and even antibiotic treatment, helps to shape demand for and dependence on drugs. In fact, a crucial objective of much DTCA is to empower patients to seek out diagnosis and drug treatment—and, most importantly, to ask for drug treatment by name. In its campaign, the CDC warns parents and patients of the harms of such empowerment and invites physicians not to think of themselves as merely the dispensers of drug treatment. Yet the CDC’s campaign does not assign a role to stakeholders in industry, even though research suggests that pharmaceutical promotion has an impact on antibiotic demand and on demand for drug treatment in general. Nor does Get Smart encourage parents, and patients, to examine more closely the claims made in drug marketing, particularly about antibiotics.

“Z is for . . . Zithromax”: Pharmaceutical Companies and the Limits of Personal Responsibility

Underlying the CDC’s rhetoric of personal responsibility is the presumption that the evolution of ARIs stems from antibiotic dependency and demand. Get Smart, however, fails to explain where dependency and demand come from. Instead, individuals shoulder the blame for both. Although the rhetoric of personal responsibility is too limited to adequately address the problem of ARIs, the focus of this rhetoric on the individual’s role supplies an
alternative to costlier interventions—for example, stricter regulations surrounding the
marketing of broad-spectrum antibiotics. In this concluding section, I explore the influence of
the pharmaceutical industry, a systemic factor driving antibiotic dependency and demand. To
demonstrate, I discuss issues surrounding the promotion of Zithromax (azithromycin), a
broad-spectrum antibiotic launched by Pfizer shortly after the CDC introduced Get Smart, in
1995. The Zithromax campaign sought to generate dependence on and demand for the drug
of ear infections (otitis media) in children and included extensive marketing targeting
children directly. Sales representatives gave plush zebras to doctors—to give to sick children
alongside a prescription for Zithromax—and plastic replicas of Max to attach to their
stethoscopes. Pfizer donated a zebra to the San Francisco Zoo and held a naming ceremony at
which the zebra was called Max.

The company also sponsored a season of Sesame Street. During that season’s
episodes, a short commercial periodically aired featuring a building block emblazoned with
letter Z. As the block bounced around on the screen, a voiceover narrator announced, “Pfizer
brings you the letter Z, for Zebra and, of course, Zithromax” (“Sesame Street Funding”). As
Melody Petersen reported, writing about the child-friendly promotion of Zithromax in the
New York Times, the campaign was a success, if not in terms of dependence on then at least
in terms of increased demand for broad-spectrum antibiotics: “with Max’s help, Zithromax
has become a billion-dollar drug in just a few years.”84 Several Pfizer competitors began
adopting the company’s techniques to promote their broad-spectrum antibiotics to
physicians, parents—and to children. SmithKline Beecham’s “Auggie the Froggie” promoted
Augmentin (Amoxicillin), while Abbott Laboratories sold Biaxin (Clarithromycin) with the

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84 Petersen’s first article about the Zithromax campaign was titled, “What’s Black and White and Sells Medicine?”
help of “Bix the Bulldog.” Of these two drugs, the CDC recommended only Amoxicillin as the most effective drug to be used for an acute ear infection, and only once testing confirmed the presence of a bacterial rather than viral infection.

Pfizer’s promotion of Zithromax not only undercut the introduction of messaging that sought to lessen dependence on and demand for antibiotics specifically for sick children. More problematically, the company’s promotion of Zithromax conflicted with the CDC’s recommendation of other more affordable, more effective treatments for ear infections. CDC guidelines for antibiotic prescription, developed in large part to counter the evolution of antibiotic resistance, also encouraged treatment only for acute otitis media, a painful type of ear infection marked by inflammation of the middle ear. In 2000, as Pfizer bequeathed Max to the San Francisco Zoo, two physicians obtained an internal document discussing the company’s plans for Zithromax. The document confirmed that Pfizer planned to use physician-directed promotional exercises to counter the CDC’s recommendation of Amoxicillin for the treatment of ear infections in children. The physicians who discovered this document quickly issued a formal complaint to the secretary of the U.S. Department of Health and Human Services (HHS). There, they argued that Pfizer’s claims about Zithromax’s effectiveness lacked a basis in scientific evidence.

Soon after, 19 U.S. states filed a class action lawsuit against Pfizer for making false claims in the promotion of Zithromax. By 2003, Pfizer settled the lawsuit for $6 million. Two million dollars went into a three-year education campaign echoing the CDC’s message that broad-spectrum antibiotics such as Zithromax should only be used for treatment once testing confirmed the presence of a bacterial infection. Campaign advertisements aired on television

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85 For an extensive account of Pfizer’s promotion of Zithromax and subsequent complaints issued to the HSS, see Petersen, Our Daily Meds.
and radio during cold and flu season. Whether this campaign altered the demand for and dependence on antibiotics matters less than the precedent set by the HSS’s decision against Pfizer. In attempting to undercut CDC guidelines, the company compromised a federal campaign to alter antibiotic use among individuals, especially for infections that cannot be cured using these drugs.

Patients (ideally) take antibiotics for bacterial infections, and once the infection has cleared, treatment ends. So, drug consumption is time-limited. That bacteria inevitably develop resistance to antibiotics over time further inhibits the profitability of this formerly celebrated class of drugs. Unlike antibiotics, some drugs can, as STS scholar Joseph Dumit puts it, be taken for life. So, over the past few decades, the development of antibiotics has been displaced by the innovation of lifelong treatments for chronic conditions: statins for high cholesterol, bisphosphonates for osteoporosis. Conversely, antibiotics tend to be taken long term only for less common conditions, such as Helicobacter pylori, Crohn’s disease, and Lyme disease—and new antibiotics have yet to be developed to profit from these conditions. Given the profitability of drugs to be taken for life, governments have been urged to develop policies to make antibiotic research and development more advantageous for drug companies. In their 2013 Global Risks Report, for example, the World Economic Foundation called for the creation of financial incentives to entice the pharmaceutical industry to develop new antibiotics.

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86 Dumit argues—as do many others—that pharmaceutical companies create a lifelong demand for drug treatment by entreating us, often through promotional activities, to see ourselves as inherently ill or at least at risk for illness. See also Jeremy Greene, Prescribing by Numbers (2007), and Alan Cassel and Ray Moynihan, Selling Sickness (2008).

87 Drug critic David Healy discusses the industry’s shift away from antibiotics and other “magic bullets” and toward the development of drugs for chronic conditions, a process called “pharmaceuticalization,” in his book, Pharmageddon (2012).
The use of public health messaging to manage dependence on and demand for antibiotics may seem to be justified by the pharmaceutical industry’s apparent lack of interest in developing new antibiotics. However, the focus on education, rather than regulation, ignores the influence of industry on current patterns of use. In addition to marketing antibiotics directly to individuals, drug companies invest billions of dollars annually to promote their products to healthcare providers. According to the Pew Research Center, for example, in 2012, the industry spent more than $27 billion on prescription-drug advertising in the U.S. (“Persuading the Prescribers”). More than $24 billion of that total went into physician-directed marketing activities. To put these figures into context, after Pfizer pulled its controversial Zithromax campaign, the company paid only $2 million for a health education campaign that complemented rather than contradicted the CDC’s *Get Smart.*

Pharmaceutical-industry efforts to persuade physicians have a profound effect on prescribing habits. Drug detailing, one such effort, involves sending pharmaceutical sales representatives to hospitals, clinics, and doctors’ offices, where they promote drugs directly to physicians. Research on this and other industry-sponsored practices suggests that drug detailing has the potential to undermine efforts to cultivate antibiotic stewardship. According to a meta-study published in the *Journal of the American Medical Association,* drug detailing significantly affects prescribing habits, in part because healthcare providers tend to be poor judges of their own susceptibility to promotional activities. Physicians and medical residents, for example, reported being skeptical of industry representatives, and they also saw

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88 This 2000 meta-study remains one of the most comprehensive assessments of the impact of drug detailing on prescribing habits. For an account of more recent research, see DeJong and Dudley, “Reconsidering Physician-Pharmaceutical Industry Relationships,” from a May 2017 issue of the *Journal of the American Medical Association.*
themselves as impervious to industry influence—despite the proven impact of drug detailing on their prescribing habits. Other effects of drug detailing include the following:

- an impact on knowledge (inability to identify wrong claims about medication), attitude (positive attitude toward pharmaceutical representatives; awareness, preference, and rapid prescriptions of a new drug), and behavior (making formulary requests for medications that rarely held important advantages over existing ones; nonrational prescribing behavior; increasing prescription rate; prescribing fewer generic but more expensive, newer medications at no demonstrated advantage). (378)

While researchers have more broadly questioned the ethics of drug detailing, findings about its impact on prescription have specific implications for worldwide efforts to forestall the evolution of antibiotic resistance. Amid such efforts, the rhetoric of personal responsibility is too limited a response because this rhetoric obscures from view a prime influence over patterns of both antibiotic use and antibiotic prescription.

Patient and parental dependency and demand may only be two among numerous pressures on prescribing habits—and yet these sources become the most obvious because of efforts to correct them. Get Smart equips physicians to deal with patients who, among other things, make unreasonable requests. In debates about ARIs, little to no mention is made of their need to be more vigilant in their interactions with industry representatives. Moreover, while drug companies spend far less money on direct-to-consumer advertising (DTCA) than on drug detailing, DTCA, which significantly shapes the demand for prescription drugs, involves the promotion of drugs directly to the public. A study conducted by pharmaceutical policy researcher Barbara Mintzes sheds insight into the influence of DTCA on both patient requests and subsequent prescription rates. The study compared these effects of DTCA in the U.S. and Canada, where promotion is limited to “advertising of product name, price, and

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89 According to this meta-study, “85% percent of medical students believe it is improper for politicians to accept a gift, whereas only 46% of them found it improper for them to accept a gift of similar value” (Wazana 373)

90 In 2013, according to the Pew Charitable Trusts, drug companies spent just over $3 billion on direct-to-consumer advertising, and $15 billion on drug detailing (“Persuading the Prescribers”).
quantity” (405). According to Mintzes and her co-researchers, patients in the U.S. “reported more advertising exposure and requested more advertised drugs” than patients in the Canadian context. “Patients who requested DTCA drugs,” the study reports, “were nearly 17 times as likely to receive 1 or more new prescription as patients who did not request medicines” (411). In both contexts, patients who were exposed to more advertising were in general likelier to request prescriptions.

A report on the study by Mintzes et al. published in the British Medical Journal explains, “In most cases physicians prescribed requested medicines but were often ambivalent about the choice of treatment. If physicians prescribe requested drugs despite personal reservations, sales may increase but appropriateness of prescribing may suffer” (279). What is most striking about this observation is how well it accounts for the pharmaceutical industry’s influence not only on patterns of antibiotic prescription and use, but on the evolution of ARIs. In response to survey questions about their prescribing habits, doctors explain that they prescribe drugs because patients demand them, even if they may not really need them. And, as Mintzes and co-researchers found, patient requests for specific drugs increase with heightened exposure to DTCA. Even so, DTCA has not, for the most part, been a prominent solution to the crisis of antibiotic resistance.

