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Rhetorically Framing the "Inside Woman": Female Healthcare Workers across Editions of *Our Bodies, Ourselves*

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Abstract: This article examines the framing of female healthcare workers—the "inside women"—in the 1971 edition of *OBOS*, the 1973 edition when it transitioned to Simon and Schuster, and the current 2011 edition. While each historical moment was marked by ideological shifts in the goals of feminist health movements, the editions are consistently mistrustful towards female healthcare workers, arguing that they approach healthcare like men. Drawing on rhetorical frame analysis, this article demonstrates how this perspective remained anchored over time and considers the implications of this mistrustful stance towards healthcare insiders for both *OBOS* and feminist health movements today.

Keywords: doctors, frame analysis, healthcare, women's health movement

> Doctors are doctor chauvinists as well as male chauvinists. Most women doctors are no exception to this, having taken a role of "honorary men." (*Our Bodies, Ourselves*, 1970, p. 187)
>
> I chose one of the two women doctors because I believed a woman would be less likely to push drugs and surgery…In the first visit, she suggested not only thyroid medication but also a routine X-ray; she talked crisply, rapidly, coolly, with many complicated medical terms. I felt as if I were sitting across from a medical school curriculum. (*Our Bodies, Ourselves*, 2011, p. 673)

These two quotations show the consistency in messaging about female providers across four decades of the feminist health book, *Our Bodies, Ourselves* (*OBOS*): that they approach healthcare just like men. This is a surprising stance for a book that advocated female empowerment through acquisition of bodily knowledge, rhetorically enacting this commitment by juxtaposing women's testimonies alongside excerpts from medical textbooks (Wells). While critics have recognized *OBOS*'s limitations, calling attention to the exclusion of women of color, lesbians, and women with disabilities from early editions, few have considered the exclusion of women in healthcare from the text's collective "we." Early editions framed the female healthcare worker as opponent rather than collaborator. They constructed the medical field as a "men's club" and women within it as alienated from their feminine identities. And while the most recent 2011 edition revises pronouns for doctors to present day gender-neutral standards, it still reveals vestiges of an insider/outsider divide that distances readers from women working in healthcare. This divide becomes all the more problematic in an age where women's decisions about controversial care like vaccines often rely on accounts of bodily experience while villainizing medical professionals.

In this article, I examine framing of female healthcare workers—the "inside women"—in the 1971

edition of *OBOS*, the 1973 edition that marked its transition to mainstream publisher Simon and Schuster, and the most recent 2011 edition. While previous authors have pointed to the 1984 edition as a key turning point for the collective's critique of medicine, I show how the 1973 edition's framework created a basis for that critique (Davis; Wells). In addition, rather than tracking changes from one edition to the next, my project is interested in showing what lingers and unpacking the remarkable consistency that emerges in how the editions treat female healthcare workers; hence, my focus is primarily on the first two publications and the 2011 edition. I draw on frame analysis to help understand this consistency, a methodology based on Erving Goffman's theory about how events are presented and placed within a field of meaning. Rhetorical frame analysis attends to how discourse impacts the presentations of events, people, or things over time. Specifically, Snow and Benford's concept of "ideational anchoring" provides a lens for this project and unpacking how "[social] movements that emerge later in the cycle will typically find their framing efforts constrained by the previously elaborated master frame" (212).

Overall, I argue that the most recent edition of *OBOS* is rhetorically torn between maintaining faithfulness to its original strategies—demonizing doctors and mobilizing a radical feminist movement—and updating its perspective to reflect a medical industry in which women serve as both laborers and patients. The result is a guide that simultaneously discourages cooperation between female healthcare workers and medical consumers, even while it espouses messages of access and collaboration. While critical, my aim is not to discredit *OBOS* or other women's health initiatives. By demonstrating how the consistent insider frame of *OBOS* leads to a mistrust of medical authorities and an overreliance on the experiences of the individual, I can also offer pragmatic implications for those involved in women's health advocacy and for feminist rhetoricians who study health and medicine. In the discussion, I address connections between *OBOS*'s framing of female healthcare workers and rhetorics of anti-science to consider both the pitfalls of this framing and potentials for reimagining the position of the "inside woman" within feminist health initiatives (Dubriwny; Scott; Whidden).

The Women's Health Movement and Feminist Activism 1970-Today

Before delving into an analysis of rhetorical framing across editions of OBOS, it is important to contextualize the book within the shifting landscape of the women's health movement more broadly from the 1970s to today. The contemporary women's health movement began as a radical, grassroots initiative that spread techniques for attaining personal embodied knowledge, but with the aim of large-scale institutional and social change. Today, women's health is a billion-dollar industry that "depict[s] health as both the responsibility and the obligation of individuals and consistently reif[ies] traditional gender roles for women" (Dubriwny 3). Alongside these shifts, the feminist movement has undergone its own ideological transformations, grappling with how to maintain emphasis on foundational concepts like embodiment while accounting for intersectionality and individual choice (Hayden; Fahs).

