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The Stories We Sell:
A Narrative Analysis of Direct-to-Consumer Pharmaceutical Advertising

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The Stories We Sell:
A Narrative Analysis of Direct-to-Consumer Pharmaceutical Advertising

by

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Dissertation

Presented to the Faculty of the Graduate School of

The University of Texas Medical Branch

in Partial Fulfillment

of the Requirements

for the Degree of

Doctorate of Philosophy

The University of Texas Medical Branch

May, 2007

Dedication

To Holden

Acknowledgments

This work would not have been possible were it not for the support of a wide circle of faculty, friends, and family. First and foremost, I would like to thank the faculty at the Institute for the Medical Humanities for their constant support and encouragement. I am particularly indebted to Anne Hudson Jones, whose exacting professional standards are matched only by her poise, grace, and kindness. I am also especially grateful to Tom Cole, whose initial encouragement brought me to the IMH in the first place, and also to my committee members: Ron Carson, who guided me through Heidegger with Yeats and blurred every genre along the way; Michele Carter, whose intellectual rigor has challenged me and greatly improved my work; Harold Vanderpool, whose enthusiasm for scholarship and love for American culture has been infectious; Tess Jones, whose energy reflects her fresh approach to cultural studies; and Fred Huang, whose thoughtful approach to clinical medicine has been invaluable. Donna Vickers has also provided cheerful and reliable administrative assistance for which I am quite grateful.

Much of what I've learned in graduate school has come not from faculty, however, but from the friends and fellow students who have shaped my ideas and outlook to a greater extent that I would have thought possible. For many hours well-spent, I want to thank Mike, who makes it look easy; Jason, who does what can't be done; Laura, who stands her ground; Jordan, who is the best of us; Dan, who is, truly, a humanist; Melinda, who has become the kind of doctor I've always wanted to be; and John, who reads carefully and writes well.

I'd like to thank Charles and Marian Scott, who provided not only constant support and generosity but countless hours of childcare to make this dissertation possible. My parents, Luke and Kathy Lea, deserve credit for whatever I've managed to string across these pages. Anyone puzzled by my stubborn refusal to choose between a love of science and a love of words did not share my good fortune to grow up reading Dr. Seuss and singing Bob Dylan in the car on the way to some ancient mountain range whose story was folded in limestone and sandstone and granite and shale.

I am forever indebted to my sister, Megan Buck, who knows why, or should; to Corey, who reminds me of what matters and loves me when I don't deserve it; and, finally, to Holden, who (as it turns out) is aptly named, and has caught me, already, more times than I could ever repay him for.

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Publication No._____

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The University of Texas Medical Branch, 2007

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Abstract:

This dissertation focuses on the issue of direct-to-consumer (DTC) television advertising for prescription drugs. First, it explores the terms and categories currently used to understand and debate this issue. Then, it draws from the traditions of history, hermeneutic philosophy, interpretive anthropology, visual studies, and the ethical criticism of literature to develop and advocate an alternative paradigm for thinking about pharmaceutical marketing. The project involves a theoretical exploration of an interpretive, and specifically narrative, approach to drug commercials, as well as a demonstration of this approach in three analytical chapters, each dedicated to a single advertisement.

The methods used in this dissertation are those of humanities scholarship, and include careful and comparative reading, rigorous linguistic interpretation, philosophical investigation, and narrative analysis. By bringing these scholarly approaches to bear on the issue of DTC advertising, this project offers a novel perspective from which to

consider issues in health policy, one which allows and encourages an active, participatory stance on the part of patients and the public as a whole. This kind of critical, interpretive reframing of pharmaceutical advertising not only divests the industry of the free-market rhetoric upon which it relies to justify its marketing practices, it also directs public discourse towards a careful examination of the suggested narratives conveyed by these commercials. Ultimately, this narrative paradigm highlights the extent to which individuals are free to rigorously evaluate, and then deliberately accept, reject, or retell the stories told by drug companies about health, illness, and American medicine.

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Introduction: Asking Different Questions

In novels and on television, over dinner tables, and even on the senate floor, Americans tell stories about disease. These shared accounts of health and disease constitute our understanding of medicine, which is to say, they constitute the cultural institution that *is* American medicine. From this perspective, the project of reforming medicine–the project of bioethics and the medical humanities–involves the telling of better stories.

What would it mean to say that some stories are better than others? How, in a pluralistic society, can we agree on what *better* might mean? Can we judge these stories on ethical grounds without resorting to a narrow moralism? I propose that we can, and should, undertake a responsible ethical critique of the shared stories that we tell about disease. In this dissertation, I will explore the stories of health and disease told by direct-to-consumer (DTC) advertisements for prescription drugs. A brief overview of the historical development of this marketing strategy, as well as a summary of the contemporary debate surrounding it, will serve both to provide important background information on this controversial issue as well as to underscore its significance for the cultural experience of illness. Once I have placed the issue of DTC advertising in its proper historical and political context, I will undertake an in-depth examination of the conceptual framework within which we currently understand, discuss, and evaluate prescription drug commercials. Then, drawing on traditions within the various disciplines of philosophy, history, anthropology, and literary studies, I will set forth an alternative paradigm, one which allows for a richer and more productive evaluation of pharmaceutical advertisements. This alternative style of thinking is, at its core, an

interpretive one. It relies upon and encourages a particular way of looking at advertisements, and involves asking different kinds of questions than the current framework involves. The questions we generally ask of drug commercials tend to be the questions we might ask of a textbook or scientific treatise: Is the information accurate? Is it presented clearly? What is its educational potential? It seems to me that we would get further in understanding and responding to these advertisements, however, if we asked questions which are more akin to those we ask of literary works: What is this story about? What have we learned from it? How might it have influenced us? Are we better or worse for having heard it? If we were to retell it, what would we change?

In later chapters I will urge readers to consider the kind of audience an author, or advertiser, implies with the use of pronouns like *we* and *our*. Therefore I'd like to briefly address the way in which I intend to use these terms throughout the text and even in the title. I include within my use of *our* and *we* the broadest grouping of readers possible within the bounds of a shared, and specifically Western, intellectual and cultural community. Given the subject and scope of this project, and specifically its call for a widely encompassing, active, participatory stance toward the shared ideas which constitute culture, I have deliberately chosen to address, and thus hopefully involve, this audience in a way which is both broad and direct. While I recognize the significant differences between the groups debating DTC advertising (the financial and power differential, for instance, between the pharmaceutical industry, health-care professionals, and patients), I also call for an alternative conception of public discourse-one which demands the critical attention and active participation of the citizenry as a whole. My audience, therefore, could roughly be described as the sum total membership of American culture, an institution I understand to be pluralistic, democratic, heavily influenced by

modernity and modern science and, as opposed to the European heirs of the Enlightenment, constantly exposed to television advertisements for prescription drugs.

This project is roughly divided into three major sections. The first, comprised of chapters 1 and 2, is intended as an introduction to the issue of DTC advertising of prescription drugs. It begins with a discussion of the historical link between pharmaceutical sales and brand-name mass marketing in the United States, traces the development of the current federal regulations regarding these advertisements, and provides an overview of the arguments, both supportive and critical, concerning their effects and implications. The second section, comprised of chapters 3 and 4, attempts to lace together several distinct but related intellectual traditions in order to provide the theoretical justification for an interpretive approach to DTC advertising. The third section includes chapters 5 through 7, each one an interpretive analysis of a specific prescription-drug commercial. These chapters are meant to demonstrate a contextualized, narrative approach to advertisements. They are offered as examples of the kind of conceptual work I believe we can, and must, undertake together to adopt a broad, participatory, active public stance towards health care. The analyses themselves are conceived of as conversation starters rather than definitive statements, and while I am necessarily invested in my readings of these commercials, I extend alongside them an invitation for disagreement, negotiation, and further clarification within the inclusive, dialectical, actively creative activity that I understand our culture to be.

Because the first section is relatively self-explanatory, and the third is really an invitation for further thought, I wish to focus the remainder of this introduction on the second, in which I try to articulate the connections between several intellectual traditions, each with a distinct relationship to what many refer to as *the interpretive turn*. Much of the recent scholarship in moral philosophy, narrative theory, and cultural studies has

revealed a contrast between two fundamental ways of knowing. Each is connected to its own account of human nature, and each comes with its own implications for the project common to many of these disciplines: exploring the ethical dimensions and meeting the ethical demands of our pluralistic, democratic, postmodern society. Within the realm of medical ethics and humanities, this project has taken various forms and has benefited from the wisdom of scholars in a variety of fields. As we view the social and ethical challenges specific to the arena of health and illness from an increasingly multidisciplinary perspective, particular patterns appear. Fundamental connections are drawn between traditions that previously seemed to have nothing to do with each other. Deep chasms appear between fields that are supposedly closely related, or even, and often, between distinct groups of thinkers within a discipline. To a certain extent, interdisciplinary approaches to medical humanities and ethics encourage the recognition of these *blurred genres*.[1] Yet above and around the emphasis of this particular approach, and, in fact, evident in the recent popularity of interdisciplinary scholarship, a reconfiguration of ideas is taking place. In virtually all academic disciplines, the basic categories of thought and action are being questioned, revised, rejected and (often with good reason) strongly defended. Richard Bernstein extensively surveys the implications of this reconfiguration of ideas, a trend he identifies throughout the social and natural sciences as well as the humanities. Moreover, he recognizes the same shift operating within cultural and political tensions. "There is an uneasiness," he explains, "that has spread throughout intellectual and cultural life."[2] Bernstein characterizes this "disquietude" as the growing dissatisfaction with key concepts such as *reason, human*

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[1] Clifford Geertz, "Blurred Genres: The Refiguration of Social Thought," chap. 1 in *Local Knowledge: Further Essays in Interpretive Anthropology* (New York: Basic Books, 1973), 19-35.

[2] Richard J. Bernstein, *Beyond Objectivism and Relativism: Science, Hermeneutics, and Praxis* (Philadelphia: University of Pennsylvania Press, 1983), 1.

nature, certainty, and *knowledge*, which our contemporary Western tradition has inherited from its most immediate predecessors–the scholars and visionaries of the European enlightenment.[3] Their lasting influence on cultural, political, scientific, and moral realms of thought remains the dominant Western worldview–referred to generally, and hereafter in this dissertation, as the *modern* worldview, which structures our habits of thought and action at such a fundamental level that we are rarely aware of it.

In fact, the gradual recognition of this legacy, with its shortcomings along with its successes, is what Bernstein considers to be the cause of our widespread unease. The scope of this phenomenon is broad and its individual manifestations vary greatly. The particular conceptual history of a given academic tradition often determines the extent to which it may be brought to bear on the project of examining the modern worldview, as well as the specific habits and assumptions that may become the target of that critique. By definition, a tradition cannot question an assumption upon which it still unknowingly rests. Yet the cacophony of challenging voices, each privy to a unique perspective, each well-placed to view the assumptions of its neighbor, and each becoming increasingly aware of its own foundation in the process, has gown loud enough that what we hear is not so much the individual complaints and suggestions but the resounding noise of the conversation and the patterns that have begun to emerge from it.

While Bernstein believes our troubles stem from a false dichotomy and describes the alternative as a view that looks "beyond objectivism and relativism," other scholars characterize the emerging patterns in slightly different terms.[4] Jerome Bruner speaks of the fundamental difference between "paradigmatic" and "narrative" thinking.[5] Mark

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[3] Ibid., 2.

[4] Ibid.

[5] Jerome Bruner, *Actual Minds, Possible Worlds* (Cambridge, Mass.: Harvard University Press, 1986), 11-43.

Johnson compares "imaginative moral reasoning" to "the moral law theory."[6] Charles Taylor contrasts the "empirical" or "scientific" study of human behavior to a conception of the social sciences as "interpretive."[7] Hans-Georg Gadamer argues that truth is more clearly understood as a form of "participation" rather than an external, objective "foundation" for knowledge.[8]

Similar shifts are taking place in specific realm of health and illness, as physicians debate the relative merits of evidence-based medicine and interpretive clinical judgment, characterized by some scholars as "narrative-based medicine."[9] The traditional approach to bioethics (generally identified with the use of moral principles or, more broadly, as the application of a variety of ethical theories to specific instances of conflict) has been challenged by calls for a more interpretive framework, the most thoroughly characterized of which is likely the recently conceived notion of narrative ethics. It is within this conversation that I would like to place the theoretical grounding of the project at hand. The issue of pharmaceutical advertising falls, of course, within the realms of medicine, medical ethics, and medical humanities. Yet I believe it also represents one of the numerous ways in which our understanding of health and disease, and our relationship to the health-care system, can only be adequately understood in the context of our contemporary culture as a whole.

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6 Mark Johnson, *Moral Imagination: Implications of Cognitive Science for Ethics* (Chicago: University of Chicago Press, 1993), 1-12.

7 Charles Taylor, "Interpretation and the Sciences of Man," in *Interpretive Social Science: A Reader*, ed. Paul Rabinow and William M. Sullivan (Berkeley and Los Angeles: University of California Press, 1979), 25-71.

8 Hans-Georg Gadamer, "The Hermeneutics of Suspicion," in *Hermeneutics: Questions and Prospects,* ed. G. Shapiro and A. Sica (Amherst: University of Massachusetts Press, 1984), 55-65.

9 See Trisha Greenhalgh and Brian Hurwitz, eds. *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice* (London: BMJ Books, 1998).

My goal in this dissertation, then, is not only to undertake an interpretive, ethical evaluation of several individual drug commercials. It is also to develop and demonstrate a particular way of addressing cultural, political, and ethical issues in medicine and, theoretically, beyond. The perspective from which I will view the issue of pharmaceutical advertising is one located at the intersection of philosophy, anthropology, American studies, and literary theory, and it is one which relies, at every step, upon the depth and focus of a historical gaze. I will draw upon several traditions of scholarship, not all of which are necessarily compatible with each other at every level. I have selected these particular traditions not because they afford a privileged perspective or special claim to truth. I have selected them because I find them to be the most useful for the specific challenge at hand: the challenge of evaluating and responding to pharmaceutical advertisements. And, as my standard is a practical one, I have felt free to make use of certain concepts and techniques within a given tradition while ignoring or even rejecting others. My aim is to gather what I consider to be the best tools and most useful insights and bring them to bear on a problem, and while I may find a deep coherence and conceptual resonance within and between the traditions I draw from, I will consider it more important that the reader find these ideas productive and provocative than ultimately unified or even compatible.

The interpretive approach that I advocate draws from philosophic hermeneutics, interpretive anthropology, and ethical (literary) criticism. And, because interpretive scholarship depends heavily upon careful attention to historical context, I have attempted to place the issue of DTC advertising, as well as the intellectual traditions that I want to bring to bear upon it, in a historical framework that allows readers to understand how relevant concepts and standards developed, and how they may or may not serve us well in the context of the present. Although the second chapter, an overview of the history of

pharmaceutical advertising, serves primarily to introduce the controversy, it also helps to frame the discussion of DTC within the interpretive framework that I later develop. This framework involves a particular understanding of culture derived from interpretive anthropology, founded on the basis of philosophic hermeneutics and most accessible, I believe, through narrative studies. The conception of culture I wish to put forth is one that highlights each individual's participation in and responsibility towards our shared social reality. This active stance towards culture depends upon hermeneutic philosophy not only for its interpretive epistemological foundations but also for an appreciation of its far-reaching significance. Within the scope of this project, I turn to philosophical hermeneutics to elucidate (with a depth and precision perhaps unavailable to other traditions) the nature of modernity and its hegemony over areas of human thought and action for which it actually represents quite a poor fit. I also intend the philosophic section to address the ramifications of interpretive scholarship in general, and specifically in regards to the project at hand. In order to grasp the significance that DTC advertisements hold for our shared understanding of health and disease, we have to take seriously the strongest claim of the hermeneutic tradition: a fundamental denial of essentialist modes of thought. The careful practice of interpretive scholarship does not necessarily require us to take the leap from objectivism to a fundamentally hermeneutic worldview, but it does ask that we are at least aware of the more radical consequences of rejecting modern conceptions of knowledge and human nature. Yet while I believe we must at least peer over the ontological ledge, so to speak, I also admit the difficulty in working from that precarious position. So while I turn to hermeneutic philosophy to elucidate the implications of interpretation, and the tradition of anthropology it inspired for an understanding of our collective participation in that activity, I then turn to literary criticism for an accessible and intuitive, yet rigorous and powerful, account of the activity

of interpretation itself: the kinds of thinking that characterize it, the skills we can cultivate to do it well, and a unique perspective on the various relationships it engenders. The sum total of these traditions, brought together in this way, results in what I hope is a rich exploration of DTC advertising cast in the interdisciplinary style of American studies, and a discussion of public discourse at the intersection of contemporary capitalism, mass media, and popular culture. Much of this hinges on the connection between human beings and the words, images, and narratives we use to communicate with one another to develop and share our workable truths. I understand this connection, ultimately, to be an echo of the Renaissance humanists' insistence on the fundamentally transformative power of language, the essential connection between life and letters, the telling and receiving of good stories, and the cultivation of the moral self. It is within the tradition of Renaissance humanism, then, that I believe this project to operate, born as it is from my own training and understanding of the pedagogical ideal set forth by Petrarch and his contemporaries at the dawn of modernity itself: the notion that we become ourselves and are, quite literally, humanized through the careful reading of well chosen stories.

SECTION I: PHARMACEUTICAL ADVERTISING

Chapter 1: A Historical Perspective

INTRODUCTION

The contemporary debate surrounding pharmaceutical marketing tactics can be properly understood only in relation to the history of drug advertising in the United States, a practice that turns out to be older than the country itself. The development of modern advertising is, in fact, directly linked to medical therapies, from the early days of secret-formula remedies to the complex system of federal regulations for drug commercials on television. In this chapter I attempt to situate the debate over DTC advertising in the historical context of a culture struggling with issues of the free market and consumer protection, and to provide the background necessary to understand the current federal policy regarding pharmaceutical marketing.

I begin with a discussion of the patent-medicine craze of the eighteenth and nineteenth centuries, and although I must look to this time period to understand the fundamental link between drug makers and modern advertising, I also recognize the possible connotations of beginning an analysis of the pharmaceutical industry with a description of snake-oil salesmen peddling their wares. I therefore wish to preface this chapter with an explicit acknowledgment that the contemporary pharmaceutical industry can hardly be recognized in the image of its modest beginnings. The makers and marketers of patent medicines operated largely outside the medical system and were soundly denounced as quacks by practitioners of nearly every therapeutic tradition. The nostrums and remedies they sold were ineffective and dangerous even by the standards of

the day. Today, many of the issues facing the pharmaceutical industry stem from the opposite problems: critics charge that the relationship between medicine and industry is too intimate, and that the extraordinary influence medical therapeutics now have over the processes of aging and disease presents challenges that previous generations could never have imagined.

Yet even while Swaim's Panacea or Lydia Pinkham's Vegetable Compound could never compare in medicinal power or social value to Lipitor or Cymbalta, an important history connects these therapies, one which is directly related to the marketing techniques that lend them a cultural cache perhaps even beyond their chemical capacities. As a preface to the larger discussion of pharmaceutical advertising in the following chapters, I intend this chapter, and in particular its first section, as a reminder of what has really, always, been for sale–not a drug so much as an idea, and one that the contemporary market owes, in large part, to snake-oil salesmen and patent-medicine peddlers: a name-brand product.

PATENT MEDICINES

Advertising prescription medications to the public may seem like a recent development in health care, and television commercials for prescription drugs certainly are. Yet much of pharmaceutical marketing over the course of American history has been targeted to patients themselves. During the middle and late nineteenth century, a wide variety of "secret formula" medicines were marketed and sold, often by "snake-oil salesmen" who traveled from town to town. The makers and peddlers of these medications earned a reputation for fraud and dishonesty, "hawking their goods to a

hopeful but uninformed populace," and operated almost exclusively outside the realm of orthodox medicine.[10] Yet their negative image did not prevent them from achieving unprecedented success in marketing and sales. These early drug makers not only set the precedent for aggressive pharmaceutical advertising, but also are considered to have "pioneered promotion and marketing as no other business had to that time."[11]

The term *patent* medicine originally had nothing to do with issues of copyright and propriety, and actually served as a kind of endorsement. Medicines had been for sale to the public in England long before the American colonies were ever established, but only some received a "patent of royal favor," demonstrated by the symbol of the royal crest on their bottles. Eventually the original meaning of the name was lost, and although the nostrums and formulations were not actually patented, the term came to represent the secrecy under which they were manufactured. By protecting their ingredients as trade secrets, the makers of patent medicines were able to market their products as exclusive "secret-formula medicines," available only from a particular source and considered more powerful for their mysterious compositions. Although it represented a successful marketing technique, keeping therapeutic formulations secret defied the well-established tradition of scientific disclosure. "In every developed nation," explains Philip Hilts, "doctors and lawmakers worked together to construct a … list of medicines and their ingredients." These catalogues functioned as national pharmacologic formularies, and were maintained through a desire "to regularize medicine" by establishing "universal formulas for each known remedy." The trend toward regularization and centralization of

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[10] Edward Greg Koski, "Renegotiating the Grand Bargain: Balancing Prices, Profits, People, and Principles," in *Ethics and the Pharmaceutical Industry*, ed. Michael A. Santoro and Thomas M. Gorrie (New York: Cambridge University Press, 2005), 393-404.

[11] Philip J. Hilts, *Protecting America's Health: The FDA, Business, and One Hundred Years of Regulation* (Chapel Hill: University of North Carolina Press, 2003), 25. Subsequent references to this work are given parenthetically in the text as *PAH*, followed by the page number.

knowledge concerning effective medical therapeutics had "advanced from the seventeenth century to the nineteenth with little trouble," until the increasing popularity of patent medicines in the mid- to late 1800s began to represent a significant exception to this rule (*PAH, 24).*

The secret-formula remedies represented an exception to another well-established medical tradition, one that insisted, through centuries of ethical and professional pressure, that the therapeutic treatment of an ailing patient be undertaken with the patient's best interest in mind, or at least in strong counterbalance to the financial interests of physicians. Jerome Kassirer describes the tension between altruism and personal interest in medicine as follows:

> Medicine has always been recognized as part business, part profession, and although the credo "the patient comes first" was not always honored, it was an important ideal to which the profession aspired. Louis Brandeis captured the credo when he described a profession as follows, "it is an occupation which is pursued largely for others and not merely for one's self; … it is an occupation in which the amount of financial return is not the accepted measure of success.[12]

The nostrums and remedies sold to the public in the eighteenth and nineteenth centuries were sold, primarily, as consumer products, and while those who manufactured and marketed them may have believed them to be effective cures or treatments (although this was not necessarily always the case) they were working soundly outside of the medical tradition understood in this way. The image of the snake-oil salesman represents the essence of what medical practitioners of all stripes consider "quack medicine." While traditional or orthodox medicine itself was, of course, characterized by competitive struggles between philosophies and styles of practice during this time (and continues to

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[12] Jerome P. Kassirer, *On the Take: How Medicine's Complicity with Big Business Can Endanger Your Health* (New York: Oxford University Press, 2005), 171.

be today), a particular contempt was reserved for those who peddled remedies to the public not out of concern for public health or patient welfare but, rather, for personal profit. In truth, patent-medicine manufacturers and marketers might be more fairly considered within the tradition of capitalism than that of medicine, although the intersection of these two venerated cultural forces is what lends pharmaceutical advertising its particular tension. Given the medical worthlessness of the tinctures and ointments they sold, the revolutionary role that patent-medicine salesmen played in the development of contemporary consumerism is really quite impressive.

Patent medicines could not be differentiated from known medicines in terms of their ingredients. In fact the only chemical difference between these compounds came from the tendency of patent medicines to be heavily diluted with water, alcohol, and other substances, both benign and dangerous. If the original mineral, herb, or chemical substance actually had any medical efficacy, therefore, it was present in patent medicines in smaller amounts, and because the secrecy surrounding their formulations made it impossible to know what the substance was cut with and by how much, the patent medicines posed a significantly greater risk than known medicines. In what Fran Hawthorne terms the "free-for-all era" of pharmaceutical manufacturing, no medicinal compound, known or patent, was subject to any amount of regulation or testing.[13] Without the presence of these safeguards, "the market in medicines … was essentially the same as the only market today with no regulation–the trade in heroin, cocaine, and other drugs. The supply was unreliable, the purity suspect, the price high and variable, and the corrupted substances sometimes fatal" (*PAH* , 27). And although this was true of all pharmaceutical substances at the time, the profit motive and secrecy surrounding the

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[13] Fran Hawthorne, *Inside the FDA: The Business and Politics behind the Drugs We Take and the Food We Eat* (Hobooken, N.J.: John Wiley & Sons, 2005), 36.

production of patent medicines made consistency and safety even more of a concern. How, then, working with a product that was usually ineffective, often dangerous, and whose active ingredients were often available in other, more reliable forms (either the local physician or the local pub) did pharmaceutical manufacturers and salesmen achieve unprecedented commercial success with patent medicines? The answer lies in the realization that these factors (efficacy, safety, and consistency) all related to the actual medicines-the chemical mixtures, tinctures, ointments, and so forth. But the patent-medicine salesmen had long understood that they were not selling the substance, which generally could not stand up to its competitors. Instead, they were selling something that known medicines could never claim to be, but patent medicines had always been: they were selling a product. The real difference between known and patent substances had nothing to do with medicine. "The difference," as Hilts points out, "was one of marketing" (*PAH*, 24).

The history of pharmaceutical advertising is inextricable from the history of advertising in the United States because patent-medicine manufacturers and salesmen were the pioneers of modern marketing. While other products were certainly advertised before and alongside them, patent medicines were the first product to achieve large scale consumption based on nationwide, brand-name product advertising. That these medicines would spur the field of American marketing is no accident. Although the heyday of patent-medicine and brand-name advertising did not come until the nineteenth century, the link between this product and its marketing techniques can be seen even as far back as seventeenth-century England, where the endorsement of the Crown, in the form of the Royal Crest displayed on the bottle, gave patent medicines their very definition. These medicines traveled to the new world and eventually, like many European products, became scarce and highly desired by the colonists who often had little access to doctors

or medical care. Salesmen realized that although the original compound was scarce, the medicine itself was not the important thing when it came to public demand and consumption. The important thing was the bottles, which were collected and refilled with whatever substances were available. Because the medicines had become known by their packaging (the specific size, color, shape, and labeling of the bottle, and so forth) the ingenious colonial salesmen could capitalize on public demand without actually providing the consumer good that it called for. In other words, the demand itself was both driven and met by marketing–the deliberately constructed idea of a product–rather than the compound itself. Understanding this counterintuitive feature and its centrality to the very definition of patent medicines helps to make sense of the proprietary laws that eventually formed around them. As mentioned above, the substances themselves were never patented. What the drug manufacturers and salesmen patented was the advertising and packaging that the public came to associate with the product. That, in truth, was what was for sale, and it sold remarkably well.

Before patent medicines spearheaded the marketing of name-brand products, "tobacco was tobacco and flour was flour."[14] Only a few years later, consumers were no longer buying rolled oats or whiskey. They were buying Quaker Oats and Old Granddad. If the contents of these well-decorated containers were dumped into unmarked bins, they ceased to be as desirable. As their value came to be inextricably connected to their marketing, these goods became products, and this pivotal step in the development of the contemporary market is attributed, largely, to the makers of patent medicines. Why should it matter to loyal consumers of Lydia Pinkham's Vegetable Compound if the "grandmotherly face" on its label belonged to a woman who had been dead, as a 1905

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[14] Juliann Sivulka, *Soap, Sex, and Cigarettes: A Cultural History of American Advertising* (New York: Wadsworth, 1998), 48.

expose in *Ladies Home Journal* announced, for over two decades? (*PAH*, 46) The medicine, which was "one of the most popular alcohol-sodden remedies," was advertised according to the sympathetic stance that Lydia herself took towards women suffering from vague and unspoken-of female complaints. The extent of Lydia's caring and companionship was so great that she invited women to "write to her personally, saying that 'no man' would ever see the letter" (*PAH*, 46). The shock that the journalists' revelations caused, and the sense of betrayal associated with it, can only be understood when the product is viewed for what it really represented: not (only) a bottle of forty-proof liquor (which it was), but, more importantly, the comfort of sympathetic companionship and the validation of suffering. Lydia herself, her face and persona, was the product for sale, and customers got what they paid for up until the moment they learned of her none-too-recent death, at which point they realized they had been cheated. This kind of advertising works by creating a close association between the consumer good itself and a deliberately designed experience of a product, and its continuing influence, both economically and culturally significant, is testament to the lasting influence those who spearheaded the technique during the patent drug era.