After Zithromax, it might be safe to assume that pharmaceutical companies have become less invested in developing antibiotics and more reluctant to advertise treatments, either directly to individuals or to healthcare providers. However, while public health messaging increasingly mandates the need for individuals to rethink their relationship to antibiotics, expenditures on drug promotion, both in the U.S. and beyond, continue to grow. These investments compete against the rhetoric of personal responsibility both by
emphasizing the effectiveness of antibiotics and by underrepresenting their limits and potential dangers. Such messages have a noticeable impact on demand for and dependence on antibiotics. Further, given the impact of drug detailing on prescribing habits, industry messages may even benefit from messaging that encourages compliance with healthcare providers as an expression of personal responsibility. According to a National Ambulatory Medical Care Survey (NAMCS), between 1995 and 2006, the CDC’s Get Smart initiated a “25% reduction in antimicrobial use for outpatient office visit for presumed viral infections.” However, during this same period, prescriptions for broad-spectrum antibiotics, “namely azithromycin [Zithromax] and quinolones, increased substantially” (765).

Rhetorical study helps to illuminate how the framing of a complex issue may sometimes work against its resolution—sometimes because that framing helps to accomplish other objectives. Indeed, in her writing on public health, rhetorician Lisa Keränen argues that the framing of disease exigencies such as antibiotic resistance often serves political and economic imperatives. Catastrophic representations, for example, foster a culture of “bio(in)security,” and the urgency generated by this framing affects both understandings of and responses to infection, sometimes in ways that work against public health. To illustrate, Keränen observes that an apocalyptic framing of bioterrorism justified the implementation of initiatives that diverted resources away from more serious public health concerns. Not only did U.S. expenditures on an emerging biodefense industry quickly outpace expenditures on HIV/AIDS, for example, but health researchers also abandoned problems like tuberculosis and malaria.

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Brigitte Nerlich argues similarly that framings of antibiotic resistance can work against its resolution. Different framings may even work against one another, a point Nerlich stresses in her discussion of the competing meanings stemming from the apocalyptic metaphor often used to generate attention for antibiotic resistance. Microbiologists, she explains, use the metaphor of a “post-antibiotic apocalypse,” in which the increasing failure of antibiotics heightens the risk of death and disease, to make antibiotic resistance a public health priority. This metaphor implies that the evolution of resistance may be inevitable. So, Nerlich writes, “[t]he two connotations—that one can do nothing and that one can do something—fight each other and might distract from the message that microbiologists wish to convey” (582). As recently as 2016, the metaphor of a post-antibiotic apocalypse has been used to justify the creation of financial incentives to engage industry in the development of new antibiotics.

An exemplar of the rhetoric of personal responsibility, Get Smart stresses the individual’s role at the expense of an ecological perspective. According to this rhetoric, ARIs evolve because patients and parents depend on and demand antibiotics even for infections not treated by these drugs. Personal responsibility entails the refusal of antibiotics, an intervention that seems difficult to quantify, and increased compliance with the role of expertise in the administration of antibiotics. As a corrective, Get Smart also educates patients and caregivers about the limits of antibiotics as well as their potential dangers. The overarching rhetorical work accomplished by antibiotic-use campaigns such as Get Smart is

92 Nerlich’s discussion includes a response from microbiologist Richard James, whom she regards as first popularizing the notion of a “post-antibiotic apocalypse.” According to James, a catastrophic rhetoric is usually necessary, otherwise politicians and governments will fail to take seriously the claims of scientists and other experts.

93 A Guardian article from May 2016, for example, describes a UK-based proposal to create a “market entry reward” of “around $1.3bn,” to pharmaceutical companies for the development of new antibiotics. See Boseley, “England’s Chief Medical Officer Warns of ‘Antibiotic Apocalypse.’”
to alter the culture of antibiotic use among individuals and their healthcare providers. Indeed, research shows that public-health messaging about antibiotic resistance has helped to bring about such change. It remains a problem that the very same campaigns work to maintain and even generate ignorance—for example, about the pharmaceutical industry’s impact on trends in antibiotic prescription and use.

My analysis has drawn attention the potential for public health messaging—and specifically the rhetoric of personal responsibility—to perpetuate rather than redress ignorance about antibiotic resistance. Indeed, complex factors shape both the evolution of antibiotic resistance and the demand for and dependence on antibiotics. Recent moves to acknowledge this complexity fail to address the pharmaceutical industry’s investment in the latter. Antibiotic resistance has even created opportunities for drug companies to expand their influence, specifically through the creation of industry-funded antibiotic-use campaigns. In my next chapter, on “epidemic” obesity, I expand upon my assertion that the rhetoric of personal responsibility benefits the private sector, often at the expense of public health.
CHAPTER FOUR
Responsibilizing Citizens Amid “Epidemic” Obesity

In 2013, the American Medical Association (AMA) announced the decision to classify obesity as a disease rather than only as a risk factor for other diseases (e.g., type II diabetes, cardiovascular disease). According to an AMA press release, the new policy had the power to “change the way the community tackles this complex issue that affects approximately one in three Americans” (“AMA Adopts New Policies”). The recasting of obesity as a disease, some argued, might motivate doctors to be more proactive in addressing weight issues in their patients (“Doctors Urged to Treat Obesity as a Disease”). The policy also had the potential to improve funding and insurance coverage for medical treatment. Finally, a disease label might reduce the stigma of obesity by challenging the presumption that the condition results from an unhealthy, inactive lifestyle. Prior to the announcement, however, the AMA’s Council on Science and Public Health had recommended against declaring obesity a disease. The Council questioned the capacity for such a policy to reduce rather than perpetuate stigma. This potential new classification, they claimed, also further medicalized obesity, inflating the number of people designated as diseased based on their body mass and size alone.94

The AMA’s decision and responses to it represent only a recent development in ongoing debates about the status of obesity and how to address it. In these debates, obesity is often framed not only as either a disease or a risk factor for disease, but also as a disease

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94 In The Medicalization of Society, Peter Conrad deems diagnostic inflation a common consequence of the transformation of social problems into medical ones. While my chapter examines how medicalization benefits the mandating of personal responsibility, Conrad’s chapter, “Measuring Medicalization,” connects the medicalization of obesity—for example, through diagnostic inflation—to the growth of the bariatric surgery industry.
“epidemic” that must be monitored and guarded against.\textsuperscript{95} Changing patterns in average body mass and size have been deemed signs of a global pandemic—sometimes called “globesity,” for example by the World Health Organization—with serious implications for health on a global scale.\textsuperscript{96} To call obesity an “epidemic” is to imply that this condition poses a public health threat on par with the dangers posed by disease-causing pathogens. Obesity, however, is not contagious and thus not an epidemic in this conventional sense of the term. It is, as sociologist and fat studies scholar Natalie Boero asserts, a “postmodern epidemic,” one in which “no discrete disease entity is required for a phenomena [sic] to be identified as epidemic” (4).\textsuperscript{97} The “entire premise of ‘obesity epidemic’” argues Julie Guthman, “rests on the presumption that humans are naturally or have been historically thin” (190). The framing of obesity as an epidemic also prioritizes certain kinds of responses to a complex condition that might be addressed in other ways—and that makes this postmodern epidemic a potential site for rhetorical investigation. How are people persuaded, for example, that obesity is an epidemic, and to what actions and attitudes does “epidemic obesity” persuade them?

Indeed, obesity becomes a public health priority in large part because of an “epidemic” framing, which functions as a Burkean terministic screen to direct attention to this issue’s urgency. It is no coincidence that what Guthman calls “epidemic talk” (188)

\textsuperscript{95} An “epidemic” framing first appears in 1974, in \textit{Obesity and Fad Diets}, a report of the U.S. Senate’s Select Committee on Nutrition and Human Needs. Among experts, characterizations of obesity as “epidemic” intensified in the 1990s, when new body mass index (BMI) thresholds radically increased the number of people designated as either overweight or obese.

\textsuperscript{96} See, for example, WHO, “Controlling the Global Obesity Epidemic.” Epidemic obesity is, according to the WHO, a global concern, but it is also still commonly seen as an American export. Charlotte Cooper writes about the Americanization of both epidemic obesity and of fat studies in her chapter, “Maybe it Should Be Called Fat American Studies,” where she quotes British fat activist Simon Murphy as saying, “the world sees fat as American [sic] export, but America thinks this too” (328).

\textsuperscript{97} “In the tradition of critical race studies, queer studies, and women’s studies,” explain Sondra Solovay and Esther Rothblum in their introduction to \textit{The Fat Studies Reader}, “fat studies is an interdisciplinary field of scholarship marked by an aggressive, consistent, rigorous critique of the negative assumptions, stereotypes, and stigma placed on fat and the fat body” (2). My own use of the terms “fat” and “fatness” is marked by a concern with negative associations—for example, the association of both with the failure of personal responsibility.
about obesity became more common during the 1990s, a decade marked by widespread anxiety about the catastrophic potential of emerging infectious diseases, most notably, HIV/AIDS. Scholars of public health from various disciplines, rhetoric included, have argued that these societal anxieties have serious implications for public health priorities and funding for scientific and health research. The framing of obesity as “epidemic” also has implications for perceptions of responsibility within the context of public health. Developed in accordance with this framing, much public health messaging portrays change at the individual level as an antidote to its spread. Within the context of an epidemic, everything from diet and exercise to intervention into one’s own community comes to signify one’s assumption of personal responsibility. Even efforts to revise societal perceptions of obesity in ways that absolve the individual of responsibility—as illustrated by the rethinking of obesity as a disease—present opportunities to emphasize personal responsibility. According to the U.S. Centers for Disease Control and Prevention (CDC), for example, obesity is a “complex health issue to address,” partly because of the influence of genetics and family history. However, the CDC explains, “[f]amilies can’t change their genes but they can change the family environment to encourage healthy eating habits and physical activity.”

Throughout this chapter, I use the term “epidemic obesity” rather than “obesity epidemic” to signal that societal anxieties about obesity tend not to be limited to a given nation or geographic locale. The term “globesity,” for example, reflects the belief that the threat to public health posed by current rates of overweight and obesity is now a global problem. In public health discourse, “overweight” is typically used in its noun form, to refer

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98 See, for example, Nicholas King’s “The Scale Politics of Emerging Diseases” and Lisa Keränen’s “Concocting Viral Apocalypse,” both of which describe the ways in which different conceptions of disease outbreak function rhetorically to influence research funding priorities.

99 See CDC, “Adult Obesity Causes and Consequences.”
to any “[w]eight that is higher than what is considered a healthy weight for a given height” ("Defining Adult Overweight and Obesity"). A key feature of the discourse of epidemic obesity is its emphasis not just on the urgency of obesity, but also on the need for individual behaviour change to prevent it. The World Health Organization, for example, characterizes epidemic obesity as a problem to be resolved by “mak[ing] healthy choices easier to make” among individuals.100 Any campaign developed to encourage healthy choices as a defense against epidemic obesity thus typically reinforces the sense of overweight and obesity as primarily matters of personal responsibility.