While women's health advocacy undoubtedly has a long and varied history, Barbara Seaman's 1969 book, *The Doctors' Case Against the Pill*, is often referenced as a starting point for the second-wave feminist health movement in the United States. Seaman drew on testimony from women about their dangerous health experiences with legal birth control, as well as interviews with physicians and medical researchers to show the limitations of scientific knowledge about the pill (Dubriwny 17). This book, as well as early editions of *OBOS*, exemplified three modes of storytelling that Sobnosky (2013) describes as key to the rhetoric of the second-wave women's health movement. Sobnosky argues that women used three modes to (1) link current medical care to biased and unscientific practices of the past, (2) demonstrate how these practices negatively impacted their care through "doctor stories," and finally, (3) position themselves as the real experts "test[ing] theoretical knowledge against their empirical experience" (219). These narratives relied on tactics of feminist consciousness-raising, which worked to bridge the personal and the political by demonstrating that "what were thought to be personal deficiencies and individual problems are common and shared, a result of their position as women" (K. Campbell 79). They also relied on the unique practices of embodied self-help characteristic of the second-wave feminist women's health movement, like the vaginal self-exam. In her analysis of this exam, Michelle Murphy describes how a learned process of "producing the evidence of experience" taught women to value and claim their embodied knowledge and to leverage it as evidence for institutional and social change (119).

Indeed, many of the women's health initiatives emerging in the early 1970s were deeply radical—aiming to overhaul and replace a patriarchal medical system with grassroots women's health clinics and self-help practices. A project launched by the Boston Women's Health Collective during the early 70s to provide training to Harvard medical students on performing women-centered pelvic exams exemplifies this trend. After several revisions to the collaboration that gave Collective members exceptional input and leadership in designing and implementing the pelvic exam training, the group proposed a program for only women students based on "reciprocal sharing" (Kline 58). This request was untenable and led to the dissolution of the program, despite its initial widespread support from the university, professors, and students.

However, Roe v. Wade's passing in 1973 also provided an impetus for cooperation with medical practitioners. Feminist abortion clinics came under federal jurisdiction and were legally required to hire licensed physicians, "typically a white male" (Morgen 127). By 1976, there were approximately fifty women-controlled clinics in the United States (Kline 41). Relationships with physicians in these clinics were tenuous—they faced ridicule and harassment from their colleagues in hospitals and resistance from feminist at the clinics themselves (Morgen 127). Still, the institutionalization of previously feminist women's health spaces began a trend that would carry steadily through into the 1980s when women's health centers were "coopted by hospitals and health care systems," lacking any of the "radical, alternative approach to care for women" that had characterized feminist health centers of the 70s (Bernhard 76). Meanwhile, changing legislation in the 70s provided increasing opportunities for women to access medical education. During this decade, the proportion of women medical students nearly tripled, from 10 percent to nearly 28 percent (Kline 46).

Characterized by “ten uninterrupted years of antifeminist, antiliberal, self-identified conservative presidential administrations,” Katzenstein argues that the 1980s necessitated that feminist movements develop new tactics, specifically “unobtrusive mobilization” (30). Working within institutions like higher education, social services, and medicine, feminists managed a marked growth in gender consciousness during a period of political resistance (Katzenstein 30). Still, there was a growing divide between radical feminist initiatives and liberal women’s health movements that by the 1990s meant the two were facing very different fates. While unified feminist movements declined, the women’s health movement flourished spurred by both a specific focus on issue-based initiatives as well as cooperation with institutional insiders (Baird 15). In fact, the leaders of women’s health organizations were often working professionally in medicine or law and were capable of expressing their demands in “culturally acceptable terms” that appealed to the institutions they sought to change (Baird 18).

Of course, institutional collaboration also came with significant risks of co-optation and loss of political vision. In these contexts, “The conditions for success or even continued existence often undermine[d] feminist goals and processes” (Katzenstein 31). Thus, what looks like a flourishing women’s health movement today—in the form of nationwide campaigns to support breast cancer awareness, research on women’s heart disease, or attention to postpartum depression—has lost many of its connections to feminist aims. Instead, these movements promote a vision of what Dubriwny calls “the vulnerable empowered woman,” who “through her various practices of risk management and consumption, functions to support a variety of neoliberal power structures, ranging from reifying traditional gender roles to supporting certain research agendas over others” (9).

Admittedly, our vision of what feminism and feminist rhetoric entail has changed dramatically in the intervening decades as well. The second-wave feminist focus on individual embodied knowledge as a source of radical political change has come under fire for its naïvity, while women’s studies programs have shifted towards more theoretical and abstract notions of the body (Fahs; Kline). Meanwhile, the idea that all women across cultural, racial, and socio-economic boundaries share essential and universal experiences has also been critiqued, with more recent movements emphasizing the necessity of intersectional approaches and a diversity of perspectives. Some recent rhetorical research has worked to recoup the tactics of second-wave feminist health movements to demonstrate their complexity and contributions to contemporary feminist conversations about individual experience, choice, and institutional change (Fahs; Hayden; Sobnosky). Still, new technology for tracking women’s health demonstrates how radical political acts like the vaginal self-exam can be co-opted into ideologies of self-regulation, as women are asked to enter their cervical position into their fertility apps—one data point among many. With the advent of online health communities and the rise of the e-patient, we face a proliferation of health misinformation that frequently blurs lines between corporate interests and scientific work, between expert knowledge and individual experience. It is in this context, I will argue, that collaboration between feminist health activists and healthcare insiders becomes all the more important. Understanding how and why OBOS maintained its mistrustful stance towards insiders across multiple decades can provide one means for reimagining that relationship in future feminist work.