Another key factor in the success of patent medicines concerns their relationship to the development of the mass market. Pharmaceutical sales benefited greatly from the newly developed possibility of large-scale marketing, a feature of the capitalistic landscape which emerged simultaneously with, and largely supported by, the successful advertising of patent medicines. The relationship between the pharmaceutical industry, the burgeoning field of professional advertising, and the rapidly expanding systems of newspaper and mail distribution in the mid-1800s was symbiotic to an extent that few contemporary consumers appreciate. It may be fair to say that without patent-medicine sales, the American mass market could not have developed as it did. Pharmaceutical

manufacturers needed a national market to establish themselves as the behemoth industry that they became, just as the new field of advertising needed a test case–a product whose consumer success depended not (or not entirely) on the entity itself but rather on its successful promotion. And the newly developing American newspapers needed revenue to fund their own rapidly expanding enterprise, revenue which became almost exclusively provided by pharmaceutical advertising and sales. This period of time represents a significant turning point in the evolution of the American market. "Industrialization was just coming into place," and although manufacturers and advertisers were increasingly expanding the scope of their sales strategies, "America had not yet figured out how to deal with commerce that stretched beyond the local community."[15]

During the 1800s, mass communication gradually established its place within the American market. During the early years of that century, as well as the one preceding it, patent-medicine salesmen were limited by the isolation of local markets and the illiteracy of those within them. The latter had always been bypassed by the emphasis on the visual appearance of the packaging. The shape and color of the bottle, for instance, identified a name brand to those who could not read the label. The focus on pictures and symbols, and their importance to successful patent-medicine sales, led to the practice of copyrighting a specific image associated with a product–the beginnings of the now ubiquitous trademark. Patent-medicine makers' "efforts to claim legal jurisdiction for their promotional materials were essentially new in commerce, and far in advance of those for any other product" (*PAH*, 24). Yet their success in dealing with visual images did not prevent them from branching into the world of print marketing once it became an appropriate avenue to potential consumers. Literacy rates rose dramatically in the beginning of the nineteenth century. The upper class, with their educational and

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[15] Hawthorne, 37.

occupational privileges, had previously been considered the only appropriate target for print advertising, but by the mid-1800s, public education had become a widespread and firmly entrenched institution. The general populous gained the basic skills required to read the nations' increasingly numerous newspapers and therefore become the target audience of the "patent-medicine advertising blitz [that] swamped the nation's newspapers."[16] Newspapers themselves were simultaneously entering a heyday of rapid growth and expansion. Of course, printed news had always been a part of American history and lore, from the days of Benjamin Franklin and his political pamphlets. The difference by the mid-nineteenth century was one of frequency and scope of readership: "while only a handful of papers could manage daily publication in the early days of the United States, by Lincoln's day … there were four thousand newspapers in America" (*PAH*, 25). Patent-medicine manufacturers and marketers enjoyed a symbiotic relationship with the rapidly expanding newspaper industry. The papers brought in a significant share of their revenue from the advertising space purchased by drug manufacturers, who in turn profited from the unprecedented size of an increasingly national market. By the time of the Civil War, "patent-medicine advertisements accounted for more than half the advertising lineage in many papers."[17] The war itself, through terrible circumstances, became quite an important turning point in the popularity and sales of patent medicines. As one handbook of drug advertising points out, pharmaceutical production and sales have been "repeatedly stimulated by wars," and that this trend has been visible "particularly since the Civil War."[18] In the face of widespread

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16 Ibid., 38.

17 Sivulka, 38.

18 Mickey C. Smith, "General Principles," in *Pharmaceutical Marketing: Principles, Environment, and Practice,* ed. Mickey C. Smith, E. M. Kolassa, Greg Perkins, and Bruce Siecker (New York: Pharmaceutical Products Press, 2002), 5.

disease, caused both by battlefield injury and the loss of economic and social infrastructure, orthodox medicine of the mid nineteenth century had little to offer. Doctors faced with hopeless situations and desperate suffering at hospitals for the war's wounded relied heavily on patent medicines, often generously laced with cocaine, opiates, and stronger concentrations of alcohol than those available in liquor. Wounded soldiers often became addicted to the pain-numbing properties of these concoctions, and those who survived continued their addictions long after the war was over. Thus, as the nation began the process of social and economic reconstruction, the pharmaceutical industry, along with the newspapers that remained intimately connected to it, found itself in a more profitable position than it had occupied before the conflict. Prior to the beginning of the war, newspaper revenue from patent-medicine advertising, at a national level, reached approximately $3.5 million per year. With the remedies becoming "tremendously popular" during and after the war, the sale of pharmaceutical-advertising space "soared to $75 million annually by the turn of the century and accounted for one-third of American publishers' revenues."[19] In addition to newspaper advertising, the makers of patent medicines took maximum advantage of, and actually helped to implement, changes in the postal service that would allow for direct-mailing campaigns. As the first to rely upon politically savvy businessmen, who eventually became known as "lobbyists," the pharmaceutical industry represents the first instance of a "special interest group" attempting to influence public policy to optimize its business environment. Thanks to its influence on postal legislation, mass mailing became affordable in the mid-1800s, and patent-medicine salesmen sent "pamphlets, letters, simulated newspapers, and other devices hawking cures" directly to the front doors of a consumer market that had, virtually overnight, expanded in size from one town or area to every literate American

[19] Sivulka, 38.

citizen with a mailbox (*PAH*, 25). Whereas a hundred years before, patent-medicine sales depended largely on a willing consumer happening across the route of a traveling nostrum-peddler, by the late 1800s, virtually anything could be advertised, purchased, and delivered by mail to and from anywhere in the country. Recognizing this advantage, the industry began designing its products as small capsules rather than liquid formulations and as mixtures that would withstand a long journey without fading in color or flavor. Thus, "not only were patent medicines the first to be marketed and promoted directly to the people, they managed to achieve the first nationwide markets in the young country" (*PAH*, 25).

With a seemingly limitless market, the patent-medicine industry invested increasing energies into advertising, spending more money than had ever been spent on marketing of any product before. The makers of the popular Lydia E. Pinkham's Vegetable Compound reportedly spent a million dollars in advertising in the year 1900 alone. The commercial success of patent medicines, due in large part to the industry's marketing innovations, had transformed snake-oil salesmen, traveling from town to town peddling their wares, scarcely more than beggars, into the radically wealthy and well-respected members of the newly urban society: "one critic estimated that almost fifty makers of patent medicines in New York City made fortunes over $100,000 in the last two decades of the nineteenth century. In today's dollars, that would be fifty multimillionaires living in a single city, in a single trade" (*PAH*, 26). Patent medicines not only meant huge profits for their manufacturers and salesmen, but also came to serve as the financial underpinnings of the newspaper business. At the turn of the century, the vast majority of advertising space in the nation's newspapers was bought by the makers of patent medicines who were experiencing a "spectacular growth in sales."[20] As a result,

[20] Ibid., 47.

it was not uncommon for the financial solvency of a newspaper to depend directly upon this particular market, which often amounted to "half of a newspaper's entire advertising income" (*PAH,* 23). And as the scope and importance of marketing efforts increased, a new group of professionals emerged. By and large, patent medicines were advertised and sold by the same people who made them. By the late 1800s, however, the business of advertising appeared as an activity that far exceeded the scope of those already busy with product manufacturing. In the twenty years just before the turn of the century, the amount of money spent on advertising more than doubled.[21] And as the professional activity of product promotion grew in size and strength, the relationship of advertising to product design and production began to change. While originally (and intuitively) drug manufacturers created a compound and only then began marketing it, the reverse soon began to occur. Advertisers, recognizing an available market for a product, soon took to creating the medicine to match the demand. Professional marketers found themselves central to the hugely profitable patent drug industry, and soon "admen themselves bought, sold, and created remedies" (*PAH*, 24). As the business of advertising grew, so did the audacity with which marketers felt free to claim nearly anything in order to sell a product. While patent medicines had always gained much, if not all, of their value by the claims they made, the ads broadcast to the newly national market soon became more elaborate, more all-encompassing, and more ridiculous than ever before. Just as there were no regulations applied to the manufacturing of medications, there were no legal limits as to what an advertisement could claim about it. The copy, or "puffery" of the pharmaceutical advertisements became not only a vehicle for admen to forge their reputation in the business, but also the testing ground for the industry as a whole to see how far it could push the consumer into believing the unlikely, untrue, and outlandish in

[21] Ibid.

order to sell product. Young men interested in advertising viewed patent-medicine puffery as "the most important test of ad writing," largely because it was understood within the business that these compounds had little value on their own, and yet made millions of dollars profit based upon the skill of those who marketed them (*PAH*, 26). Far from being simply deceptive or overtly false, many of these ads seemed to have little to do with any believable reality. The design and marketing of "Ripans" serves as one example among many. This particular remedy was created by George Rowell, an adman turned drug-maker. Rowell transformed a drug that had long been available for indigestion into a form that could be easily and cheaply mailed directly to consumers. These small tablets were then advertised heavily and claimed to be effective for a wide range of ailments. Rowell made successful use of a catchy slogan which might serve to describe his era's fundamental stance towards the marketing of medicines: "No matter what's the matter, one will do you good" (*PAH*, 26). Another of countless examples is Swaim's Panacea, which was advertised as a cure for "cancer, scrofula, rheumatism, gout, hepatitis and syphilis" (*PAH*, 25).

Whether the claims had any relation to the nature and effects of the drug was not only beside the point, it was impossible to determine-unlike known medications that could be manufactured and used by a wide variety of physicians, who could then make intelligent judgments about their worth, these proprietary formulas offered no proof other than word of mouth–and while they had very little to offer in the face of human illness, they did offer an alcoholic level sometimes upwards of forty proof, if not significant amounts of cocaine or heroin, which tended to garner a high level of customer satisfaction and repeat business. While the content and quality of patent medicines had always been suspect, the scope and bravado of their marketing had increased exponentially, so that the same potentially dangerous compound represented a

significantly greater threat in the late nineteenth century than it did in the early eighteenth. This outrageous style of advertising took full advantage of the lassiez-faire attitude toward business at the turn of the century. Patent-medicine manufacturers and marketers had achieved unprecedented access to potential consumers through nationwide newspapers and mailing and the simple, direct power of printed ad copy which "had virtually no limits to the claims it made to stimulate demand for often worthless merchandise."[22]

Although there were no legal limits on the claims made in advertisements, patent-medicine marketing soon became so obviously false and seemingly predatory that newspapers became increasingly hesitant to display the ads under their presumed approval or endorsement. As those in print media became less willing to "sully their pages with such lurid advertisements," they developed individual and profession-wide policies and standards regarding the ads they were willing to display. Less inclined to change their marketing strategies than to find a new way of distribution, patent-medicine marketers opted for alternative sources of advertising, painting messages on "barns, fences, and even rocks, particularly where trains passed–sites that conventional advertising had yet to utilize."[23] As difficult as it must have been for newspapers and other print media to insist on any standard for patent-medicine ads, considering the huge percentage of the media profits that depended on that ad space, their eventual disavowal of the extravagance of these ads demonstrates what had become a rather strong public distaste for the marketing strategies of various nostrums and cures. Even during the mid-1800s, during the peak of "near hysteria among competitive drug hawkers," there were those who voiced disapproval of the products and their promotion (*PAH*, 26). Yet the

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[22] Ibid., 36.

[23] Ibid., 38.

market proved to be the most important judge of business practice in the young country, so "although critics blasted the ethics of these advertisers, their extraordinary success demonstrated the possibilities" of the newly developing marketing industry.[24] Once the patent-medicine makers were firmly established as financial moguls, however, signs of resistance began to come from the most important factor in a market economy: the public. Although these medicines had long since established a place in their homes, consumers began to complain about the tiresome barrage of promotion constantly confronting them. "The ads were in any visible spot not policed by lot owners, and in many places where the proprietors were willing to allow it, for a price. Ads appeared on rocks in the country, on wagons rumbling through the streets of a city. 'There is no relief in all the earth,'" wrote one citizen as early as 1860 (*PAH*, 27). By the last years of the nineteenth century, the public and legislative tolerance for the patent-medicine makers and promoters was decreasing. The turn of the century saw the struggle between a lasseiz-faire, market-driven economy and the call for fairness and compassion in the form of regulation and social policy. As "tragedy and public outcry" led the country toward legislative action, the pharmaceutical makers became increasingly criticized for their "unacceptable marketing practices," consisting of "false claims of efficacy for untested products, many of which were devoid of benefit and actually harmful to human health."[25] The patent-medicine industry was only one instance of this debate, which was occurring on a large scale across American politics and business as a whole. Yet the history of pharmaceutical-advertising regulation, which began around the turn of the century, highlights the difficulties in deciding how much regulation is fair, what to regulate, and who should make such decisions. Examined broadly, the convoluted series of

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[24] Ibid., 36.

[25] Koski, 393.

compromises that amount to our current regulatory system represent the struggle to answer a simple question: What standards should be used to differentiate pharmaceutical advertising that many in society find troubling and inappropriate from that which society must tolerate as a necessary and, at least theoretically, helpful element of a consumer-driven economy?

FDA Regulation of Pharmaceutical Marketing

The first major piece of federal legislation concerning drug advertising came in the form of the Pure Food and Drugs Act of 1906, also known as the Wiley Act, which set up the Food and Drug Administration (FDA) as an independent government agency charged with consumer protection and pharmaceutical industry regulation. The Wiley Act addressed advertising only in so far as it prohibited the inclusion of false claims on drug labels, which referred at the time to the labels adhering to bottles and packages of pharmaceutical products, but eventually came to include the informational inserts included inside the packages. Any claim not included on the label was not covered by the legislation, and while much of the promotional material for the drug was contained on the label itself, this did leave a loophole for manufacturers to make unsubstantiated claims through other kinds of advertising media, such as print ads in newspapers or the less sophisticated technique of marketing via painted barns or rocks.

In 1914, advertising in all industries came under the oversight of the Federal Trade Commission (FTC), although this agency could only take action against inappropriate marketing if it could prove that the false claims made were actually

detrimental to the manufacturer's competitors.[26] Given this patchy network of regulation, and the increasing opportunities provided by radio, magazines, and newspapers to reach consumers in mass, drug advertising became more common, more complex, and less controllable. Progressive-era concern over consumer safety called attention to potential abuse in this arena, and Congress began discussing potential additions and corrections to the Wiley Act. The ensuing debate between public interest groups, Congress, and business interests foreshadows the current controversy over regulation of pharmaceuticals.

The first amendment proposed to the Wiley Act was drafted in 1933 and was called (in the spirit of bureaucratic clarity) Senate Resolution (S.R.) 1944. Proposed by members of the FDA and the Department of Agriculture, S.R. 1944 set out to "discourage the public advertisement for sale … of drugs for diseases in which self-medication may be especially dangerous, or patently contrary to the interests of public health."[27] The bill then went on to list over thirty such conditions, including arthrosclerosis, high blood pressure, prostate gland disorders, and sexual disorders, along with infectious diseases such as smallpox and typhoid. It stipulated that promotional statements claiming "directly or by inference to have any affect in the treatment [of those diseases] shall be deemed false."[28] Notice that the word *false* is being applied to claims simply by virtue of their being in a particular category or their claiming efficacy against particular conditions. The fact that none of the pharmaceutical manufacturers was required, at the time, to provide scientific evidence of a drug's effectiveness prior to marketing underscores the rather odd

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[26] Francis B. Palumbo and C. Daniel Mullins, "The Development of Direct-to-Consumer Prescription Drug Advertising Regulation," *Food & Drug Law Journal* 57, no. 3 (2002): 424.

[27] U.S. Congress, Senate Resolution (S.R.) 1944, 73rd Cong., 1st sess. (1933), quoted in Palumbo and Mullins, 425.

[28] Ibid.

way that *false* is used in the context of this legislation–an individual claim is not false because it has been proven wrong or unsubstantiated. *False*, in this sense, seems more like *inappropriate* than *inaccurate,* particularly given the notable exception to the rule included at the end of the section: "No advertisement shall be deemed to be false under this paragraph if it is disseminated to members of the medical and pharmacological professions or only appears in scientific periodicals."[29] Thus, S.R. 1944 makes an explicit distinction between drug advertisements directed to the public and those directed to the medical community, recognizing the important difference that medical knowledge would make in evaluating information and making sound health decisions. This distinction effectively carves out a small group of professionals as the only appropriate market for drug manufacturers, or at least for those products which claim to treat the illness mentioned. Thus, in addition to limiting the scope of pharmaceutical advertising, S.R. 1944 widened the government's regulatory powers by its particular use of the word *false*. Older legislation, such as the Wiley Act and the FTCA, prohibited false claims in a literal sort of way: the information presented in the advertisement about the therapeutic powers of the drug could not be inaccurate. In the case of the FTCA, this regulatory power applied only to those statements that were not only untrue but also injurious to another company. Yet the use of the word *false* in S.R. 1944 differs significantly. A claim is false, and thus prohibited, based not on its literal veracity, but on its content and audience. *False claims* are those which purport therapeutic effectiveness against the set list of conditions to a popular audience. If the same claim were being made to a different audience (health professionals), it would not be considered false. This language sets the standard for appropriate and responsible pharmaceutical advertising higher than simple accuracy of information. It implies that certain claims made to certain groups are

[29] Ibid.

inappropriate not because they are untrue but because the audience may lack the background knowledge to evaluate, interpret, and utilize them, even if they were completely accurate.

Given the significant increase in regulatory power that S.R. 1944 would involve, and the significant profits being generated in pharmaceutical production and promotion in the early part of the century, the reaction of the pharmaceutical industry to this increased regulation is not difficult to predict. Arguing that the bill "would compromise an individual's right to self-medication," drug manufacturers lobbied strongly against it.[30] They were joined by groups such as the National Publishers Association and the American Newspaper Publishers Association because S. 1944 would also hold publishers accountable for printing false drug advertisements in their newspapers or magazines. Given the political and economic strength of this combined opposition, S.R. 1944 was destined to undergo several significant changes before it was passed. Five years later, a highly altered version of the bill was passed as the Federal Drug and Cosmetic Act (FDCA) of 1938. If the FDCA appears weak or patchy to contemporary eyes, it makes sense within the context of the debate over S.R. 1944 and the political compromises that were necessary to mediate the concern for public safety and the economic interests of the industry. The most significant aspect of the FDCA for this discussion is that it does not mention drug advertising at all. In an effort to separate the debate over promotion from the already politically charged area of drug safety regulation, Congress granted the newly formed Food and Drug Administration jurisdiction over drug labeling alone. The changing nature of pharmaceutical promotion is evidenced by the fact that labeling now played a minor part, if any at all, in marketing efforts. Thus, the FDA had little to do with drug advertising regulation, which Congress determined to be, after all, the purview of

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[30] Palumbo and Mullins, 426.

the Federal Trade Commission (FTC). The Federal Trade Commission Act (FTCA) was amended to grant the FTC oversight of all pharmaceutical advertising and shore-up its previously hap-hazard regulatory power, although its authority still fell far short of that proposed by S.R. 1944 or granted to the FDA. Violation of the FTCA, unlike the FDCA, carried no criminal charges, and while the FDA could theoretically seize products they determined to be unsafe, the FTC could, at most, order a manufacturer to pull or amend an advertisement.

While this state of affairs served as a feasible compromise between regulation and industry, it made distinctions which, in practice, became increasingly difficult and pointless to maintain. The arenas of drug labeling, drug safety, and drug promotion became increasingly entangled as the years passed, and in 1951, when the FDCA was amended to create the distinction between prescription and over-the-counter drugs, the issues of pharmaceutical indications, labeling, promotion, and access became even more complicated. In 1954 the FDA and the FTC entered a formal "Working Agreement" to prevent duplicated and/or counterproductive efforts at regulating the pharmaceutical industry. Not quite ten years later, Congress once again amended the FDCA. With the Kefauver-Harris Drug Amendment of 1962, advertising of prescription drugs became the prevue of the FDA, while the FTC retained jurisdiction over the advertising of over the counter (OTC) drugs. This decision may seem strange when viewed from a contemporary setting where both types of drugs are advertised in relatively similar ways, and products often "cross over the counter" after extensive marketing campaigns for their prescription formulations. In the early 1960s, however, prescription drugs were only marketed to the physicians whose discretion was required for their use. The important distinction was that these drugs required medical supervision, and issues of safety, labeling, and promotion seemed more efficiently grouped together under the same agency. According to this way

of thinking, OTC aspirin, in that it did not require the permission or supervision of a doctor, was more like a household product that an average consumer could safely evaluate, purchase, and use than was penicillin, which was powerful, potentially dangerous, and should only be used by those with specialized training. Of course aspirin can be dangerous if misused–thus, the need for childproof caps and appropriate warning labels. Yet the very distinction between OTC drugs and prescription drugs indicates a dividing line below which consumers can be expected to understand the risks and benefits of a substance and above which health professionals are required to evaluate the complex clinical factors that must mediate the appropriate use of a drug. It was this fundamental difference, and the common-sense difference it would make in the promotion efforts for each type of product, that split the regulation of OTC and prescription drug advertising between the two agencies, where they remain still today.

DTC Advertising of Prescription Drugs

Today, however, the distinction between OTC and prescription drug promotion is no longer so intuitive. In 1981, Boots Pharmaceuticals ran a print advertisement for Rufen, a prescription-strength pain killer. Instead of targeting the physicians who could grant a consumer access to this drug via prescription, however, the advertisement targeted consumers directly. Although unprecedented, this marketing strategy was not altogether surprising given the context of American medicine in the late 1970s and early 1980s. As patients were increasingly encouraged and expected to take an active role in their own health care, an inquiry or even outright request for a specific treatment could be considered the prerogative of an educated, informed patient within the context of patient autonomy, a concept receiving increasing attention in medical ethics and cultural

discourse.[31] Although supporters of DTC advertising saw it as a further step toward shared decision making, others were skeptical of its educational value and worried that physicians would be pressured into therapeutic decisions they might not otherwise make. Regulatory agencies recognized that DTC ads for prescription drugs comprised an entirely different kind of marketing tool than previous ones, and that current industry standards and regulations were not adequate to evaluate their appropriateness. In 1982, the FDA called for a voluntary moratorium on DTC advertising of prescription drugs. Three years later the federal regulations for direct to consumer advertising were established, and the pharmaceutical industry once again took up what has become a major marketing tool.[32]

The decision reached by the FDA in September of 1985 was that pharmaceutical advertisements directed at the public must meet the same regulatory standards already in place for those directed at physicians. The regulations reflected the agency's position that "pre-existing regulations governing prescription drug advertising would sufficiently safeguard consumers."[33] To comply with the established FDCA requirements, a drug advertisement must contain the drug's generic name along with its brand name. It must also summarize the associated risks and benefits. The Federal Code of Regulations provides specific criteria for adhering to the more general description of appropriate advertising given by the FDCA. The regulations set forth two major standards for the

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31 For more on the movement towards patient autonomy, see Jay Katz, *The Silent World of Doctor and Patient* (Baltimore, Md.: Johns Hopkins University Press: 1984); Lonnie D. Kliever, ed., *Dax's Case: Essays in Medical Ethics and Human Meaning* (Dallas, Tex.: Southern Methodist University Press, 1989); and Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2004).

32 Food and Drug Administration, "Prescription Drug Advertising," in *Code of Federal Regulations (CFR),* Title 21: Food and Drugs, vol. 4, section 202.1, revised April 1, 2006, http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm (accessed March 21, 2007).

33 Palumbo, and Mullins, 424.

content of drug advertisements: they must include a "brief summary" of the drug's indications, side effects, warnings, and contraindications, and they must present all information in a way that achieves a "fair balance" between risks and benefits associated with the drug.[34] These two stipulations apply only to one of the three types of pharmaceutical advertisements: those that mention the product's name and indication, called "product-claim" or "indication" advertisements. "Reminder advertisements," which mention the product name without including its indication and "help-seeking" or "disease-awareness" ads that educate audiences about a health condition without making reference to a specific treatment need not include a brief summary or necessarily adhere to the fair balance requirement.[35]

Pharmaceutical manufacturers and marketers maintained that while reminder and help-seeking ads could be effectively translated into broadcast media such as radio or television slots, the brief summary requirement was too burdensome to include in a short commercial and prevented the practical use of product claim advertisements on television. As broadcast DTC advertising became more prevalent, debate over the appropriateness of the agency's regulations increased. In 1995, the FDA held public hearings on direct-to-consumer advertising, during which spokespeople from the pharmaceutical industry as well as consumer groups argued the relative risks and merits of the marketing practice. The result of these deliberations came two years later when the FDA released a draft version of a document intended to clarify its position in respect to DTC advertising, particularly those involving broadcast media such as radio and television. The FDA "Guidance," as such documents are called, does not replace the official code of regulations and technically carries no legal weight. Rather, it "represents

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[34] 21 *CFR* 202.1 (e) (1).

[35] 21 *CFR* 202.1 (e) (2).

the Agency's current thinking" and interpretation of the regulations.[36] Generally speaking, guidance documents tell the pharmaceutical industry what the FDA considers appropriate fulfillment of the regulations and, although it may not do so explicitly, offers relative assurance that it will not take action against advertisements that meet the description contained within. The final version of this document, "Guidance for Industry: Consumer-Directed Broadcast Advertisements" was released in 1999 and clarifies the ways in which this specific type of advertising is expected to meet the standards included in the regulations. Because of the limitations of their format, broadcast DTC advertisements are not required to contain the same amount of detailed information as a print advertisement would be expected to contain. Rather, they must include a "major statement" which includes "all of the products most important risk information" as well as its indications.[37] Rather than include all of the side effects, contraindications, and warning information that would fulfill the brief summary requirement, broadcast ads may instead "make adequate provision for the dissemination" of that information in some other form. They may, for example, offer a toll-free telephone number or refer the audience to a website or a print-advertisement running concurrently in a publication considered to reach the same audience as the commercial would.[38]

Critics have argued that the 1999 guidance gives pharmaceutical advertisers too much leeway in adapting the regulations to broadcast media, and that the FDA is not fulfilling its charge to protect the public from misleading pharmaceutical marketing. The same year that the agency issued its guidance on broadcast DTC advertising, it released

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[36] Office of Medical Policy, Division of Drug Marketing, Advertising and Communications, *Guidance for Industry: Consumer-Directed Broadcast Advertisements* (Washington, D.C.: U.S. Government Printing Office, 1999), 1.

[37] Ibid,. 2.

[38] Ibid., 3.

another such document addressing advertisements for drugs that had been approved on an accelerated basis.[39] This document reflects the arrangement entered into in 1999 by the FDA and the pharmaceutical industry, which has since come under public criticism: to address the problem of delayed approval of life-saving drugs, a manufacturer can help to speed up the process by underwriting some of the agency cost for its processing. While this state of affairs does allow for quicker turn around time on new drug applications, it also sets the pharmaceutical industry up as the major funding source for the agency charged with regulating it. Some, including Representative Henry A. Waxman (D-CA), have voiced concern over the FDA's failure to enforce the guidelines it sets forth for DTCA, arguing that the consequences for inappropriate promotion have never been particularly strong, and that the frequency with which the agency actually enacts those consequences has been decreasing.[40] Except in the case of accelerated drug approval, the FDA does not require ads to be submitted for review before they are released to the public. While some companies choose to submit promotional materials ahead of their distribution, the agency generally relies on a system of "routine surveillance and monitoring" of ads already running.[41] This surveillance, in addition to the efforts of concerned citizens and competing companies alerting the agency to potential abuses, constitutes the enforcement of the pharmaceutical-advertising regulations. If an ad is found to be in violation, the manufacturer is sent a Notice of Violation, or NOV, letter, which informs the company that its promotional materials have been found inappropriate. More serious violations may warrant a second kind of letter, called a warning letter,

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[39] Office of Medical Policy, Division of Drug Marketing, Advertising and Communications, *Guidance for Industry: Accelerated Approval Products–Submission of Promotional Materials* (Washington, D.C.: U.S. Government Printing Office, 1999).

[40] Henry A. Waxman, "Ensuring That Consumers Receive Appropriate Information from Drug Ads: What Is the FDA's Role?" *Health Affairs* Web Exclusive 4 (April 28, 2004): 257.

[41] Palumbo and Mullins, 429.

which basically threatens further agency action if the company does not pull or correct the advertisement.[42] The FDA has the authority to enact stronger penalties, such as seizure of the misrepresented product or imposing fines upon the manufacturer.[43] To date, however, there has never been an instance of the agency using the full force of its enforcement powers.[44]

In 2002, a Congressional study reported that the FDA's output of both NOV and warning letters had greatly declined, falling to less than 70 percent of what it had been three years before. According to the report, the "decline could not be explained by a change in the number of drug ads reviewed by the FDA (which increased) or by a drop in complaints about ad content (which remained constant.)"[45] Some in the media speculated that the apparent decrease in advertising regulation enforcement was related to the political climate at the time, in which certain drug manufacturers were challenging the extent to which marketing regulation represented an inclusion upon the free speech of advertisements in a market-driven economy. Daniel Troy, who served as the FDA's chief counsel in 2002, had previously voiced the same concerns while still in private practice. In response to the suggestion that his presence at the FDA had contributed to the drop-off in censure letters, Troy asserted that the agency was no less committed to oversight, but that "he [was] trying to ensure that every FDA action [could] stand up in court."[46] Yet perceived or actual political pressure from the industry concerning the

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[42] Ibid.

[43] Kimberly A. Kaphingst and William DeJong, "The Educational Potential of Direct-to-Consumer Prescription Drug Advertising," *Health Affairs* 23, no. 4 (July/August 2004): 144.

[44] Waxman, 257.

[45] Ibid., 256.

[46] Alice Dembner, "Bush's FDA Action on Drug Ads Declining," *Boston Globe,* October 19, 2002, national edition, sec. 1(C).

agency's authority over promotional content does not account for all of the criticisms raised in the 2002 Congressional report and a similar report released by the U.S. General Accounting Office (GAO) soon thereafter.[47] Despite this negative attention, and the resulting FDA pledges to strengthen its enforcement actions against pharmaceutical-advertising violations, Representative Waxman continues to assert that "the FDA is doing a poor job" of protecting the public from "false and misleading claims" about prescription drugs.[48] In a 2004 follow up study, Waxman found that the decline in NOV and warning letters had continued, and that "in 2003, the average delay between the placement of a false and misleading ad and an FDA action in response to that ad was 177 days–almost six months." FDA penalties for inappropriate advertisements few and far between, and often issued after consumers have been exposed to the advertisements for months. Waxman maintains that, furthermore, the penalties themselves "had little deterrent effect." Since the typical consequence for inappropriate advertising is the possible (although not certain) receipt of a warning letter ordering the cessation of an ad campaign that has already enjoyed months of the public's attention, Waxman argues that "there simply is no incentive for drug manufacturers to tell the whole truth to consumers, and there is no real penalty for them if they do not." (Waxman, 257)

Other critics have maintained that the problem lies not only with the FDA's relative lack of enforcement but also with the agency's general lenience in designing and applying the federal guidelines to DTC advertising in the first place, particularly in the case of broadcast advertisements. In 1994, 13 percent of DTC advertising took the form of television commercials. By 2001, this percentage had increased to 64 percent.[49] The

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[47] U.S. General Accounting Office (GAO), *Prescription Drugs: FDA Oversight of Direct-to-Consumer Advertising Has Limitations*, Pub. No. GAO-03-177 (Washington: GAO, 2002).