Public health campaigns frequently endorse individual behavior change as benefitting both self and society. Messaging about epidemic obesity, however, incorporates a rhetoric of personal responsibility to make uniquely burdensome demands of individuals. Some messaging urges individuals to take initiative to transform their communities from “obesogenic” environments into putatively healthier ones. First proposed by public health scholars Garry Egger and Boyd Swinburn, an obesogenic environment is one that limits the potential for individual behaviour change, and specifically improved diet and exercise, to reduce overweight and obesity rates. Increasingly a common feature of the discourse of epidemic obesity, appeals to obesogenic environments seem to absolve individuals of responsibility while asserting the need for their participation in societal-level interventions. The discourse of epidemic obesity operates as an epideictic rhetoric, a rhetoric that both celebrates individual efforts as crucial to public health and ascribes public “epidemic obesity” to failures of personal responsibility. This discourse also functions as a constitutive rhetoric, a means of cultivating self-governing health subjects, here again defined as those who regard public health as an effect of their individual actions and choices.

100 For the full text of this discussion, see WHO, “Controlling the Global Obesity Epidemic.”
The ideological work of the discourse of epidemic obesity, including its responsibilization of individuals, has made it a focus of scrutiny for scholars in multiple disciplines. Here, I underscore some of the ways in which, despite its appeal, the rhetoric of personal responsibility used to address epidemic obesity has the potential to work against the aims of public health. In my chapter’s first section, I mobilize scholarship on epidemic obesity to emphasize the ways that the discourse of epidemic obesity benefits the mandating of personal responsibility for public health. I also stress the stigmatization of overweight and obesity as both an effect of this discourse and significant to its rhetorical work within the context of neoliberalism. Following this section, my analysis of key texts from a federal campaign created by the CDC highlights its endorsement of practices of self-governance as critical to epidemic obesity’s containment. A series of “Success Stories,” these texts provide insight into “fitness” rather than health risk as an important motivator for the assumption of personal responsibility. Finally, I explore the rhetorical dimension of a public-private partnership developed to address “epidemic” obesity, including the appropriation of public health ethos to depict media consumption as a meaningful form of agency.

My study does not oppose the use of public health messaging with respect to overweight and obesity. I do not make any claims about the reality, or urgency, of increased body mass and size either within North America or beyond. Nor do I speculate about their economic impact or implications for morbidity and mortality rates, as such assessments of etiology and epidemiology lie beyond the purview of rhetorical study. I do, however, stress the utility of these assessments of “epidemic” obesity to the rhetoric of personal responsibility. Shifting definitions of overweight and obesity, as defined by the Body Mass Index, or BMI, have for example been essential to the framing of obesity as “epidemic,” an
important precursor to responsibilization. A measure of body fat based on height and weight, BMI, or the “Quetelet” Index, remains a standard measure of overweight and obesity in public health jurisdictions worldwide. BMI also functions as a rhetorical device for enforcing the assumption of personal responsibility. Above all, I do not oppose the desire to reduce the risk of disease that motivates the promotion of health in the context of epidemic obesity. Rather, taking a rhetorical approach, I demonstrate how public health messaging about epidemic obesity serves the goal of responsibilization.

**Epidemic Obesity, Stigma, and the Rhetoric of Personal Responsibility**

Over the past few decades, concerns about epidemic obesity have incited numerous calls to action, particularly in the United States. In 2001, for example, the U.S. Surgeon General made the increasing prevalence of overweight and obesity the subject of the Department of Health and Human Services’ annual “Call to Action.” A “science-based document,” the Surgeon General’s annual report aims “to stimulate action nationwide to solve a major public health problem” (“Surgeon General’s Calls to Action”). More than a decade later, epidemic obesity remains for many governments a public health crisis that demands attention. In 2015, for example, the Surgeon General again called on individual Americans to “step it up,” this time, to “make the decision to walk” in part to reduce the incidence of overweight and obesity (“Step it Up!”). Such discursive enforcements of personal responsibility have been met with both skepticism and resistance. Scholars in humanities and social sciences have, for example, responded to this discourse by questioning the assumptions, ideas, values, and beliefs that underpin efforts to address epidemic obesity.

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101 Waist circumference is also increasingly a standard measure and is for example endorsed by the U.S. CDC alongside BMI as a tool for estimating “weight status in relation to potential disease risk” (“Assessing your Weight”).
In what follows, I draw on the insights of some of these scholars to emphasize epidemic obesity’s value to the mandating of personal responsibility for public health. Given the discourse’s implications for personal responsibility, a defining feature of neoliberalism, much writing on epidemic obesity draws on concepts first proposed by Michel Foucault. Sociologist Deborah Lupton stresses in her 2012 book, *Fat*, that Foucauldian concepts of governmentality, biopower, and biopolitics have been among the most useful to critics of the discourse of epidemic obesity (13). Biopolitics describes the state’s disciplining and monitoring of individuals, in large part through discourses directed at the body. A related term, “biopower” refers to the power produced by the disciplining and monitoring of the body as biopolitical processes become internalized over time. Finally, biopolitics and biopower are closely tied to “governmentality,” a term proposed by Foucault in his 1978 lecture, *Security, Territory, and Population* and later developed in *The Birth of Biopolitics*. Governmentality describes the use of practices, regulations, and discourses to encourage rather than coerce individuals to assume personal responsibility—for example, for public health.

Scholars have used Foucault’s notions of biopolitics, biopower, and governmentality to illustrate how the discourse of epidemic obesity informs perceptions of responsibility. Communications scholar Kathleen LeBesco, for example, draws on Foucault’s ideas in observing that “attempts by the state—via BMI bills, obesity report cards, curtailment of custody . . . [seek to] enlist individual citizens in the war on obesity” (154). The adoption, and internationalization, of standard measures of overweight and obesity is an important

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102 LeBesco also deems epidemic obesity a “moral panic,” sociologist Stanley Cohen’s term for a situation in which some condition, event, individual, or group becomes defined as a threat to certain societal values. See, also, Campos et al., “The Epidemiology of Overweight and Obesity” (2006); Lobstein, “Obesity—Public Health Crisis, Moral Panic or a Human Rights Issue?” (2006); and Patterson and Johnston, “Theorizing the Obesity Epidemic” (2012).
facet of the cultivation of personal responsibility within the context of epidemic obesity. The prime function of the discourse of epidemic obesity, as LeBesco argues, is not to diminish the putative health risks of overweight and obesity so much as to engage individuals in becoming “partners in the governance of their own affairs and their own bodies” (155). The discourse also provides an outlet for societal anxieties about stagnating economic and labour productivity, in part by blaming those deemed overweight and obese according to standard measures. As one of the most commonly used measures of overweight and obesity, the BMI is critical to the discourse’s cultivation of self-governing health subjects. “Know Your Numbers” campaigns, an increasingly common initiative with ties to the prevention of epidemic obesity, demonstrate the rhetorical utility of BMI in engaging individuals in activities of self-governance. Those who “know [their] number,” for example, may be expected to understand and address their personal responsibility both for epidemic obesity’s spread and for its prevention.103

As BMI categories, overweight and obese also function to medicalize fatness and fat bodies as inherently risky even though fat is in and of itself a fluid designation. The fat acceptance movement—a social movement that opposes the stigmatization of fatness—and the emerging field of fat studies thus both assume a neutral rather than negative view of the term “fat.” In my use of the term, I share with fat-acceptance activists and fat-studies scholars the concern with the stigma perpetuated by the BMI designations, “overweight” and “obese.” Another thread that cuts through many examinations of the discourse of epidemic obesity is thus the challenging of the bias that often stems from fatness’s associations with BMI. Fat bias also has implications for encouraging personal responsibility via the discourse

103 BMI, though, is only one measurement to be tracked by individuals as part of their responsibility for health; other measurements include waist circumference, blood sugar, blood pressure, and cholesterol levels.
of epidemic obesity. Being perceived as fat is not the same as receiving a BMI designation within either the overweight or obese range; nor is the experience of fatness narrowly tied to BMI.

In *Fat*, for example, Lupton’s focus on the shifting meanings of fatness sheds insight into BMI’s implications for perceptions of health risk—both one’s own perceptions as those of others. A person with a “healthy” BMI (18.5 to 24.9), for example, may feel fat when weight gain affects the fit of their clothing. Conversely, someone “who has gone from a BMI of 65 (‘extremely obese’) to 35 due to gastric band surgery [may be] considered to be no longer in need of intervention” (10). In designating individuals as overweight and obese, the BMI marks them if not as “diseased,” then as “at risk” of disease. Fat people who develop any one of the chronic diseases typically associated with these BMI categories may be blamed for failing in their responsibility to manage risk. Critics of the discourse of epidemic obesity seek to problematize efforts to foster personal responsibility via the BMI, positing a fixed relationship between fatness and health. Because fat people may be likelier to experience blame upon the development of diseases associated with overweight and obesity, some scholars therefore describe the stigmatization of fatness as reinforced by BMI as a form of “victim-blaming.”

Stigmatizing—and blaming—those deemed overweight or obese has proven medical, psychological, and social consequences, among them the increased risk of depression.

Obesity stigma often finds its expression in observations about health risk, but it too is rooted in broader societal anxieties, for example about of the “excesses” of fat bodies. In

104 Alan Petersen expands upon the significance of “victim-blaming” to broader debates about personal responsibility for public health in “Risk, Governance, and the New Public Health,” from the anthology, *Foucault, Health and Medicine*.

105 For a review of the negative consequences of obesity stigma, including its role as a risk factor for depression, see Rebecca M. Puhl and Chelsea A. Heuer, “Obesity Stigma: Important Considerations for Public Health.”
Fat Shame, American studies scholar Amy Farrell details the origins of this view of fatness as an expression of “excess.” Farrell’s critique of fat discourse and its relationship to the more recent discourse of epidemic obesity is partly historical. She writes that prior to the nineteenth century, fatness tended to be associated with privilege, as “only the very privileged—in terms of both wealth and health—could become fat” (16). By the end of the nineteenth century, the association of fatness with privilege began to loosen, largely in response to the Industrial Revolution. In societies marked by industrialization, fatness began to take on moral meanings that reflected broader concerns about the excesses of industrial capitalism and consumer culture. As Farrell explains, during this period, the fat body came to signify the “greed” of those “who could not handle the riches and abundance of modernity” (18). By the twentieth century, the moral meanings surrounding body fat began to broaden. Alongside race, gender, and sex, body fat became a “marker of inferiority . . . another divider marking the differences between white people and people of color, between native-born, white American citizens and new immigrants, between the wealthy and the poor, and between men and women” (19). Claims about the health risks of overweight and obesity, Farrell implies, extend from this more entrenched view that sees fatness as a marker of “excess” and “inferiority.”

The discourse of epidemic obesity both medicalizes and extends the moralization of fatness, as to be categorized as either overweight or obese in an epidemic context signals more than a failure to manage one’s own risk of disease. The BMI classifications, “overweight” and “obese,” also mark fat people as potential threats to the health of their society—or, put differently, as those who work against the maintenance of public health. Societal anxieties about epidemic obesity thus intensify perceptions of responsibility, and
blame, implying a regard for fat people as undisciplined and in need of heightened self-control. Again, these anxieties significantly predate the medicalizing of overweight and obesity. Communications scholar Charlene Elliott, for example, explores anxieties about the threat posed by fat bodies, as espoused by Alexis de Tocqueville in his 1840 *Democracy in America*. Produced by the French political scientist upon his return from the United States, de Tocqueville’s report describes the ideological underpinnings of American democracy. Throughout the report, as Elliott explains, de Tocqueville portrays “the active body, the working body, the non-slothful body [as] that [which] makes democracy strong” (136). This conflation of bodily fitness and healthy democracy persists to this day: “the figurative concept of ‘fitness’ is often (incorrectly) equated with the visible look of leanness” (135). The fat body, conversely, takes on metaphorical meaning as that of the “failed citizen.” The fat person, by extension, depletes a society’s health by being a drain on valuable resources.