Rhetorical Frame Analysis of the 1971, 1973, and 2011 editions

While the shifting landscape of the women's health movement in the 1970s certainly impacted *OBOS*' messaging, their move from the radical publisher New England Free Press to mainstream publisher Simon and Schuster in 1973 also played a role. This move was one of the most controversial decisions for the collective, but was born of a desire to reach wider audiences outside feminist organizations and even the women's health movement (Kline 17). Meanwhile, Musser argues that the book's move to a larger, mainstream publishing house in 1973 also marked a shift away from collective health goals towards a more essentialist, individual vision: "In the 1973 edition of *OBOS*, the pull toward a collective identity had been displaced by a desire to foster the growth of the individual" (102). But why did this shift to a more individualist perspective on healthcare also reinforce the alienation of the female healthcare worker? To make sense of this perpetuation of the "insider frame" between the 1971 and 1973 editions, and its continuation in the latest 2011 edition, I turn to rhetorical frame analysis.

Based on Erving Goffman's 1974 book of the same title, frame analysis was initially developed as a method in Sociology to analyze mobilization of participants in social movements. Sociologists understand framing as "meaning work" and frames are described as "'schemata of interpretations' that enable individuals 'to locate, perceive, identify, and label' occurrences within their life space and the world at large" (Benford et. al., 464). Rhetoricians have since adapted frame analysis to attend to how discursive choices shape the framing of events, people, or things over time. Kuypers (2010) describes a rhetorical methodology that begins by identifying themes that appear in narratives over time and then examines "key words, metaphors, concepts, symbols, visual images, and names given to persons, ideas, and actions" to understand how that theme is being framed (301). His approach resonates with other methodologies, such as Condit's (1999) tracking of the "rhetorical formations" in discourse on the gene (14). However, frame analysis is particularly apt for this project both because it aligns with a critical feminist orientation and because it offers an analytic vocabulary specifically tied to social movements.

First, Hardin and Whiteside argue that frame analysis is ideally aligned with feminist goals; it enables them to "advocate pragmatic ways that social movement organizations can advance more progressive framing" (315-316). Similarly, my project aims to unpack the processes that caused the ideational anchoring of *OBOS*'s insider frame with the goal of revealing how part of an organization's message might remain inconsistent with the greater goals of a movement. In addition, frame analysis provides a language for describing frames that emerge as a social movement seeks to align participant's perspectives with its own. One method for linking individual perspectives to organizational frameworks is frame amplification, which clarifies and invigorates a previously established frame (Snow et al. 469). Rather than radically altering their mistrustful attitude towards female doctors between the 1971 and 1973 editions, I argue that the authors amplified their perspective of the woman insider.

To make sense of the amplification of this "insider frame," it is necessary to contextualize it alongside the changing diagnostic, procedural, and motivational frames occurring between the 1971 and 1973

editions. According to Snow and Benford, the diagnostic frame "identif[ies] a problem and [attributes] blame or causality" (200). Meanwhile, prognostic frames "not only suggest solutions to the problem but also identify strategies, tactics, and targets" (201). Finally, the motivational frame is "the elaboration of a call to arms or rationale for action that goes beyond the diagnosis and prognosis" (203). These three components help bring to light the relationship between the amplification of the "insider frame" and *OBOS*'s vision. Finally, I turn to the 2011 edition, which reveals vestiges of an insider/outsider divide that distances readers from female healthcare workers. Snow and Benford argue that early on in a movement a "master frame" is developed which often remains intact: "provid[ing] ideational or interpretive anchoring for subsequent movements within the cycle" (212). If each edition of *OBOS* is read as a "movement within a cycle," then the remains of a mistrustful framing of female healthcare workers in the 2011 edition can be understood as part of an "interpretive anchoring." Overall, this analysis draws on and adapts frame analysis to better understand the mechanisms of ideational anchoring and the interactions between an anchored frame and other central frames in a text.

Diagnostic Framing in 1971 and 1973: Blaming the Doctors

Both editions of *OBOS* begin with a similar diagnostic account of the "problem" that prompted the book: bad doctors. Ultimately, doctors are described as personifying the more comprehensive institutional problems in healthcare. The doctor is a natural scapegoat—often white, male, and upper-class he embodies the institutional forces at work in maintaining the status quo and is often the face that accompanies the collective's medical experiences. Thus, the diagnostic task of *OBOS* in both 1971 and 1973 involves identifying patriarchy and capitalism as causes for the inadequate health system in America and subsequently "blaming" the doctor for those problems. In order to link the doctor to an overarching patriarchal system, the authors eliminate female healthcare workers from their narrative through the use of male pronouns, parallelism between male problems and doctor problems, and causal links between patriarchal doctors and sexist medical institutions.

First, the authors consistently use the male pronoun "he" when discussing doctors, associating the profession with masculinity. Some may argue that attending to male pronoun use for books published in the 1970s is problematic, since the use of "he" as gender-neutral was so widespread at the time. Still, linguistic studies have shown that readers' interpretations of a text are directly affected by gendered pronouns. Miller (1994) reports that "women tend to avoid responding to job advertisements containing generic *he*, because they feel that they do not meet the qualifications outlined in the ads" (269). In addition, in 1970 7.6 percent of physicians were female, so the male pronoun did represent the vast majority of doctors (Kline 14). Thus, female readers were already unlikely to associate themselves with the doctor's role. The use of the masculine pronoun then served to augment this disassociation and to position them in opposition to the "masculinized" women who did take on roles as health practitioners.