[48] Waxman, 256.

[49] Kaphingst, 143.

exponential growth of broadcast DTC advertising combined with the policies set forth in the FDA's 1999 guidance document have put the nation in a situation where the vast majority of pharmaceutical advertisements directed at consumers are the very ones which are subject to the least rigorous requirements. They are unlikely to be held to even the most lenient of regulations unless they so blatantly mislead the public as to catch the attention of a concerned citizen or a regulatory agency both overwhelmed and subject to political and economic pressure from the drug industry itself. And, even if ads are censured, their messages will likely have reached millions of consumers in the meantime.

Despite the controversy and confusion surrounding the FDA oversight of DTC pharmaceutical advertising, the general position of the agency, and thus the federal government, is relatively clear: "Rather than attempt to deter DTC advertising, the FDA appears to be concentrating on making certain the advertising is informative and well balanced, and that it adheres to the current Guidance."[50] The debate about the relative strength of the regulations and the penalties for failing to adhere to them overlook the underlying issues: should drug manufacturers be allowed to market prescription pharmaceuticals to the public rather than to their traditional market of physicians? Are the concerns about public safety voiced years ago in S. 1944 still valid? Does the "gatekeeper" effect of a prescribing physician guard potentially vulnerable patients against inappropriate and dangerous self medication? Are standards such as *informative* and *well balanced* the best way to evaluate pharmaceutical advertisements? Are there other ways in which the task could be envisioned and carried out?

In the years since the broadcast guidance was released and the extent of DTC advertising has grown, these questions have begun to occupy a more prominent place alongside issues of regulation in Congressional and public debates about pharmaceutical

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[50] Palumbo and Mullins, 431.

advertising. In 2003 the FDA held another set of public hearings on the issue and launched a major research initiative to examine the extent and empirical effects of DTC advertising. The results of this study, released in November of 2004 and commonly known as the FDA's "Final Report," join the growing stockpile of scientific data collected by various sources on the effects of this marketing strategy. Public debates surrounding DTC advertising, including the FDA's latest meeting in November of 2005, now have recourse to information that, in some cases, can provide answers to questions that years ago could only be speculated about. Yet while the research data on DTC advertising certainly aid our understanding of certain aspects of the practice, information alone cannot answer the multitude of questions raised by pharmaceutical advertising about the nature of American medicine.

Chapter 2: The DTC Controversy

INTRODUCTION

As DTC advertising of prescription drugs became increasingly prevalent following the FDA's release of the 1997 guidance document, a heated debate began among policy makers, consumer advocates, health-care practitioners, and the pharmaceutical industry itself concerning the effects and implications of this type of promotion. And while DTC advertising, particularly in the form of television commercials, has always been a polemical issue, the controversy is receiving even more attention as the newly inaugurated democratic Congress reveals its intentions to hold legislative hearings on pharmaceutical issues–the first since the Kefauver hearings of 1962. This chapter aims to provide an overview of the DTC debate (including a summary of the empirical investigations concerning the effect of pharmaceutical advertising on health-care costs and prescription writing) as well as an examination of the major conceptual framework within which the current conversation is taking place. I will argue that the particular categories and standards used to evaluate DTC advertising are neither neutral nor adequate, that they favor the pharmaceutical industry quite heavily, and that they fail to account for most powerful aspects of the advertisements themselves. In later chapters, I will call for a richer, more interpretive perspective which will complement and strengthen the terms of the current debate over DTC advertising.

THE EMPIRICAL EFFECTS OF DTC ADVERTISING

The years immediately following the relaxation of broadcast advertising guidelines saw a dramatic increase in DTC spending in the U.S., from $1.1 billion in 1997 to $4.5 billion in 2004.[51] Even against the backdrop of other pharmaceutical industry expenditures, which were rising along with health-care costs in general, this increase in spending reveals a significant shift in strategy. While money spent (by the pharmaceutical industry as a whole) to promote prescription drugs directly to the public more than doubled between 1997 and 2001, research and development costs during this same period increased only fifty-nine percent.[52] Over the last four years of the 1990s, DTC advertising expenditures more than tripled, yet the amount spent on other types of marketing changed relatively little.[53]

Critics of the industry point to these exorbitant sums as evidence that promotional activities, while increasing profit for pharmaceutical companies, drive up the price of prescription drugs and contribute to the seemingly unstoppable increase in the cost of health care. Pharmaceutical industry spokespersons insist that the cost of promotion is covered by the subsequent increase in sales volume, resulting in little or no added cost for each consumer. They also contend that the high price of prescription drugs in general is necessary to cover the costs of research and development. If Americans expect access to life-saving treatments, it is argued, they must be willing to support the cost of producing

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[51] GAO, *Prescription Drugs, 3;* Richard L. Kravitz and Jodi Halpern, "Direct-to-Consumer Drug Ads, Patient Autonomy and the Responsible Exercise of Power," *Virtual Mentor: Ethics Journal of the American Medical Association* 8, no. 6 (June 2006): 407.

[52] GAO, *Prescription Drugs*, 3.

[53] Meredith B. Rosenthal et al., "Promotion of Prescription Drugs to Consumers," *New England Journal of Medicine* 346, no. 7 (February 14, 2002): 498.

them. The figure that each new medicine released to the market costs approximately $800 million has been often repeated and nearly as often contested in recent skirmishes between the pharmaceutical industry and its critics.[54] The larger debate over industry profit versus production costs aside, precise information about the effect of DTC advertising on prescription drug costs is, in and of itself, quite controversial.

In 2003, the Kaiser Family Foundation funded a study conducted jointly by Harvard Medical School, the Harvard School of Public Health, and Massachusetts Institute of Technology to examine the role of DTC advertising in prescription drug costs. By looking at expenditures for five different classes of drugs relative to sales in 2000, the investigators correlated a one percent increase in sales with each ten percent increase in DTC promotion. By extrapolating this relationship to the drugs representing the highest sales in the U.S. that same year, the authors estimated that DTC spending increases accounted for twelve percent of prescription drug growth during that period, or about $2.6 billion.[55] Yet even if pharmaceutical companies were more forthcoming about the profit yield of DTC advertising, the relationship of money spent on drug commercials to the complex economics of health care would perhaps still not be completely clear. While prescription drug spending represents "one of the fastest growing components" of health-care spending in general, this rise is not consistent across all drugs, or even all classes of drugs.[56] Research has shown the "recent rapid spending growth for retail drugs has largely arisen from increased use of new drugs, rather than from increasing prices of old

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[54] See Marcia Angell, *The Truth about Drug Companies: How They Deceive Us and What to Do About It* (New York: Random House, 2004), and Merrill Goozner, *The $800 Million Pill: The Truth behind the Cost of New Drugs* (Berkeley and Los Angeles: University of California Press, 2004).

[55] Kaiser Family Foundation, "Impact of Direct-to-Consumer Advertising on Prescription Drug Spending," June 2003, http://www.kff.org/rxdrugs/6084-index.cfm. (accessed February 1, 2007).

[56] Kaiser Family Foundation, "Prescription Drug Trends," Fact Sheet #3057-04, November 2005, www.kff.org/insurance/upload/3057-04.pdf (accessed February 1, 2007).

drugs."[57] A significant part of this trend, as even industry critics admit, "is almost surely the result of an increase in the number of highly effective medications."[58] During the very years that the pharmaceutical industry increased its use of DTC advertising, it also enjoyed great success in terms of innovative and important products. If the 1990s became the decade of pharmaceutical promotion, they were also the decade pharmaceutical success. "It is difficult to tease apart the actual effect of advertising" from the larger trend, which is that pharmaceutical companies have became more productive, more involved in health care, and more visible to the public in the relatively recent past. [59] They have also become the subject of increasing controversy as patients and consumers have taken note of the pharmaceutical industry's astounding financial success. In a 2004 survey, sixty-nine percent of adults sampled believed that "high profits made by drug companies are a 'very important' reason behind rising health-care costs." Pharmaceutical profits were cited as the single most important factor in rising health-care costs by twenty-four percent of Americans sampled, more often than both malpractice lawsuits and "waste in the system." [60] Yet the precise step in the complex process where the industry is allegedly taking advantage of patients is difficult to pinpoint, even for the most persistent of critics. Yes, prescription drug costs are rising, but is that not a natural consequence of the increasing sophistication of therapeutic research and the resultant availability of new drugs? If pharmaceutical research and development, funded by the

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[57] Cynthia Smith, "Retail Prescription Drug Spending in the National Health Accounts," *Health Affairs* 23, no. 1 (January/February 2004): 160.

[58] Rosenthal, 498.

[59] David R. Work and Marisa Elena Domino, "The Cost of Prescription Drugs: Rising Concerns over Equity, Fairness and Access to Essential Care," *North Carolina Medical Journal* 64, no. 6 (November/December 2003): 272.

[60] Kaiser Family Foundation, "Health Poll Report Survey," October 2004, http://www.kff.org/spotlight/rxdrugs/upload/Spotlight_Feb05_RxDrugs.pdf, (accessed February 1, 2007).

cost of the currently available medications, successfully generates new and better drugs at an increasing rate, then surely doctors are right to make use of these resources. Therefore we should not be surprised or upset that "newer, more expensive brand-name drugs continue to replace older, less costly" ones.[61] If the additional cost of patented drugs generates the capital needed to continue to improve upon medications now decades old (therefore off-patent and available in cheaper generic form) this seems a fair component of the system, and is theoretically completely independent of DTC advertising.

Yet other data suggest that the increasing cost of prescription drugs in general is not spread out over the entire class of new pharmaceuticals patented and released every year, as would be expected if the increase was simply the necessary overhead required for continued research and development. Instead, the steadily increasing prescription costs seem to be the result of dramatic increases in a small subset of medications. That the twenty top-selling drugs in 2000 were all patented, brand-name drugs is not as surprising as the fact that these twenty, out of the hundreds of new, brand name medications available, generated nearly one third of all prescription drug sales that year.[62] This pattern of increasing cost, while not directly accountable to promotional efforts, closely matches the pattern of investment in DTC advertising. "Unlike promotion to professionals, which is used for nearly all name-brand drugs, spending on direct-to-consumer advertising is concentrated on a few products."[63] Of the total amount that the industry spent on DTC advertising in 2000, the top twenty most advertised drugs together made up roughly two

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[61] Kaiser Family Foundation, "Understanding the Effects of Direct-to-Consumer Prescription Drug Advertising", Publication Number 3197, November 2001, http://www.kff.org/rxdrugs/3197-index.cfm (accessed February 1, 2007).

[62] Ibid.

[63] Rosenthal, 501.

thirds.[64] While it is worth noting, as pharmaceutical spokespeople often do, that this does not establish a cause and effect relationship, the similarities in the pattern of increased prescription drug cost and the pattern of DTC advertising suggests to many that a significant part of the increasing cost comes not from research or overhead, but rather from increased consumer demand. A few authors have attempted to follow the money through the complex system of drug manufacturers, insurance companies, and provider networks. The most precise of these estimates, from the Kaiser Family Foundation study mentioned earlier, estimates an industry profit of $4.20 for every DTC advertising dollar spent. Yet the only accurate account of the economic effect of DTC prescription drug advertising is likely known only to the industry itself.[65] Therefore, when pharmaceutical spokespeople continue to insist that "no clear evidence exists to support a link between direct-to-consumer (DTC) advertising … and drug price increases," it is difficult to prove them wrong.[66]

Lack of clear-cut evidence, however, does not stop skeptics from asserting the common-sense truth of their argument. "Though nonproprietary data [on the profitability of DTC advertising] are sparse," industry critics point out, it would make no sense for pharmaceutical companies to "make investments of this magnitude [a total expenditure of twenty billion dollars since 1997] without achieving consistently good returns."[67] Even if, as the pharmaceutical industry maintains, "advertising costs are often recovered through increased sales volume, not higher prices," this translates to more patients on advertised drugs, which means more patients on newer, brand-name drugs. The concern

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[64] Ibid.

[65] Kaiser Family Foundation, *Prescription Drug Spending*.

[66] Lloyd G. Millstein, "Prescription Drug Advertising: Is It a Driving Force on Drug Pricing?" *North Carolina Medical Journal* 64, no. 6 (November/December 2003): 289.

[67] Kravitz and Halpern, 407.

then becomes that many of the patients whose health status represents the industry's "increased sales volume" might be just as well treated, or perhaps even more appropriately treated, with older and/or generic drugs. The claim that DTC advertising inflates health-care spending because it "diverts patients" from equivalent, less expensive treatment is complicated by the difficulty in determining whether two treatments are actually equivalent. This is done on a large scale with randomized controlled trials. Yet things become blurrier when the task is not to show statistical significance over a population but to decide, as a practitioner, if an individual patient would do just as well or better on drug A or drug B. Such decisions become even more difficult to negotiate given that the patient's own beliefs about the therapeutic alternatives in question have likely been shaped, as have the doctor's, by drug company marketing efforts. Particularly in situations where several drugs demonstrate relatively equivalent efficacy (such as nasal allergies), or in situations where the majority of patients would probably do just fine on an older drug when a newer and vastly more expensive wonder drug appears (such as frequent heartburn), pharmaceutical marketing can have a significant impact on treatment decisions. This may be especially true if physicians feel pressure from patients requesting a medication they learned of through an ad, claim DTC critics.[68] Proponents, on the other hand, insist that the physician, as the "learned intermediary" or "gatekeeper," is equipped

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[68] Jonathan Marks, "The Price of Seduction: Direct-to-Consumer Advertising of Prescription Drugs in the U.S.," *North Carolina Medical Journal* 64, no. 6 (November/December 2003): 292; Jerome R. Hoffman and Michael Wilkes, "Direct to Consumer Advertising of Prescription Drugs: An Idea Whose Time Should Not Come," *British Medical Journal* 318 (May 15, 1999): 1301; Knight Steel, "The Time to Act Is Now," *Archives of Internal Medicine* 164 (August 9/23, 2004): 1604; Sidney M. Wolfe, "Direct-to-Consumer Advertising–Education or Emotion Promotion?" *New England Journal of Medicine* 346, no. 7 (February 14, 2002): 525-26.

with all the information and training needed to ensure that prescriptions are only written in a medically and financially appropriate way.[69]

Several studies have attempted to determine the effect of DTC promotion upon prescribing practices, examining the behavior and attitudes of both physicians and patients alike. Perhaps the most consistent finding within this body of work is "a nearly universal awareness of DTC advertising," with studies reporting that anywhere from eighty-one to ninety-nine percent of Americans have encountered such an advertisement, usually in the form of a television commercial.[70] Surveys attempting to describe the extent to which Americans request and receive prescription drugs as a result of DTC advertising report more varied data. As many as twenty-three percent of adults reported having "talked to a doctor about a specific prescription medication as the result of an advertisement" in a 2005 Kaiser Family Foundation survey.[71] FDA research indicates that one third of respondents "generated a question for their doctor" as a result of seeing a prescription drug advertisement. Direct requests for specific medications have been reported by 7.2% (compared to 3.3% of those living in an area without legal DTC advertising) 12%, and 13.3% of patients surveyed in smaller studies.[72] Patients who

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69 Jeffrey M. Drazen, "The Consumer and the Learned Intermediary in Health Care," *New England Journal of Medicine* 346, no. 7 (February 14, 2002), 523-24; Alan F. Holmer "Direct to Consumer Advertising-Strengthening Our Health Care System," *New England Journal of Medicine* 346, no. 7 (February 14, 2002), 526-27; Marks. 292.

70 Andrew R. Robinson et al., "Direct-to-Consumer Pharmaceutical Advertising: Physician and Public Opinion and Potential Effects on the Physician-Patient Relationship," *Archives of Internal Medicine* 164 (February 23, 2004): 427; Kathryn J. Aiken, John L. Swasy, and Amie C. Braman, *Patient and Physician Attitudes and Behaviors Associated with DTC Promotion of Prescription Drugs–Summary of FDA Survey Research Results* (Washington, D.C.: U.S. Department of Health and Human Services, Food and Drug Administration, Center for Drug Evaluation and Research, November 19, 2004).

71 Kaiser Family Foundation, *Health Poll Report*.

72 Barbara Mintzes et al., "How Does Direct-to-Consumer Advertising (DTCA) Affect Prescribing? A Survey in Primary Care Environments with and without Legal DTCA," *Canadian Medical Association Journal* 169, no. 5 (September 2, 2003), 405; Barbara Mintzes et al., "Influence of Direct to Consumer Pharmaceutical Advertising and Patient's Request on Prescribing Decisions: Two Site Cross Sectional Survey" *British Medical Journal* 324 (February 2, 2002): 278; Robinson, 427.

reported seeking care or initiating discussion with their physician about a previously untreated condition comprised 14% of one survey population and 10.5% of another.[73] These numbers tend to be far lower than the percentage of physicians who, when surveyed, believe patients will request and expect a prescription for the advertised medication. Some studies note a significant variation between primary care physicians, who tend to perceive more pressure to prescribe, and clinical specialists, who report feeling such pressure less often.[74] The percentage of patients who say they received the medication they requested also varies, from as low as three or four percent to more than half, depending upon the study.[75]

Recognizing that the significant variation in these numbers may result from recall bias in self-reported surveys, several investigators attempted to devise experimental settings to more accurately correlate DTC advertising with prescribing practices. Two studies utilized surveys but altered the approach slightly by asking physicians about a discrete number of patient encounters in the recent past in which a specific prescription request was motivated by an advertisement. Both investigations revealed that, in a significant amount of encounters, physicians write prescriptions for the requested medications when they feel another drug may be equally appropriate or even when they believe the requested medication is actually inappropriate for the patient. Weissman et al., found that in thirty-two percent of visits where patients requested medications as a result of DTC advertising, the physician complied and wrote the requested prescription. Forty-six percent of these prescriptions were believed to be "the most effective drug,"

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[73] Elizabeth Murray et al., "Direct-to-Consumer Advertising: Public Perceptions of Its Effects on Health Behaviors, Health Care, and the Doctor-Patient Relationship," *Journal of the American Board of Family Medicine* 17, no. 1 (January/February 2004): 6; Robinson, 427.

[74] Aiken et al., 4; Robinson, 427.

[75] Mintzes et al., "Influence of Direct-to-Consumer Pharmaceutical Advertising," 278; Aiken et al., 4.

but, forty-eight percent of the time, the physicians believed that "others were equally effective."[76] These data seem to lend credence to concerns that DTC promotion diverts prescribing patterns towards advertised (thus newer and more expensive) drugs when most patients may do just as well on a less expensive alternative. More troubling, however, are the findings of Murray et al, that although physicians characterized forty-nine percent of patient requests which stemmed from DTC advertising "inappropriate," they wrote the prescriptions anyway, despite their belief that it was the wrong medical decision, in sixty-nine percent of these cases.[77] These data call the idea of the learned intermediary or gatekeeper into serious question, since patient requests can apparently influence prescription decisions to an extent that often outweighs the physician's own misgivings.

Which is to say nothing of the instances where physicians misjudge the appropriateness of a prescription under the pressure of patient expectation, a phenomena highlighted by a creative study by Kravitz et al., in 2005. Using standardized patients trained to present as patients with either major depressive disorder (MDD) (for which prescription antidepressants are medically indicated) or adjustment disorder (for which they are not), the authors designed a randomized controlled trial to measure the effect of a patient requesting antidepressants from family practitioners. Their results lead them to assert that such requests have a "profound effect on physician prescribing," both in instances when a prescription is appropriate and when it is not. This was true whether or not the standardized patients requested a specific brand of medication. Of the patients

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[76] Joel S. Weissman et al., "Physicians Report on Patient Encounters Involving Direct-to-Consumer Advertising," *Health Affairs* Web Exclusive 4 (April 28, 2004): 219.

[77] Elizabeth Murray et al., "Direct-to-Consumer Advertising: Physicians' Views on Its Effects on Quality of Care and the Doctor-Patient Relationship," *Journal of the American Board of Family Practice* 16, no. 6 (November/December 2003): 513.

presenting with MMD, fifteen percent made no request and received an antidepressant. Two percent of these prescriptions were for Paxil, a drug heavily advertised to the patient population at the time of the survey. An equal number of patients presented with the same symptoms (those of MMD) and requested a prescription for antidepressants in general. Thirty-eight percent received prescriptions, one percent of which were for Paxil. A third group of patients presenting with MMD requested Paxil specifically, and twenty-seven percent received prescriptions, fourteen percent of which were for the requested drug. The group of patients presenting with symptoms of adjustment disorder, for which antidepressant treatment is not appropriate, were less likely than the MDD group to receive prescriptions if they made no request or made a general request for a prescription. However, when they requested a specific brand, they were as likely as the MMD group to receive a prescription (twenty-seven percent), and actually more likely to receive a prescription for Paxil itself (eighteen percent).[78]

Pharmaceutical manufacturers can rightly argue that physicians must take responsibility for inappropriate prescription practices when they are aware of them, and that doctors ought to possess the expertise to recognize when a medication is and is not indicated, regardless of patient requests. As for advertising leading to increased prescribing of the advertised drug, who would deny that this is precisely the result that manufacturers and marketers hope for? Is this not the point of product promotion? If a physician believes a patient request to be appropriate, or even reasonably so, why should patent preference not influence the decision as to which medication among many should be chosen? While critics of DTC advertising are usually the ones highlighting its effect, proponents view the same information and see evidence of its success. Why should

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[78] Richard Kravitz et al., "Influence of Patients' Request for Direct-to-Consumer Advertised Antidepressants," *Journal of the American Medical Association* 293, no. 16 (April 27, 2005): 1995.

pharmaceutical companies be blamed for marketing techniques that result in increased sales and higher profit? They are, after all, accountable to their stockholders. While some argue that the standards of the market are inappropriately applied to issues in health care, industry proponents counter that the values of a free market benefit consumers, in health care as well as any other field. As part and parcel of a healthy market, advertising fosters competition and enables consumers to take their proper place as informed decision makers in the marketplace. The effect of DTC advertising, according to this line of thinking, "is therefore consistent with a larger pattern in which marketing has been found to improve markets and increase consumer welfare."[79]

Yet the argument that DTC promotion fosters competition and/or adheres to the standards of a free market, while embraced wholeheartedly by some, is not the most common argument put forth in defense of the practice. Rather than demand they be judged by the standards of free enterprise alone, most pharmaceutical spokespeople instead argue that DTC advertising fits well within, and actually engenders, the best ethical standards of medicine.

THE SOCIAL IMPLICATIONS OF DTC ADVERTISING

The empirical evidence gathered about DTC advertising, some of which was summarized in the previous section, has given policy makers, regulators, industry leaders, health-care professionals, and the public various pieces of important information concerning the scope, costs, and consequences of this promotional strategy. Yet measurable, factual information can only go so far in answering the questions society has

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[79] John E. Calfee, "What Do We Know about Direct-to-Consumer Advertising of Prescription Drugs?" *Health Affairs* Web Exclusive 3 (February 26, 2003): 118.

raised about DTC promotion, and even in instances where data can help, they are often interpreted differently by the various parties. Several years of research, discussion and debate have generated several arguments for and against DTC marketing of prescription drugs, and specifically the category of television commercials. Although these issues and arguments have appeared in numerous forms, I believe it is safe to conceptualize the basic policy dilemma as one which revolves around two broad areas or themes: the implications of DTC advertising for the individual clinical encounter between patient and physician, and the implications for the broader arena of public health.

The pharmaceutical industry has strongly argued, in political as well as medical arenas, that DTC advertising strengthens the doctor-patient relationship. "The purpose of this advertising," according to Alan Holmer, a spokesperson for The Pharmaceutical Research and Manufacturers of America (PhRMA), "is to encourage patients to talk to their physicians about their medical conditions and treatment options."[80] Of course no one would believe the primary purpose of any kind of advertising was anything other than sales, but in the case of prescription pharmaceuticals where the doctor is a necessary intermediate between the consumer and product, encouraging people to seek help from their doctors works simultaneously in the interests of the patient's health and the pharmaceutical company's bottom line, or so goes the argument. Commercials can inform patients of a new medication, sending them to their doctor to try an alternative therapy for their condition. But not only does it inform patients of available therapies, pharmaceutical marketing actually informs them of available conditions. This idea has been espoused by critics of the industry, whose objections to "selling sickness" I will

[80] Holmer, 527.

return to in a later section.[81] Yet although PhRMA has rebutted these claims, or at least the critic's interpretation of them, the industry often points out the valuable role that DTC marketing can play in reaching those who recognize the symptoms described on television having never before realized that they may suffer from a (treatable) illness. Supporters of DTC advertising rely on the empirical data showing the number of physician visits prompted by advertisements and resulting in new diagnosis to argue that television commercials do more for people's health than inform them of available therapy. They facilitate not only the treatment but also the diagnosis of serious medical conditions.

Education, then, has been the most common justification of DTC advertising, and a mainstay of pharmaceutical response to the controversy. According to this line of thinking, marketing drugs to consumers not only encourages people to visit their doctor and discuss their health, it also equips them with the information to participate more fully in health-care decision making. Pharmaceutical makers and marketers speak of DTC advertising as part of the larger trend towards patient autonomy and shared decision making in health care, an argument that works well to justify targeting consumers directly rather than only advertising to physicians. In fact, from this perspective, the older practice of marketing only to the medical profession begins to seem embarrassingly supportive of the now defunct paternalistic style of medicine which did not allow for patient access to information except through the sieve of a physician who made decisions for and about them. The recent sea change from the paternalism that once pervaded the practice of American medicine to the now virtually universal championing of patient empowerment and autonomy has been considered the great success of medical ethics in the last quarter

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[81] See Ray Moynihan and Alan Cassels, *Selling Sickness: How the World's Biggest Pharmaceutical Companies Are Turning Us All into Patients* (New York: Nation Books, 2005).

century. Some in bioethics and the medical humanities, however, have begun to notice the extent to which the values adopted by our new, reformed system have come to be applied uncritically and, ironically, with a seemingly unquestionable authority. The quip about patient autonomy as a "trump card" in any bioethics case applies equally well to policy debates. Having brilliantly (which is not to say inappropriately) couched DTC marketing in terms of patient education and empowerment, the pharmaceutical industry has effectively forced anyone opposed to these marketing tactics into the greatly unpopular position of appearing not only to limit patients' access to information but, more broadly, to deny their rightful place as an partner in the doctor-patient relationship.

Yet some, like philosopher Joseph Farrell, have argued that a healthy doctor-patient relationship can never eliminate all elements of medical paternalism, nor should it.

> Certainly, patient-consumers should be encouraged to involve themselves in their treatment to the extent that they feel confident and comfortable doing so. However, it is also important to remember that we seek out physicians for their expertise and guidance, and that this relationship is, to an extent, paternalistic.[82]

Lay people, by definition, lack the necessary training to interpret and treat the symptoms they experience, which is what leads them to the doctor in the first place. Keeping this fundamental difference between physician and patient in mind makes the argument for patient autonomy no less important, but perhaps more complex, especially in regard to DTC advertising. If one of the primary sources of authority held by physicians is the "power to prescribe," reserved only for those with a medical license, then the issues of pharmaceutical advertising are more precisely centered around the balance of authority in

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[82] Joseph M. Farrell, "The Ethical Implications of Direct-to-Consumer Pharmaceutical Advertising," *Philosophy & Public Policy Quarterly* 23, no. 3 (Summer 2003): 23.

therapeutic decision making. This is, of course, related to the ethical stance of patient autonomy, but represents a specific instance of it that requires careful attention. The point, according to Farrell, is not whether patients should play an active role in their health care. The point, rather, is to think about what that active role might actually involve, specifically in relationship to prescription therapies.

Some have argued that the trouble with DTC advertising is not that it provides patients information with which to have a more productive discussion with their physicians, but that it necessarily encourages, and depends upon, a certain degree of self-diagnosis and creates expectations that the physician may not, or should not, completely meet. These critics maintain that characterizing these commercials as educational paints an idealized image which does not necessarily reflect the real-world effects of DTC marketing. The advertisements themselves often picture an informed patient receiving consumer-friendly yet scientifically accurate information from some non-medical source (such as a friend or a website) that prompts an intellectual, emotionally neutral conversation with their physician. In reality, however, the information is presented to appeal to the patient's emotional as well as cognitive aspects, and the high degree of motivation that the profit motive requires creates not simply an informed patient, but rather a patient who is already significantly invested, intellectually and emotionally, in the idea–or perhaps more accurately, the promise or hope–that this therapy will change their lives for the better. It is this hope and emotional investment that they bring to the doctor's office, not neutral information about available therapies, and it is the force of their hope and expectations that makes the conversation quite difficult for a doctor who must now go farther than correcting false or inappropriate ideas, but rather disavow her patient of the notion that help exists in the form of this particular treatment. While some might argue, and rightly so, that this is difficult task is part of a doctor's job, the

empirical data on the pressure perceived by physicians to prescribe an advertised drug when they feel it is unnecessary or even inappropriate demonstrates the difficulty involved in such a task. The job of a physician undoubtedly requires a willingness to negotiate these difficulties, and to do it well. However, in light of these data and a more realistic understanding of the "discussions" that take place between an "informed patient" and her physician, the argument that these advertisements ease communication and improve relations between doctor and patient seem overly simplistic and quite a bit less compelling.