Amid debates about epidemic obesity, claims of labour productivity losses and increased healthcare costs frequently shore up the case for personal responsibility, as exemplified by the 2016 report, “The State of Obesity,” from the non-profit Trust for America’s Health. According to the report, obesity costs the U.S. healthcare system $210 billion per year, and $4.3 billion annually in terms of labour-productivity losses. Observations about the costs of epidemic obesity reinforce public health messaging that places the onus for epidemic obesity on individuals by concretizing the threat to society’s health posed by overweight and obesity. The use of economic figures to quantify the threat posed to societies in terms of productivity or economic losses also moralizes overweight and obesity—often without seeming to do so. This quantification of human value has ties to the broader neoliberalization of public health. Numerous jurisdictions, for example, have sought
to implement policies aimed at offsetting the apparent costs of epidemic obesity. One such measure, a “fat tax,” entails the addition of a surcharge on certain food and beverage sales to discourage the purchase of these products. Soda is a popular target.\textsuperscript{106}

Some fat taxes take aim directly at overweight and obese individuals, and these policies create an incentive for the careful monitoring of one’s BMI. As a rhetorical construct, BMI plays a key role in enforcing distinctions—for example, between a “healthy” and an “unhealthy” weight—that help to transform epidemic obesity into a matter of personal responsibility. Online public health messaging, for example, frequently incorporates BMI calculators so that individuals can assess their level of health risk and in doing so determine their degree of responsibility for epidemic obesity. In fact, in 2015, one of the top five search terms used on an external search engine that led Internet users to the U.S. CDC’s website was “bmi calculator.”\textsuperscript{107} BMI tends to be both a prominent feature of public health websites and increasingly a common reason for visiting them.

Where they have been introduced, fat taxes have frequently been described as a counter to epidemic obesity. In 2016, government officials in the Indian state of Kerala imposed a 14.5 per cent “fat tax” on fast foods. The tax applies only to foods typically served at “branded” fast food chains such as McDonald’s and Pizza Hut. The policy, which mirrors similar efforts in Denmark and Japan, arose from the concern that Kerala has nearly the highest rates of obesity in India. In Kerala, finance minister Thomas Isaac described his fat tax as a “preventive measure,” adding that the “fight against fat ha[d] begun” (“Why Has an Indian State Imposed a Fat Tax?”). Opponents of Kerala’s fat tax argued that, in targeting

\textsuperscript{106} Taxes on sugary and high-fat foods imposed to address epidemic obesity do not always last long. In November 2017, for example, Cook County repealed its penny-per-ounce tax on sodas after less than a year, in part because of industry opposition.

\textsuperscript{107} For information about top search keywords for CDC.gov, see “2015 NCHHSTP Site Metrics.”
multinational corporations, policymakers implied that more traditional Indian food might be healthier than food produced by popular non-Indian chains.

Also targeted were the personal habits of the fat citizens who had apparently failed to fend off the spread of epidemic obesity to India, reinforcing the perception of fat as an American export. This latter, more nationalistic interpretation of Kerala’s “fight against fat” rarely surfaced in public debates. As medicine studies scholar Jonathan Metzl argues, in the context of epidemic obesity, “appealing to health allows for a set of moral assumptions . . . to fly stealthily under the radar” (2). That health is the “new morality” of the twenty-first century means that judgments about individual or moral worth often pass as seemingly neutral observations—for example about health risk. The moralizing tendency of health discourse is especially pronounced when it comes to obesity. As Metzl observes, it is realized whenever “we encounter someone whose body size we deem excessive and reflexively say, ‘obesity is bad for your health,’ when what we mean is not that this person might have some medical problem, but that they are lazy or weak of will” (2). Not surprisingly, the stated goals of fat taxes—to reduce risk and contain an epidemic—often obscure their potential to exacerbate the stigmatization of fat people.

These stigmatizing effects appear more obvious when it comes to those fat taxes that impose surcharges on individuals, typically based on their BMI scores. These more punitive initiatives seek to hold overweight and obese people directly responsible for their apparent role in generating a public health crisis. In the past decade, several U.S. states, using BMI as their baseline, have implemented a fat tax aimed at state employees. These include the State Employees’ Insurance Board of Alabama (ALSEIB), which in 2008 announced that all public employees would undergo monthly medical screening. Those employees found to
have a BMI in the obese range would be given a year to “start getting fit.” According to their website, the ALSEIB expected these employees to use that year to see a doctor and enroll in a wellness program or “take steps on their own to improve their health” (“Editorial: Obese Workers Pay More”). The ALSEIB did not, however, clearly explain the criteria for determining whether progress had been made. Instead, it stated only that those public employees “who don’t make an effort to slim down” within a year would be expected to pay an extra $25 per month for their health insurance (“Editorial”).

As with Kerala’s fat tax, ALSEIB’s policy is presented as a motivation to public employees to “adopt healthier habits” and diminish “identifiable health risks.” The plan’s stated aim is to “encourage employees to act responsibly, lose weight and lower their health care needs.” (“Editorial”). Unlike a tax on beverages or foods, however, the tax on individuals is directly dependent on BMI, to quantify health risk in simple, individualistic terms. Fat taxes of this kind depend on the BMI to encourage the assumption of personal responsibility through the enumeration of risk.¹⁰⁸ These more personal taxes also illustrate the measure’s implications—not just for perceptions of fat people, but also for their economic and employment stability in the context of epidemic obesity.

Surrounding the emphasis on the costs of epidemic obesity is a popular culture premised not just on the stigmatizing, but also the shaming of fat people. Whereas stigma functions externally, to mark as unacceptable certain attributes and the individuals who possess them, shame arises internally, among individuals who perceive themselves as possessing a stigmatized attribute. My comments about the relation of stigma and shame

¹⁰⁸ Petersen and Lupton describe the use of enumeration as a persuasive device in public health discourse—what they call “quantification rhetoric.” As they explain, “quantification rhetoric tends to suggest the figures used are not subject to doubt or uncertainty” (38). See their chapter, “Epidemiology: Governing by Numbers,” in The New Public Health.
derive from observations made by sociologist Erving Goffman in the introductory chapter to *Stigma: Notes on the Management of Spoiled Identity*. Goffman writes, for example, that while stigma describes any attribute “that is deeply discrediting” (3), “[s]hame becomes a central possibility, arising from the individual’s perception of one of his own attributes as being a defiling thing to possess” (7). Stigma and shame work together, Goffman argues, to normalize individuals: in fact, individuals seek to normalize themselves, for example by “mak[ing] a direct attempt to correct what [they see] as the objective basis of [their] failing, as when a physically deformed person undergoes plastic surgery” (9). The use of popular culture to amplify fat shame finds similar justification in the belief that shame may motivate in individuals these direct attempts to “correct” their personal failing and in doing so diminish health risk.

Fat shaming has become the subject of an entire franchise of reality television programs, including *The Biggest Loser, Embarrassing Fat Bodies*, and *Heavy*. Dubbed “fat TV,” reality shows such as these put fat shaming on display to motivate weight loss through extreme diet and exercise regimes that have been criticized as dangerous and potentially deadly to contestants.109 The popular culture of fat-shaming deems as praiseworthy only those who, to quote qualitative health researcher Pirkko Markula, “confess being fat and . . . seek the appropriate bodily discipline” (55). Popular culture’s celebrating of those who seek to transform themselves also reinforces both the blame of fat people for epidemic obesity and the valuing of personal responsibility as the key to containing it.

Given the discourse’s myriad associations with stigma, shame, and blame, critics have sometimes argued that epidemic obesity is a “moral panic.” This view of epidemic obesity

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109 In 2015, for example, contestant Kai Hibbard’s decision to speak out against *The Biggest Loser* despite having signed a non-disclosure agreement generated discussion about the harmful tactics used induce weight loss among participants. See, e.g., Callahan, “The Brutal Secrets Behind ‘The Big Loser.’”
derives from the theory of moral panics first proposed by sociologist Stanley Cohen in the early 1970s.\textsuperscript{110} LeBesco summarizes Cohen’s theory in “Fat Panic,” her contribution to Metzl’s anthology, \textit{Against Health}. Moral panics, she explains,

are marked by \textit{concern} about an imagined threat; \textit{hostility} in the form of moral outrage towards individuals and agencies responsible for the problem; \textit{consensus} that something must be done about the serious threat; \textit{disproportionality} in reports of harm; and \textit{volatility} in terms of the eruption of panic. (73, emphasis in original)

According to Cohen, a moral panic arises whenever a target or group is singled out as responsible for a “crisis,” and then stigmatized, shamed, and blamed because of its responsibility. Mainstream media play a vital role in amplifying concerns that become the basis of a crisis. Often, however, the crisis itself may be an effort to concretize a more liminal anxiety. Recent claims of an emerging “sleepidemic,” for example, both respond to and reinforce societal anxieties about changing patterns of play and increasing exposure to screens among children and adolescents.\textsuperscript{111} These more liminal anxieties find their expression in debates about the \textit{number} of hours that children spend inactive or in the presence of a screen.\textsuperscript{112} Similarly, as a moral panic, epidemic obesity depends on BMI to substantiate a more insidious worry about the capacity of individuals for self-governance.

BMI has therefore been criticized, not only because it induces stigma, but because of its unstable relationship to the very risks that it measures. To characterize BMI’s influence on

\textsuperscript{110} Cohen’s theory in turn draws on sociologist Howard Becker’s “moral entrepreneur,” a concept that describes any individual, group, or organization that seeks to define and perpetuate a social norm. Becker saw moral entrepreneurialism as primarily a rhetorical process—that is, a discursive effort to define, label, and enforce the view of certain behaviours as either positive or negative. See \textit{Outsiders} (1963), in which first proposes his theory of moral entrepreneurialism.

\textsuperscript{111} So far, a group has yet to be singled out and held responsible for the “sleepidemic.” However, in Canada, the introduction of “movement guidelines” intended to “help parents and children make better decisions” implies that poor parenting may be to blame. The stigmatization of parents is also a feature of anxieties about childhood epidemic obesity.