In addition, the problems with doctors are often conflated with problems of masculinity, in both editions, so that the masculine pronoun is necessary for the logic of the collective's arguments. For

example, the 1971 edition accuses “doctors” of a lack of knowledge about female sexuality: “Doctors in general are as ignorant about sexuality as the rest of the men in society” (135). Here, “doctors” are equated with men, and to read “doctors” as meaning both male and female would make the sentence illogical. Similarly, the 1973 edition describes defensive men using psychological diagnosis as a weapon against female patients: “In a strange way, a doctor often feels personally attacked or threatened when he cannot find any physical cause for the symptoms you report, and this can cause him to become hostile and use a label of ‘neurotic’ or ‘psychosomatic’ as a weapon” (246). Again, while one could read the “he” here as gender-neutral, one would miss the larger argument being made about the patriarchal construction of the hysterical woman as indicative of male ignorance. A number of metaphors in the two editions also emphasize the parallels between doctors’ and men’s weaknesses. For example, connections are drawn between medical training and a fraternity rush (1971, 6) or the priesthood (1971, 129). Meanwhile, the 1973 edition discusses women’s instinct to equate the doctor role with a father role and cautions against it (250). In these ways, doctors’ weaknesses are tied specifically to men’s limitations solidifying their masculine positioning.

Finally, both editions articulate a causal link between the patriarchal doctor and the oppressive healthcare system. The 1971 edition uses an excerpt from Fortune magazine to put the faults of the medical system on the doctor’s shoulders: “Fortune magazine says: ‘The doctors created the system. They run it. And they are the most formidable obstacle to its improvement” (182). Here, doctors are both “obstacles” and decision-makers, controlling the fate of consumers in numerous areas of medical access. The 1973 edition features a nearly identical attribution of blame, although Fortune magazine is removed as a source, with the authors taking ownership of the sentiment: “The American doctor has claimed for himself unusually broad powers. It is he who decides which patients are treated and where, the cost of treatment, who goes to the hospital, which treatment is given and for how long” (240). Interestingly, the 1973 edition removes the language of a “system,” instead speaking of “unusually broad powers,” which the American doctor actively claims. This portrays each American doctor as taking part in claiming power, rather than participating in an oppressive system that was created before them.

Overall, then, the diagnostic frame remains consistent across the two early editions of *OBOS*: the doctor is the scapegoat, a face for the institutional problems of the medical industry. Meanwhile, his masculinity is fundamental to occupying that position. However, the 1973 edition diverges from the 1971 edition by providing far more elaboration on why the “inside woman” could not be an active participant in the women’s health movement. This is directly related to the larger frame shift from a collectivist project in 1971 to an essentialized understanding of all Women as already unified in 1973.

Prognostic and Motivational Framing in 1971 and 1973: From Collective to Individual

In general, the 1971 and 1973 editions share a prognostic frame as well. To counter patriarchal doctors and an oppressive healthcare system the authors encourage women to gain self-understanding of both their minds and bodies. Learning about one’s body is the fundamental strategy and tool that undergirds both editions. However, because of a shifting understanding of their audience, there are

also distinctions in how the two editions view that process of self-understanding contributing to the creation of a feminist collective (their motivational frames). The 1971 edition argues that all women are coming from a position of alienation to their bodies and thus, need education about those bodies in order to become a collective and overhaul the system. Meanwhile, the 1973 edition still speaks to women's lack of bodily understanding, but also assumes an already existing bond between all Women. Its motivational frame, then, is focused on informing individual consumers rather than motivating a revolutionary collective. While Davis attributes the shift away from collective transformation to individual action to the 1984 edition, this analysis shows the origins of this shift appear much earlier in revisions between the 1971 and 1973 editions.

Setting out its prognostic frame, the 1971 edition outlined a number of steps that must be taken for women to become part of a successful feminist collective: "First, subjectivity had to be composed of both the body and the mind. Second, the particularly female body had to be redeemed from its debased status. These things taken together allowed for the third, the formation of female bond and ultimately feminist collectives political female social bodies" (Musser 96). Along these lines, then, the authors in 1971 edition describe their initial alienation from their bodies and reaction to the bodies of other women as an experience that is mediated through the male gaze: "Every part of our body is an area of real or potential disgust to us…And the objectified disgust we have for ourselves we feel towards other women" (9). All women, then, are in need of an education that will allow them to remove the male gaze from themselves and others. Thus, when the authors go on to casually mention female doctors as "having taken a role of 'honorary men'" (186), this does not prove particularly surprising. After all, patriarchal society has caused all women to objectify one another and be disgusted with their own bodies; female doctors naturally share in these prejudices.

Meanwhile, the motivational frame of the 1971 edition was visible even through its layout: it is book-ended by two chapters that address the patriarchal and capitalist forces at work in medicine, contextualizing all of the informative chapters within a movement to revolutionize healthcare. In both chapters, justice in healthcare is depicted as only possible outside of the current system: "We will gain nothing by pumping more money into our present system. Healthcare for everyone is possible only outside of the profit system" (191). Thus, learning more about one's own body is part of a larger process in becoming a member of a feminist collective and enacting revolution. To stop at self-help is to understand the strategies (prognostic frame) being articulated in the 1971 edition, but to miss the call to arms (motivational frame).

The 1973 edition, in contrast, proposed similar methods for developing bodily understanding, but assumed an already unified female readership: "Since one was already taken to be a member of the community of women, one did not become a woman/subject in the same way as in the 1971 edition, but rather one was informed" (Musser 102). This was part of their broader shift to a motivational frame that focused on being informed rather than systemic overhaul. The 1973 edition allocates all of the information about systemic injustice to a final chapter entitled "The Women's Health Movement." Even this is a deceiving title, since the chapter focuses primarily on practical advice for receiving the best possible treatment in the current medical system. The authors optimistically suggest the potential of

systemic change but also assert that these changes are already in progress:

> Lots of changes are coming…but for most of us for a long time doctors and hospitals as they are now will be part of our lives. Just being enraged with the system shouldn't keep us from trying to the very best medical care that money can buy right now, for the very least we can pay, whenever we need it. (269)

This articulation is sharply juxtaposed to the call not to "pump more money into our present system" in the 1971 edition and followed by concrete advise on mediating interactions with doctors and medical staff and gaining access to insurance benefits and treatment. Ultimately, rather than overthrow the system, the revised *OBOS* helps readers "to negotiate the system instead of allowing the system to negotiate you" (269).