The difference between the civil discussions described by the defenders of DTC advertising and the frustrating, emotionally charged office visits described by those who oppose it reflects the contradictory conceptions of drug commercials as patient education and/or product promotion. Pharmaceutical marketers don't deny that the commercials are produced and distributed in order to advertise prescription drugs. However, they cite education as an important secondary purpose and benefit. Critics point out the fundamental difference between the two purposes attributed to these commercials, and argue that promotion masquerading as education can be misleading at best and irresponsible at worst. As Jonathan Marks puts it, "the principle purpose of product advertising is not to educate but to seduce."[83] Prescription drug commercials must present their product in favorable terms in order to persuade patients that they need or want the drug. Yet the inherent selectivity of information required for them to be effective marketing tools prohibits them from functioning as reliable sources of patient education. On the other hand, no educational source, physicians included, can ever offer a completely unbiased description of therapeutic options, because even if the information is presented in as balanced a fashion as possible, there must still be a selection of

[83] Marks, 292.

information judged important enough to include, a choice of which details to leave out, and so forth. The relaxed FDA regulations allow television commercials to exclude some of the possible side effects or risks of the medication, but physicians often omit the same information when educating patients about a prescription drug. Sometimes the omissions are due to time constraints, and sometimes they are made deliberately by physicians who don't believe them to be important or appropriate for patients to know. The difference, however, between the selectivity of information in DTC ads and the selectivity of information in discussions with physicians, however, is one of motive and purpose, and it is the underlying profit motive of the pharmaceutical industry that many find at odds with the underlying motives of health education–improved health and well-being. As Farrell insists, "advertisement selectivity serves not the patient, but the corporate sponsor." The difference in promotional selectivity and educational selectivity is that "when a physician selects among all the information she has in educating her patient, she does so with the patient's best interest in mind."[84]

Yet another important issue underlies the alleged separation between the pharmaceutical companies, operating according to the standards of the free market and therefore appropriately engaged in product promotion, and physicians, operating according to the ethical standards of their profession and therefore appropriately utilizing their medical knowledge to advocate for the patient's best interest. This simple characterization, so often invoked by the pharmaceutical industry, fails to account for the industry's effects on medical education and practice guidelines. The line between product promotion and medical education is even more difficult to determine in regards to the marketing materials and strategies aimed at physicians rather than patients themselves. An adequate account of the relationship between pharmaceutical companies and the

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[84] Farrell, 23.

medical profession is far beyond the scope of this project.[85] Let it suffice to point out, for now, that the industry's characterization of promotional materials as educational, and the characterization of medical professionals as educated, scientific, and therefore allegedly immune to advertising or inappropriate influence, solidifies not only the industry's relationship with the medical system, but also provides additional support for the characterization of DTC promotion as, essentially, educational in nature. The effect of pharmaceutical promotion therefore finds its way into the clinical encounter not only through the patient but the physician as well.

Although the physician-patient relationship is considered the ethical center of the medical system, critics of DTC advertising worry that the most profoundly negative effects of this type of marketing may stretch beyond the individual clinical encounter to the larger arena of health policy and public health. What begins in an exam room as a conflict between patient expectations and physician judgment, and may lead, in the long run, to a health-care system which not only fails to distribute limited resources fairly but also endangers the health of the population as a whole. While much of the argument concerning the effects of DTC advertising on the doctor-patient relationship has centered around the concept of patients' rights, Richard Kravitz and Jodi Halpern point out that "lost in the debate is whether, along with rights, patients have any duties as health-care consumers."[86] By convincing countless patients that they want, need, and deserve a particular drug, pharmaceutical marketers fulfill their purpose of generating profit for the industry but at a great social cost to those who eventually feel the pinch of health-care funds which might have been more appropriately spent elsewhere. Because of the

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[85] See Howard Brody, *Hooked: Ethics, the Medial Profession, and the Pharmaceutical Industry* (New York: Rowman & Littlefield, 2006).

[86] Kravitz and Halpern, 407.

complexity of the health-care system and the often unknown or unappreciated financial trade-offs made by physicians and patients who generally don't know what drugs cost and (if they are lucky) don't pay full price anyway, focusing the DTC advertising debate on an individual clinical encounter misses the significant economic impact of that such decisions may have on other doctors and other patients down the line. Even if prescription drug commercials present medical information, and even if patients have a right to this information, it doesn't necessarily follow that patients have a right to receive an expensive medication simply because they know of it. "Patients shouldn't demand inappropriate medical treatment," argue Kravitz and Halpern, and when they do it "devalues medical care and also wastes resources that are needed for other patients."[87] Even if physicians do their best to prescribe only necessary and appropriate medications, nationwide campaigns to convince patients to request new, expensive medications hardly facilitates the difficult task of controlling the cost of health care. By framing the debate over DTC advertising within the context of the individual clinical encounter, the pharmaceutical industry successfully distracts policy makers and the public from the larger economic effects of such marketing. "The little-noticed victim of clinically unwarranted prescribing," industry critics point out, "is the patient who could have benefited from an effective treatment but cannot gain access to it because society's resources have been exhausted."[88]

In addition to the economic effects of DTC advertising, critics call attention to the individual and public health risks created by the inappropriate use of prescription pharmaceuticals. As the empirical data demonstrate, DTC marketing can lead to medication use that even the prescribing doctors have some qualms about. While the

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[87] Ibid.

[88] Ibid., 409.

percentage of doctors willing to write a prescription against their clinical judgment is small (and rightly considered a failure of nerve or professional responsibility), the data show that a greater number of doctors can be persuaded to prescribe a requested medication if they feel it won't do the patient any harm. These physicians are more difficult to fault for their efforts to negotiate and compromise with patients who may demand their right to try a particular medication if they so choose. The line between appropriate and inappropriate prescribing may be finer than many outside of clinical medicine would think, especially since a physician may not be able to predict if a medication will benefit an individual patient. One could argue that the placebo effect alone may induce positive health outcomes for a patient who believes so strongly in a medication that he has gone to the trouble to come to his doctor and ask for it. When the drug requested is not contraindicated, obviously inappropriate, or significantly risky, who is a doctor to tell an informed patient that she can't have access to a medication because it probably won't help? Much of clinical medicine is based on what is probable, according to the clinician's best guess, and given the inherent uncertainty involved in any therapeutic decision, it is difficult enough for a doctor to responsibly withhold medication that may be dangerous, excessively costly to third parties, and will more than likely not result in any significant clinical improvement. Appropriate prescribing, then, is not the easy, black and white task that many in the DTC advertising debate take it for. Yet from the point of view of the industry, no prescription, "no matter how expensive or inefficacious, is inappropriate if it increases profits."[89] As prescription medication use becomes increasingly more common, many individuals will no doubt experience health benefits from the therapeutic regimens they have begun to take. But consider the public health effects on the population as a whole. Certainly effective disease treatment is a

[89] Hoffman and Wilkes, 1302.

primary goal of public health. But as the use of powerful prescription medication in situations of questionable clinical efficacy increases, so, too, do the risks associated with the use of any medication. Even if a particular side effect or reaction is relatively rare, all it takes is for a large enough group of patients to begin taking the drug for some of those reactions to occur. Encouraging the use of prescription medications on a large scale is certainly the goal of pharmaceutical marketing, but it is not necessarily in the public health interests of a population. The characterization of DTC advertising as patient education forces society to understand it as an unqualified good–something we couldn't possibly have too much of. But serious doubts exist as to whether the advertisements are, or could ever hope to be, truly educational. Even the argument that this promotion-cum-education encourages people to seek medical attention for conditions that would otherwise go undiagnosed must be considered in light of the potentially negative effects of increased medication use over the population as a whole. Certainly, increased health-seeking behavior and access to effective therapies serves the public health. But these issues, especially in regard to pharmaceutical advertising, represent only one side of a complex situation, and when DTC advertising is debated as if it were patient education rather than product promotion, the other side of the situation becomes more difficult to recognize.

THE INFORMATION PARADIGM

The preceding sections have addressed, albeit briefly, the major issues in the mainstream debate over DTC advertising. The terms of this controversy, whether parlayed in medical journals and professional meetings or FDA hearings, have been

relatively constant on both sides of the argument. The issues addressed have been those of promotion versus education, appropriate versus inappropriate use of therapy, responsible or irresponsible distribution of resources, etc. The standards used to evaluate the television advertisements themselves center on the accuracy of the information presented as well the balance between the risks and benefits mentioned. The terms of this debate–the categories and standards within it-reveal a conceptual framework which orients our perspective in favor of the pharmaceutical industry before any conversation takes place at all. The majority of those discussing and arguing about DTC advertisements speak of them in terms of information: what kind of information do they provide? How accurate is it? How educational is it? How much of the information regards risks and how much regards benefits? The federal regulations themselves use this paradigm to consider the appropriateness of the individual advertisements under review. The notices of violation and warning letters consist of an analysis of the information presented in the ad: is it misleading? Is it consistent with the drug label and scientific studies that label is based on?

A brief look at two FDA warning letters sent to drug companies in response to television commercials demonstrates the nature and limitations of the terms currently used to evaluate these advertisements. Each letter includes a summary of the information on indication, risks, and benefits taken from the originally approved drug application that all labeling and promotion is supposedly based on. It then describes the commercial (both of them dramatic counter-examples to the industry's characterization of DTC advertisements as sober and educational) and offers a specific explanation of why the advertisements "misbrand [the drug] in violation of the Federal Food, Drug and Cosmetic

Act."[90] The first example is a warning letter sent to Pfizer in 2004 regarding a thirty-second television ad for Viagra. The letter includes the following description of the commercial:

> "Remember that guy who used to be called 'Wild Thing?' (Man watching wife examine high-heeled shoe in store)
>
> "The guy who wanted to spend the entire honeymoon indoors?" (Man looking at high-heeled shoe in store)
>
> "Remember the one who couldn't resist a little mischief?" (Man gazing at black bra, panties, and negligee in store window)
>
> "Yeah, that guy." (Blue "horns" sprout from behind man's head) (Trumpet blasts)
>
> "He's back." ("He's back" written across man's forehead) (Man moves and the horns become the "V" in Viagra)
>
> "Viagra. Not all medications are for everyone" (Man opening door to lingerie shop)
>
> "Ask your doctor if Viagra is right for you." (Man taking wife's hand and leading her into shop)[91]

The warning letter states that these ads "make representations about sexual activity," and refers specifically to the characterization of the man's previous identity as "wild thing" to conclude that the ads "make clear that Viagra is intended for sex."[92] The letter does not discuss the distinction between sexual activity in the context of erectile dysfunction and sexual activity in general, nor does it address the specific ways in which this ad

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[90] Christine Hemler Smith, Consumer Promotion Analyst, Regulatory Review Officer, Division of Drug Marketing, Advertising, and Communications, letter to Robert B. Clark, Vice President, U.S. Regulatory Division, Pfizer Inc. November 10, 2004, "RE: NDA # 20-895 Viagra (sildenafil citrate) Tablets MACMIS ID # 12726." http://www.fda.gov/cder/warn/warn2004.htm (accessed February 1, 2007).

[91] Ibid., 2.

[92] Ibid.

encourages its audience to think about sexual activity (using images such as demonic horns, nicknames like "wild thing" and euphemisms like "mischief") or gender relationships (watching one's wife shopping for shoes versus leading her into a lingerie store, focusing on images such as the high heel on a woman's shoe and a negligee) or even aging and masculinity ("Remember…? … He's back…") What the warning letter says, instead, is that the ads in this campaign "claim that Viagra will provide a return to a previous level of sexual desire and activity" because "they refer to the sexually active past of the man." It continues by saying that the "FDA is not aware of substantial evidence … demonstrating this benefit" in relation to the drug, and that it therefore constitutes a false or misleading claim. The letter concludes by addressing Pfizer directly: "If you have data substantiating this claim, please submit them to the FDA for review."[93]

The second letter refers to a 2005 commercial for Strattera, a prescription drug approved for the treatment of attention deficit/hyperactivity disorder (ADHD). Here again, the letter begins by explaining that "the TV ad is false or misleading because it fails to "adequately communicate" the indication and risk information the drug. [94] Yet the agency goes a bit farther in this example to elaborate its concerns:

> This ad is concerning from a public health perspective because by failing to adequately communicate the … indication for Strattera, it potentially broadens the use of the drug beyond the indicated patient population, while also minimizing the serious risks associated with the drug.[95]

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[93] Ibid., 3.

[94] Joan Hankin, Consumer Promotion Analyst, Regulatory Review Officers, Division of Drug Marketing, Advertising, and Communications, Federal Drug Administration, letter to Stacy Holdsworth, Manager, U.S. Regulatory Affairs, Eli Lilly and Company, June 14, 2005, "RE: NDA 21-411 Strattera (atomoxetine HCL) MACMIS ID#: 13282." http://www.fda.gov/cder/warn/warn2005.htm (accessed February 1, 2007).

[95] Ibid., 1.

The commercial, as described in the letter, "presents a person in a variety of situations as seen through the screen of a videogame." Switching back and forth from the perspective of someone watching the game from the outside and that of the character operating within it, the ad involves several typical daily activities at home and at the office. Superimposed on these images, a box appears over part of the screen that flashes, in capital letters, words like "DISORGANIZED" and "DISTRACTED." While the character engages in various activities such as leaving the house only to return for his car keys or sitting down in front of a computer, another "box with the words 'SCORE' (including a running tally of numbers) and 'LEVEL 1' is shown in the … corner of the screen" and the text within it "scrolls and flashes," all the while accompanied by "eerie sound effects."[96]

The detailed description of the commercial, along with the added commentary about the potential effects on public health in the first paragraph of the letter, reveal the extent to which the FDA reviewers found this commercial significantly troubling. Yet the specific reason given for determining the ad to be inappropriate (according to the standards of misleading or false) reads as follows, and without any hint of irony:

> All of this [the text, graphics, voice-over narration and sound effects] distracts from the viewer's ability to process the visual information related to the product's indication … All of these competing graphics distract from and overcome the important contextual information to such an extent that the presentation interferes with the viewer's ability to process the information in the ad relating to the indication.[97]

If we take the FDA reviewers at their word, then, the problem with this ad is that it presents information in a way that deliberately distracts those with ADHD from concentrating on the important factual elements communicated, not that it portrays the

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[96] Ibid., 3-4.

[97] Ibid., 4.

life of those with attention-deficit disorder as a video game that they are constantly losing. Whether the metaphor of a video game is an appropriate or helpful way to conceive of ADHD could be explored and debated. The larger point in relationship to the FDA regulation of pharmaceutical advertising, however, is that the regulatory language, like that of the debate as a whole, limits the available standards with which to evaluate these commercials to the relatively narrow categories of false or misleading. And as the FDA warning letters themselves demonstrate, the potentially inappropriate elements of advertisements extend far beyond the factual information which the language of regulation and of the debate in general was designed to address.

Evaluating the information presented is certainly an appropriate standard for advertising regulation. But it is hardly the only appropriate standard and, when it dominates the discussion to the point that the commercials themselves are treated as individual units of information (which is how the patient-education argument treats them), then it becomes easy to lose sight of other important standards. As long as advertisements for prescription drugs are evaluated in these terms, which inherently consider them to be bits of information provided to consumers, then the debate is limited to a particular set of categories by which to judge them and their place in American medicine. Information can be evaluated in terms of truth or falsehood, balance or imbalance, consistency, etc, which is precisely how DTC advertisements are discussed, be it in FDA warning letters or medical journals. Debating the issue of DTC advertising in this way, according to these standards and categories, grants the pharmaceutical industry their most vital (and, I would argue, most unconvincing) argument: that television commercials for prescription drugs represent a particular media for the transfer of health information. Once this is established, either by explicit agreement or by uncritical acceptance of linguistic and conceptual assumptions, then all that remains is to

quibble over the details–which "facts" to include and how much time to lend to each. This, unfortunately, is much of what the DTC advertising controversy is currently about.

Understanding advertisements as information limits our ability to evaluate their content and reflect upon their implications for health care. It allows us to determine when the particular facts presented are inaccurate or out of context, perhaps chosen in a way that creates an imbalanced impression of the drug's safety and efficacy. These are all important things to consider. The problem with this framework is that it limits the evaluation to these issues and discourages us from questioning the basic assumption that what we're dealing with is, actually, information. Even if the facts of a specific commercial are determined to be false, its content is being granted the status of information–of facts to be evaluated. Under this rubric, ads can be false or misleading. But they can hardly be inappropriate; how could anyone consider it inappropriate to communicate medical information to the public? Additionally, the information paradigm allows only certain aspects of the ads to be evaluated, and in fact these aspects are perhaps the least powerful in terms of the impact and effect of the commercials. Federal regulators go to great lengths to explain exactly what part of the ad they consider inaccurate or imbalanced and why, but because they operate as if they are judging information, their focus is limited. Often the most powerful elements of a commercial are not the information provided in text or voiceover, but the visual images, cinematographic staging, and musical backdrop that affect viewers on an emotional and personal level, instilling hope and faith rather than conveying information. These elements are impossible to evaluate according to the terms currently used to debate DTC advertising. While images are also recognized to convey information, their evaluation is, to a certain extent, more subjective, admitting only to terms like *misleading* rather than *inaccurate*, and therefore only the most outrageous of visual images are attended to.

Judgments regarding information, whether they are phrased in terms of accuracy or balance, ultimately rest on the binary categories of true and false. If an ad is characterized as imbalanced, it is not the individual statements themselves but the overall statement made about the drug or disease that is determined untrue. If a fact is misleading, then it is presented out of context or in such a way to encourage a false conclusion without explicitly expressing one. In fact the term *misleading*, so culturally and historically associated with the field of advertising, belays a nagging dissatisfaction with the linguistic categories available to evaluate promotional efforts. When we are troubled by an ad, we want to be able to call it *false* advertising–not because we are only troubled by advertisements which lie outright, but because no other meaningful, authoritative category exists. Our language (and, as we shall see in the next chapter, the philosophical framework it reflects) establishes truth and falsehood as the available standards for judgment, although advertising is perhaps a good example of where we struggle to fit our experience into these binary categories. One option is to redefine *false*, in regards to advertising, so as to take the context of the information as well as its technical accuracy into account, as did S. R. 1944 when it stipulated that *false claims* were only those made to the public about particular conditions. Another is to use a term like *misleading* which lends us a bit more interpretive give while ultimately remaining grounded in the objective determination of truth or falsehood. *Misleading* is both a conceptually interesting and, given its intimate association with advertising regulation, particularly relevant term for this discussion. An ad which is *misleading* seems to invite us to become mistaken about something, to encourage the wrong idea. Yet we can't put our finger on exactly what, if anything, we have been directly deceived about. Unfortunately, however, the convenience of this term represents a shortcut, a reprieve from the task of struggling to reflect upon and articulate exactly what an ad leads us to or

away from, and how so, and why that should concern us. Considered from the perspective of an interpretive framework, which I will describe and advocate in later chapters, all advertisements–all forms of communication–lead us somewhere. To say that something is misleading implies that it has led us astray, off the path, farther from where we're going. It implicitly assumes that we've already agreed upon where we want to be. It is this level of questioning that the terms of the DTC advertising debate, reinforced by the industry they favor, prevent the rest of us from reaching.

ALTERNATIVE VIEWPOINTS

The majority of the debate regarding DTC promotion, and virtually all of the regulatory and legislative language concerning this issue, continues to be framed according to the categories and standards described above. Recently, however, scholars from a variety of fields, including the social sciences, bioethics, and medical humanities, have begun to look at pharmaceutical advertising from alternative perspectives, many of which offer a more contextualized approach to a complex social issue.

Perhaps the most recently publicized and polarizing conception of pharmaceutical marketing is the argument, mentioned briefly above, that what drug commercials advertise is not actually medicine but the conditions that call for it. "Once upon a time," quips Marcia Angell, former editor of the *New England Journal of Medicine* and outspoken critic of the pharmaceutical industry, "drug companies promoted drugs to treat diseases. Now it is often the opposite. They promote diseases to fit their drugs."[98] The idea that pharmaceutical companies are "selling sickness" rather than therapies has

[98] Angell, 86.

recently taken hold and is now often incorporated into the long-standing sociological concept of medicalization–the transformation of what were previously considered normal experiences or processes into symptoms or disease states. Sociologists rightly point out that a wide range of factors within American culture contributes to this trend, but many argue that the pharmaceutical industry, and, according to some critics, the medical establishment as a whole, plays a major role in the process of medicalization, and does so deliberately and for financial motives. Jörg Blech, a German writer and one of the more extreme critics of the industry, contends that "pharmaceutical companies and medical associations are inventing diseases–illness is becoming an industrial product."[99] And coming from a country that, like every other industrial nation except the United States and New Zealand, prohibits DTC advertising for prescription drugs, Blech sees the industry utilizing other means (disease awareness campaigns, marketing strategies to physicians, and political power within government and the medical profession itself) to shape the public's views about disease in ways which encourage the consumption of prescription medication. "The fabrication and marketing of diseases," he states unapologetically, "has become a global trend."[100] American critics recognize the same strategies working alongside the overt marketing campaigns allowed in this country. Many disease awareness organizations and support groups are funded primarily by drug companies with a financial stake in just how many Americans become "aware" of the condition in question. Additionally, through sales representatives bestowing gifts upon physicians and financial sponsorship of continuing medical education courses, the pharmaceutical industry maintains an intimate connection with the medical profession

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[99] Jörg Blech, *Inventing Disease and Pushing Pills: Pharmaceutical Companies and the Medicalisation of Normal Life,* trans. Gisela Wallor Hajjar (New York: Routledge, 2003), ix.

[100] Ibid., x.

which allows it, according to many critics, far too much influence over decisions about how diseases are defined, diagnosed, and treated. Recently more attention has been paid to links between medicine and industry that involve more significant, and more blatant, conflicts of interest, such as the practice of journal article ghostwriting, where pharmaceutical companies produce articles evaluating their own product, not surprisingly in a generally positive light, and then pay doctors to sign their name as author. The articles are often published in well-known journals that provide clinicians with scientific, (supposedly) objective data about the relative safety and effectiveness of various treatment options. Other objections have been raised to the relationship of the pharmaceutical industry and members of expert panels who produce guidelines that become the standard of care for thousands of physicians who trust and follow their advice. Even those who hesitate at the accusation that the pharmaceutical industry's primary product is illness rather than its treatment see these activities as evidence that, at least to some extent, our ideas about disease are being influenced by those who profit from its diagnosis.

> Marketing executives don't sit down and actually write the rules for how to diagnose illness, but they increasingly underwrite those who do. The industry now routinely sponsors key medical meetings where disease definitions are debated and updated. In some instances … the medical experts writing the rules are at the same time taking money from the drug makers who stand to make billions, depending on how those rules are written.[101]

The various roles which the pharmaceutical industry plays in medicine and society that allow it opportunity to affect ideas about disease are vast, and while a complete account of the industry's influence on definitions of illness would be a fascinating (and, I would argue, greatly needed) study, it is beyond the scope of this

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[101] Moynihan and Cassels, xiii.

project. Although it makes up only one part of a much more complex system of influence, DTC advertising provides an example of what kind of power the industry can yield by targeting patients directly rather than reaching patients through physicians or disease awareness groups. In this way, television commercials for prescription drugs can perhaps be considered the most direct and transparent view of a given disease state and its treatment according to the sponsoring company. For these reasons, as well as its relatively recent proliferation and high visibility, scholars examining medicalization and the pharmaceutical industry's effect on disease conceptions often pay particular attention to DTC advertising. Because television commercials have long been an accepted form of product advertisement within American capitalism, and because they seem to represent, in and of themselves, the consumer-driven nature of modern life and mass communication, the suggestion that they are being used to sell an idea (an explanation of disease, rather than the product they claim to be selling) seems an especially startling and powerful form of deception. People are relatively used to the idea of selling an idea (although they might not phrase it that way) in the context of political campaigns or efforts to raise awareness of some social cause. In many of these cases, the presence of deception is taken for granted. But even the most skeptical American might balk at the idea that ideas about health and disease are being deliberately shaped through the mass media for a profit motive. Yet that is precisely what pharmaceutical industry critics are asserting, and they point to broadcast advertisements as a key factor in that effort. As Ray Moynihans summarizes the issue rather directly: "increasingly … these commercials are not just selling drugs, but also the diseases that go with them."[102]

Particular attention has been paid to these allegations in light of the often flamboyant tone of the early DTC commercials. Perhaps the most obvious and wide-

[102] Ibid., 101.

reaching transformation of our conceptions of disease took place somewhere between Bob Doyle bravely and soberly speaking to us about a condition that no one talked about (and certainly not on TV) to images of athletes in the prime of their careers hitting home runs while a voiceover narrator spoke frankly about erectile dysfunction. Commercials for drugs like Viagra, Rogaine, and, often, psychiatric medication, drew criticism from those who saw them as blatant attempts to convince the public that any form of unpleasantness or hardship can (and should) be considered the purview of the medical field and be treated by medication. "Lifestyle drugs," marketed for conditions that struck many as dubious-either rare diseases dusted off and popularized to provide a niche for a new treatment, or overt fabrications of the pharmaceutical industry working either with or despite the medical system. Many of the more egregious examples never gained much momentum in the states, although some appeared, at least briefly, on the radar of doctors and epidemiologists in Europe and Australia. "Leisure sickness," the inability to enjoy time away from work, was apparently quite common and often most severe in tropical resort settings, where it sometimes degenerated into the more fulminate "paradise depression." While erectile dysfunction and perhaps hair loss may have overlapped to a certain degree in the U.S., German men apparently fell victim to these as well as a constellation of other degenerative processes known collectively as "Ageing Male Syndrome."[103] More locally and more recently, critics have voiced concern over conditions such as social anxiety disorder, restless leg syndrome, and pre-menstrual dysphoric disorder, all of which are recognized by the medical profession, although, some would contend, largely through the influence of the pharmaceutical industry.

Not only, maintain critics, are drug companies taking advantage of the increasing medicalization of American culture, they are propagating it for their own advantage. No

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[103] Blech, 2.

one would question that "it is part of human nature to strive for good health." The trouble, according to Jörg Blech, is that "the disease mongers nourish this desire, calculate it so that it meets their own purpose and exploit it deliberately."[104] Pharmaceutical advertisers offer the public an available treatment, and also, therefore, an available explanation of various symptoms that fits the model of the disease that the drug is intended to treat. For many diseases, prescription treatment has long been accepted as the appropriate and normal medical response. Others, however, have only relatively recently become conditions that call for prescription drugs, taken often for long periods of time, and often in the absence of immediate, obvious illness. Critics of the industry have listed the way in which pharmaceutical manufacturers and marketers "sell" various medical conditions–in other words, the way they attempt to convince the public that their experiences or health status call for a visit to the doctor and a prescription request. The methodology for inventing disease includes, according to critics, selling normal experiences or life processes as problems requiring medical attention (e.g. hair loss, menopause), selling personal and social problems as illnesses (e.g. social anxiety disorder), selling a risk factor for future illness as a disease itself (e.g. high blood pressure, high cholesterol), and selling the recurrence of common symptoms as chronic pathology (diarrhea becomes irritable bowel syndrome, heartburn becomes erosive esophagitis). While the more extreme critics of the pharmaceutical and medical system would question the existence of these diseases in any patient, most critics take a more sophisticated view. Although they would not fault the industry for treating those whose symptoms truly cause them great suffering (and there are certainly those who do suffer, tremendously, from conditions such as irritable bowel syndrome), they would nonetheless look askance on the industry's attempt to widen their market by convincing more and

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[104] Ibid., ix.

more people that they are victims of a disease. Millions of Americans have frequent heartburn, and fifteen years ago they would not have been considered sick. Perhaps reshaping our ideas about occasional heartburn is an innocuous trade off for the medication we now have to relieve it. Any sociologist or anthropologist will readily admit that cultural ideas about health, disease, and specific illness change over time and in response to cultural and technological changes. Yet a growing number of physicians and scholars find themselves uneasy with what they recognize as the deliberate shaping, or at times, creation, of definitions of disease for profit. A business journal offering investment advice perhaps provides the most cynical, yet ironically positive, summary of these concerns.

> Pharmaceutical companies are searching for new disorders, based on extensive analysis of unexploited market opportunities (whether recognized today or promoted as such tomorrow). The coming years will bear greater witness to the corporate sponsored creation of disease.[105]

Arguments about the medicalization of culture and the creation of disease often degenerate into arguments about whether a given condition is "real" or invented. Pharmaceutical companies are able in most cases to answer this challenge by producing a patient who suffers from it or looking to physicians for validation. This, of course, begs the question of whether the industry's influence on the medical profession is strong enough to create the very institutional and professional opinions it relies upon to answer charges of fabrication. Bob Erlich, a pharmaceutical executive and editor of an e-newsletter for marketers who specialize in DTC advertising, summarizes the official

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105 J. Coe, "The Lifestyle Drugs Outlook to 2008, Unlocking New Value in Well-Being," *Datamonitor*, *Rueters Business Insight* (2003): 12, quoted in Moynihan and Cassels, 179.

industry position on the charges that they are fabricating and selling diseases rather than therapies:

> Social anxiety, restless leg syndrome, erectile dysfunction … are recognized medical conditions, and while they may be viewed skeptically by those who do not have them, they cause mental anguish and physical discomfort to those that do have them. All drug companies do is take hard to understand conditions and make them consumer centric.[106]

The concept of selling sickness provides an alternative paradigm for thinking about, discussing, and evaluating DTC advertising. Over and above the informational paradigm, this viewpoint more clearly links television commercials for prescription drugs with the larger pharmaceutical marketing campaigns targeting both physicians and patients, and it calls into question the relationship of big PhARMA to the medical profession. In these ways, it offers us a framework for understanding DTC marketing which is broader in scope and deeper in context than most of the current debate allows for. Yet although it successfully places the ads in context of cultural ideas about disease and the forces that influence them, as well as in the context of the ever-more complicated relationship between medicine and industry, it is less able to place the ads in the context of individual and social meanings other than conceptions of health and disease. Additionally, it provides a less than satisfying ground from which to evaluate not only what these ads are doing but whether they ought to be doing it. Other than the justifiable and obvious, but perhaps not fully examined, concerns about the deliberate and deceptive shaping of culture for profit, this paradigm has little to say about the selling of sickness, and more specifically, the resulting change in our ideas about illness, in evaluative ethical terms.