\textsuperscript{112} To truly qualify as a “moral panic,” the sleepidemic must also display stigmatization, and to date no group has been targeted overtly. Parents, however, have been taken to task for failing to support healthy activity and sleep patterns in their children, just as in the context of childhood overweight and obesity, they have been blamed for failing to encourage a healthy diet and regular exercise.
perceptions of the incidence and severity of overweight and obesity, sociologist Natalie Boero uses the term “diagnostic fluidity” (5). As she explains, “a lack of connection with a known biological pathology makes the question of diagnostic categories potentially more fluid as it allows for diagnostic expansion and the inclusion of ever more individuals within these categories” (5). In certain public health jurisdictions, for example, claims that overweight and obesity rates have become “epidemic” have been linked directly to changes to the BMI threshold for these classifications.113 A commonly cited illustration of BMI’s diagnostic fluidity took place in the U.S. in 1998. That year, the U.S. CDC and National Institutes of Health (NIH) adapted federal BMI categories to correspond with the World Health Organization (WHO) guidelines. The policy change involved lowering the threshold for overweight from a BMI of 27.8 to a BMI of 25. As reported in the New York Times, the move saw “29 million Americans who had been considered normal become overweight even though they hadn’t gained an ounce.”114

In response to criticisms of BMI, medical and public health establishments have thus sought to acknowledge this measure’s limitations and to qualify its use in public health messaging pertaining to overweight and obesity. These more cautious messages tend to highlight the BMI’s utility as a simple, accessible measure for assessing potential health risk. According to the CDC, for example, BMI “can be used as a screening tool but is not diagnostic of the body fatness or health of an individual” (“About Adult BMI”). BMI persists as a standard measure, or “indicator,” of “high body fatness,” as the CDC explains, because it

113 Similarly, as recently reported, many more people became hypertensive when the American Heart Association and American College of Cardiology changed the guidelines for diagnosing and managing high blood pressure. In a December 2017 issue of the New York Times, Aaron Carroll argues that although intended to “potentially scare people into changing their behavior,” the new guidelines may more likely lead to overtreatment for hypertension.

114 This quotation about the impact of changes to BMI appears in a 2014 discussion by health columnist Jane Brody about the limitations of BMI, including its failure to “distinguish between dangerous and innocuous distributions of body fat.” See “A Number that May Not Add Up” (2014).
is “inexpensive” and “easy to use for clinicians and for the general public” (“About Adult BMI”). Regardless of whether BMI presents an accurate measure of health risk, what matters is that BMI indicates one’s degree of responsibility for epidemic obesity as well. Even the CDC positions it as such—that is, as a metric for gauging the necessity of personal responsibility.

**The U.S. CDC’s “Success Stories”: Cultivating Fitness Amid Epidemic Obesity**

Whereas the discourse of epidemic obesity assumes a negative view of patterns in body mass and size, these same patterns might be regarded as expressions of human diversity. Such has been the perspective of both fat studies and fat acceptance. Attempts to rethink the narrow perceptions of fat people implied by the discourse of obesity, however, have had little to no effect on the moralizing of fatness or the stigmatizing of those deemed overweight or obese—just the opposite. In many public health jurisdictions, the fat body remains the focus of intense scrutiny. This scrutiny, as I show in my analysis of a federal anti-obesity campaign, is partly tied to the mandating of personal responsibility for public health.

In their emphasis on epidemic obesity’s urgency, anti-obesity campaigns make unprecedented demands of individuals. Typical demands emphasize personal responsibility for diet and exercise, to diminish the individual health risks of overweight and obesity. The U.S. CDC’s anti-obesity website, for example, includes extensive information about “community efforts,” to teach individuals about how to support “healthy eating and active living” in “early childhood care, hospitals, schools, and food service.” These celebrations of the potential for individuals to transform their communities reinforce the sense that epidemic obesity in these contexts arises mainly from failures of personal responsibility. Even when the praise of individual efforts results in significant improvements to quality of life, the very
same messages about epidemic obesity presuppose a model of public health premised largely on personal responsibility. Within this model, issues of access to whole foods or exercise opportunities become the purview of individuals rather than governments.

In what follows, I highlight some of the persuasive means used to transform epidemic obesity into a matter of personal responsibility. My focus is on the website for the U.S. Centers for Disease Control (CDC), which includes extensive information about overweight and obesity. In keeping with the agency’s increasing emphasis on epidemic obesity’s complexity, many parts of the CDC’s website portray it as an environmental problem or community issue. As explained on the page “Strategies to Prevent Obesity,” there exists “no single or simple solution to the obesity epidemic. It’s a complex problem and there has to be a multifaceted approach.” State and local organizations must also contribute to the prevention of overweight and obesity, but their involvement is required mainly to facilitate the creation of “a supportive environment to promote healthy living behaviors that prevent obesity.”

Despite an emphasis on the need for a multifaceted approach, the goal of federal, state, and local organizations is to adopt interventions that enhance the assumption of personal responsibility. Individuals have their part to play, and encouraging their involvement, as I argue, is central to the CDC’s addressing of overweight and obesity. Although numerous parts of the CDC’s site target lay individuals, my interest is in the rhetorical work of a series of “Success Stories” showcasing the efforts of five individuals to address overweight and obesity. Risk discourse is often considered vital to the rhetoric of personal responsibility and appeals to health risk thus essential to the encouragement of personal responsibility. Within the “Success Stories,” however, health is equated with belonging or fitting in, and this

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115 In August 2017, the CDC renamed this series “Personal Stories.” Although the website does not explain the agency’s reasons for changing the series title, one reason may be an interest in reducing the stigma and blame of fat people that stems from the view of overweight and obesity as failures of personal responsibility.
sense of fitness also has strong ties to one’s identity as a self-governing subject. A prominent theme of the CDC’s “Success Stories” is the yoking of “thinness” and “fitness” that Elliott describes in her writing on historic association between bodily health and civic identity. As Elliott explains, thinness has long signified fitness with respect to one’s civic duties: it has powerful associations with productivity and economic prosperity. Given epidemic obesity’s association with economic and labour productivity losses, the workplace remains an important site for the encouragement of personal responsibility. Within the context of epidemic obesity, this dual notion of “fitness”—on one hand, physical fitness, and on the other hand, fitness as social acceptance—becomes a prominent means of persuasion. Further, according to the campaign’s rhetoric, a “healthy” weight is achieved by engaging in practices of self-governance. This emphasis on self-governance contributes significantly to the constitution of a health subject for whom the assumption of personal responsibility is a given.

The “Success Stories” celebrate the assumption of personal responsibility by emphasizing the ways in which thinness facilitates enhanced participation within the workplace and other typically competitive spheres of activity. The first story in the series details the experiences and weight-loss efforts of Curtis, a forty-year-old man who spent most of his childhood and adolescence as an outsider in his community because of his weight. Upon entering the workforce, however, his desire to fit in with his coworkers finally provides him with the motivation to lose weight: “In my early 20s, I started a new job where they had a ‘fitness challenge’ for employees. I won by losing the most weight—37 pounds! Thus began my whole dance with fitness.” Curtis’s success story culminates in the achievement of social acceptance, when he discovers himself to be the “most fit person” at his high school reunion. Curtis’s workplace is throughout an important site of his weight-loss
efforts, a space in which he maintains his “healthy” weight by carefully monitoring his diet and exercise. His narrative also recalls Elliott’s comment that fat people have long been viewed as “failed citizens” whose failures are often couched in economic and labour terms. Curtis’s thin self is also a “fit” citizen whose healthier weight improves his status within the workplace and beyond.

Concerns about health risk factor significantly into the discourse of epidemic obesity, but most of the “Success Stories” echo this emphasis on the appearance of fitness as the prime reason for pursuing weight loss. Four of the five stories narrate the experiences of women designated overweight or obese according to their BMI. Like Curtis, these women describe their motivation to lose weight in terms of fitness, and specifically the appearance of fitness, rather than health risk. Gender is also a persuasive resource, a means of strengthening associations between thinness and fitness, often through the highlighting of gendered consumption patterns. Jackie, a 50-year-old woman, gained 30 pounds after being prescribed a medication to treat “a nerve problem in [her] face.” The weight gain placed her at a BMI of 25.1, making her overweight according to the CDC’s measures, but just barely. Jackie decides to lose weight only after reaching “the point where none of [her] clothes fit [her] anymore,” an experience that left her “feeling horrible emotionally and physically.” Jackie’s failure to fit into her clothes also signifies her failure to fit in, as demonstrated in her story by her shopping habits.

Jackie’s story exemplifies the gendered dynamics of the CDC’s enforcement of personal responsibility. As her story suggests, a “healthy” weight is tied to one’s participation in stereotypically female activities such as shopping. For Jackie, achieving a

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116 Boero observes that bariatric surgery is also promoted as facilitating participation, as a “normal female,” in gendered activities such as shopping for clothing (111). See “Bypassing Blame,” in Killer Fat.
BMI of 19.5, a score that places her on the lower end of the “normal” weight range, matters less than the ability to wear a smaller size: “For the longest time I didn't trust my weight loss, so I never bought any smaller clothes. Finally, I am beginning to buy some new things. I try something on, and it's too big. I get a smaller size, and I almost can't believe the size on the tag. It's outrageous!” She reports taking pleasure in “[s]eeing what clothes sizes fit me now”—“I look at the size tags on the clothes that fit me now and think, ‘What could be better than this?’” For Jackie, the satisfaction of weight loss resides not in having reduced her risk of disease. Rather, “healthy” Jackie is defined more by her thinness and the shift in consumption patterns that accompanies her smaller size.117

Dorothy, who turned to diet and exercise in response not to health issues but to a divorce and subsequent midlife crisis, similarly describes her transformation in terms of her consumption patterns. Whereas before her weight loss, she had sought comfort in food and media consumption—“I used to take a box of cookies and plop down in front of the TV”—she now relies on shopping as a source of motivation: “When I feel really good about something, I will reward myself by buying a CD, a new book, or I will get my nails done.” Dorothy’s realization of a “healthy” or “normal” weight is accompanied by a transformed relationship to consumption. For her, the “biggest thrill” is having “choices when I buy clothes.” Media studies scholar Tania Lewis has argued that within a neoliberal model, responsibility for health “is increasingly devolved to the individual, but in a way that seamlessly connects health issues to other forms of consumption in the realm of lifestyle” (522). The transformation of citizens into consumers has been and remains central to the

117 Indeed, a 2016 episode of the podcast This American Life dedicated to stories about obesity stigma, literary scholar and writer Roxane Gay proposes that the “fat acceptance” movement’s critique of the discourse of epidemic obesity is more common among those who still possess the ability to shop for clothes that fit (what she calls “Lane Bryant fat,” meaning a body weight and size that can still be accommodated by off-the-rack clothing). For a full transcript, see “Tell Me I’m Fat.”
neoliberalization of society. Indeed, the CDC “Success Stories” define a “healthy” weight relationally, in terms of lifestyle and choice, in doing so shoring up the conception of consumption habits as expressions of fitness. Dorothy’s case helps to specify the rhetoric of fitness as consumption. Consumption habits also factor into the CDC’s portrayal of the ideal “female” health subject.

In addition to underscoring the value of fitness, the “Success Stories” teach the necessity of self-governance. Each profile highlights the strategies used to achieve a “healthy” weight. Further, within each profile, qualities of the ideal health subject—self-surveillance, self-deprivation, self-discipline, and self-control—take precedence over the adoption of new diet and exercise routines as the sources of success. Jackie, for example, reports that she returned herself to a “healthy” weight through willpower. “When I eventually got back to being only 20 pounds overweight,” Jackie writes, “I decided to change my self-image from ‘I have no willpower’ to ‘I do have willpower.’” Through willpower, Jackie restrained her impulse “[w]hen faced with high-calorie or fattening foods.” As a result, “[o]ver time, the weight kept coming off and it was thrilling.” In attributing her “healthy” weight to the exercise of “willpower”—an important feature of the self-governing subject—Jackie implies that epidemic obesity may be rooted in the lack of self-discipline or self-control.