However, for the 1973 edition, the idea of an existing bond between women proves problematic in the case of female healthcare workers alongside the consistent diagnostic frame that identifies all doctors as patriarchal: could someone be a doctor and thus responsible for the capitalist and patriarchal medical system as well as a Woman? In response, the authors amplify the insider frame, highlighting the masculinity and self-alienation of the female healthcare worker to address this discrepancy.

Amplifying the Insider Frame from 1971 to 1973

With these shifting prognostic and motivational frames also comes a shifting relationship to female healthcare workers. In the 1971 edition, the potential for the reader to develop a new relationship to her body also leaves open the potential for the female doctor to do the same, to come to understand herself and other women through participation in a feminist collective. The authors discuss their previous cooperation with insiders in the medical field in the introduction to the text and also envision future cooperation as part of the process of overturning the current healthcare system. Meanwhile, the 1973 edition takes the initial accusation that female doctors are "honorary men" and amplifies it, emphasizing the masculinity of the workers and arguing that medical training has inducted them into the patriarchy.

The 1973 edition amplifies the masculinity of female healthcare workers through both descriptions of their training and by separating them from the book's collective "we." The authors discuss how female doctors overcame prejudice in medical school: "They had to 'outman the men,' so to speak—to be more conservative, more rigid, 'better' in every way than their male colleagues, or even renounce the mother-wife role altogether, just to survive" (350). Hyper-masculinity is viewed as necessary over-compensation for the inside woman. In addition, the Collective makes rhetorical moves to separate female doctors from themselves and their readers. Female doctors are not seen as mothers or wives, and, therefore, just like a male doctor, they cannot understand "women's issues" of pregnancy, birth control, or sexuality. To further this separation, the 1973 edition also suggests that the female doctor might be sexually repressed: "It has also been suggested that as women they had problems with their sexuality, and perhaps…they did, having absorbed so much contempt for their sex

from doctors and from society and yet still wanting to be doctors" (350). In the 1973 edition, alienation from her body is not a shared trait of the unenlightened woman like it was in the 1971 version, but a further mark of estrangement for the female healthcare worker. The "and yet still wanting to be doctors" comment suggests that a continued desire to stay in medicine is evidence of one's acceptance of a patriarchal perspective.

That said, the 1973 edition does discuss the potential for new women doctors who are coming out of the feminist movement to be more resistant towards the patriarchal medical institution but these female doctors are still not a part of the collective "we" of *OBOS*. The book suggests that some of these doctors have similar goals to the women's health movement generally: "Many of these women are deeply interested in community medicine and family practice…Some hope to be able to improve medical care for women and families, and will be looking for communities in which to do this work" (241). However, the use of "these women" and "some" separates female doctors from the movement rhetorically, highlighting again the notion that female doctors are not part of a shared feminine subjectivity. Later on, the authors become altogether dismissive of any course offered by a medical professional: "Courses taught by people who are part of the 'health' system have rarely given really honest consumer information…Only when health education is based in the community and run by the community will women be able to get truthful information" (270). Even "these women" who want to work in community medicine are not to be trusted, coming from within the system. The authors invalidate both their ability to participate in sharing female experience and the legitimacy of their information. In examining the 1973 edition's positioning of female healthcare workers, then, one can see how the amplified insider frame expanded on their masculinity to align them with a patriarchal system and repeatedly distanced them from the readers of *OBOS* and its feminist health project.

The 2011 Edition: Ideational Anchoring of the "Insider Frame"

Given the changing landscape of healthcare in the nearly forty years that separate the 1973 edition of *OBOS* and the 2011 edition, one might expect the newest edition to offer a transformed "insider frame" that reimagines female healthcare workers as part of the book's collective "we." Indeed, the authors acknowledge the large population of female insiders in healthcare: "Women are now more often healthcare professionals (accounting for 49 percent of medical school graduates in 2007, compared with 9 percent in 1970)" (759). In fact, beginning with the 2005 edition, healthcare practitioners contributed to the text, included among a group of 400 external contributors that also involved journalists and administrators" (Davis 40). In addition, beginning with the 1998 edition, *OBOS* authors hired voice and tone editors to ensure that the book best spoke to its diverse readership. Among the considerations for these authors were racial differences, disability issues, sexual orientation, and religious background (Bonilla). While healthcare practitioners were not explicitly identified as a diverse group, grammatical changes reveal that the book is responding to the changing role of women in medicine. Doctors are primarily referred to as "healthcare providers/professionals" and the authors now employ multiple pronouns to demonstrate gender flexibility in the profession. Bonilla specifically describes how part of her work as voice and tone editor of the 2005 edition was to "acknowledge the many individual women, advocates, and families who have learned to fight the

medical-zation of women's bodies from inside the medical establishment" (181). Still, the tentative relationship to female healthcare workers that began back in the early editions remains anchored in the newest edition. As they reassign blame to the more abstract agent of the "United States" and articulate models for self-education that might involve collaboration with healthcare insiders, the authors of the newest edition face what Benford and Snow describe as "dilemmic contradictions." These contradictions emerge as a result of an anchored frame that no longer aligns with the larger views of an organization. The authors resolve these contradictions, in part, through a turn to technological innovations at the end of the edition, presenting a vision for feminist health movements that positions the Internet as a radical space where non-experts can share information and mobilize. In this way, they still look towards a future where change can happen without collaboration with female insiders.