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106 Bob Ehrlich, "DTC Critics and Naiveté 101," *DTC in Perspective: eNewsletter for DTC Executives*, no. 230 (September 8, 2006), dtc_in_perspective@rxinsight.com (accessed September 8, 2006).

Other writers have reflected the concerns about the creation or shaping of disease but taken the analysis a step further by exploring the actual meanings that we have attached, perhaps prompted by PhARMA, to specific drugs and disease states. Jonathan Metzl traces the way in which mass media representations of psychiatric medications (specifically Prozac) reflect and propagate the norms and categories of Freudian psychoanalysis, a therapeutic practice generally believed to have been eclipsed by the rise psychopharmacology. As Metzl convincingly argues, images of family relationships and gender roles in pharmaceutical ads reinforce older analytic concepts by using them to place the new medication into an established cultural and medical context, and implicitly offer their product as a quick and easy route to a vision of the good life that is heavily laden with Freudian norms about what that might be.[107]

Peter Kramer also explores the meanings attached to Prozac and its cultural function in the national bestseller, *Listening to Prozac*.[108] Examining questions about psychopharmacologic treatment and personal authenticity, Kramer attempts not only to understand the image and function that the pharmaceutical industry used to sell a blockbuster drug, but also the way in which those meanings were then taken up and shaped by cultural forces no longer in the hands of those who originally made and marketed the product. Focusing on American conceptions of the self, he asks questions such as: what do we believe Prozac can do for us or change in us, and why is that a desirable change? Does the celebrated effectiveness of the drug speak to its medical power in the face of pathology or to its potential use, and perhaps its actual function, as an almost recreational drug used to turn the self into a better self?

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[107] Jonathan Metzl, *Prozac on the Couch: Prescribing Gender in the Era of Wonder Drugs* (Durham, N.C.: Duke University Press, 2003).

[108] Peter D. Kramer, *Listening to Prozac* (New York: Penguin Books, 1993).

Caught by Kramer's description of patients who described feeling "more like themselves" on Prozac, Carl Elliott took up the notions of self-transformation and authenticity to better understand our cultural conception of medical treatment and technology as a whole.[109] Although he focuses specifically on "enhancement therapies" (such as cosmetic surgery or even accent-reduction clinics), Elliott's primary contention could easily be extended to more mainstream medical therapeutics, and specifically the way that some have been presented to the public through television commercials. Be it breast enlargement, acid reduction, or mood enhancement, "what is being sold … is old-fashioned, American-style self-improvement."[110] Examining the nature of the American self, the split between the self that is presented to others and the self that is hidden, inner, and true, Elliott ties self-enhancement or improvement to social status, relationships, and most importantly, the concept of identity and the moral implications of altering it with medical therapeutics. As he explains, the moral implications of our ideas about health and illness are more easily accessible when we consider the effects of therapeutic alteration of the self:

> Identity is better than enhancement for thinking about these technologies, because our ambivalence about so many enhancement technologies is often ambivalence about the kinds of people we want to be … If we have mixed feelings about accent-reduction clinics, cosmetic surgery, or Prozac, this is partly because we have mixed feelings about the visions of the good life these technologies serve.[111]

I agree, and would argue that although they may not immediately strike us as troubling in the way that cosmetic surgery might, pharmacologic therapies also alter us in significant

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[109] Carl Elliot, *Better Than Well: American Medicine Meets the American Dream* (New York: W. W. Norton, 2003).

[110] Ibid., 13.

[111] Ibid., 27.

ways and, more importantly to my particular interest, the advertisements for these medications contain strong messages about how we ought to be sick, how we ought to get better, and how we ought to respond to the things we most fear: illness, aging, and the inevitability of death. A happily voluptuous woman on a billboard advertising breast enhancement has something rather obvious to say about the good life. A middle aged man jogging through a commercial for his anti-hypertension medicine does the same thing, although perhaps more successfully because we're not prompted to consider him in an ethical context.

Elliott's framework of identity can contribute greatly to the DTC advertising debate, particularly in a culture as grounded in the concept of the autonomous self as is ours. Not only does it allow us to explore these advertisements in terms of important cultural categories not immediately or already related to health and disease, it also opens up the possibility of considering the content of the ads as morally significant, and therefore lays the groundwork for being able to evaluate them based on a standard much richer and, I believe, reflective of our intuitive hesitation about DTC marketing, than the informational paradigm. Yet for all its power, a framework based on identity has certain limitations which I believe prevent it from adequately dealing with the moral content Elliott recognizes imbedded in therapeutics and their promotion. While identity, authenticity, and the self are undoubtedly central concepts within American culture, they represent only a fraction of the individual and social meanings that interact to form our complex society. I agree that identity plays a unique role in that it seems to operate within the overarching message of the pharmaceutical industry and is therefore involved, to a great extent, in the connections that drug commercials make to our lives, there is no limit to the deeply-held beliefs and cultural stances that a specific advertisement might tap into.

I propose yet another alternative paradigm for thinking about DTC advertising, one that allows for the inclusion of the unique insights of each of the paradigms discussed in this chapter. Yet unlike the informational paradigm, it provides a rich context and the epistemological flexibility to take seriously the categories of truth and falsity while simultaneously challenging the assumptions upon which that dichotomy is based. Unlike the paradigm of selling sickness, it reaches into a theoretically infinite pool of individual and shared meanings rather than trying to separate disease conceptions into the still-binary divisions of real and fake. Unlike the identity paradigm, it recognizes the centrality of the self without necessarily limiting its ethical analysis to this one concept. It also allows for, and in fact depends upon, an evaluation of the moral content of these advertisements, and insists upon this type of analysis as a central issue in the debate. The alternative paradigm I will propose acknowledges and invites us to take the morality of these commercials seriously–to pay attention to the moral content of the advertisements individually and use the insights gained there to guide our discussion about the ethical implications of the larger marketing strategy. It is both instantly accessible to people with vastly different backgrounds and fortified by a long-standing tradition of rigorous scholarship. And because it allows us to think and speak differently about television commercials for prescription drugs, and to ask different questions of them, it acts to balance the immense power of the pharmaceutical industry with an increasingly active role for those of us–scholars, health-care professionals, and patients both current and future-affected by it.

SECTION II: THEORETICAL FRAMEWORK

Chapter 3: Reading Culture

INTRODUCTION

In the previous chapters I attempted to provide a brief history of DTC pharmaceutical advertising as well as an overview of the contemporary debate surrounding it. I have argued that the conceptual framework within which we currently discuss and debate DTC advertising is inadequate to deal with important elements of the issue and unfairly skews the argument in favor of the pharmaceutical industry. In this chapter and the next, I will examine the nature of our current conceptual framework in greater detail, identify the specific way in which it fails to provide a complete understanding of the issues, and explore an alternative approach to DTC promotion.

This chapter draws upon the work of scholars in various fields who have come to be associated with a conceptual shift known as the *interpretive turn*. I will first examine the philosophical grounding of the interpretive worldview which they have adapted to their various disciplines. Then, I will turn to interpretive anthropology for an understanding of culture based upon the metaphor of the text, as well as take a brief look at the relationship between this tradition and the field of visual studies. Having explored the philosophical foundations of interpretive scholarship, and extended this foundation to the understanding of action and images as well as text, I hope to demonstrate, by the end of this chapter, both the necessity and the possibility of an interpretive approach to DTC advertising. Then, in the next chapter, I will move from a broad, philosophic account of interpretive understanding to a specific interpretive tradition, that of the ethical criticism

of literature, which I believe provides the most useful framework for the critical interpretation of both the ads themselves and the marketing practice as a whole.

Before I turn to these issues, however, I want to make a few comments about my discussion of the interpretive turn, and specifically the overarching set of beliefs about human knowledge and human nature that interpretive thinkers understand themselves to have turned away from. Richard Bernstein undertakes an extensive survey of various academic traditions in his work, *Beyond Objectivism and Relativism*. From seemingly disparate intellectual debates in disciplines from physics to literary studies, Bernstein identifies a particular pattern of skepticism surrounding predominant notions of truth, rationality, certainty, and liberty–concepts which underlie many cultural as well as scholarly traditions and which are generally associated with the intellectual legacy of the European Enlightenment. During the last quarter of the twentieth-century, thinkers in various fields have begun to explore and challenge these predominant conceptions of knowledge and human nature, and in particular the privileged status afforded to the natural sciences, whose critical, exacting methodology not only arose out of the Enlightenment but perhaps best represents the intellectual aspirations of that period. This fact coupled with the astounding success of the scientific method in the past few centuries, evidenced by everything from antibiotics and water sanitation to airline travel and email, has cast the natural sciences as an exemplar-not only for scholarship but human reasoning in general. The *interpretive turn* is a phrase used to capture and characterize, on a broad scale, the increasing dissatisfaction with this paradigm, generally referred to as *modern*, and the diverse, yet thematically unified responses to it.

For the remainder of this dissertation, I will use the terms *modern* and *modernity* in the sense that they are most often used by thinkers associated with the interpretive turn: not to mean recent or contemporary, but to refer to the predominant intellectual and

cultural Western worldview, associated with Enlightenment thought and its continuing effects. In the following section I rely upon the work of Charles Taylor, who provides, in my opinion, the most accessible account of the development and implications of modern thought, if not the most precise or nuanced account of that complex tradition. Taylor's definition of modernity captures the way in which interpretive scholars generally use the term, and the way in which I intend to use it throughout this dissertation:

> The main stream of radical Enlightenment thought … developed through the seventeenth and eighteenth centuries in England and France. By this I mean the line of thought which begins with the epistemological revolution which was part inspirer, part beneficiary of the seventeenth-century scientific revolution. It develops through such diverse thinkers as Bacon, Hobbes, Descartes, and Locke; and authenticated by the science of Galileo and Newton, it entrenches its hold in the eighteenth century not only as a theory of knowledge, but as a theory of man and society as well.[112]

The diverse scholars engaged in examining and challenging this legacy include not only those scientists, philosophers, and historians trained in and through the traditions of Enlightenment Europe, but also thinkers from a variety of fields who recognize predominant patterns of thought and characterize them from the specific perspective of their own background. Many write for a wide, interdisciplinary audience, and many are writing about broad, overarching patterns of in cultural and intellectual life. I consider myself in the same authorial situation, and therefore face similar authorial challenges. It will be necessary to summarize huge and complex traditions in only a few short pages, and in focusing on the issues most pertinent to this project, many important issues will go unmentioned. It is beyond the scope of this project to provide a detailed account of modern philosophy, and like the philosophers, anthropologists, and literary critics I draw from, my goal will be to identify the major themes and characteristics of this tradition. I

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[112] Charles Taylor, *Hegel* (New York: Cambridge University Press, 1999), 4.

will not, for example, attempt to address the important divisions and tensions within the modern period, such as divergent philosophical ideas (rationalism, empiricism, etc) or regional and historical variation in the development of the Enlightenment. However, I recognize the potential for confusion when interpretive scholars use terms like *objectivist* or *essentialist* to characterize modernity in general, whereas philosophers within the modern tradition use these terms in a different, and more specialized, sense. In order to avoid this problem, and also to introduce the interpretive critique of modernity, I turn to Richard Bernstein's discussion of Kantian philosophy. I include the following quote not to call special attention to any one modern thinker, but to highlight Bernstein's use of *objectivist*, and the overarching level at which he recognizes this pattern of thinking across traditional boundaries within the modern tradition:

> By "objectivism," I mean the basic conviction that there is or must be some permanent, ahistorical matrix or framework to which we can ultimately appeal in determining the nature of rationality, knowledge, truth, reality, goodness, or rightness… "Objectivism" has frequently been used to designate metaphysical realism – the claim that there is a world of objective reality that exists independently of use and that has a determinate nature or essence that we can know… This dominant form of objectivism is only one variety of the species… From my perspective, Kant is no less an objectivist and foundationalist than the empiricists and the rationalists he was criticizing… [He] identifies the transcendental turn with the "proper way" of philosophy … All those who share this commitment – all those who think that only by taking the transcendental turn and who claim that there is an a priori universal and necessary structure of human knowledge – share the objectivist bias.[113]

A detailed account of the similarities and differences between these philosophical factions is, again, beyond the scope of this project and tangential, at best, to the specific issue of DTC advertising. Bernstein's recognition of "the objectivist bias," however, is

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[113] Bernstein, 8-9.

important for my specific goals in this chapter: to offer a broad characterization of the modern tradition and its influence on current standards for public discourse.

In addition to the challenge of providing an adequate account of the modern tradition, I will also face the challenge of advocating an alternative framework without discounting the important contributions of the modern paradigm currently in place. My goal in this project is to outline an interpretive approach to pharmaceutical commercials, but I intend this way of thinking as a complement to, and not a replacement of, our current ways of thinking and talking about DTC advertising. I emphasize this because much of interpretive scholarship has developed as a reaction against (and has therefore had to define itself in opposition to) modern thinking, especially the tenets of modernity that are embodied within scientific methodology. Yet while clear differences exist between the interpretive and scientific paradigms, this does not mean that both ways of thinking cannot be simultaneously brought to bear on pharmaceutical advertising, or any other issue for that matter. It is important to remain cognizant of the tendency for the natural sciences to be "schematically imagined… not [as a] a living institution… with a vast amount of internal diversity and an open future, but [as] a stereotype and scarecrow."[114] While I recognize, and struggle with, the difficulty of clearly articulating an alternative paradigm while not oversimplifying the predominant framework currently in place, I do believe that the reactionary tone of some interpretive scholarship can lead to an "artificial and unnecessary estrangement" of scholars who would do well to work together.[115] In arguing for an interpretive analysis of these ads, I mean in no way to dismiss the importance of ensuring that the factual statements they make are accurate and

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114 Clifford Geertz, *Available Light: Anthropological Reflections on Philosophical Topics* (Princeton, N.J.: Princeton University Press, 2000), 144.

115 Ibid., 156.

balanced when read in the light of scientific and medical evidence. I am not suggesting that categories like *true* and *false*, or *fair* and *misleading*, are unnecessary. Alone, however, they are not sufficient for the critical evaluation of prescription drug commercials.

FORM AND CONTENT

The fundamental inadequacy with the information paradigm regarding DTC advertising, I would argue, relates to the issue of meaning. Much, and in certain cases I would say all, of the power of advertisements stems from their personal, cultural, and even political significance: the meaning conveyed by the sum total of the imagery, narration, musical background, and even cinematography. Conceiving of pharmaceutical commercials primarily as information fails to account for the total experience of viewing them–an experience which is partially cognitive but, often, is also highly emotional, broadly cultural, and deeply personal. Certainly, information is conveyed within these ads. Yet the information cannot be satisfactorily separated from the way in which it is presented, because the total meaning of the commercial is born from the combination of the two.

Martha Nussbaum, philosopher and literary theorist, argues against the traditional distinction between form and content. As I will discuss in the next chapter, particular traditions of literary criticism were greatly influenced (along with nearly every other academic discipline) by the standards of objective inquiry set forth by the Enlightenment. Although much of literary scholarship attends to the connections between the message or subject of a work and its style or structure, and although a close relationship between the two is considered a reflection of authorial skill, the two elements are generally

understood as separate, or at least separable. This way of thinking about works of literature reflects a particular understanding human communication in general, one which is closely related to the modern legacy. The content of a work or statement is conceived of as a piece of information (or an opinion) that is either obscured or made clear by our attempts to present it. Scientific text, therefore, is ideally written in a style that presents the facts as starkly and clearly as possible, without the addition of rhetorical embellishments or figurative language. Creative writing makes use of elements such as metaphor, allegory, and even artistic word choice, but these elements are understood to enhance, dramatize, or, in the case of political rhetoric or advertising, gloss over the actual content being communicated. Nussbaum points out, however, the fundamental way in which literary style itself "makes its claims."[116] Language is not merely a vehicle for the transmission of independent information. The way in which an idea is presented powerfully shapes the meaning conveyed by an instance of communication, be it a novel, a verbal statement, or even a television commercial. Although we speak of form and content as distinct, if potentially related, categories, it is the fusion of the two which creates and transmits meaning. As Nussbaum points out, "some views of the world and how one should live in … cannot be fully and adequately stated" except through the use of particular literary styles."[117] A poem, in other words, may say something that no scientific treatise could possibly say, and vice versa. One cannot transfer the content of Yeats' "The Second Coming" into prose or scientific style or haiku: the meaning would not survive it.

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116 Martha C. Nussbaum, *Love's Knowledge: Essays on Philosophy and Literature* (New York: Oxford University Press, 1990), 3.

117 Ibid.

Television commercials differ in important ways, of course, from poetry, but both perhaps serve as equally obvious examples of the centrality of style. The text transcribed from the narration of a prescription drug commercial offers a completely different experience, and conveys a different meaning, than the commercial itself, complete with the visual and musical elements of style. The information presented within the commercial is simply one part of the whole, and arguably among the least important in terms of its contribution to the larger meaning being conveyed. It is this level of meaning which positions the product within the broader context of our collective and individual lives, and it is therefore on this level that we must seek to understand and evaluate television commercials for prescription drugs. Our current ways of thinking about the issue of DTC advertising, however, fail to account for the meaning of the ads, and to address this inadequacy we must first understand something of the historical and philosophical legacy that largely determines our current patterns of thought.

MODERN EPISTEMOLOGY

As mentioned previously, Western scholarship (as well as culture) has been powerfully influenced by the legacy of modernity and the methodology of the natural sciences which exemplify its intellectual ideals. The epistemological stance upon which the scientific method is based has come to underlie modes of thought and standards of reasoning in nearly every academic field, from biology to literary criticism to sociology. Charles Taylor asserts, however, that adopting the methods of the natural sciences ultimately strips some disciplines of any real power to understand the object of their inquiry. Human behavior, he argues, cannot be adequately understood within the framework of empirical science because it is inextricably bound up with meaning, and

meaning cannot be studied or understood outside the contextualized web of social significance in which it participates. [118] It cannot, in other words, be isolated and observed as a distinct entity apart from its surroundings and, more importantly, from its observer. Yet this is exactly what empirical observation demands: an object that can be studied from a distant, neutral perspective. Modern scientific thought, when traced back to its fundamental assertions about the world and our ability to know it, can be characterized as a series of dichotomies–strict divisions and categories which organize our observations and experience. Distinctions such as objective versus subjective, rational versus emotional, even truth versus falsehood not only underlie our scientific methodology, but actually provide the epistemological and ontological foundation of modern culture. [119]

This account of knowledge and the process by which we gain it is so fundamental to our contemporary way of thinking that we take it for granted, and have trouble articulating the process precisely because we can conceive of no alternative. It becomes clear to only us by examining the cultural and historical context in which it developed and therefore recognizing it as one way of operating in the world among others. The worldview of Western modernity could be brought into finer focus by comparison with an altogether different cultural tradition, such as that of the East. Taylor, however, uses not cultural but historical difference to illuminate the modern mode of thinking.

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[118] Taylor, "Interpretation and the Sciences of Man," 29-45.

[119] Of course, the nature and scope of this project allows only for the briefest treatment of this important subject and demands the use of broad categories rather than attention to fine details. By referring to "modern epistemology," I intend to roughly characterize the fundamental elements of this tradition, and while I recognize the controversy and disagreement within the modern tradition over such huge topics as epistemology, an accounting of these details would require a separate project. Similarly, my treatment of the historical development of modern thought, upon which much interpretive scholarship relies, serves only to highlight major developments and concepts. For a more satisfying account of nature and origins of the Western tradition, see Charles Taylor, "Two Theories of Modernity," *Hastings Center Report* 25, no. 2 (March/April 1995), 24-33.

The progenitors of the Western tradition, the Greek and Roman scholars of antiquity, understood the universe and their place within it as a divine order, the meaning of which could be fully appreciated only by the gods. The ancients' was a world of "meaningful order," heavily laden with cosmic significance, and "manifesting the rhythm of divine life."[120] Every element therein fulfilled a unique and significant role to complete the larger pattern, which reflected a unified, ultimate design because every part of creation represents "the same idea reflected in different media."[121] The complexity, order, and beauty of the human body, so famously reflected in classical art, was thought to be reflective of, and mirrored by, the complexity, order, and beauty of nature. Everything meant *something*, even the way the stars were arranged in the sky. Mathematics, and especially geometry, enjoyed a particular status among ancient scholars since it seemed to embody the very language of nature's divine organization. Yet while part of man's role was to study and admire the divine cosmos, he did so always from his perspective within it.[122] He could never step outside the system and observe it from a neutral perspective, as modern scientists would later believe themselves to do. The meaning inherent in the universe, and therefore inherent in the microcosm of each object within it, could never be fully understood by man, who was, even at the time he sat down to stare and wonder at it, necessarily connected to it in ways that he could never appreciate. Only the gods, looking down at the universe from their distanced perspective, could ever fully divine the meaning with which they had infused the world.

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120 Taylor, *Hegel,* 5.

121 Ibid.

122 I use masculine pronouns in the sections describing both the ancient and modern selves because the "selves" at stake represent, to a large extent, not the individual men and women who lived in these times but the theoretical understanding of what it meant to be a "self" according to the predominant worldview. I think few would disagree with the contention that both the ancient and (early) modern selves were men, and that referring to them with feminine pronouns would be anachronistic.

In reaction to this worldview, along with that of medieval Christianity (which, while differing in significant ways from antiquity, shared its penchant for complex visions of divine order), sixteenth- and seventeenth-century scholars began to question mankind's entrenchment within a predetermined and, ultimately, unknowable universe. The very act of questioning, in fact, reflected the beginnings of an epistemological and ontological shift, wherein man came to understand himself not as one piece of a puzzle from which he could never escape, but as an independent, autonomous agent whose singular capacity for reason allowed him to understand nature by stripping away the layers of religious and historical tradition and observing the world just as it is. These thinkers experienced the matrices of meaning proffered by their ancestors as stifling to the full development of individual reason and liberty. Skeptical of what they saw as superstition and oppressive authority, they believed their intellectual predecessors to have been "caught in a web of illusion which they themselves spun, self-indulgently projecting meanings devised in the mind on to the facts."[123] The facts, of course, were those of an external reality, separate from and therefore available to human inquiry, carried out using neutral observation and pure reason alone. While ancient thought tended to focus on overarching patterns and seek understanding by viewing each piece of the universe in terms of its relation to the whole, modern science began by relinquishing all assumptions about what the overarching system might be. Only by examining each element in isolation, and attempting to understand what it really was, could an understanding of the larger system be reliably constructed. Descartes, who for better or worse often represents this entire intellectual tradition, famously went about a philosophical search for certitude

[123] Taylor, *Hegel,* 5.

by looking for "an Archimedean point upon which we can ground our knowledge."[124] If we can "discover one thing which is certain and indubitable," he contended, we can use our capacity of reason to broaden the scope of our understanding, all the while confident that, because we have built it from "the foundation," we are working within a "firm and permanent structure" of knowledge.[125] Descartes demonstrates the essence of the Enlightenment reaction against antiquity in that he "demand[ed] that we should not rely on unfounded opinion, prejudices, tradition, or external authority, but only upon the authority of reason itself."[126] Only then, according to modern thought, can we be confident that we know the world as it really is, rather than as we have imagined or supposed it to be. This idea is reflected in the emphasis on empiricism and taxonomy in early Enlightenment science as well as in the tendency towards a strictly logical philosophical analysis, such as Anselm's deductive proof of the existence of God.[127]

The natural world, as well as mankind itself, was understood by dividing it into smaller and smaller pieces and sorting its elements into various binary categories. So, too, is the modern understanding of human nature separated into dichotomies which make this scientific style of thought possible. To distinguish between subjective belief and objective fact, man had to rely upon his rational nature, which he began to understand as separate from, and, in many ways, superior to, his emotional nature. The modern conception of the self, more independent from than connected to his surroundings, more rational than emotional, represents the locus of the intimate link between autonomy and reason which

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[124] Bernstein, 16.

[125] Rene′ Descartes, *Meditations*, vol. 1 of *Philosophical Works of Descartes*, trans. Elizabeth S. Haldane and G. R. T. Ross (Cambridge: Cambridge University Press, 1969), 144, 149.

[126] Bernstein, 17.

[127] See Brian Davies and G. R. Evans, eds., *Anselm of Canterbury: The Major Works* (New York: Oxford University Press, 1998).

supports not only scientific thought but also liberal government and consumer capitalism. Able to recognize and minimize the subjective influence of the passions, rational man gains the capacity to live freely: to make his own decisions within the confines, as Locke and Rousseau's social contract theories remind us, of a logical social structure which exists, ultimately, to serve the best interests of the autonomous individuals within it.

Certainly, the complete protection of the intellect from the passions and the absolute capacity to act according to logic and reasoned self-interest alone is (usually) understood more as an ideal than a description of human behavior. Yet, as scholars have begun to critically examine the tenets of modernity, they have come to question whether the fully autonomous, rational self ought always to serve as our model. Iris Murdoch speaks of the "Kantian man-god" as the dominant character within the story of our cultural tradition, so grounded in rational individualism that "even when confronted with Christ [he] turns away to consider the judgment of his own conscience and the voice of his own reason."[128] Murdoch's description of modernity's "hero" as "independent, lonely, powerful, rational, responsible [and] brave" speaks both to the skepticism of many contemporary scholars regarding the enlightenment project and to the deep sympathy with which they have begun to view its protagonist as a tragic hero in the ancient sense: a character doomed to fail in aspiring to transcend his human limitations, and yetsomehow triumphant in his ability to inspire us with the audacity of his efforts. For Murdoch, this hero "is the offspring of an age of science, confidently rational and yet increasingly aware of his alienation from the material universe which his discoveries reveal." [129] The separation of self from the world (and the division of the self into

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[128] Iris Murdoch, "The Sovereignty of the Good over Other Concepts," in *Existentialists and Mystics: Writings on Philosophy and Literature*, ed. Peter Conradi (New York: Penguin Books, 1999), 365.

[129] Ibid.

separate capacities) allowed for independence and objectivity, yet it did so at the expense of meaning and connection. Much of the contemporary dissatisfaction with the modern worldview stems from the feeling of having been divested of something vital. It is not that the thinkers associated with the interpretive turn long for a return to ancient cosmology. It is rather that they long for a way to understand our experience as beings who are, to a certain extent, free to act on our own accord and yet still, in ways that the modern paradigm doesn't account for, shaped by, invested in, and ultimately responsible for our world.

THE PROBLEM OF MEANING

When modern man divided and categorized himself along with his environment, he devised a particular way of dealing with meaning. The web of significance within which the ancients had lived and studied was now understood as subjective, i.e., suspect, superstitious. Meaning became opinion, or, more respectfully, belief. Of course this is not to say that significance has no place within modern science. The entire scientific enterprise could be conceived as an attempt to know the meaning of the objects it studies. But *meaning,* in this sense, is more clearly understood as *definition*. To know what something means is to know what it is. Meaning is one of many properties belonging to an object and is susceptible to being known. It is out there, in reality, waiting to be observed or deduced. We can be right or wrong about it, because (and in order for words like right and wrong to make sense) it exists independently of our idiosyncratic opinions of it. The alternative is to speak of what something means *to* someone, in which case meaning is framed as personal and relative. By conceiving of meaning in one of these

two ways (as either admitting to only one correct interpretation and thus a definition or fact, or as admitting to more than one possible interpretation and therefore subjective belief) modernity essentially carved out the former category as the proper subject of human reasoning and excluded the later from the enterprise of serious, scientific inquiry.

This way of understanding the world and our place in it has undoubtedly worked, and worked well, for a good many people in a good many circumstances, and it continues to do so. Ironically, however, the very notion of pure reason, originally a rebellion against authority and tradition, has become so successful that it has been taken for granted as not only the best way of thinking about things, but, in fact, the only one available. Autonomous reason, celebrated as the liberator of free thinkers from intellectual and cultural tyranny, has now attained so much intellectual and cultural authority that we feel the need to force every object of study into a form which is susceptible to it. And, perhaps because of the overwhelming success which they have found within this worldview, the natural sciences have become a model for many disparate disciplines. Even in fields such as literature, as I will discuss in the next chapter, the legacy of the Enlightenment has been a perceived requirement to align the very activity of human inquiry and thought with the principles of objectivity, empiricism, and deductive logic. Thus the great intellectual liberation of the Renaissance and Enlightenment has come to be viewed by Hans-Georg Gadamer and other postmodern thinkers, as "the particular falsehood of modern consciousness; the idolatry of the scientific method."[130] This is precisely Taylor's lament about empiric social science.

Human behavior, Taylor contends, has everything to do with meaning and connection–the very things that we cannot, by definition, separate ourselves from in order

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[130] Hans-Georg Gadamer, "Hermeneutics and Social Science," *Cultural Hermeneutics 2* (1975): 312.

to view them objectively. We are not free from them, and they cannot survive our attempts at distanced explanation without gross distortion. Social science, in attempting "to fulfill the requirements of the empiricist tradition" must effectively "reconstruct social reality as consisting of brute data alone … identified supposedly beyond interpretation."[131] Such data, according to Taylor, are the remaining vestiges of human significance forced into categories such as objective or subjective. Social science can identify particular bits of brute data (such as the fact that someone voted in a certain way, or the fact that they agreed to hold a particular belief when asked) and can then draw correlations between these units of objective truth according to the same logical deduction used by their colleagues in natural sciences and mathematics. Which is all well and good, except that, as Taylor insists, our ultimate aim is not to know, with certainty, how individuals vote or answer survey questionnaires but to understand, with sophistication, what it is that prompts them to do so. It is meaning that we want to discuss and evaluate-not the observable facts that serve as placeholders for it. Yet we cannot get very far in doing so without encountering the brick wall of binary thinking, which prevents serious inquiry into significance because it insists that things either are what they are (in which case the task is to deduce their definition) or that they exist only as subjective, idiosyncratic, and irreconcilable differences of opinion.