Another area of self-governance, food consumption in the “Success Stories” takes on significance as an expression of biopower, Foucault’s term for the power produced by disciplining and monitoring the body. The narrators of the CDC “Success Stories” recount

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118 See, for example, media scholar Robert McChesney’s introduction to Noam Chomsky’s People Over Profit, in which he argues “[i]nstead of citizens, [neoliberalism] produces consumers. Instead of communities, it produces shopping malls” (11).

overcoming “horrible … habits” to live “a whole new life in many ways.” This self-transformation requires overcoming ignorance, and it is by overcoming ignorance that narrators signify their internalization of the discourse of epidemic obesity. Joan, for example, a woman in her fifties who lost 79 pounds over two years, sees her eating habits as rooted mainly in ignorance: “Because I had grown up as a thin person I never had to think about what I ate, when I ate or why I ate—ever! I wasn't an emotional eater. I just didn't realize that the food I was eating was pretty unhealthy. I grew up outside Philly and I ate Philly cheese steaks every day for lunch. That's just what we did” (emphasis added). Joan’s “unhealthy” weight stems not from her lack of access to healthy foods: it is her lack of awareness that causes her problems. This foregrounding of lack of awareness contributes to the rhetorical work of the campaign, as it asserts an association between self-awareness and self-control. Joan must even learn to develop such awareness within a context in which those around her appear to lack both self-awareness and self-control. As she explains of her earlier habits, “[t]hat’s just what we did.” A “healthy” weight, according to the “Success Stories,” is achieved through the formation of self-awareness, a process that necessarily involves examining—and altering—the cultural or family norms that shape personal habits.

Joan, who had a BMI of 37 at her highest weight, is one of only two people in the series who at their highest weights fell within what the CDC deems the range for obesity. Her current weight places her at a BMI of 24.9, on the upper end of the “normal” weight range. A key to her achievement of a “healthy” weight is Joan’s effort to overcome her “complacency,” her “biggest challenge,” which requires that she adopt new practices of self-surveillance and self-tracking. For example, Joan begins using an online weight loss program that taught her “the importance of putting healthy things into my body, like fruits and
vegetables.” Going forward, she worked to become “very aware . . . of what I ate. I started keeping track of what I was eating. I coupled the consciousness raising with several questions that I still ask myself throughout the day, ‘Do I really want this?’ ‘Will it set me back?’ ‘Is eating a pastry or chocolate worth it?’ The answer to that question is usually ‘no.’”

Joan’s inner dialogue illustrates the internalization of the discourse of epidemic obesity, and more importantly, it reinforces the notion that a “healthy” weight is attained mainly through constant self-surveillance and self-deprivation. Joan reports that over time she began to apply scrutiny to her exercise habits as well: “Once I had tackled my food intake, I began walking three to four miles almost every day. When winter came and it was too dark or too cold to walk outside, I did aerobics and weight training indoors. Eating healthy and exercising really helped me to associate what I ate with how much I’d have to exercise to burn it off.” As Joan explains, however, increased exercise must be matched by a heightened attentiveness to her new habits: “I weigh myself nearly every day and track my weight weekly.” A “healthy” weight, then, is achieved not only through diet and exercise. Other practices must be adopted—not just self-surveillance and self-tracking, but also self-optimization.

Phyllis’s “success story” concludes the CDC’s anti-obesity series. Hers is also the most dramatic weight loss. In two years, Phyllis lost over 200 pounds, and went from a BMI of 64 to a score of 27. So, despite having lost more than half her body weight, Phyllis is still overweight according to CDC measures. As in earlier stories, fitness and not health risk provides the impetus for behaviour change. Phyllis describes her weight and body size as becoming an issue for her only once they posed an obstacle to her active involvement in different areas of her life: “Moving from place to place took a great deal of effort and became
very difficult. As I got larger and larger, my world got smaller and smaller. I stopped traveling. I knew when I couldn't get on a plane to go to my nephew's wedding that I had reached my all-time low. I had to do something.” Phyllis is motivated to adapt her habits only once her weight and body size prohibit her participation in social and family life.

To achieve her “healthy” weight, Phyllis initially reports making changes only to diet and exercise. The keys to her dramatic weight loss, she says, were “eating right and exercise. There was no magic solution.” However, the transformation of her diet and exercise habits is here, too, couched in terms of self-optimization. Her new eating habits, for example, require that she learn to follow “recommended guidelines for eating lots of fruits and vegetables,” and be “mindful of the number of calories [she’s] consuming.” She also reports the need for increased self-control in the workplace, where convenience foods tend to be more accessible than whole foods and meetings with coworkers and clients typically revolve around eating. Finally, Phyllis must learn self-discipline in unfamiliar environments: “I do a lot of traveling for work now, and the places I stay offer healthful food choices, often right next to the waffles and doughnuts.” As Phyllis explains, it “is possible to stick to a healthy program while traveling. It's all about personal responsibility and personal choice—making the healthy choices, not the bad ones” (emphasis added). The series tagline—“They did it. So can you!”—implies that what worked for Phyllis might work for anyone faced with a BMI within the overweight or obese range. There is “no magic solution,” only “personal responsibility and personal choice.”

Undoubtedly, some may be motivated, and moved, by messages about the capacity for personal responsibility to improve health in the context of epidemic obesity. Such reactions might even be expected among people who discover the “Success Stories” after
having used the CDC’s online BMI calculator and earning a score of 25 or over. Underlying the CDC’s yoking of thinness and fitness, however, is the same capacity for stigma that motivated the AMA’s Committee on Science and Public Health to recommend against declaring obesity a disease. In telling their stories, the “Success Stories” narrators confess to displaying qualities typically associated with the stigmatization of fat people—for example, as complacent, or ignorant, or lacking in willpower. These confessions have the potential to perpetuate such stigmatization, which has proven implications for mental health. In their 2010 review, for example, Rebecca Puhl and Chelsea Heuer report that obesity stigma “has been documented as a significant risk factor for depression, low self-esteem, and body dissatisfaction” (1023). Despite having been developed to improve health, the CDC’s messaging about overweight and obesity may work against it as well.

“Taking Action” Against Epidemic Obesity via Public-Private Partnerships

In illustrating the acceptance of personal responsibility, the CDC’s “Success Stories” demonstrate both the epideictic and constitutive work of the discourse of epidemic obesity. This discourse, as Guthman has observed, “is most centrally about disciplining the so-called normal” (94). Because it benefits the outsourcing of responsibility for public health, the framing of obesity as epidemic also serves as an invaluable “technique of neoliberal governance” (Guthman 194). Indeed, public health messaging about epidemic obesity displays a concern both for the reducing the putative health risks of overweight and obesity and for the responsibilizing of self-governing subjects. The need to expand the reach of messaging about the value of personal responsibility within the context of epidemic obesity has in recent years motivated public health officials to enter into public-private partnerships
(PPPs). A prominent feature of neoliberalism, as I discuss below, PPPs create a role for the private sector in public enterprises.

Governments typically form PPPs to secure private-sector funding for infrastructure projects such as waste-management and transit facilities. The rhetorical work of transforming public issues in matters of personal responsibility, however, also motivates the formation of these arrangements. An essay published in the *American Journal of Public Health*, for example, describes PPPs in terms of their potential to extend the reach of public health by engaging private-sector agents in the development of public health messaging. In it, public health scholars Valerie Curtis, Nana Garbrah-Aidoo and Beth Scott argue that “[c]ompanies thrive or fail by their ability to market their products or services. Marketing is the main route to creating shareholder value and is the core competence that gives an enterprise its competitive edge.” Public-private partnerships benefit the rhetorical work of public health, and in return “[t]he public sector typically brings . . . institutional anchors, delivery infrastructure, access to resources and expertise, and a guiding vision” (634). In exchange for the contribution of their marketing expertise, private-sector partners gain access to both the ethos associated with the public sector and the opportunity to shape perceptions of public issues.

In the context of epidemic obesity, private-sector involvement also provides a vehicle for influencing the very meanings of personal responsibility. To illustrate, I explore the rhetoric of personal responsibility incorporated into The Weight of the Nation. Launched in the U.S. in 2012, this anti-obesity campaign and public-private partnership brings together Home Box Office (HBO), the CDC, the Institute of Medicine (IOM) and the National

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120 See, e.g., Valerie A. Curtis, Nana Garbrah-Aidoo, and Beth Scott, “Masters of Marketing” (2007), which uses the case of hand hygiene promotion to describe the advantages for public health of public-private partnerships.
Institutes of Health (NIH). My analysis demonstrates HBO’s appropriation of the ethos of public health to depict media consumption as a meaningful expression of agency in the context of epidemic obesity. Ethos appropriation potentially both expands the audience for HBO programming and affords the network some influence within debates about the impact of media consumption on the onset of overweight and obesity. My aim is to stress the problems of HBO’s ethos appropriation, such as its implications for understandings of agency amid efforts to encourage personal responsibility.

The Weight of the Nation includes both a website and a documentary series. The documentary series *The Weight of the Nation* consists of four case studies detailing various aspects of epidemic obesity in the U.S. The interactive website, also called The Weight of the Nation, advertises the series by providing access to trailers and online episodes; it also creates space for HBO to portray media consumption as an expression of agency in the context of an epidemic. On the website’s homepage, a grayscale U.S. map animation appears to be crushed by the words, “The Weight of the Nation.” Implied by this visual imagery is the framing of obesity both as epidemic and as damaging to the nation’s health. The map is also an allusion to the need for personal responsibility, or for individuals to take part in efforts to contain epidemic obesity. My focus here is on the campaign’s depiction of media consumption as both a factor influencing epidemic obesity and potentially its antidote. To “take action” against the U.S. obesity epidemic means to view trailers for and episodes of HBO’s documentary series or share information about epidemic obesity via one’s social networks.

121 Additional financial support, as *The Weight of the Nation* website indicates, comes from the Michael & Susan Dell Foundation, a philanthropic organization, and Kaiser Permanente, a U.S. based healthcare consortium.  
122 Episodes of and trailers for HBO’s four-part documentary series can also be viewed online, through the campaign website.
Part of the impetus behind public-private partnerships is the belief that public health organizations must more effectively engage individuals using web and social media. Introduced in the mid-2000s, for example, the “Health 2.0” movement touted the advantages of user-driven web campaigns designed to facilitate the spread of public health information. Since then, to expand the reach of their web-based campaigns, most public health organizations have begun to engage the interactive, information-sharing features of the web. Visitors to public health websites have the option to share just about everything they learn online. With the click of a button, for example, I can tweet a link to the CDC’s “Success Stories” or publish one of the stories in my Facebook feed. In response to the popularity of online health information sites such as Livestrong and WebMD, public health organizations have also introduced online health quizzes, BMI calculators, and self-tracking applications. On the CDC’s website, for example, I can test my knowledge of heart disease. Digital self-tracking functions especially expand the reach of public health, as these technologies of surveillance “compel norm-conforming behaviour,” to quote political theorist Rachel Sanders, and “interpellate individuals in relation to population norms” (46). On SuperTracker, an initiative of the U.S. Departments of Agriculture, for example, I can track my diet and exercise and, in a nod to the valuing of fitness, see how my efforts “stack up” against those of other registered users on the site.