In constructing their diagnostic framework, the authors of the 2011 edition have shifted the blame from doctors and healthcare workers to politicians and the United States' government. Wells traces this shift to the 1984 edition when she argues the focus on the doctor as scapegoat no longer held political resonance: "They had begun by investigating the individual doctor-patient relationship and criticizing its power relationships; in 1984, they confronted medicine as a corporate practice that posed questions of access to care" (13). In the 2011 edition, Chapter 26 is entitled "The Politics of Women's Health" and begins with a discussion of how the widening economic gap that was a result of the Reagan and Bush administrations has negatively impacted access to healthcare across the country. The primary agent of blame in this section is the "United States." The "United States" is useful as an agent since it descriptively encompasses a range of injustices and systemic forces, allowing the authors to make sweeping statements such as: "The United States does not ensure access to healthcare and related services" (651). At the same time, opposing this agent and all of the various forces involved in its agency is nearly impossible to imagine. Instead, this diagnostic frame offers the potential for only individualized, small-scale interventions, often focused on acquisition of knowledge.

Meanwhile, the prognostic frame of the 2011 edition does envision a degree of cooperation with healthcare providers in the process of gaining more knowledge about personal health. The authors address groups and classes that are run by "physicians, medical centers, and hospitals" and "emphasize self-care and activities that we can do to manage our care in conjunction with our providers" (659). Still, they urge readers that when it comes to "self-help groups," it is only without the presence of institutional insiders that real interrogation of the system can occur: "When these groups are independent of healthcare institutions and professionals, we can freely question, challenge, and evaluate accepted medical treatments and explore nonmedical therapies and providers" (659). As Snow and Benford argue, the perpetuation of the "master frame" can often lead to "dilemmic contradictions" in a text and here we see those contradictions at work. The authors want to acknowledge the productive potential of expert-lead groups, but still feel that the most productive knowledge building can only occur outside of institutional contexts because of their book's ties to feminist consciousness-raising.

Similar contradictions appear in explicit discussions of female healthcare workers in the 2011 edition,

where the ambivalence of the authors towards female insiders is made clear. The book references research that finds female healthcare workers tend to be more in-line with feminist health practices: "Studies have found that female physicians spend more of the visit on preventive care…and patients of female physicians report higher satisfaction with their care" (673). Yet, at the same time the authors urge readers not to choose practitioners based on gender, since all doctors emerge from the same training programs: "Unfortunately, female physicians emerge from the same stressful and dehumanizing medical training process that affects all doctors" (673). Here, the author's have switched from a view of medical training as "de-feminizing," removing the potential for female healthcare workers to be in touch with their female sexuality, to "dehumanizing." This is in line with the abstracting work of the diagnostic frame, which removes human agents by giving action to a system.

The mistrustful positioning towards the female healthcare worker as a result of this dehumanizing education remains the same, however. For example, the 2011 edition shares an anecdote from a patient who chose a woman doctor and was appalled when: "In the first visit, she suggested not only thyroid medication but also a routine X-ray; she talked crisply, rapidly, coolly, with many complicated medical terms. I felt as if I were sitting across from a medical school curriculum" (673). While female healthcare workers are no longer described as paternalistic or hyper-masculine, the authors of the 2011 edition still highlight their participation in a medical school system that alienates them from personal, woman-centered care. Even in the case of alternative female practitioners, the 2011 edition emphasizes emergence from a "system" that is not aligned with feminist ideals for health practice. The authors acknowledge that when it comes to nurse practitioners and midwives, institutional training may lead to better care but add the caveat that "they often learn in a hierarchical learning model similar to that for physicians and face some of the same constraints as physicians" (673). Thus, even as they describe a range of healthcare providers, they align alternative practitioners with more mainstream caregivers through discussions of their training and thus, take a mistrustful stance towards them.

The 2011 edition does break from the 1973 edition, in that it uses technology and access to information on the Internet as the means for a new motivational frame that emphasizes the potential for anyone to intervene in spreading health knowledge. Chapter 27, the last in the 2011 edition, is entitled "Activism in the 21st Century" and optimistically imagines a world in which readers can share information and become part of international health movements using the Internet. In keeping with the larger vision of the book, this chapter emphasizes the non-expert status of members in these online communities: "In this new era, traditional gatekeepers have been replaced by a decentralized assembly of digitally empowered citizen journalists" (810). These "citizen journalists" have the potential to counter mainstream medical information and challenge the doctors and pharmaceutical companies that spread misinformation. In addition, it is easier than ever to form groups without the guidance of experts in the field: "Organizing does not take experts or a lot of money. What it does take is a committed group of individuals willing to invest time and energy to work together towards a common goal" (810). Thus, the Internet has reinvigorated *OBOS*'s motivational frame, providing a new platform for collective action. At the same time, their mistrustful stance towards female insiders remains in tact. Ultimately, this view of the productive potential of non-expert online spaces has been

significantly called into question by recent developments in online health discourse, like the anti-vaccination movement, as I consider in the next section.