The kind of meaning that concerned the ancient thinkers, and the kind of meaning that interpretive, rather than empiric, social sciences take as object of their study is less like *definition* and more like *significance*. And, for Taylor, this meaning differs crucially from opinion in that its locus is not within the mind of the individuals who happen to hold it, nor out in the natural world as part of an external reality separable from human thought and action. This kind of meaning exists within, and is constitutive of, the social

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[131] Taylor, "Interpretation and the Sciences of Man," 53.

reality that we participate in and contribute to. It is important to distinguish this kind of meaning, described as *intersubjective,* from the conception of shared meaning we understand as *consensus.* Consensus arises when several individuals simultaneously hold a particular opinion, each in common with one another and yet each independently, within their own mind. Intersubjective meaning could not conceivably exist within the mind of an individual. It is a collective interpretation of the world and an implicit understanding of how to act within it. It is not a set of individual beliefs but the social framework within which we live–the communal interpretation of our circumstances and relationships within which we have implicitly and collectively agreed upon ways to act and think. Taylor asserts that the modern scientific method, and the social science disciplines which try to emulate it, cannot deal with this kind of meaning because it fails to fit into the basic modern categories. It is neither subjective, internal opinion nor objective, external reality. It comprises the connections between and among us. I agree with Taylor when he insists that this is what we have to understand if we want to study human culture and behavior. Specifically, it is what we ought to be thinking about when television commercials become powerful sources of significance for our collective understanding and experience of health and illness.

PHILOSOPHIC HERMENEUTICS

The turn toward interpretive thinking in the past quarter century has been characterized by an increased attention, in various fields, to the hermeneutic tradition of continental philosophy. Philosophical hermeneutics offers an in-depth account of the process and significance of interpretation, which it takes to be the fundamental and defining act of humanity. The term *hermeneutics*, derived from the Greek word for

interpretation, is historically associated with scriptural study. As Kurt Mueller-Vollmer points out, the theological significance of the tradition is evident even in its namesake: Hermes, "the messenger god of the Greeks."

> In order to deliver the messages of the gods, Hermes had to be conversant in their idiom as well as in that of the mortals for whom the message was destined. He had to understand and interpret for himself what the gods wanted to convey before he could proceed to translate, articulate, and explicate their intention. To describe the different facets of Hermes' task, modern mortals have at their disposal a whole set of terms such as linguistic competence, communication, discourse, understanding, [and] interpretation.[132]

As a tradition of biblical exegesis, hermeneutics grew more significant with the Protestant Reformation and its emphasis on individual access to the word of God. Luther insisted that faith ought to rest on an active reading of scripture rather than the passive reception of church teachings. The practice of textual interpretation grew in scope and significance as the masses struggled, for the first time, with the holy text.[133] The history of the hermeneutics is the story of how this technical skill became recognized as a universal way of understanding human discourse and then a philosophy with ontological and ethical, as well as epistemic, consequences.

The hermeneutic tradition has been developed by a particular set of continental philosophers including Wilhelm Dilthey, Martin Heidegger, and Hans-George Gadamer. These thinkers came to believe that human understanding, in general, takes place through a process more akin to interpreting and understanding a book than discovering or deducing a fact. In hermeneutic interpretation of text, the reader seeks to make sense of a

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[132] Kurt Mueller-Vollmer, "Language, Mind, and Artifact: An Outline of Hermeneutic Theory since the Enlightenment," in *The Hermeneutics Reader*, ed. Kurt Mueller-Vollmer, (New York: Continuum, 2002), 1.

[133] Georgia Warnke, *Gadamer: Hermeneutics, Tradition and Reason* (Stanford, Calif.: Stanford University Press, 1987), 4.

passage by examining it in detail and then considering its possible significance in the context of the text as a whole. Yet her understanding of the text as a whole rests on, and is constantly fine-tuned by, the details. Neither part nor whole is fixed as a standard external to the process. Both are variable and interdependent. The goal is to arrive at an understanding (an interpretation) of the text that provides the best fit between the details and their context. It is done by a constant tacking back and forth between part and whole until a sense emerges that seems to account for both views. The process is a bit like focusing the two lenses of binoculars until the view becomes clear.

Hermeneutic philosophy posits that human experience must be understood in the same way, that is, contextually. A single event in the life of one person or the development of a culture cannot possibly be accounted for without reference to the larger context within which it makes sense. Yet just as surely, the whole–the culture, the times, the person–cannot be understood without reference to particular events and their meaning. "We understand the whole in terms of the parts, yet those parts have the meaning they have only in light of the whole."[134] This is the infamous *hermeneutic circle*, which becomes the epistemic foundation for all forms of human understanding.

Reflecting on the circularity of understanding quickly leads to important questions. How, where, and when can we get off the circle and call our understanding complete? This question sounds like a quip, but actually lies at the heart of our struggle to turn from our modern past to a new understanding of ourselves and our world. We meet the full force and implications of this question in the work of Martin Heidegger, who realizes the epistemology of hermeneutics does not, cannot, fit the ontology of a disengaged, modern self. Instead of an entity capable of objectifying the world–of

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[134] Frank C. Richardson, Blaine J. Fowers, and Charles B. Guignon, "What Is Hermeneutics?" in *Re-Envisioning Psychology: Moral Dimensions of Theory and Practice* (San Francisco: Jossey-Bass Publishers, 1999), 205.

viewing it neutrally, as it truly is, from a vantage point which is necessarily independent of it, Heidegger insists upon a conception of the self that is "always, already" connected to its surroundings. This way of thinking conceives of a human being primarily as an openness, a potential. It arrives and finds itself already embedded in a meaningful world that determines the boundaries of the possibilities of its existence. The process of understanding is the realization of these possibilities.

Gadamer recognized that Heidegger had transformed the hermeneutic tradition from a method of textual interpretation to a philosophy with ontological as well as epistemological implications. It was "no longer to be seen as a discourse on methods" of interpretation or study in the human sciences.[135] Yet he also recognized the practical power of interpretive thinking, and took as his challenge the task of putting philosophical hermeneutics to work in the real world, and in doing so made hermeneutic interpretation a practical, accessible, and powerful alternative to the modern paradigm of scholarship. Gadamerian hermeneutics is basically an account of the way in which we encounter and make sense of difference, and the process by which that interaction, necessarily interpretive, relates to our understanding of ourselves. This process is described metaphorically as the fusion of two horizons, each representing one party in a communicative encounter. Gadamer characterizes our horizons as the summation of our prejudices, although he uses this word without its pejorative connotation. For Gadamer, a prejudice is simply, literally, a pre-judgment: an as-of-yet-unexamined view that we hold until it is tested by new experiences. The set of all of our prejudices forms the context within which we necessarily confront any new idea or experience, and thus constitutes our "horizon," the point of view from which we understand the world. Yet that point of view is not fixed. Communication, metaphorically cast as an encounter with another

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[135] Warnke, 3.

horizon, can alter it by making us aware of our prejudices and allowing us to evaluate them. And because Gadamer, like Heidegger before him, conceptualizes the self not as a free-floating rational entity, but as a being comprised of the sum total of its experience and beliefs, the process of discovering and testing our prejudices through our encounters with the world and each other is more than intellectual discovery. It is a critical interpretation of the world, and it leads to critical self-awareness and even self-cultivation. As Gadamer explains, "it is not so much our judgments as it is our prejudices that constitute our being."[136] In other words, we *are* our prejudices and our horizons; we not only function in the world according to, but are necessarily ontologically connected with, our interpretations of it. When we encounter difference, challenge our prejudices, and shift our horizons, we do not simply acquire knowledge or even understanding. We change ourselves. We understand the world only from a perspective necessarily situated in and connected to the world we are trying to make sense of. We cannot escape our perspective to view the world neutrally because our *perspective* is simply another way of referring to ourselves.

By describing interpretation as fundamentally ontological, I intend to align my hermeneutic analysis with Gadamer's emphasis on the relationship of the self to the process of understanding.

> Among those willing to adopt some sort of hermeneutical perspective on the human sciences, two philosophical orientations developed. They came to be distinguished by the labels "critical" and "ontological." [Jurgen] Habermas is a leading exponent of the former, Gadamer of the latter. Applying "critical" to Habermas's work is not, of course, intended to suggest that Gadamer's analyses are slack. "Critical" was chosen in this context to indicate a nearer affinity to the

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136 Hans Georg-Gadamer, "The Universality of the Hermeneutical Problem," in *Hermeneutical Inquiry, Volume I: The Interpretation of Texts*, ed. David E. Klemm (Atlanta, Ga.: Scholars Press, 1986), 183. See also Hans-Georg Gadamer, *Truth and Method*, trans. Joel Weinsheimer and Donald G. Marshall (New York: Continuum, 2004).

> Kantian project of stating the conditions for reliability in knowledge, with its inclination to look for models in the empirical and comparative sciences, and also for its contention that meanings are not trustworthy as they stand.[137]

In this section and those that follow, I rely primarily on Gadamer's analysis. I am persuaded by his insistence that we cannot, and need not, radically separate ourselves from the traditions within which we live in order to adopt a critical stance towards them, or even alter them. The very process that Gadamer considers fundamental to understanding, the encounter with difference, is what leads to the recognition and testing of our own traditions. From this perspective, each instance of interpretation represents an opportunity to reshape the system of meaning we live through and in. I recognize, however, the potential difficulties that power imbalances might represent for this dialectical conception of understanding. Habermas sees Gadamer's analysis as based on the metaphor of genuine, open, honest conversation between two interlocuters, and I believe his concerns about power and abuse are important, particularly when the interpretive encounter takes place between a mammoth pharmaceutical corporation and a vulnerable patient. A more complete analysis of the debate between Gadamer and Habermas is beyond the scope of this project, however, and so while I will return to issues of power in communication, I want only to emphasize here that this difficulty requires our careful attention but may be adequately dealt with, from my perspective, from within the stance of ontological hermeneutics.

However outlandish the fusion of horizons and the shaping of the self may sound when compared to the modern epistemology discussed above, I would contend that it actually comprises a better description of our actual human experience, particularly when pared down to everyday language. Everything we see, we interpret. There is no such

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[137] Roy J. Howard, *Three Faces of Hermeneutics: An Introduction to Current Theories of Understanding* (Berkeley and Los Angeles: University of California Press, 1982), 121.

thing as objective observation because we always experience the world from a particular point of view, with a particular set of biases which, no matter how hard we try, we can never completely escape. The reason we cannot do so has to do with what it means to be human: to experience the world from within a particular historical, cultural, and personal existence. It means to always, necessarily, fall short of pure, disengaged reason. Almost every proponent of modern scientific thinking would admit this, of course. The real message of the interpretive turn is that we ought not aspire to such a task-not because we recognize it's impossible and therefore must settle for the best we can do, but because the ideal upon which it is based is less appropriately considered a model for excellence in human understanding than a definition of what human understanding could never be. We don't need to strive for a kind of certainty beyond our reach in order to live well and think carefully within the world. The epistemological standard set by interpretive thinking is not certainty but practicality. What we seek is not ultimate truth but adequate, productive, provisional understanding. We can never know the world from a superhuman point of view, but we don't need to do that in order to know the world. What we need to do is not so much observe it as encounter it, interpret it, and thereby understand what it means–which is always, only, what it means *to us, for now.*

This contextualized understanding is not simply the best we can do. It is our best and only way of accounting for the shared, intersubjective meaning that modern objectivist thinking fails to account for. Hermeneutic interpretation is always dialectical. It is always co-created in the space between two horizons and it consists of the shared understanding which arises out of an encounter with the initially foreign. The meaning we gain from this encounter is not discovered or divined or deduced. It is created in the process of trying to make sense. It is the sense that we literally make of something that seems initially strange. And this kind of sense, of meaning, is always tied to encounter,

and therefore always intersubjective. Unlike opinion, it belongs always and necessarily to a *we* and rather than an *I*. The metaphor is best understood as a conversation between two individuals and represents the process of their each coming to understand the alternate viewpoint of the other, each testing and altering their worldview in the process. Yet it can also represent an individual's encounter with a text, or sculpture, or even a ritual. When we encounter an image or a story, for example, we may not encounter another individual with his or her set of prejudices, but we encounter, nonetheless, an understanding of the world. The original practice of textual interpretation involved an attempt to make clear the particular perspective of the world offered by a text. And by coming to understand this new perspective, we find our own point of view changed. We see the world from a new place. Our horizon has been altered. Of course, the metaphor insists that two horizons are fused, and thus that the text also be transformed through its encounter with us. In the case of conversation, both participants are affected. The way in which a text is actually changed by our reading it is a complicated notion taken up by those both in philosophy and literature, and largely outside the scope of this discussion. The relevant point is that the process of reading is not simply the act of one individual receiving objective information conveyed through the neutral vehicle of words. It is, like every other kind of human understanding, the contextualized making of sense–not so much *of* the book as *with* and through it. I will return to this idea later when I discuss the literary practice of thinking with stories.

For now, however, I want to briefly examine the way in which the specific metaphor of human understanding as textual interpretation has been extended to serve as a way of thinking about the interpretation of images, actions, and culture as a whole. While a complete account of these topics would require an examination of interpretive anthropology and visual studies beyond the scope of this project, it is my intention to

address them briefly with an eye toward establishing this kind of hermeneutic thinking as a feasible and useful means of interpreting pharmaceutical commercials, a practice that must take into account various elements such as images, text and music in order to make sense of their specific contribution to the ad as a whole.

INTERPRETING CULTURE

In bringing this tradition to bear on the analysis of pharmaceutical commercials, I wish to highlight the ways in which the meanings conveyed by these commercials function, in essence, as suggested interpretations of health and illness. I would like to suggest that we think of these commercials as horizons–as particular perspectives on health and disease that we encounter just as we would if we were granted a window into the particular significance that, say, heart disease, holds for another individual. Imagine that we were privy to this view–not only the cognitive, explanatory response that we might receive if we asked someone what they thought of cholesterol lowering drugs or heart disease, or even what these concepts meant to them, but the complex interaction of information, emotion, past experience, personal and cultural identity, hopes, fears, misperceptions, and value judgments-all of the particular biases, in other words, that form an individual's conception of a disease. Taken together, these elements form a hermeneutic horizon, and the understanding or perspective that they allow for and comprise is, basically, a particular meaning. And, as any ethnographer would acknowledge, this kind of meaning is difficult if not impossible to access by simply asking someone what something means to them. Certainly, if we wanted to know what heart disease meant to a person, we could ask them, and the answers they gave would be enlightening. However, a rigorous interpretation would also call for a consideration of

their actions as well as their words, as well as a contextualized understanding of their particular historical, cultural, and personal experiences. To understand what heart disease means to someone, we would have to follow her to her physician's office, to the pharmacy, to the gym, to her office. We would have to traffic, in other words, in human action rather than communication alone. Interpretive anthropology takes as its starting point the assertion that such action contains, conveys, is motivated by, and further propagates the same kind of meaning that we seek to understand when confronted with a text.

While this is, to a certain extent, implicit within hermeneutic philosophy in the idea that we interpret everything we encounter, the specific nature and implications of the interpretation of human action have been further explored by various scholars who sought to lay the groundwork for a hermeneutic understanding of culture. Paul Ricoeur takes as his starting point Max Weber's characterization of "the object of the social sciences" as "meaningfully oriented behaviour."[138] Ricoeur then explores the possibility of a hermeneutic practice of anthropology by exploring the extent to which this object "conforms to the paradigm of the text."[139] He asks, in other words, how feasible and useful it is for anthropologists to think of the "meaningful action" they study as a text to be interpreted rather than a piece of information to be discovered or divined.[140] He argues against the positivist idea that an instance of meaningful action admits to only one interpretation–that there is a right answer to be decoded through an external framework which transcends human culture in order to understand it. He argues, instead, that our

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[138] Paul Ricoeur, "The Model of the Text: Meaningful Action Considered as a Text," in *Hermeneutics and the Human Sciences*, ed. and trans. John B. Thompson (New York: Cambridge University Press, 1981), 203.

[139] Ibid.

[140] Ibid.

understanding of meaningful action, like our understanding of a text, is always provisional, judged not only in its own time by those wishing to understand contemporary society, but forever thereafter by those for whom it will become history. The subject of an anthropological investigation, such as a rain dance, for example, holds significance not only for those who participate in it but also for individuals outside the culture, who may encounter and interpret it within the context of their own lives. To speak of *the* meaning of an event, therefore, is to overlook the numerous and unpredictable ways in which it would be meaningful from different cultural perspectives, and the theoretically infinite ways in which it will become significant for future generations.[141] Given this "openness" of the meaning of human action, Ricoeur argues that the metaphor of textual interpretation captures the activity of studying it more aptly than the model of the natural sciences:

> Like text, human action is an open work, the meaning of which is "in suspense." It is because it "opens up" new references and receives fresh relevance from them, that human deeds are also waiting for fresh interpretations which decide their meaning. All significant events and deeds are, in this way, opened to this kind of practical interpretation … Human action, too, is opened to anybody who can read.[142]

The study of culture, according to Ricoeur, is best considered an interpretive activity, and this realization not only underscores the relevance of hermeneutic philosophy, it also emphasizes the pragmatic nature of human inquiry and its accessibility to the populous at large. We don't necessarily have to be experts in Native American history or culture in order to make sense out of a tribal dance. We all make sense out of everything we

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[141] Of course modernity allows for meaning to be framed relative to a particular individual or culture. The difference, which will be made clear in later sections, comes with the supposed irreconcilabilty of these perspectives, or nihilistic cultural relativism, ascribed to this conception of meaning by the mainstream of modern thought.

[142] Ricoeur, "The Model of the Text," 208.

encounter, perhaps most often the meaningful behavior of others. We all read the world around us, and we do it whether we're conscious of it or not. Yet having said that, we need to account for what our common sense and experience tells us about human understanding: some people do it better, in particular situations, than others. Anyone who witnesses a rain dance will make some sense of it. But that is not to say that every interpretation is as good as any other. The goal of hermeneutic interpretation, from its origin as a method of textual interpretation, is to come to an understanding of the text by tacking back and forth between the details and the larger structure, between the individual elements of the text and the larger webs of significance it participates in. To do this well means to arrive at an understanding that is able to account for all the features of the text and that is able to explain the relationship of its details to its whole. An interpreter who comes to a text or text-analogue with more background experience, more previous understanding, and even more critical skill will be better equipped to come to a satisfactory understanding. Some horizons, in other words, afford better views than others. Of course all of these terms (*better*, *satisfactory*, and so forth) serve to frame interpretive judgment as both provisional and relative. As Ricoeur points out, there is no such thing as a definitive interpretation because there can be no such thing as the last or only interpretation. Our understanding of something, therefore, must always be judged in comparison with that of others, and by negotiating the differences of our various perspectives. Interpretation occurs by co-creating a mutual understanding of the text by encountering not only the text itself but the particular meaning it holds for our conversation partners. Through this dialogical process we negotiate an understanding which represents the best we can do for now. And we remain open to its potential revisions by some new partner with a new perspective to bring to the conversation.

> The role of falsification [in the natural sciences] is played here by the conflict between competing interpretations. An interpretation must not be only probable, but more probable than another … If it is true that there is always more than one way of construing a text, it is not true that all interpretations are equal.[143]

How do we decide if one interpretation is better or more probable than another? How do we negotiate differences of interpretation? We do so always in conversation and always in careful reference to the text itself. An interpretation is more probable, more complete than another when it is able to better account for the features of the text-to answer our questions about why each detail was included, the relationship of the parts to the whole, and each element works in harmony with each other, etc. Hermeneutic textual interpretation requires that a satisfactory reading account for the coherence and scope of the text in this way. Yet inherent within this tradition is another issue that we must consider when comparing and negotiating between alternative interpretations. We must examine not only the way an interpretation fits the text and provides a coherent account of it, but also the way it fits our experience of the world and the way in which it presents, or opens up, new possibilities for our collective and individual lives that we believe to be helpful, enabling, and positive. There is a sense in which we are responsible for the joint meanings we create together because those meanings constitute the social reality (the web of meanings that structure our thought and experience) that determines the possibilities for our ability to live well together. In the next chapter, I will introduce a specific tradition of literary criticism which helps us conceptualize and undertake the ethical evaluation of various interpretations, conceived of, for the purposes of this very task, as narratives. At this point, however, I want to draw out the implications of a hermeneutic

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[143] Ricoeur, "The Model of the Text," 213.

conception of culture regarding our relationship to, and responsibility for, the social reality in which we live.

Our interpretations of all that we encounter in the world (text, stories, human action, and so forth) not only represent our understanding of a particular part of the web of significance within which all our experience is located, but also represent newly created connections within that web itself. When we interpret, we literally make sense: we create an understanding, always necessarily connected to our other understandings, that then constitutes part of the reality of significance we encounter and attempt to understand. Considered from within the hermeneutic tradition, culture is not organized as a set of empirically observable events and our subjective beliefs about them but rather as an organic system of inextricably connected interpretations, and our interpretations of those interpretations, and so on. Our relationship to our world is therefore not one of distanced, objective study but active participation. Our lives are structured by the individual and cultural interpretations of who we are and what choices are available to us. Our experiences are directed by the structure of significance within which, as Gadamer reminds us, we are always, already situated. Yet at the same time, our interpretation of the various ideas, individuals, and actions that we encounter alter our perspective, and each contribute (although some to a greater extent than others) to the possibilities available to us. As we form these interpretations together, and negotiate between them to come to a mutual understanding and operate from the perspective of a shared horizon, we participate in the never-ending revision and construction of the very culture we belong to. This idea is not simply one consequence of an interpretive view of culture. It is, as Heidegger insists, the fundamental and defining activity of humanity: creating the meaningful world we live in.

The ethical consequences of hermeneutic thinking are therefore implicit within the tradition. Yet they become clearer when fortified with narrative thinking. Literary theorists argue for the philosophical relevance of narrative interpretation when they claim that reading and understanding a story is more than indulging in a form of entertainment or participating in a particular sort of mental exercise. It is, rather, an activity through which we envision new possibilities and imagine new ways to live. Martha Nussbaum claims that all literature functions as one potential answer to our most fundamental question: how should we live? When ethics is conceived of as the broad attempt to explore and answer this question, rather than the application of method or theory to resolve specific instances of conflict, and when narrative interpretation is placed within the context of a hermeneutic conception of culture, then the significance of our mutual, negotiated interpretations of shared experience becomes clear. Not only do we read culture, but in doing so we simultaneously write it. And so it is up to us to write it well–to write it in a way that gives us the best chance to live well, together, within it.

INTERPRETING IMAGES

Of course no framework for interpreting television commercials would be adequate without at least some attention to the interpretation of visual images, and an examination of the ways in which our experience of images, and our response to them, differs from our response to and experience of text. While I have chosen to adopt a theoretical framework which is primarily based on hermeneutic interpretation and literary criticism, I would be remiss to exclude the helpful perspective offered by the field of visual studies, and particularly the work directed at understanding the visual elements of

our mass media. My aims in this section will be to acknowledge the centrality of image in our culture (specifically as it pertains to marketing images), briefly explore some of the particular features of visual experience which must be considered in our interpretation of images rather than text, and to explain the relation of visual interpretation to both hermeneutic and narrative approaches to understanding culture. This section is in no way intended as a complete introduction to visual studies, nor does it serve as even a brief survey of techniques of visual interpretation. This field represents an invaluable source for a more complete, interpretive approach to pharmaceutical marketing, and while I am more directly interested in the narrative implications of these advertisements for our culture, I believe that further input from the fields of visual and media studies would greatly augment efforts to view and evaluate pharmaceutical advertisements more carefully and responsibly.

The extent to which Western culture would become "an image-driven society" would have been difficult, if not impossible, for scholars just a century ago to predict.[144] The transition from text to image as the defining mode of communication has been perhaps most starkly evident in the last half of the twentieth century, and scholars in visual and media studies believe this trend to rival the invention of the printing press in terms of its cultural and intellectual significance. What Donis A. Dondis called "the domination of the human psyche by the photograph" has become such an obvious feature of our cultural landscape that we rarely take the time to ponder the enormous influence that images hold over our individual lives, particularly in terms of our relationship to mass media and consumer capitalism.[145] Americans may have grown tired of statistics

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[144] Ann Marie Seward Barry, *Visual Intelligence: Perception, Image, and Manipulation in Visual Communication* (Albany: State University of New York Press, 1997), 1.

[145] Donis A. Dondis, *A Primer in Visual Literacy* (Cambridge, Mass.: MIT Press, 1973), 6.

and diatribes regarding the number of hours children spend watching television (an average of 25,000 by age eighteen) compared to the hours they spend in school (only 13,000 from kindergarten through high school in comparison), which were widely cited, usually in the context of conservative stances toward politics and culture, in the 1980s.[146] Yet our widespread weariness of such admonitions and the common-sense realization that culture will never move backwards to "undo" the influence of technology as entrenched as film or television should lead neither to a fatalistic acceptance of a force beyond our control nor to a willful inattention to the way in which images shape our individual and collective experience. "As sleeping becomes the only activity that occupies children more than watching a video screen," says Ann Barry, referring not only to television but video games and computers as well, "we must become more sensitive to how images shape the fabric of our lives."[147] The kind of sensitivity we need, according to Barry, is a visual intelligence:

> A quality of mind developed to the point of critical perceptual awareness … not only the skilled use of visual reasoning to read and communicated, but also … an understanding of how the elements that compose meaning in images can be manipulated to distort reality.[148]

The concern reflected in the last section of this statement (the fear that images will distort reality, and prevent us from seeing things as they really are) hints at the philosophic and historical depth which characterizes our relationship to vision, both as the primary physiologic sense capacity through which we interact with the world, and as a metaphor for our intellectual capacity to apprehend and cope it. "The notion of the

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[146] Barry, 1.

[147] Ibid., 3.

[148] Ibid., 6.

autonomous individual who seeks excellence through the exercise of free choice" relies upon faith in man's capacity to observe and, thus, understand his environment, and it relies specifically on "the power of sight to master the world."[149] Common colloquialisms like "seeing is believing" reflect the long-standing epistemic significance of vision. A. Richard Turner emphasizes the literal and metaphoric importance of sight when he characterizes the age of the enlightenment as "a triumph of the eye" and also "of the I … an individual who takes a view from a specific vantage point, and so in a sense possesses what he sees."[150]

The centrality of the vision metaphor in modern thought demonstrates a fundamental connection between visual studies and hermeneutic scholarship: like interpretive approaches to human behavior and narrative, the deliberate interpretation of images rests upon on the fundamental realization that "we only see what we look at," that our experience of the world is mediated by our own contextualized perspective. [151] Whether we encounter the world through visual imagery, text, verbal communication, or all of these at once, our encounter with it is necessarily our own. We do not, and cannot, see the world as it *is*. We see it as it *appears to us*. Were it not for this foundational understanding of sight as interpretive, contextualized, and therefore imbued with several layers of potential meaning, we would not need to examine images carefully, or to ask what they mean to us or how they operate in a certain context. If vision were, in every sense of the word, definitive, we wouldn't need visual studies at all. The careful examination of images and how we respond to them takes as its starting point the

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149 A. Richard Turner, *Inventing Leonardo* (Berkeley and Los Angeles: University of California Press, 1992); 153.

150 Ibid., 164-65.

151 John Berger, *Ways of Seeing* (London: British Broadcasting Corporation and Penguin Books, 1972), 8.

recognition that vision is not the direct and unfettered route to an unchanging reality but rather one more way in which we encounter, accept, reject, and participate in meaning.

Nowhere is this more evident than in advertisements, where images are used not only to communicate but also, and explicitly, to affect a change in belief or desire which will prompt a specific action, such as purchasing a new car or voting for a school bond. Careful attention to the way in which we interact with images, both at a conscious, face-value level and also in more subtle ways which require critical examination for us to even apprehend, much less understand, becomes a requirement for navigating a society characterized by ubiquitous exposure to visual persuasion. "Lighting, colors, camera angles, tone, every detail of every item shown … in a national ad campaign nothing is left to chance."[152] This would be the case, and would still be quite significant, if the purpose of an advertisement was simply to make consumers aware of an available product, to portray it as favorably as possible in order to drive demand and sales. But the power of image in advertising goes far beyond the deliberately persuasive presentation of a consumer good. It operates at the powerful level of intersubjective meaning, shaping our ideas and understandings of entire systems of concepts within which a product will seem logical, or desirable, or necessary.

> The history of advertising in the twentieth century has been characterized by the steady movement away from function ("What does the product do?") … to the identification of the consumer and the nature of social meaning ("What does the product mean in terms of the type of person I am now and how I relate to others?")[153]

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[152] Barry, 353.

[153] Barry, 254, quoting William Leiss, Stephen Kline, and Sut Jhally, *Social Communication in Advertising* (New York: Methuen, 1986), 232-34.

Visual and media studies have recognized, perhaps to a greater extent than any other field, the ways in which power is garnered and maintained by visual communication. These disciplines have also explored the far-reaching implications of an image-oriented society for individuals who are, for the most part, unequipped to critically evaluate the barrage of pictures they encounter every day.