The emergence of “Health 2.0” also fuelled interest in public-private partnerships as a mechanism for improving the reach of public health messages. As a division of Time Warner, the world’s second-largest media conglomerate, HBO has a powerful incentive to advance its aim of increasing market share through partnership with the public sector. The

goal of HBO’s partnership with the CDC, IOM, and NIH, however, appears not to be merely
to expand the premium cable network’s audience. Instead, throughout The Weight of the
Nation website, media consumption is invoked as an effective means of “[c]onfronting
America’s obesity epidemic,” and more importantly not a contributor to the crisis. The
multinational food and beverage industry, as Susan Greenhalgh observes, increasingly seeks
to portray its products as health promoting in response to the targeting of convenience foods
as the source of epidemic obesity. The Weight of the Nation represents a similar effort on
behalf of mainstream media to push back against the negative view of media consumption
that emerges from the discourse of epidemic obesity.

As an ethos appropriation, HBO’s messaging shares much in common with the
CDC’s efforts to encourage the assumption of personal responsibility for epidemic obesity.
Throughout The Weight of the Nation website, HBO adopts to terms used in public health
messaging to represent epidemic obesity as a crisis to be remedied through the assumption of
personal responsibility. Before it appears to be crushed by the words, “The Weight of the
Nation,” for example, the U.S. map animation displays a mosaic of individual citizens of
varying size. Most of the bodies depicted appear to be adipose bodies, which within the
context of epidemic obesity take on meanings associated with risk and responsibility. Above
the map animation, the campaign’s slogan, “[t]o win, we have to lose,” enforces the need for
self-governance to overcome epidemic obesity. Beneath the map, a web marquee provides
“facts” about epidemic obesity. Some facts describe the pervasiveness and severity of
overweight and obesity and assert a relationship between BMI designations and rates of
death and disease. Other facts—for example, that “[o]ne in four adults gets no leisure-time
moderate or vigorous physical activity at all”—portray epidemic obesity as tied to patterns of diet and exercise among Americans.

Taken together, however, the “facts” presented on HBO’s site provide only superficial insight into the problem of epidemic obesity—and they suggest different motivations for private-sector involvement besides extending the reach of public health. Instead, on The Weight of the Nation, facts function primarily to influence perceptions of agency. For example, the marquee that displays these facts features a red button, shaped like an arrow, and emblazoned with the words, “Take Action.” Users who click this button then have the option to share a given fact via their online social networks. The visual rhetoric and design of HBO’s interactive website conveys the impression that participating in online discussions counts as an expression of personal responsibility within the context of epidemic obesity.

If the goal of contemporary public health is to encourage personal responsibility, then private partners may wish to portray participation in certain activities as expressions of agency. However, private sector partners also benefit from the marketing capacities that make them ideal partners within public-private partnerships. For example, whereas public health websites increasingly incorporate information-sharing functions, on The Weight of the Nation website, these functions have been streamlined for ease of use. The website itself also has a simpler, sleeker appearance than many of its public counterparts, reflecting its corporate origins. Formal features of the site have implications for HBO’s perceived credibility as a source of information about epidemic obesity. According to rhetoric scholar Barbara Warnick, web users, when surveyed, purport to rely on source or creator information in assessing a website’s trustworthiness. Warnick observed, however, that in practice
credibility assessments tend to be influenced more by formal features, such as usability and information design. HBO’s interactive website showcases its ability to command an audience. Yet while the ease of information sharing via The Weight of the Nation potentially increases support for federal efforts, the site’s visual rhetoric also enhances HBO’s profile as an authority on epidemic obesity. More clicks through the site's interactive features mean more coverage of the corporation’s efforts on behalf of public health.

Throughout The Weight of the Nation website, what it means to “take action” is also limited. For its intended audience, “confronting” epidemic obesity (again, to use vocabulary repeated throughout the site) means watching and promoting the documentary series and sharing campaign information via social media. Users without social media accounts participate by exchanging their personal information for more facts about the putative health risks of overweight and obesity. At first glance, it may not seem to matter for apparently low-stakes activities—online viewing and information sharing—to be redefined as expressions of fitness. Would it not be an improvement for some of that time to be spent engaging with others on issues such as public health? Proponents of online displays of agency argue that by raising awareness, web-based initiatives such as The Weight of the Nation increase the likelihood of in-person participation in social causes.

While public-private partnerships potentially expand the reach of public health and improve its persuasiveness, PPPs have also been criticized for introducing power imbalances into this and other areas of governmentality.\textsuperscript{124} PPPs may begin with an interest in improving public health, but in practice may tend to favour the aims of the private sector—for example, the opportunity for market expansion. These arrangements also cede to private interests those

\textsuperscript{124} Development studies scholar Anna Plyushteva’s critique of the Global Public-Private Partnership for Handwashing, which I discuss in chapter one, exemplifies the concern with power imbalances within PPPs.
functions typically associated with public governments. Urban studies scholar Faranak Miraftab thus calls the PPP the “Trojan Horse” of neoliberal development. The public goals that motivate the formation of public-private partnerships, Miraftab argues, “are often overwhelmed by those of the most powerful member of the partnership—the private sector firms” (89). PPPs enable the privatization and marketization of areas of public service, and in doing so extend the reach of neoliberalism. Within PPPs, coordination and cooperation with the public sector enhance the credibility of private-sector partners and potentially obscure perceptions of private-sector motivations and gains.

This effort to shift perceptions has implications for perceptions of activism. Debates about the character of contemporary public engagement have led to the theorizing of “slacktivism,” that is, a joining of “slacker” and “activism,” to describe online displays of support for public causes. Slacktivism refers to actions such as signing a web petition or liking a social-media page, low-stakes activities that give the impression of support for a cause without requiring more tangible contributions. In their study of slacktivism, Kirk Kristofferson, Kathryn White, and John Peloza thus call these activities “token support.” As they explain, token support for a cause “allow[s] consumers to affiliate with a cause in ways that show their support to themselves or others, with little associated effort or cost” (1150). According to Kristofferson, White, and Peloza, individuals who display token support for a cause tend to be less likely to get involved offline, for example, by volunteering their efforts or contributing funds.

This finding about token support has implications for The Weight of the Nation, which in its emphasis on “taking action” implies a capacity to initiate meaningful change. The likelier outcome is that HBO’s campaign will not inspire its audiences to take significant
action against epidemic obesity. An emerging program of research has begun to document the societal implications of the use of web and social media to engage individuals on pressing political, social, and health issues. A key finding of this research program is that online and social media tend to have a negative impact on meaningful engagement. In the highly public arenas of web and social media, users may be even more likely to display their support for a cause. However, in the long term, token acts such as likes and shares tend not to be associated with increases in meaningful action, such as volunteerism or charitable donation. For this reason, in 2013, the same year the AMA declared obesity a disease, UNICEF created a public service announcement, “Likes Don’t Save Lives,” to urge web users to move beyond token acts. That the public sector may be unlikely to benefit from online engagement does not mean that the same holds true for private-sector players. HBO stands to benefit from its representation, via The Weight of the Nation, of media consumption as not a token act (or even a health risk) but rather a meaningful expression of agency.

Corporations have a long history of contributing to public health messaging, but the formation of public-private partnerships permits private-sector entities to engage in public health as equal partners. HBO’s involvement in efforts to address epidemic obesity illustrates both the potential advantages for private-sector involvement in PPPs and the rhetorical form such advantages might assume. For example, even though HBO has a longstanding reputation for airing in-depth documentaries, The Weight of the Nation documentary series and website gains its trustworthiness from the imprimatur of “the nation’s leading research institutions.” PPPs tend to be described as “win-win” situations for public and private
partners alike. Even so, attention must be paid to the rhetorical advantages gained by the private sector. Some may regard HBO’s impact on what it means for individuals to “take action” against epidemic obesity as working against public health efforts to address increasing rates of overweight and obesity.

**Profiting from the Rhetoric of Personal Responsibility**

In 2013, when the AMA made available its report on their investigation into the decision to declare obesity a disease, the report also listed some of the arguments against a disease label. These included the potential for the medicalization of obesity “to drive financial gains of certain providers/interests” (“Report” 11). Given that the framing of obesity as “epidemic” is itself a kind of medicalization, the same might be argued of efforts to address epidemic obesity. HBO’s partnership with the U.S. CDC, for example, increases both the company’s influence within debates about overweight and obesity and its profile among individuals. These advantages accorded to the private sector by their involvement in PPPs depend to a significant extent on the persuasiveness—and pervasiveness—of a rhetoric of personal responsibility. This very rhetoric gains both from the development of anti-obesity campaigns produced by public health agencies, through their stressing of overweight and obesity as complex issues to be addressed through individual efforts. Taken up by the private sector, the rhetoric of personal responsibility becomes a vehicle for profiting from this work. Certainly, for the private sector, epidemic obesity presents an opportunity to expand market share while appearing to advance the aims of public health.

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CONCLUSION

*ObamaCare will be replaced with something that actually works—bringing freedom and individual responsibility back to American health care.*

U.S. Vice President Mike Pence via Twitter (2018)

My project concluded during one of the Northern Hemisphere’s most severe flu seasons in the past decade. “Levels of influenza-like illness (ILI) across the country,” the U.S. Centers for Disease Control and Prevention (CDC) reported, “are as high as what we saw during the peak of the 2009 H1N1 pandemic.”126 In a press briefing, the CDC urged continued vaccination to limit both the spread of ILI and the development, in immunocompromised individuals, of secondary infections such as pneumonia. “You also can help reduce the spread of flu through simple good health habits,” explained CDC representative Anne Schuchat,

like staying away from people who are sick, frequently washing your hands and covering your cough and sneeze. For those who are already sick, please stay home from work or school. That is such an important recommendation to follow. Otherwise you run the risk of spreading the virus to others—and what may be mild symptoms to you could be deadly to someone else.

After Schuchat concluded her remarks, she took questions from reporters, one of whom addressed the capacity of individuals to adhere to CDC guidelines. “We have been talking to people who have been fired, including a nurse who lost her job for staying home from work,” observed NBC reporter Maggie Fox, “Can you talk about the importance of having sick day policies and sick leave for people?”

Whether catastrophic or minor, infection demands the assumption of personal responsibility. Indeed, as Schuchat remarked of the 2017-2018 flu season, speaking on the

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126 The CDC defines an ILI as “as fever (temperature of 100°F [37.8°C] or greater) and a cough and/or a sore throat without a known cause other than influenza” (“Overview of Influenza Surveillance”).
CDC’s behalf, “if we all stay vigilant and take steps to fight the flu, we can help reduce the risk of getting—and transmitting—it.” The rhetoric of personal responsibility, though, addresses more than the demand for information about how to protect oneself and others from sickness. As I explain in my introduction, this rhetoric also responds to concerns about rising health care costs by inviting individuals to participate more actively in disease prevention. Yet as Maggie Fox implied, asking individuals to help contain influenza means little in the absence of workplace policies supporting their efforts to follow CDC guidelines. The very same argument had been made during H1N1, for example by New York Times columnist Randy Cohen in an essay about encouraging personal responsibility for pandemic flu. “If we expect individuals to act ethically,” Cohen argued, “we have a societal obligation to protect them when they do—for instance, by guaranteeing paid sick days to all.” While it is invaluable for individuals to help limit the costs of treatment and care, such work requires a supportive context.