Overall, while the frames *OBOS* authors used to describe female subjectivity, blame individuals or institutions, and suggest potential venues for action have all responded contextually to historical changes over the past three decades, the treatment of the "insider woman" has remained ideationally anchored. Its anchoring, despite the shifting relationship between female insiders and outsiders in the women's health movement generally, leads the authors to a motivational frame in 2011 that encourages grassroots action but does not imagine successful cooperation with women inside the medical institution.

Looking Forward: Directions for Activist-Expert Collaboration

Reflecting on how the critical lens of science studies has been taken up by anti-science organizations to argue against climate change, pre-eminent science studies scholar Bruno Latour notes: "a certain form of critical spirit has sent us down the wrong path, encouraging us to fight the wrong enemies and, worst of all, to be considered as friends by the wrong sort of allies" (231). In a similar way, second-wave feminist critiques of medical institutions have provided a rhetorical foundation for radical anti-science movements such as the anti-vaxers. Here, I consider anti-science movements' appropriation of arguments about bodily expertise and antagonistic stance towards expert insiders. Then, I discuss existing models for activist-expert collaboration as future directions for feminist health movements and feminist rhetoricians.

Like the authors of *OBOS*, much anti-vaccination rhetoric that circulates in online forums relies on the evidence of women's bodily expertise—particularly their motherly intuition—to counter scientific claims about health. Whidden (2012) describes the MMR-autism controversy: "a number of celebrities join other mothers to advance the idea that a mother's personal experience with her child is stronger evidence than research validated by the standards of the technical sphere" (251). Similarly, Scott (2016) notes how Jenny McCarthy's account describes her son as "her science" in her book about autism: "exemplifying the way that the observations and experiences of parents are constructed as scientific evidence" (67). Of course, this is not merely a replication of feminist health rhetorics. *OBOS* was radical in part because of its willingness to engage directly with scientific sources like medical textbooks and put these sources in conversation with women's embodied experiences (Wells). Rather than simply repeating or validating a single experience or perspective, the juxtaposition of accounts in *OBOS* created a cacophony of different perspectives. As Hayden (2018) explains, "[the authors] acknowledge that their perspectives are partial and they seek out the opinions of others, including those whose experiences differ from their own and with whom they disagree. The result is a text replete with contradictions" (241). And yet, my analysis has also shown that even if there was variation in how women's experiences were described in *OBOS*, there was also consistency across many decades in *OBOS*'s orientation towards female insiders. We can see the spirit of this skepticism of and resistance towards health "experts" replicated in the rhetorics of anti-science movements in ways that

suggest a need for reimagining the relationship between feminist health movements and mainstream practitioners.

Just as the current edition of *OBOS* envisions online spaces as radical places to continue the work of feminist health movements, these spaces can also create opportunities for more interaction between experts and lay-people. Bakke (2018) offers one model for this kind of collaboration in her examination of a Parkinson's discussion forum that includes a physician moderator. She notes how the moderator facilitated trust with the forum participants "as he interacted and empathized with members" (3). Meanwhile, Dubriwny provides a vision for feminist health activism to act as a "watchdog of biomedicine" on a larger scale with the example of the grassroots organization Breast Cancer Awareness (BCA), which takes on "an activist orientation that exists both alongside and in opposition to biomedicine" (157). Through activities like testifying at FDA hearings and gathering their large-scale evidence through online surveys of women, BCA participants frequently read scientific research and engage directly in expert conversations rather than rejecting scientific work. These modes of engagement create opportunities to align themselves with like-minded health practitioners rather than taking an antagonistic stance towards anyone involved in healthcare practice.

Meanwhile, the call for more cooperation with healthcare insiders extends to feminist rhetoricians of health and medicine as well. As Reed (2018) and Campbell (2018) have noted, research in the rhetoric of health and medicine has frequently taken a critical stance towards health practitioners and researchers, aligning themselves with the patient's embodied experiences that so often go unheard. However, there are many risks inherent in calling for more collaboration between activists and healthcare insiders, from abdicating responsibility for medical monitoring and responsibility to patients (Kopelson 357) to corporate appropriation of personal discourses of embodiment (Whidden 246). Thus, feminist rhetoricians have much to contribute in reimagining productive modes of engagement between disparate groups with varying levels of expertise while also looking out for slippages that disadvantage the patient. However if, like the authors of *OBOS*, we consistently prioritize the embodied experiences of patients and alienate the experts, we run the risk of replicating the kinds of logic that have fueled anti-science movements rather than contributing to a future vision for productive collaboration with science experts. Thus, looking forward, it is imperative for both feminist health movements and feminist rhetoricians of health and medicine to consider how expert-activist cooperation might be accommodated in our rhetorical frames in innovative and revolutionary ways.

Works Cited

Baird, Karen L. "Introduction—Beyond Reproduction: The Women's Health Movement of the 1990s." *Beyond Reproduction: Women's Health, Activism, and Public Policy*, edited by Karen Baird, Dana-Ain Davis, and Kimberly Christensen, Fairleigh Dickinson University Press, 2009, pp. 9-34.

Bakke, Abigail. "Trust-Building in a Patient Forum: The Interplay of Professional and Personal Expertise." *Journal of Technical Writing and Communication*, Online First, 2018.

Bernhard, Linda A. “Women’s Health Nurse Practitioners, Feminism, and Women’s Studies.” *Women’s Studies Quarterly*, vol. 31, no. 1/2, 2003, pp. 76-89.