However, while a common perspective on the need for critical interpretation of images stems from a recognition of their power, I want to bring a particularly hermeneutic perspective to the question of how that power affects us, and what the proper response to it should be. When approached from within a hermeneutic tradition, necessarily skeptical of binary divisions, the common understanding of pictures as powerful stimulators of emotion, and thus threatening to the appropriate use of critical reason, falls short of an adequate understanding of visual experience. Much of the scholarship in visual and media studies, and particularly scholarly attention to advertising and its effects on culture, operates as if it would strip away the manipulative, emotional influence of visual imagery by revealing its effects on us and, by providing us ways in which to "see through" the images and symbols to apprehend their true function in the ad, dissolve their power to trick and manipulate us. While I appreciate the ethical stance inherent in such an enterprise, I cannot reconcile this conception of visual interpretation with the kind of participatory, dialectic negotiation of meaning that I understand hermeneutic scholarship to be. While the scholarly literature on semiotics, for example, and the reflection of this kind of thinking in more publicly accessible works such as Judith Williamson's classic work *Decoding Advertisements* represents an important resource and serves to stimulate thought about what kind of meanings we attach to images and why, my goals for the interpretation of images in this project are quite

different.[154] I am less interested in decoding advertisements–in discovering what an image "really" means or revealing the hidden purposes behind it–than I am in exploring, in conversation with others, the potential meanings opened up by the images in the ads–in imagining, evaluating, and negotiating between candidate suggestions for what the images do, and should, mean to us. The appropriate questions for this type of inquiry are not questions of authorial intent but rather, as Ricoeur puts it, the intent of the text or image itself, where its "intention is the direction which it opens up for thought," the world of possibilities it unfolds before us. An alternative way of framing this task would be to ask, along with W. J. T. Mitchell, "what do pictures want?" Instead of "relying on a preexisting theory, method, or 'discourse' to *explain* pictures," a hermeneutic approach to visual interpretation is one which attempts to *understand* pictures, or, as Gadamer would have it, to encourage the possibility of allowing understanding to occur by dropping the pretension of a methodological answer-key and inviting the pictures "to speak for themselves."[155]

This conception of visual interpretation means not identifying and then allegedly disregarding the affective power of an image but attending to it, concentrating on it, and, according to Martha Nussbaum's insistence on the ethical centrality of emotional (rather than exclusively cognitive) knowledge, learning from it.[156] If all that was needed to adequately cope with the power of pharmaceutical advertisements was to uncover the way in which various elements of the commercial were intended to affect us, the task would be much easier. But even if FDA regulators had direct access to internal memos

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154 Judith Williamson, *Decoding Advertisements: Ideology and Meaning in Advertising* (New York: Marion Boyars, 1978).

155 W. J. T. Mitchell, *What Do Pictures Want? The Lives and Loves of Images* (Chicago: The University of Chicago Press, 2005), 5-6 (emphasis mine).

156 See Nussbaum, *Love's Knowledge.*

and meeting notes from the marketing firms that created an ad, they would still not have the answers to the questions I believe we ought to be more interested in, questions that extend beyond the short-term goal of these advertisements. What will it mean for us, as a society, if we adopt and live within the shared meanings conveyed through these commercials about health, illness, aging, sexuality, relationships, and mortality? Asking these kinds of questions requires us to consider the insight of marketing executives and the expertise of scholars in semiotics and media studies. But more than this, it requires the interpretive participation of all of those whose experience of health and illness is at stake, which is to say, all of us.

The kind of widespread critical reading of commercials that I want to call for insists on the necessity of an active, interpretive public debate about the meanings conveyed in these advertisements and also on the social cultivation of interpretive skill which would make this participation possible. It is with this in mind that I will discuss a few specific techniques for the interpretation of narrative in the next chapter, but because the experience of image does differ in important ways from the experience of text, I first wish to highlight a few of the issues specific to the interpretation of images. The experience of image is immediate in a way that the experience of text can never be. The physical act of reading a string of words and, one by one, connecting them to form the idea that a sentence represents may seem instantaneous, but both the process itself and the kind of logic it calls for is linear and temporal. Pictures, however, are capable of stimulating an audience almost immediately in ways that cannot be explained or accounted for through the same step-by-step propositional logic. Visual experience is quicker and often more powerful for its ability to stimulate even physiologic responses in the viewer. Professional marketers are not the only ones to realize this and make use of it. Retailers often decorate their shops in blue because it calms customers and encourages

them to browse for longer. Red "invokes tension" and tends to hurry consumers along. Restaurants with primarily yellow interiors enjoy a demonstrated increase in complements to the chef, while in this setting, red is also positive, since it "stimulates glandular activity and induces hunger."[157] Not only pharmaceutical advertisements but, increasingly, the pills themselves are designed with the powerful effects of color in mind. Leslie Harrington, a color consultant who works with pharmaceutical companies as well as a variety of other industries describes the intensive research that goes into the decision, for instance, to make Levitra tablets a "vibrant and energetic" orange in contrast with the "grounded, responsible," but perhaps, ultimately, "chilly" blue of Viagra.[158] Both the physiological response to colors and their strong association with various moods is part of why we commonly believe that "images are… the surest route to the emotions."[159] And while the emotional affects of images certainly extend far beyond the use of particular colors, this kind of instantaneous response is what makes image "a primary means," according to Barry, "of influencing attitudes before critical thought is engaged."[160] While I agree, to some extent, with this sentiment, I would take issue with the idea that attitudes (intended here to represent subjective opinions) are completely separate from, or incompatible with, critical thought. As Nussbaum argues, thinking critically about our emotional responses provides us with insights and wisdom that are only accessible through particular kinds of experiences, and only communicable through certain stylistic expressions. There are important things, in other words, that we can only learn from pictures, just as Nussbaum insists that there are certain things we can only

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157 Barry, 264.

158 Eric Konigsberg, "Made in the Shade," *New Yorker* January 22, 2007, 45.

159 Barry, 255.

160 Ibid.

learn from novels, and the nature of our reaction to them (both cognitive and emotional) has everything to do with the lessons themselves.[161] The aim, therefore, is not to attempt to block our reactions to images or literary style, or to ignore them or override them with logic, but rather to attend to them carefully and critically.

The non-linear nature of visual experience also has implications for the kind of connections it encourages us to make. Just as words as strung together one by one, textual (or verbal) communication encourages a style of thinking characterized by step-wise, propositional logic. We are offered the opportunity to test each connection as it is being made. Image, however, happens all at once, and the connections are made, it seems, before we even encounter them. Therefore, we may not even become consciously aware of the connections themselves, much less ask whether they make sense. "Cigars can be sold in the name of a King, underwear in connection with the Spinx" and we don't find this odd because images don't encourage us to question them. They appear to us as already given. We don't expect them to make sense in the way we are used to "sense" being made, one step at a time. And yet images are able to convince us, often without our realizing it, of relationships we would never accept from a text.

> Without directly stating a causal relationship between Newport cigarettes and an active young lifestyle, for example, the advertiser uses the associative perceptual logic of the viewer to make the product seem an essential part of a visual story, and the product a metaphor for the socially rewarding experience depicted. Linear logic cannot achieve this; rather the success of the ad depends upon the formation of a gestalt in which all of the parts become inseparable within the whole.[162]

A hermeneutic approach to visual studies is one that simultaneously recognizes the unique features of visual experience and their implications for the possibility of a critical

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[161] See Nussbaum, 149-67.

[162] Barry, 254.

response, as well as understands images as a particular stylistic manifestation of human communication, and therefore rightly included within the larger framework of interpretive philosophy.

COMPLEMENTARY PARADIGMS

I have argued (and will continue to argue in the coming chapters) that categories such as *true* and *false* cannot adequately deal with pharmaceutical advertisements. Yet while I believe these distinctions to be far from sufficient, I also consider them a necessary part of any responsible analysis. It is my belief that an interpretive paradigm will greatly enhance and enrich our current understanding of the nature and significance of drug commercials, and while an interpretive mindset will necessarily change our perspective on the terms and categories currently in use, I don't believe that it renders them any less useful or effective. Having said that, I admit that the process of examining the problems of one viewpoint and offering, by way of solution, an alternative perspective may seem like an outright rejection of the first in favor of the second. Specifically, any adequate comparison between the modern paradigm and the interpretive turn away from it must reflect, or at least approach, the controversial issue of essentialism. The scientific thinking exemplary of the modern world view is *essentialist*, as interpretive thinkers use the term, in that it is characterized by a belief in absolute certainty and external reality. In contrast, the hermeneutic tradition (in its strongest form) denies not only the existence of a truth external to our interpretation of it, but also refutes the charge that this rejection necessarily leads to relativism or nihilism, concepts which it considers the artifacts of modernity's false dichotomies.

Even if a complete exploration of this issue were possible within the scope of this project, and even if I considered myself capable of leading a reader through the complex philosophical positions involved, I would still hesitate to attempt an account of it for the following reason: if I am successful in articulating my vision for an interpretive evaluation of prescription drug commercials, it will be one that is (that has to be) available to the individuals who receive these messages across their television sets every day. Which is to say, almost all of us. It is not that I'm shying away from the topic of essentialism because I don't believe the average citizen intelligent enough to understand it (although a good deal of background information would be necessary to even frame the question.) It is more that a rejection of essentialism, as its proponents would be the first to say, is a fundamental rejection of the basic categories and assumptions upon which most of our daily lives, not to mention our social, political, and intellectual institutions, are built. And while interpretive thinkers have provided, to my mind, compelling reasons why such a rejection benefits us, as well as an account of why it need not paralyze us into intellectual confusion or existential fear, it is still quite a lot to ask. And, luckily, I don't believe it is necessary for everyone to take this step, although I hope it will come to seem like a more available, less drastic one through the reading of this dissertation. While the various thinkers associated with the interpretive turn would certainly not claim to be of one mind concerning this issue, I think it is safe to say that most of them are prepared to follow the interpretive tradition of philosophic hermeneutics all the way to its logical conclusion, which might be captured in Nietzsche's argument that there are no facts, but only interpretations.[163] The reason that hermeneutic thinkers can agree with this statement and go on about their scholarship and daily lives is the counterpoint upon

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163 Friedrich Nietzsche, *The Will to Power*, ed. and trans. Walter Kaufman (New York: Vintage, 1968), 261-324.

which I understand a project like this to be based: yes, everything is interpretation. But some interpretations are better than others. I hope that my readers are prepared to accept and work with the second half of this dictum even if they are not necessarily convinced of the first. A full account of interpretive understanding necessarily leads us to an anti-essentialist philosophy, and while I find the thinking of Heidegger, Gadamer, and even Nietzsche quite compelling on this point, the beauty of interpretive thinking lies in its capacity to be practiced with rigor and care without requiring us to fully accept, or even fully understand, the entirety of its philosophical implications.

Even this brief attention to the rejection of essentialism within interpretive philosophy may unnecessarily confuse the issue, and if that has been true I encourage readers to disregard my answer to a question that may not even need to be asked. I do feel the need to provide a thorough and contextualized account of why our current ways of thinking have failed us in the instance of DTC advertising, and how interpretive thinking can help. I have included this account of hermeneutic philosophy, however incomplete, to describe the epistemological and ontological basis upon which the paradigm I'm suggesting must rest. But lest it appear that in doing so I'm rejecting scientific ways of thinking altogether, rather than advocating the cooperative interplay between two complementary frameworks, I think it may be helpful (at the risk of getting ahead of myself) to frame the issue in literary rather than philosophical terms.

As I will explain in the next chapter, one of the reasons I advocate the use of narrative thinking within the larger interpretive framework is that it may be more familiar and accessible to a wide audience. Relatively few people understand Heidegger when he says that "language speaks."[164] But almost everyone has read or heard a story and

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164 Martin Heidegger, "Language," in *Hermeneutical Inquiry, Volume I: The Interpretation of Texts,* ed. David E. Klemm (Atlanta, Ga.: Scholars Press, 1986), 144.

thought about it. So when a philosophic account of the interpretive alternative to modernity seems incompatible with my insistence that a scientific framework can and should be used alongside an interpretive one, perhaps it is easier to reconcile the two as alternative narratives rather than incompatible philosophies.

Chapter 4: Judging Stories

INTRODUCTION

I intend the tradition of hermeneutics, discussed in the previous chapter, to provide several elements of my theoretical framework for this project. The first is to examine the nature and scope of the modern tradition, including the specific ways in which it fails to adequately account for the kind of shared meaning conveyed through pharmaceutical commercials. The second is to elucidate the philosophical implications of interpretive thinking and provide an account of the hermeneutic circle that leads to its strongest claim: the insistence that our interpretive understanding of our world not only structures the possibilities for us within that world but actually comprises our identity and existence. The third is to extend the hermeneutic ontological stance to the level of culture. The claim that we are our interpretations, not only individually but also collectively, thus provides the grounding for a particular conception of culture as the aggregate of shared, interconnected, and always provisional interpretations of human experience.

Several tasks remain undone, however, and I will now turn to narrative theory, and specifically to the tradition of ethical criticism of literature, to provide the missing pieces of my theoretical approach to pharmaceutical advertising. The ethical criticism of literature takes as its primary focus the moral content of stories and the ethical nature of narrative itself. If the modern framework has difficulty dealing with shared meaning, those meanings that are described (for better or worse) as *ethical* tend to suffer the clumsiest handling of all. Much of the challenge of modern moral philosophy, and the analytical style of ethics based upon it, lies in the attempt to rescue moral judgment from the untouchable realm of subjective opinion. Even within the bounds of an interpretive

framework that rejects the categories of subjective and objective, scholars often struggle to explicitly account for particular challenges of ethical thinking. These challenges surround the delicate yet unavoidable activity of interpreting, critiquing, and responding to a candidate meaning according to its ethical content and implications. If hermeneutic thinking insists that shared interpretations comprise our culture and ourselves, then both our moral capacity and responsibility rest upon our interpretive skill. And while the original tradition of textual interpretation on which hermeneutic philosophy is based gives an account of the process of interpretation (the tacking back and forth between the details of a text and the context of its whole to reach a coherent meaning), the contemporary tradition lends much more attention to the implications of interpretive thinking than to the specific challenges of the activity itself. It is this task that the tradition of ethical criticism of literature is particularly well-suited to help with. It serves to reframe the complexity of hermeneutic culture in terms of the familiar, accessible, and intuitive practice of reading stories, and it speaks directly to the cultivation of specific narrative skills with which we can attempt, to the best of our ability, not only to read but to read well.

The ethical criticism of literature addresses this challenge in three specific ways. First, it offers a broad conception of ethics that lends itself to a pragmatic, interpretive mode of scholarship and is intimately connected to an equally broadened conception of narrative. Second, it lends an account of how we might undertake a rigorous, scholarly, and collective critique of the ethical content and implications of a story, an interpretation, or a candidate meaning. And third, it provides a unique way of thinking about the relationships involved in collective interpretation by exploring the ethics of storytelling and allowing us to respond creatively to important issues of power highlighted by the particular focus of this project. Additionally, the literary tradition of ethical criticism has

been recently adapted by scholars in the medical humanities to explore alternative ways of understanding and practicing medical ethics. The incarnation of ethical criticism as narrative ethics provides an important backdrop to the analysis of pharmaceutical advertisements. It not only offers a superb example of the connection between literary scholarship and practical understanding of the social world, but it also places the concept of narrative within the realm of medicine, where, as it turns out, it fits rather nicely into the inductive, interpretive framework of clinical judgment that offsets the deductive, scientific side of health care. Because it serves as such a well-placed example of the kind of connection I wish to make between literary theory and ethical action, and because it deals specifically in the concepts of health and disease that the pharmaceutical commercials traffic in, narrative ethics represents an important resource for the kind of interpretive work I wish to do with these advertisements. I will draw heavily, therefore, on the work of narrative scholars in medicine, such as Anne Hunsaker Hawkins, Kathryn Montgomery, and Tod Chambers, as well as scholars who have recently revitalized the tradition of ethical criticism in literary studies, such as Martha Nussbaum and Wayne Booth, in exploring this narrative perspective and its relationship to hermeneutics.

While I now intend to turn to an academic tradition that is related to, but distinct from, the hermeneutic tradition discussed in the previous chapter, I want to point out that I consider this transition not so much inevitable or logically necessary as (hopefully) helpful and clarifying. My intention in moving to literary studies is not to argue that literature represents the next step in interpretive thinking, or to construct a step-wise transition from the concepts of interpretive meaning to the concept of narrative. It is rather to switch metaphors–to set aside, for a moment, the specific perspective and language of hermeneutics and adopt the terminology and viewpoint of literary studies, all the while drawing connections between the two, and understanding them, finally, to be

different ways of approaching the same fundamental, and fundamentally ethical, activity. By holding these traditions next to each other, we can more easily recognize their similarities as well as their differences. And, more importantly, we can glean from each a clearer understanding of concepts that remain implicit or inaccessible in the other.

A BROAD CONCEPTION OF ETHICS

The interpretive understanding of culture developed in the last chapter describes the way in which we co-create our social reality through collective attempts to understand it. Implicit within this epistemological and ontological position lies a moral one: an insistence that with the recognition of culture as our collective and creative product must come the responsibility of careful and deliberate cultivation of the kind of reality within which we wish to live. The ethical dimension of hermeneutic anthropology stems from the realization that we shape the possibilities for our lives together, and it demands, therefore, that we consider questions about how we ought to live as necessary and vital components of our collective interpretation and negotiation.

The kind of ethical thinking required by this interpretive perspective fits precisely within the broad conception of ethics advocated by Martha Nussbaum in her efforts to revitalize the ancient connection between literature and moral philosophy. Working within what she characterizes as "an Aristotelian conception" of ethics, Nussbaum calls for an understanding of moral inquiry which centers on the "broad and inclusive question: 'How should a human being live?'"[165] This approach to ethics differs significantly from that of modern moral philosophy. The tradition of analytic,

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[165] Nussbaum, 25.

philosophical ethics is often associated with the legacy of Enlightenment thinkers such Kant, Rawls, Locke, Rousseau, Bentham, and many more. Although these philosophers disagreed on significant points, together they helped to create a legacy of understanding and exploring human morality. This line of thought, arguably as successful and influential as modern science, provided the ethical foundations upon which our system of liberal government (and the ideal of tolerant pluralism it allows for) is based. In the realm of medical ethics, it has helped create a hard-won consensus concerning basic guiding principles, as well as a vocabulary and procedural style of handling disputes and conflicts that is accessible to the diverse participants in health-care decisions. The vast majority of serious and thoughtful practitioners of analytic medical ethics understand these principles, along with various alternative ethical theories such as utilitarianism, as "rules of thumb that command perceptive and improvisational interpretation by particular people in particular circumstances."[166] Yet despite having been tempered by the practical orientation of bioethics, this tradition of ethical inquiry necessarily reflects the epistemological and ontological foundation upon which it is based. Jane Adamson makes this point by observing, simply, that "philosophy" (and here she refers to modern, analytic philosophy) "works against untidiness."[167] It works to categorize, to sort out, to simplify and resolve. Which, of course, are precisely the kinds of things we need it to do in many cases.

Yet Nussbaum, along with Adamson and a host of other recent scholars seeking to reform our ideas about ethical inquiry, calls for "an expansion and reconstruction of what

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166 Anthony Cunningham, *The Heart of What Matters: The Role for Literature in Moral Philosophy* (Berkeley and Los Angeles: University of California Press, 2001), 2.

167 Jane Adamson, "Against Tidiness: Literature and/versus Moral Philosophy," in *Renegotiating Ethics in Literature, Philosophy, and Theory,* ed. Jane Adamson, Richard Freadman, and David Parker (New York: Cambridge University Press, 1998), 88.

moral philosophy has for a long time been taken to be and to include."[168] These scholars point to the dangers arising from an unchecked force for order and neatness in the task of understanding our moral lives and relationships. Anthony Cunningham warns that analytic ethical theories may "purchase systematic pictures of how we should live at the high price of failing to map the true complexities of life and character."[169] He takes as an example the work of Immanuel Kant, a seminal figure in the modern tradition of moral philosophy. Although Kant's work has unquestionably changed our understanding of ourselves and our relationships for the better in many cases, demanding a serious consideration of our obligations to others and an uncompromising insistence on the force of moral duty in our lives, Cunningham believes it "errs by fitting everything that matters morally under the umbrella of respect for equally worthy rational beings."[170] In doing so, he argues, Kantian ethics "leaves out or twists all sorts of intimate attachments that provide shape and meaning to countless lives."[171] Of course the work of any one philosopher alone cannot hope to provide a full account of morality, and those who criticize analytic ethics often point to the most extreme examples of this tendency towards tidiness. Yet, even if the day to day practice of analytic ethics ends up being messier, and more interpretive, than it appears in the abstract, the analytic stance which it takes towards human behavior aspires, fundamentally, to sort out, tidy up, simplify, and (in this sense) *analyze* moral dilemmas so that they may be resolved. Which, in a great many instances, is an important and necessary thing to do. The narrative scholars writing in reaction to analytic ethics, however, point out the shortcomings of an understanding of

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168 Nussbaum, 27.

169 Cunningham, 2.

170 Ibid., 3.

171 Ibid.

morality that seeks, above all, to tidy up the mess it perceives our less-than-ideally-rational behavior to be. To balance out this force for order, therefore, we need what Iris Murdoch calls "a renewed sense of the difficulty and complexity of moral life and the opacity of persons."[172] What is needed is a powerful reminder that the mess we find ourselves in is a tangle of complicated emotional connections, strongly held and yet conflicting commitments, and personal and cultural beliefs, not to mention forces like faith and love and fear that we can't reason with and often don't want to. The mess, in other words, is a mess of meaning–the kind of meaning that resists division, categorization, and resolution. To approach the task of ethical inquiry without unintentionally oversimplifying or devaluing the things that truly matter is to adopt a broad, and, according to these scholars, literary conception of ethics. Because it "works against tidiness," literature allows us to examine and appreciate the complex forces and systems of meaning within which we live, and to do so without the sometimes distorting pressure of strict logic.[173] Therefore, a broadened conception of ethics frames our fundamental moral task as the attempt to live well, and insists that this can only be done by recognizing, honoring, and trying to understand the dense and complex systems of meaning that contain and constitute our deepest moral commitments. This way of thinking conceives of ethics not as the circumscribed, formal analysis of expert academicians but as the broadly accessible interpretive negotiation of the way in which we understand the world and each other. It is a task, as Hilde Nelson claims, "for

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[172] Iris Murdoch, "Against Dryness," in *Existentialists and Mystics: Writings on Philosophy and Literature*, ed. Peter Conradi (New York: Penguin Books, 1997).

[173] Adamson, 88.

amateurs."[174] Her description of this broad conception of ethics draws implicitly on many of the features of hermeneutic participatory culture:

> It sees morality as a continual interpersonal task of becoming and remaining mutually intelligible. In this view, morality is something we all do together, in actual moral communities whose members express themselves and influence others by appealing to mutually recognized values and use those same values to refine understanding, extend consensus, and eliminate conflict. The narratives we tell as we jointly and collectively decide what we ought to do help us make moral sense of our lives and create common expectations about which of us is responsible for what, to whom. Here, the authority for moral intuition rests on its embeddedness in a shared form of moral life, while the basis for moral criticism lies in the tensions between, and the fissures within, the stories that circulate widely in the community.[175]

Envisioning ethical inquiry as the collective task of the members of an interpretive community helps to elucidate the moral position implicit within a hermeneutic conception of culture. It is not enough that we encounter, interpret, and therefore create the meanings within which we live. We must carefully critique our own interpretations and those that we encounter, and we must do so skillfully, with explicit attention to the ethical content of the various candidate meanings available to us. The questions involved in this kind of ethical inquiry are not those such as "What is our duty in this situation?" "How can we maximize utility?" or even "What is the right thing to do?" Once we give up the notion of there being any *one* right thing to do, any external rule or system to which we can appeal with objective reason, then we learn to ask different questions–the kind of questions that Nussbaum asserts, along with Aristotle, actually represent the bulk of our day-to-day, common-sense, practical effort to live well. Faced with confusion or conflict, we do our best to make provisional sense out of the

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[174] Hilde Lindemann Nelson, "Context: Backward, Sideways, and Forward," in *Stories Matter: The Role of Narrative in Medical Ethics*, ed. Rita Charon and Martha Montello (New York: Routledge, 2002), 46.

[175] Ibid.

situation, taking all of its complexity into account, and then, through conversation and negotiation, we attempt to evaluate and to choose between competing interpretations. The question is not "is this the correct solution to this situation?" The questions, rather, are "is this the best way available to us at the given moment?" "What does this all mean for human life? What possibilities does this recognize or deny?" [176]

The candidate meanings conveyed in pharmaceutical ads are competing for our participation, each one a suggested shift in our social reality. Their acceptance and adoption will open up certain possibilities and close off other interpretations and experiences. Once we understand that our responses to the various meanings we encounter will guide us toward particular possible futures, we understand the importance of choosing our meanings carefully. Ethics, then, conceived as the attempt to live well, has everything to do with possibilities we accept or reject for our individual and collective lives. It has everything to do with what we decide, together, that our world and the elements within it *ought* to mean to us. It rests not so much on a search for ultimate moral truth, but more on the continual enterprise of deliberately shaping an interpretive framework within which we can live well. By insisting on the connection between our understanding of the world around us and our ability to live well within it, this broad conception of ethics offers an interpretive alternative to modern moral philosophy by asserting that the realm of ethics "has to do with more than detached facts that can be conceived and appreciated independent of how we articulate them."[177] Instead, as Anthony Cunningham puts it, "ethics is a matter of judgment in a broad sense, one that necessarily involves our attitudes, patterns of reaction, and emotions."[178] Despite

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[176] Nussbaum, 12.

[177] Cunningham, 5.

[178] Ibid.

modernity's insistence on the separation of rational cognition and dangerous passion as a prerequisite for rigorous moral thinking, interpretive ethics posits that "ultimately, knowing how to live and what sort of person to be is integrally connected with feeling. Good character involves seeing the world in particular ways."[179] Through this conception of ethics, we may better appreciate the relationship between literature and moral inquiry, a relationship highlighted by a particular tradition within literary studies, that of ethical criticism.

THE ETHICAL CRITICISM OF LITERATURE

The tradition of ethical criticism of literature is one whose history intermingles with the changing standards and values of literary criticism in general. Simply put, ethical criticism of literature is the reading, analysis, and discussion of literature that deals explicitly with its ethical elements, conceived largely as the stance that a work takes, through both its form and content, toward the human project of living well. If it is difficult to immediately understand the distinction between ethical criticism and criticism in general, it may be because those of us who are not academic literary critics read with an eye toward the ethical without necessarily realizing it. In other words, most of us read and think about books without separating their ethical content from their formal or aesthetic properties. For example, Harper Lee's *To Kill A Mockingbird* and J.D. Salinger's *Catcher in the Rye* provoke ethical reflection in the large sense introduced above: they cause us to reflect on morally significant topics (such as value of innocence and the ways in which we deal with its loss) as well as issues that are more explicitly

[179] Ibid.

ethical (such as social justice and personal authenticity). The ethical content of these works rarely emerges for us as separate, or separable, from the aesthetic or formal qualities of style and structure. As high school students and, later, as adult lay readers, we gain much more from reading novels like *Mockingbird* and *Catcher* than knowledge of formal properties such as theme or character development. It could be argued, in fact, that the more significant and lasting lessons we learn from these works are those that have to do with life and how we ought to live it. Yet while both of these novels deal with the issue of innocence, and both draw much of their moral power through the perspectives of the children who narrate them, one has enjoyed a nearly universally accepted place among the literary educational canon and one has been subject to fluctuating cultural standards, banned at times from libraries and embraced at other times, in other places, as required reading for teenagers.

Those in academic circles have sought to defend such works, critically considered masterpieces. But rather than arguing for the ethical merit of controversial works, as might be seen in Holden Caulfield's visceral reaction to profanity invading the realm of childhood, or arguing that a carefully critical reading of a disturbing novel such as *Lolita* can offer us an occasion to challenge (and then alter or reinforce) our own values rather than blindly absorb those of a pedophile, literary critics have argued, instead, that morality has no place in the world of serious narrative interpretation, and that the imposition of subjective, ethical judgments upon works of literature represents a corruption of the true value of such works, which lies not in what they have to say about the world but the skill and techniques that the author has used to say it. I will return to the issues of moralism and censorship in a moment, but first I must point out that the tendency toward strict formalism in literary studies goes beyond the desire to protect good books from bonfires. Powerful elements of our philosophical and cultural traditions

have fortified and contributed to the exclusive attention to form in academic literature. The far-reaching epistemological and ontological influence of modernity continues to shape our understanding of not only philosophy and science but also of art as well, and the tendency to divide knowledge and human capacities into strict and mutually exclusive categories frames the more specific reasons for the separation of ethical inquiry and literature. The difference, for example, between the way in which ancient playwrights understood the power of tragic theater as a creative means to collective moral reflection, and the way in which Enlightenment-era thinkers recognized a fundamental distinction between literary fiction and moral truth demonstrates the extent to which our approach to literature has been shaped by the prevailing intellectual and cultural worldview.[180] While a complete history of the relationship between literary criticism and moral philosophy would require, as Wayne Booth comments, attention to "every major critic and every major philosopher (since they all deal with ethical questions)," the scope of this project will allow only the brief mention of a few key historical and philosophical themes that are most helpful for the introduction and rough characterization of this particular tradition of literary criticism.[181]

At least two distinct features of modern epistemology contributed to the radical separation of moral philosophy from literature. One is the position, often traced back to Kant's work on aesthetics, that true art exists in a pure form, and ought to be unsullied by the imperfect and inconsistent realm of human morality. According to this line of thinking, art should be appreciated for art's sake. It is placed on an intellectual pedestal

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[180] This is, of course, a radically simplified comparison of the ancient and modern relationships between literature and philosophy. It excludes most obviously, perhaps, Plato's decision to ban the poets from the Republic based on what he perceived as the dangerous nature of art. For a more complete discussion of this "ancient quarrel" and its extension through the modern era into contemporary times, see chapter 1 of Nussbaum's *Love's Knowledge*.

[181] Wayne Booth, *The Company We Keep: An Ethics of Fiction* (Berkeley and Los Angeles: University of California Press, 1988), 26.

and thus protected from those who would use it instrumentally to teach the moral values they believe it supports as well as from those who would denounce it as dangerous and morally corrupt. This protective stance works to elevate the serious consideration of literature to a purely formal level, where critics can discuss and evaluate it in isolation from the subjective world (the ethical, political, cultural, and even historical context out of which the novel came) and focus instead on the proper subject of criticism – the formal properties of the text itself.