Even in the absence of meaningful support, the belief that we all must do our part to maintain public health continues to hold considerable sway. My goal, in this project, has been to examine the rhetorical means used to enact this belief within various public health contexts. Throughout, I have used rhetorical study to illuminate the different meanings of personal responsibility. For example, in the context of hand hygiene promotion and anti-obesity messaging, to be personally responsible for public health means to help maintain labour productivity, often in the absence of meaningful governmental support. Vaccination and antibiotic-use campaigns depict compliance with public health and medical expertise as also a display of personal responsibility. My observation that personal responsibility’s
meanings are various has throughout informed my interest in the ways this rhetoric works against public health.

To support my arguments with respect to public health’s neoliberalization, a process marked by the withdrawal of governmental funds and support, I document the problems arising from the rhetoric of personal responsibility. In her introduction to Rhetoric in Neoliberalism, Kim Hong Nguyen uses news discourse to substantiate some of neoliberalism’s effects. Nguyen stresses that governments accomplish this withdrawal by making “[i]ntense demands on one’s health, family, and community” (3). As Nguyen argues, “the cultural values of neoliberalism have material impact. Public funds have both been reduced and shifted towards subsidizing and increasing corporate ventures and profits. The public good both conceptually and materially has diminished over time” (3). A key feature of neoliberalization, the rhetoric of personal responsibility has material and economic consequences, and rhetorical study supplies a means of substantiating them. My analysis underscores two prominent shortcomings of the use this rhetoric to engage individuals in working to maintain public health: (1) its focus on individual rather than systemic factors shaping health status, and (2) the advantages this rhetoric accords to the private sector at public health’s expense.

**Prioritizing Individual over Systemic Factors Shaping Health Status**

First, by prioritizing individual over systemic factors shaping health status, the rhetoric of personal responsibility potentially impairs efforts to address public health problems. It does so by distracting attention from the need for societal as well as individual change. Hand hygiene promotion, for example, engenders a culture of stigma, blame, and distrust in response to the threat of infection. As it moralizes the spread of infection through
individual body parts, this rhetoric draws attention away from the resources and support needed to ensure the assumption of personal responsibility. Ben, the “Fifth Guy,” is ostracized by his colleagues for failing to “respect certain hygienic norms” (“About the Campaign”). Conversely, his coworkers display their worth by adopting health habits, such as washing their hands according to standard procedure. Handwashing campaigns employ a rhetoric of personal responsibility not only because individual health habits reduce health risk, but also because this rhetoric helps to normalize the absence of governmental support that defines neoliberalization. This rhetoric invites Ben and his coworkers, for example, to decide for themselves whether to stay home or come to work and risk sickening others. A 2016 study comparing influenza-like illness (ILI) rates in the U.S. and Germany finds that in the absence of paid sick leave, most sick employees are likely to come to work. According to this study, which was produced for the National Bureau of Economic Research by economists Stefan Pichler and Nicolas Ziebarth, “contagious presenteeism,” or coming to work when sick, is on the rise in parts of the U.S. where employees lack access to sick days. Pichler and Ziebarth also find “that population-level influenza-like disease rates decrease after employees gain access to paid sick leave” (“The Pros and Cons of Sick Pay Schemes”). Public health messaging, however, presents Ben’s decision to come to work sick not as a calculated decision—or a consequence of his employer’s failure to support him—but rather as a moral failing.\footnote{128}{Historian David Harvey’s discussion of neoliberalization’s impact on labour sheds new light on the dilemma faced by Ben and workers like him: “Neoliberalization seeks to strip away the protective coverings that embedded liberalism allowed and occasionally nurtured. … … A ‘personal responsibility system’ … is substituted for social protections (pensions, health care, protections against injury) that were formerly an obligation of employers and the state. Individuals buy products in the market that sell social protections instead. Individual security is therefore a matter of individual choice” (168).}

\footnote{127}{One of the most recent studies asserting a connection between hand hygiene and reduced health care and insurance costs is Arbogast et al., “Impact of a Comprehensive Workplace Hand Hygiene Program” (2016).}
The rhetoric of personal responsibility overestimates not only the capacity for personal responsibility to improve health status, but also the role individuals play in exacerbating certain health issues. The consequences of seeking to resolve a public health problem by focusing on individuals rather than societies is illustrated by current approaches to vaccination promotion. In 2014, the World Health Organization (WHO) convened a working group to address the factors driving vaccination’s stagnation in recent years. The SAGE Working Group proposed the term “vaccine hesitancy” to recognize the complex factors driving the “delay in acceptance or refusal of vaccines.” In theory, the recognition of the vaccine hesitant as a prime audience for vaccine messaging might entail the development of more nuanced messaging. Current flu-vaccine messaging, however, works against the insights of the SAGE Working Group by addressing vaccine hesitancy as a problem stemming from deficits in lay knowledge of vaccine science.

Numerous campaigns have, for example, been developed in recent years to teach individuals how to distinguish vaccine science from “misconceptions,” “fictions,” and “myths.” This approach to vaccine messaging persists despite the publication of several recent studies demonstrating its failure to improve vaccination rates. Vaccine correctives may fail to improve vaccination rates, but like anti-vaccination messages, these campaigns still fit within the framework of personal responsibility. By perpetuating the notion that knowledge gaps interfere with vaccination rates, the rhetoric of personal responsibility detracts attention from the need for more meaningful solutions. Scholars of vaccine hesitancy, for example, stress the need to increase vaccination rates by improving trust in medical and scientific expertise; it is not entirely clear whether improving trust could be accomplished through public health messaging alone. In the short term, as historian Heather MacDougall observes
of the commitment to personal responsibility since Lalonde, rhetoric is still “far less expensive than effective central, state, provincial and local action” (958). Vaccine innovation, for example, might be a far more effective alternative to the rhetoric of personal responsibility, but it is also a costlier alternative because it entails increased investment in research and development.

**Private Sector Advantages at Public Health’s Expense**

Second, the rhetoric of personal responsibility accords advantages to the private sector, including the potential to profit from the work increasingly expected of individuals. This is partly an effect of neoliberalism’s cultivation, vis-à-vis rhetoric, of self-governing citizen subjects whose efforts to improve health and prevent disease serve the overarching aim of reducing governmental investment in health care. “Neoliberalism,” writes Nguyen in in her introduction to *Rhetoric in Neoliberalism*, “produces a subject that participates in ways of thinking and acting that are in accordance to [sic] capitalist structures” (4). The advantages for private-sector players is perhaps most clearly demonstrated by the case of hand hygiene promotion. Here, the rhetoric of personal responsibility helps to shore up an entire industry of personal hygiene products. The globalization of this industry, as I explain, depends upon the spread of this rhetoric to developing countries. Currently, the rhetorical work of expanding the marketplace for hygiene products happens through the formation of public-private partnerships (PPPs) that endorse the value to disease prevention of personal hygiene habits.

The case of antibiotic resistance also illustrates how private-sector players benefit from the use of a rhetoric of personal responsibility. In this case, public health officials increasingly recognize the need for industry to participate in efforts to transform the culture of antibiotic use worldwide. Antibiotic use in the livestock industry, for example, is a prime
target. Personal responsibility alone will not suffice to curtail the evolution of antibiotic-resistant infections (ARIs). Yet while public health messaging urges individuals to rethink their demand for and dependence on antibiotics, pharmaceutical companies promote antibiotics in ways that encourage individuals to request these drugs by name. Only the U.S. and New Zealand permit direct-to-consumer advertising (DTCA) for prescription pharmaceuticals, but in the U.S. alone industry investments in drug marketing have a substantial impact on both the request for and prescription of antibiotics. Rather than demand stricter regulation of antibiotic promotion, public health officials have called for the creation of financial incentives to engage industry in the development of new antibiotics. Such a response fails to attend to industry influence on current patterns of antibiotic use—in large part because the rhetoric of personal responsibility keeps the focus on individuals.

The case of “epidemic” obesity also demonstrates that the private sector stands to gain from the rhetoric of personal responsibility, often at public health’s expense. By the 1970s, medical advancements such as the development of antibiotics had considerably lessened the impact of infection. When Lalonde first proposed the adoption of rhetorical solutions to public health problems, he thus overlooked infection’s rhetorical utility to the project of encouraging personal responsibility. The framing of current levels of “overweight” and “obesity” as markers of an “epidemic” illustrates quite clearly that even the metaphor of infection is advantageous to the outsourcing of public health’s maintenance. My analysis documents the rhetorical means used to involve individuals in the containment of epidemic obesity. I also argue against corporate involvement in public health messaging, a phenomenon justified by the view that a model of public health premised on rhetorical solutions might benefit from the private sector’s marketing expertise. Public-private
partnerships (PPPs) have been described as advantageous to public and private partners alike—but there are other consequences as well. Because of corporate involvement in messaging about epidemic obesity, for example, token displays of support take on significance as meaningful displays of personal responsibility.

When, in 1974, Lalonde first proposed involving individuals more in public health’s maintenance, he celebrated this approach as offering “great opportunities for raising the level of health of Canadians” (7). Yet while public health still depends in part on individual efforts to maintain it, a model of public health premised on personal responsibility in no way guarantees improved health outcomes for all. “No matter how hard we strive to be good, self-enclosed individuals responsible for bodies and health,” argues Julie A. Wilson, in Neoliberalism,

> our lives are necessarily connected to and dependent on broader social systems and contexts. For example, just to be healthy, we need access to food, water, and environments that don’t poison our bodies, but these are conditions that we can’t possibly create, much less guarantee, on our own, as self-enclosed individuals. (4)

In Health and the Rhetoric of Medicine, a text grounded in the understanding that persuasion is “a central element in many medical situations,” rhetorician Judy Segal outlines a methodology for the study of rhetoric in health and medicine. Above all, she offers rhetorical study as “a good means of illuminating and recasting problems in health and medicine” (1).

In examining the persuasive means through which public health comes to be understood as, in the first instance, a matter of personal responsibility, I underscore the consequences of relying solely on rhetoric to resolve public health problems.

Already, the devastations of this year’s flu season have led some to question the effectiveness of premising public health too narrowly on personal responsibility. “Personal
responsibility is an attractive goal,” argued clinician and health policy researcher Dhruv Khullar in a 2018 New York Times essay, “But if it’s too aggressively pursued, it may conflict with another worthy ideal: In a nation as wealthy as the United States, sick humans deserve health care.” The point of this project has above all been to better understand the rhetoric of personal responsibility, as this rhetoric is increasingly a crucial piece of public health as practiced in jurisdictions worldwide. Throughout, I have focussed mainly on the circulation of a rhetoric of personal responsibility within Canada and the U.S. My concern with this rhetoric’s limits, and my use of rhetorical study to illuminate them, might be extended to other contexts where this rhetoric may similarly impair efforts to address public health problems. Throughout, I have also stressed this rhetoric’s omission of context as its prime shortcoming—but another, as I argue, is the ambiguity surrounding what it even means to be personally responsible for public health. Public health messaging, when effective, can improve and even save lives, so to critique its inadequacies for the sake of improvement is no insignificant matter. Rhetorical study, in clarifying the meanings of personal responsibility, lays the groundwork for more promising alternatives—for example, a model of public health premised less on culpability and more on treatment and care.

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129 The title of Khullar’s New York Times essay is “You’re Sick. Whose Fault is That?”
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