Bonilla, Zobeida E. “Including Every Woman: The All-Embracing ‘We’ of ‘Our Bodies, Ourselves’”. *NWSA Journal*, 2005, pp. 175-183.

Campbell, Karlyn Kohrs. “The Rhetoric of Women’s Liberation: An Oxymoron.” *Quarterly Journal of Speech*, vol. 59, no. 1, 1973, pp. 74-86.

Campbell, Lillian. “The Rhetoric of Health and Medicine as a ‘Teaching Subject’: Lessons from the Medical Humanities and Simulation Pedagogy.” *Technical Communication Quarterly*, vol. 27, no. 1, 2018, pp. 7-20.

Condit, Celeste Michelle. *The Meanings of the Gene: Public Debates about Human Heredity*. University of Wisconsin Press, 1999.

Davis, Kathy. *The Making of Our Bodies, Ourselves: How Feminism Travels Across Borders*. Duke University Press, 2007.

Dubriwny, Tasha N. *The Vulnerable Empowered Woman: Feminism, Postfeminism, and Women's Health*. Rutgers University Press, 2012.

Fahs, Breanne. “The Body in Revolt: The Impact and Legacy of Second Wave Corporeal Embodiment.” *Journal of Social Issues*, vol. 71, no. 2, 2015, pp. 386-401.

Hardin, Marie and Erin Whiteside. “Framing through a Feminist Lens: A Tool in Support of an Activist Research Agenda.” *Doing News Framing Analysis: Empirical and Theoretical Perspectives*, edited by Paul D’Angelo. Taylor & Francis, 2010, pp. 312-330.

Hayden, Sara. “Toward a Collective Rhetoric Rooted in Choice: Consciousness raising in the Boston Women Health Book Collective’s *Ourselves and Our Children*.” *Quarterly Journal of Speech*, vol. 104, no. 3, 2018, pp. 235-256.

Katzenstein, Mary Fainsod. “Feminism within American Institutions: Unobtrusive Mobilization in the 1980s.” *Signs,* vol. 16, no. 1, 1990, pp. 27-54.

Kline, Wendy. *Bodies of Knowledge: Sexuality, Reproduction, and Women's Health in the Second Wave*. University of Chicago Press, 2010.

Kopelson, Karen. “Writing Patients’ Wrongs: The Rhetoric and Reality of Information Age Medicine.” *JAC*, vol. 29, no. 1/2, 2009, pp. 353-404.

Kuypers, Jim. “Framing Analysis from a Rhetorical Perspective.” *Doing News Framing Analysis: Empirical and Theoretical Perspectives,* edited by Paul D’Angelo and Jim Kuypers. Taylor & Francis, 2010, pp. 286-311.

Latour, Bruno. “Why Has Critique Run Out of Steam? From Matters of Fact to Matters of Concern.” *Critical inquiry*, vol. 30, no. 2, 2004, pp. 225-248.

Miller, Cristanne. “Who Says What to Whom?: Empirical Studies of Language and Gender.” *The Women and Language Debate: A Sourcebook*, edited by Camille Roman, Suzanne Juhasz, and Cristanne Miller. Rutgers University Press, 1994, pp. 265-279.

Morgen, Sandra. “The Changer and the Changed.” *Into Our Hands: The Women’s Health Movement in the United States, 1969-1990*. Rutgers University Press, 2002, pp. 120-153.

Murphy, Michelle. “Immodest Witnessing: The Epistemology of Vaginal Self-examination in the US Feminist Self-help Movement.” *Feminist Studies*, vol. 30, no. 1, 2004, pp. 115-147.

Musser, Amber Jamilla. “From Our Body to Yourselves: The Boston Women’s Health Book Collective and Changing Notions of Subjectivity, 1969-1973.” *Women’s Studies Quarterly*, vol. 35, no. 1/2, 2007, pp. 93-109.

Our Bodies, Ourselves: A Course by and for Women. New England Free Press, 1971.

Our Bodies, Ourselves: A Book by and for Women. Simon and Schuster, 1973.

Our Bodies, Ourselves. Simon and Schuster, 2011.

Reed, Amy R. “Building on Bibliography: Toward Useful Categorization of Research in Rhetorics of Health and Medicine.” *Journal of Technical Writing and Communication*, vol. 48, no. 2, 2018, pp. 175-198.

Scott, Jennifer B. “Boundary Work and the Construction of Scientific Authority in the Vaccines-Autism Controversy." *Journal of Technical Writing and Communication*, vol. 46, no. 1, 2016, pp. 59-82.

Snow, David A., et al. “Frame Alignment Processes, Micromobilization, and Movement Participation.” *American Sociological Review*, vol. 51, no. 4, 1986, pp. 464-81.

Snow, David A. and Robert D. Benford. “Ideology, Frame Resonance, and Participant Mobilization.” *International Social Movement Research*, vol. 1, no. 1, 1988, pp. 197-218.

Sobnosky, Matthew J. "Experience, Testimony, and the Women's Health Movement." *Women's Studies in Communication*, vol. 36, no. 3, 2013, pp. 217-242.

Steinberg, Mark. “Tilting the Frame: Considerations on Collective Action Framing from Discursive Turn.” *Theory and Society*, vol. 27, no. 6, 1998, pp. 845-872.

Wells, Susan. *Our Bodies, Ourselves and the Work of Writing*. Stanford University Press, 2010.

Whidden, Rachel A. “Maternal Expertise, Vaccination Recommendations, and the Complexity of Argument Spheres.” *Argumentation and Advocacy*, vol. 48, no. 4, 2012, pp. 243-257.