The second aspect of modern thinking upon which the exclusivity of formal criticism rests is the fundamental division between objective demonstration and subjective judgment. Like nearly every other modern intellectual discipline, the study of literature has been shaped by the perceived pressure to base legitimate scholarship on the model of the natural sciences, and to therefore traffic in an almost factual critique: a style of literary analysis verifiable according to widely acknowledged, allegedly objective standards. Within this perspective, addressing issues of morality and asking questions about the good life risks "violating academic norms of objectivity."[182] Formal features of a text became fact, and the proper subject of rigorous criticism, while interpretation of the content of a work of literature (particularly any explicitly ethical analysis of what the work has to say about the world and how to live in it) was viewed as amateurish, moralistic, subjective judgment rather than serious criticism.

Yet lest it appear that I am accusing modern philosophy and science of distorting the true purposes of literature by insisting upon this separation, I want to quickly point out that, unfortunately, much has been done in the name of literature and morality to justify a skeptical stance toward any combination of the two. The distinction between serious literary scholarship and the often unreflective, moralistic judgment of those who

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[182] Ibid., 3.

believe themselves qualified to define the standards of art, or to protect the rest of us from it, is no less important now than it was in the day when Rhett Butler managed to shock an audience, riveted only moments before by gruesome scenes of cruelty and warfare, by daring to use the word *damn* on screen. If modern, Enlightenment-era thinking created strict categories such as fact versus fiction, and subjective judgment versus objective scholarship, then the attention to moral issues in the world of literature, particularly in the nineteenth century, provided ample reason for literary scholars to work according to modern standards, protecting both the legitimacy of their field and the literature which they studied. The recent revitalization of the tradition of ethical criticism represents the effort to re-examine and re-appreciate the valuable contributions that literature and literary studies can make to moral philosophy while attempting to avoid the problems that have characterized the tradition in the past. To this end, Martha Nussbaum has insisted upon the centrality of careful formal analysis to any adequate interpretation of the ethical content of a work, pointing out the way in which literary style "expresses its own sense of what matters."[183] Because formal style is, itself, an ethical statement, and because the content of the work cannot be adequately understood in isolation from the language and narrative structure that express it, formal analysis is not the counterpart to ethical criticism. The two activities must be one and the same. Without rigorous attention to metaphor, point of view, structure, irony, characterization, and the like, no reader can claim to appreciate, much less begin to judge, the implications of a work of literature for our moral lives. The problems encountered with this tradition in the past have often ostensibly been those of censorship, but are perhaps more precisely understood as problems of moralism: narrow, rigid, incomplete and unconsidered interpretations that were either never challenged by other readers or that were held and acted upon without

[183] Nussbaum, 3.

regard for or honest engagement with those who interpreted the work differently. When a novel like *Catcher in the Rye* is considered a danger to childhood innocence, rather than an insightful examination of its painful yet inevitable loss, and when other readers are consequentially prevented from testing this interpretation for themselves and challenging it within the bounds of a moral community, what we are faced with is not literary criticism, ethical or otherwise. It is the unfortunate lack thereof.

Even if the years of exclusive formalism in literary studies have unnecessarily distanced, according to Nussbaum and her colleagues, the world of literature from the world of moral inquiry, they have certainly yielded a great deal of insight and skill in the careful analysis of literary form, a skill which we must now bring to bear as a necessary part of, rather than a separate activity from, the ethical criticism of literature. Of course I must hastily add that training in formal analysis does not necessarily protect against narrow, rigid, or even grossly inadequate ethical evaluation. Even more unsettling is the realization that we can never be certain (at least in the sense that modernity has raised us to want to be certain) that our rigorous formal and ethical interpretations of a work are *correct*. A hermeneutic perspective on literary criticism helps us to make sense of Wayne Booth's insistence that our interpretations can only strive to be better than a preceding or competing interpretation, and that the only sense in which our readings can be validated is within a community of critical peers, and over the time required for fresh perspectives to emerge.[184] Our reading of a work of literature is both social and provisional in this way, and because the tradition of ethical criticism insists that it must also be practical, we cannot afford to wait for justification from potentially infinite generations of future readers, and infinitely widening cultural communities of contemporary ones, in order to

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[184] See Booth, 70-77, for his discussion of "co-duction" as the literary counterpart to deductive thinking.

learn what we can from literature and then put it to work in our daily lives. While we must do what we can to encourage a widening circle of participation and critical conversation in both of these dimensions, and to adapt our understanding as we encounter the responses of others, we must do so in the midst of our continual attempt to understand our place in the world and to live well within it. Gadamer's insistence that all knowledge is provisional, and that human nature requires this kind of comfort with ambiguity despite our modern aspirations to certainty helps to fortify Nussbaum's argument (which she adopts from Aristotle) that this is what we actually *do*, whether we take the time to theorize about it or not, when we have to reach mutually acceptable moral understandings and navigate difficult ethical paths together. We contribute what insight we can, we engage each other in open, critical, and hopefully respectful dialogue, and then we do the best we can, for now.

The connection which Nussbaum and others have drawn between the interpretive choices we make in an academic, critical community and the ethical choices we make within a moral community reflects two important aspects of the recent revitalization of ethical criticism. One is a reexamination of the nature of narrative itself, and a reconceptualization of storytelling from a specific form of literary art to a fundamentally creative form of human understanding, and the other is the extent to which ethical inquiry, as it relates to literary interpretation, requires us to seriously examine what it means to choose between competing narratives.

THINKING WITH STORIES

As a perspective different from, but closely related to, hermeneutics, the characterization of human understanding as fundamentally narrative has been supported

by scholars of philosophy and even cognitive science as well as literature. If Gadamer insists upon the primacy of interpretation in human understanding, this broad conception of narrative serves as an epistemological notion that both falls within and, in some sense, sets itself apart from, interpretive thinking in general. A narrative perspective highlights and attempts to resolve some of the same perceived shortcomings of modernity, such as the need for an adequate account of meaning and a rejection of binary thinking, that the hermeneutic tradition addresses. Yet important differences emerge between the concept of interpretation in general and a specifically narrative conception of understanding, the most important of which, for our purposes, has to do with time.

Mark Johnson relies up empirical investigations in the cognitive sciences to ground his assertion that the fundamental mode of human thought is a narrative one. As to the importance of time in our thinking, he explains that "narrative supplies and reveals the themes by which we seek to unify the temporal, historical dimension of our existence."[185] Without a narrative structure, in other words, we would conceive of our experience not as the unfolding of a unified life, but rather as "a meaningless jumble of disconnected events."[186] We understand ourselves and our lives, according to Johnson, by the very act of drawing meaningful connections between the things that have happened to us in the past, the things that are happening to us in the present, and the things we hope to happen, or not to, in the future. The conception of self which emerges from empirical cognitive science is, ironically, not the autonomous self upon which modern science is based.

> Objectivism treats the self as existing and having its identity, both temporally and metaphysically, prior to its actions. It treats the self as retaining its essential

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185 Johnson, 170.

186 Ibid.

> structure–a rational will–regardless of the contingent acts it performs and the historical situations it inhabits. In sharp contrast, the … experientialist self.. regards the person as a self-in-progress … We inhabit this world both as beings who are constituted by sedimented cultural practices, institutions, and meanings, but also as constituting beings who can gradually transform dimensions of these preexistent, inherited structures of meaning and action.[187]

Johnson's arguments demonstrate the connection of narrative to hermeneutics, particularly in the last lines of the above quote. The more important concept for the specific topic of narrative understanding, however, is the idea of "a self-in-progress." The implicit context for this progress is, of course, a temporal one. The idea that we are continually becoming who we will eventually be, that we are now different than we were, is both an intuitive and obvious element of our common-sense understanding of human experience and a powerful argument for the fundamental narrative character of that experience. A sense of meaningful development over time, a vision of life made coherent by our faith in the possibility and inevitability of relating the present to the past and thereby envisioning a possible future all reveals the fundamentally temporal nature of human experience and the extent to which "human beings exist in and through time."[188] Torn from the context of an individual past, and prevented from imaging a potential future, the self, isolated in the present, has no way to meaningfully identify or understand itself. It does not exist outside of its story. In other words, the self *is* a story that unfolds, as do all narratives, over time. "Time becomes human to the extent that it is articulated through a narrative mode, and narrative attains its full meaning when it becomes a condition of temporal existence."[189] Because it constantly leads us forward, asking, as

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[187] Ibid., 11.

[188] Ibid., 160.

[189] Paul Riceour, *Time and Narrative*, trans. Kathleen McLaughlin and David Pellauer, (Chicago: University of Chicago Press, 1990), 52.

Ron Carson puts it "… and then what?" narrative supplies the fundamental metaphor for our human experience of the world over time, and the basic form within which our understanding of that experience is produced, articulated, shared, tested, and refined.[190] Given the connection between the conditions for understanding the world and the possibilities for living well within it that we have already explored, it comes as no surprise that the next step in this reexamination of narrative is the recognition of its ethical implications.

> Narratives not only report and recount experiences or events, describing them from the limited and positioned perspective of the present. They also project our activities and experiences into the future, organizing our desires and strategies teleologically, directing them toward imagined ends.[191]

If the stories we tell to understand ourselves represent particular interpretations of our present in light of our past, they also necessarily represent the implicit requirements for our imaginable futures. Ricoeur's assertion that interpretation is the opening up of "a world which [the text] bears within itself" rather than the decoding of the (correct) meaning behind it helps to make explicit the connection between hermeneutic philosophy and narrative studies.[192] The stories we tell to make sense of our collective experience necessarily shape the possibilities for our future. Realizing this, we are faced with an understanding of ethical inquiry which insists that we therefore think carefully about which futures we would like to orient ourselves towards as we adopt some, and reject others, of the narrative structures through which we live.

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[190] Ronald A. Carson, "The Moral of the Story," in *Stories and Their Limits: Narrative Approaches to Bioethics*, ed. Hilde Lindemann Nelson (New York: Routledge, 1997), 232.

[191] Byron Goode, *Medicine, Rationality, and Experience: An Anthropological Perspective* (New York: Cambridge University Press, 1994), 139.

[192] Riceour, "The Model of the Text," 208.

Within the realm of health care, Arthur Frank and David Morris urge medical humanists, ethicists and clinicians to consider what it means to "think with stories" rather than simply thinking "about them."[193] The difference, they contend, is one which hinges upon the recognition of narrative power–the power to transform our lives and actions by attentively receiving and responding to the stories of those around us. This transformative potential of narrative helps to make sense of how we become who we are, and therefore who we will be, based on the particular stories with which we make sense of our lives and our relationships. The patient's story, then, becomes much more than a means to clinical history. It becomes an occasion for shared understanding, an opportunity for mutual moral inquiry, and a deliberate co-creation of a desired future. Understanding narrative in this way, according to Frank, represents a moral stance toward another human being that extends beyond the physician-patient relationship. Yet the fundamental respect for suffering, and the sincere desire for genuine moral connection that characterizes this stance toward the story of another makes the act of serious criticism no less important or possible.

While holding the moral value of each individual's story, and the ethical insistence on everyone's right to participate in the conversation, constantly in mind as guides to our interaction with fellow critics and storytellers, we must nevertheless accept the fact that living and thinking with stories (by recognizing the ethical implications they have for our lives) requires us to undertake the often difficult activity of honest and careful critique. The broad conception of ethics discussed in relation to the hermeneutic understanding of culture above, combined now with the fundamental nature of narrative,

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[193] David B. Morris, "Narrative, Ethics, and Pain: Thinking with Stories," in *Stories Matter: The Role of Narrative in Medical Ethics*, ed. Rita Charon and Martha Montello (New York: Routledge, 2002), 196; Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: University of Chicago Press, 1995), 23.

sets the task of moral inquiry before us in the following way: we must choose between the stories available to us, carefully critiquing and collectively negotiating among the narratives through which we ought to live. Such a project requires the interpretive skill and moral self-awareness to recognize that some stories are better than others, the capacity to articulate why we think so, and the willingness to change our minds through open dialogue with others. Characterized less as destruction, forbiddance, or even outright rejection, and more as the necessary consequence of provisional choice and careful discrimination, there is a sense in which the ethical criticism of literature necessarily involves censorship. I use the word in the sense that Wayne Booth describes as the inevitable result of the impossibility of accounting for, and in this particular context the impossibility of living according to conflicting narratives.[194] The extent to which this conception of ethics forces us to make difficult choices between stories, between particular visions of the kind of lives we wish to lead, reinforces the importance of our capacity to do so carefully. The human capacity emphasized by this perspective is not that of strict reason or cognitive logic (although certainly reason and cognition play important roles) but rather that of imagination and interpretive skill. It is this capacity that the tradition of ethical criticism, and its specific manifestation in narrative (medical) ethics, works to exercise and cultivate.

INTERPRETIVE TECHNIQUES

I do not intend, in this section, to provide a how-to manual for literary interpretation, or even to suggest that such a thing could exist. The trick of interpretive

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[194] See Booth, 26- 28.

thinking is, as Gadamer teaches us, learning how to get along without the crutch of strict method. However, while hermeneutic philosophers are right to insist that we may never step outside of our human perspective to see that we are thinking "correctly" or according to the proper set of rules, adopting an interpretive framework does not preclude the use of technique or guidelines. On the contrary, the hermeneutic circle depends upon our learning from one another's experience, and does not so much deny the possibility of method as redefine it as a collection of accumulated hints and suggestions. In this vein, the proper *method* for cultivating critical skill is extensive careful reading–not only of the kind of complex novels Nussbaum recommends, or even of stories in general, but also of the critical literature composed of the interpretive work of others. By exposure to the way in which other readers, particularly those who have received training in literary and other interpretive disciplines, approach a text and reflect upon it, we can retrain our attention to notice key features of the text and, therefore, more completely appreciate the moral implications of its acceptance or rejection. What follows is a brief sketch of a few perspectives, drawn largely from the scholarship on narrative ethics, that I find particularly illuminating and helpful for the interpretation of pharmaceutical advertisements. This is by no means meant to provide a comprehensive list of interpretive approaches or techniques, nor is it meant to represent any kind of standardized approach to narrative work. I hope instead that it will provide a brief glimpse at the work of a few scholars who make use of specific stylistic elements to approach ethical issues. I include it here not only as a window into the kind of thinking which characterizes the practice of rigorous textual interpretation, but also as evidence of the specific ways in which the tradition of ethical criticism can lend practical guidance for the task of becoming more careful readers.

Image and Metaphor

George Lakhoff and Mark Johnson have argued that metaphor plays a key role in both human understanding and communication.[195] The figurative language used to describe an aspect of our experience can tell us much about the nature of our understanding of it, and illuminate ethical stances which might otherwise remain implicit and unexamined. Critical evaluation of stories competing for our individual and collective adoption would do well to begin, therefore, with an analysis of the nature and ramifications of the metaphor. In *Illness as Metaphor*, Susan Sontag provides probably the most well known and influential text on society's tendency to understand medical conditions in and through particular metaphors, metaphors which powerfully shape the cultural reaction to and treatment of patients with particular conditions.[196] Her analysis spans from the tendency to equate consumption (tuberculosis) with intensity of spirit, creativity, and beauty in the late nineteenth century to the ways in which the identification of risk groups shaped social ideas about, and even medical and political reactions to, the early stages of the AIDS epidemic. Sontag's great gift to future theorists is her focus on the language we use to talk about diseases in everyday conversation, in medical consultations and textbooks, in literature and film and television, and to link the metaphors used in such language to foundational ideas about disease that could then be illuminated, understood, and evaluated. Her own experience as a cancer patient lent Sontag a distinctive appreciation for the negative potential of figurative language. In the 1970s, cancer patients were subjected to significant social stigma, depending, as Sontag

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195 George Lakoff and Mark Johnson, *Metaphors We Live By* (Chicago: University of Chicago Press, 1980).

196 Susan Sontag, *Illness as Metaphor and AIDS and Its Metaphors* (New York: Doubleday Books, 1990).

eloquently made clear, on the particular type of cancer they suffered. She convincingly articulated the cruelty involved in shunning those affected with particular diseases as alien, or contaminated, or even justly punished, while effectively celebrating others as innocent victims, or courageous, or constitutionally delicate.

Perhaps the most persuasive metaphor she addressed, and perhaps the most prevalent in medical and larger culture today, is the war metaphor as applied to cancer patients. Encouraged to "fight" with the "weapons" of chemotherapy and radiation, patients are addressed and referred to in terms of strength or weakness, resolve or resignment, victory or surrender.[197] While the pervasiveness of these images, and of the metaphor of cancer (or its treatment) as war, depends in part upon its success. Many people find hope, solace, and strength by hearing themselves referred to, or adopting a characterization of themselves, as fighters. Yet cancer, an often fatal disease, is quite a formidable enemy, and if victory is defined as cure or even remission, the ranks of winners number relatively small. For patients who recognize the terminal nature of their disease and choose to spend their remaining time away from hospitals and therapy, this metaphor paints their decision as weak or cowardly. And for those who "fight" to the very end, the metaphor often casts them in the last role they will ever play, described in terms that Sontag reveals to be upsettingly common opening lines to their obituaries, as those who "lost their battle with cancer."

Sontag's work underscores my claim that some stories, based on the metaphors above, are harmful, and a careful reading reveals them to be ethically undesirable. The terms with which they invite us to understand a particular experience, our role in the world and the goals we ought to aspire to in order to live well are disrespectful, divisive, and damaging. Her legacy is a call for close reading and critical analysis of our own

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[197] Ibid., 64-71.

language to illuminate hidden assumptions and potentially damaging ethical stances. Anne Hunsaker Hawkins has continued in the tradition of Sontag by paying particular attention to metaphors which patients use to understand their experiences. Narrative of illness is medical-literary form which has been studied by scholars in the medical humanities as a window into the experience of illness, and our culture's particular understanding of it. Hawkins, who uses the term *pathography* to describe a personal account of the experience of an illness, categorizes many such works according to the primary metaphors, or "myths" that the authors use to organize, describe, and ultimately understand the events of their illness.[198] She notes, as have other authors, that certain metaphors are more commonly found in association with particular diseases, and that certain metaphors seem to *work* better than others–that is, they seem better able to help the patient or author come to terms with what has happened and envision the remainder of his or her life story in a positive, enabling way. Hawkins does not explicitly characterize her work as belonging to the tradition of ethical criticism of literature, or emphasize the extent to which her judgments of the various myths at work in the pathographies are ethical in the broad sense of the term. Yet she undeniably argues that some stories are better than others, and attempts to delineate the ways in which this is true.

Authorship and Readership

Wayne Booth characterizes the ethical importance of literature by pointing out the deeply personal connections we often forge with those stories that shape us the most, and

198 Anne Hunsaker Hawkins, *Reconstructing Illness: Studies in Pathography*, 2nd ed. (West Lafayette, Ind.: Purdue University Press, 1999).

by likening the books which play this role in our lives to friends. The choice of which stories to adopt on this personal level then becomes the choice of what company to keep. If we are judged by association, claims Booth, it is not only because the moral character of our acquaintances reflects our own character and ability to judge others, but more fundamentally because the books that take this intimate place in our lives actually transform us in the same way that significant companions make us who we are. Every story, according to this way of thinking, represents the invitation to change in a particular way, just like every offer of friendship represents an invitation to take on new roles and become, in some sense, a different person for the experience of it. While we may not realize that this transformation is taking place, Booth insists that "insofar as [a] fiction has *worked* for us, we have lived with its values … we have been *that kind of person* for at least as long as we have remained in [its] presence."[199] Whether we remain the kind of person that the work invites us to become depends upon the strength of its particular influence over us, or, in Booth's terms, the strength of our relationship with it.

Yet as with friendship, the transformative element of literature is more often than not unappreciated until after the fact. We rarely enter into such a relationship (be it personal or literary) with explicit attention to the possibilities for self-change which the invitation of friendship represents. Yet Booth insists that this is precisely what we must do if we wish to take the transformative power, and the moral force, of literature seriously, and it is through this perspective that he conceives of our moral lives. "Our essential ethical experience," he maintains, "occurs in the specific relations, moment by moment, inference by inference, among multiple characters who offer and receive, construct and reconstruct, write and rewrite."[200] To help us do this well, Booth attempts

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[199] Booth, 41.

[200] Ibid., 149.

to parse out the various identities (real, potential, current, and possible) at work in the relationship of reader, text, and author. After identifying all of these personas, he asks what relationships exist between them, what responsibilities they hold for one another. Perhaps the most significant element of Booths' analysis for the specific issue of pharmaceutical advertising has to do with the "implied reader" of a work: the person, or kind of person, that the author has in mind when he or she pictures the book's eventual audience.[201] Booth's implied reader falls in line with the ideas of several other literary scholars who insist upon the importance of this inquiry for textual analysis. Tod Chambers sketches the outlines of this particular body of scholarship, noting Peter Rabinowitz's concept of an "authorial reader," Umberto Eco's "model reader," and Walter Gibson's "mock reader" along with Booth's "implied reader," all of which Chambers takes to be specific instances of inquiry into "the way writers construct their audiences."[202] The use of the word *construct*, along with his reliance on Walter Ong's claim that the writer's imagined audience is always "fiction," underscores Chambers attention to the disconnect between the reader that the author had in mind and the one who actually ends up holding the book.[203] This disconnect becomes troubling when the actual reader begins to sense ways in which he or she does not, or does not want to, fit the sort of mold offered by the author. Booth's language of invitation captures this tension quite well, I think, when he points out that these fictionalized, implied readers are visions of ourselves as potentially changed by the experience of the text, and therefore represent

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201 Ibid., 127.

202 Tod Chambers, "The Bioethicist's Audience Is Always a Fiction" (paper presented at the annual meeting for the American Society of Bioethics and Humanities, Denver, Colo., October 2006), 2.

203 Walter J. Ong, "The Writer's Audience Is Always a Fiction," in An *Ong Reader: Challenges for Further Inquiry*, ed. Thomas J. Farrell and Paul A. Soukup (Cresskill, N.J.: Hampton Press, 2002), quoted in Chambers, 3.

occasions to embrace those possible changes, accept them provisionally and with caution, or reject outright the author's characterization of the audience.

Plot and Point of View

Kathryn Montgomery and Tod Chambers have made use of the formal elements of plot and point of view in order to examine the power issues inherent in storytelling and our potential responses to the narratives that we receive.[204] I will return to this concept in more detail in the conclusion, but for now I want to describe the way in which Chambers and Montgomery manage to link a formal analysis of structure to the ethical implications of a story.

Every story, they assert, can be retold an infinite number of times. Each potential narrator has a different point of view and access to different details, and would therefore highlight different elements of the story as significant. Each narrator would tell the story for a different reason, and would draw different conclusions from the events therein. This is the power, according to these literary theorists, garnered by the storyteller. By determining the plot, the author determines the structure, purpose, and significance of the story, even when she purports (or actually believes herself to be) simply relating the events as they occurred. With a perspective that could rightly be called hermeneutic, Chambers and Montgomery insist that the corrective to the power of the author is not to strip away the *story* and find the *reality* behind it. Plot, they assert, is the meaning that emerges from a particular way of ordering and making sense of the events it contains. It

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[204] Tod Chambers and Kathryn Montgomery, "Plot: Framing Contingency and Choice in Bioethics," in *Stories Matter: The Role of Narrative in Medical Ethics*, ed. Rita Charon and Martha Montello (New York: Routledge, 2002), 77-84.

therefore "shapes the meaning of narrative and its effect on its audience."[205] Plot cannot exist independently of a particular perspective, and can therefore never be divorced from the exercise of authorial power. Even a story told in a sparse, nonfigurative style which orders the events consecutively from a third person point of view is adopting the stance and values of a particular author. "There is no 'story,'" Chambers and Montgomery assert, "without a 'plot.'"[206] There is no story unless, and until, it is told, which is to say that "stories … are always embedded in the social interaction of their telling."[207] An ethical consideration of all narrative, then, is a consideration of the power dynamics and relationships that characterize the circumstances of its being told, and this ethical consideration is inseparable from a formal analysis of plot. Only by careful attention to plot and point of view can we adequately examine the issue of authorial power. Yet the structure of narrative not only lends itself to the recognition of this power but also offers a novel response to it. "Every story," say Chambers and Montgomery, "can be retold, replotted and reinterpreted." A narrative response to power is not an attempt to remove the moral element of storytelling by dissecting the meaning conveyed from the plot that conveys it. "Plot is meaning," which is simply another way of phrasing the hermeneutic insistence that all meaning is situated.[208] A narrative response to power is, instead, to listen critically to the story told by a particular author, identify and consider the values implicit within it, and then, if we take issue with the way in which the story has been told (and, by extension, the value judgments contained within it) then to reformulate the story

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[205] Ibid., 78.

[206] Ibid., 79

[207] Ibid.

[208] Ibid.

from our point of view. We replot, reinterpret, retell. We offer our own version of the story to the community of listeners, and then we wait for the critical response of others.

FROM THEORY TO PRACTICE

The three examples of interpretive techniques above are, of course, more than examples of critical analysis. They are also specific manifestations, in relation to different narrative features, of the kind of ethical criticism I wish to weave into this theoretical framework. By tacking back and forth between hermeneutic philosophy, interpretive culture, and ethical criticism of literature, I have attempted to provide not only an understanding of the way in which I will undertake the interpretive analysis of pharmaceutical advertisements, but also the significance that interpretive thinking holds for an actively participatory moral community. The analyses of specific advertisements that follow in the next three chapters are my attempt to demonstrate this kind of thinking. I envision these analyses as jumping-off points for the kind of conversation I believe we ought to be having about pharmaceutical advertisements–both the individual commercials and the overarching cultural narratives that they both reflect and reinforce.

SECTION III: COMMERCIAL ANALYSES

Chapter 5: Of Hearts and Heroines (Plavix)

JANET'S STORY

The commercial begins dramatically, with music creating tension and suspense. Viewers encounter Janet, the story's protagonist, as the camera swiftly rotates around a close-up shot of her face. She is pictured from below, from a tilted perspective that accentuates her height and gives the audience an immediate sense of her power. She looks beyond the camera, into the waiting room of an emergency department. Although they do not hear her voice, viewers see her call out, perhaps for her next patient, with a facial expression both focused and slightly tense. The narration soon reinforces what her demeanor has already made clear. Janet is fully engaged in the task of keeping control over her surroundings–a room that many Americans picture in moments of panic, that forms the background scene to their "please don't let it be" prayers. Janet, however, is not currently experiencing any such catastrophe. She is managing the catastrophes of others. She is the person who is summoned, in times of fear and danger, to try to save the day. She's the ER doc.

"Keeping control of a busy emergency room, Janet is a formidable woman." Janet's story is told by a man. His pitch is deep and his tone is grave. His inflection is dramatic. It's as polished as a sportscast but not at all chatty. It's deeper and more serious, slightly overdone. With only a little more emphasis, a little more melodrama, the narration would clue the audience into a joke, a spoof. ("When last we left our hero …")

But the narrator does not go that far, not quite. This is a real story about real danger. Unfortunately it is not (or not only) the stuff of comic books and childhood heroes.

Janet looks appropriately serious to be cast in the role of a "formidable" protagonist. An African-American woman, perhaps in her fifties, perhaps younger, she wears her hair straight and bluntly cut at her chin. A few streaks of gray appear but the rest remains dark. She is aging but not old. A white coat covers mint-green scrubs. A stethoscope hangs around her otherwise unadorned neck. We can't see her ears to know if she wears earrings under her no-nonsense haircut. Her face is bare–no lipstick, no eye-shadow. As the camera zooms quickly backwards to reveal the chaotic waiting room, Janet reaches out with her left arm and points decisively. A bulky black plastic watch is visible on her wrist. With her other hand, she holds a metal patient chart. [209]

Illustration 5.1: Janet in the waiting room.

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[209] The images in this chapter were captured from a video recording of a television commercial for AstraZeneca's Plavix, broadcast on the Columbia Broadcasting System (CBS) on June 25, 2006, during *CBS Sunday Morning* from 8 a.m. to 9 a.m.

As the camera zooms out rapidly to capture a wider scene, a strange noise like a sound-effect accompanies its motion. Almost unnoticeable against the kitschy background music, the noise of the camera brings to mind video-game laser guns, outdated action films. The waiting room is crowded. Lights from florescent bulbs overhead and windows on the back wall reflect the sickening green of the walls and floor. People sit and stand and walk about. Although the lighting continues to draw our eyes towards Janet, she now appears much smaller, almost dwarfed by her unpleasant surroundings. Her story continues: "but she was no match for something smaller than the tip of a pen." Mounting tension in the music heightens the suspense in the moments before this tiny enemy is identified. "It K-Oed her so fast, she didn't even know what hit her." With these words, the camera zooms once again close to Janet, focused this time not on her face, but her chest. As Janet hands the metal patient chart, that symbol of medical power and authority, to someone standing beside her, she turns squarely towards the camera which zooms, literally, into her now-unprotected chest. Viewers are suddenly thrust into the most intimate of spaces-past her white coat and into the inner workings of Janet's body. As if with x-ray vision, they watch glimmering white specks travel through nearly transparent blood vessels. The camera continues through the mesh of vessels until it crosses through a vessel wall and into the lumen itself. Janet's nemesis is found not in the outside world, with all its danger and chaos, but rather in this tiny inner space. It attacked her from within. "*It*," explains the narrator, "was a clot."

The cartoon view of Janet's blood vessel shows a large clump of irregularly shaped, pearly orbs representing platelets which have stuck together and are now partially obstructing flow. The clump, or clot, as it has been identified, is resting on top of an atherosclerotic plaque, represented here by a mound of yellowish material within the wall of the vessel. With the additional height of the clot on top of the plaque, the vessel

appears less than one-third its original diameter. Audience members need not comprehend very much medical pathology to understand, visually, the danger and instability that this situation represents. As platelets continue to flow past the clot, more become entangled in it. At any moment, and with no warning, the vessel could become completely blocked. Precisely because it isn't possible to see into one's own vessels to know how much space is left, or how fast it is diminishing, the danger that this x-ray view exposes seems impossible to predict or to stop. Viewers with known cardiac disease are visually confronted with the image of their inner vulnerability, and viewers with no such history likewise face the suggestion of a hidden risk, a secret threat within them.

As if he senses that the viewers have become uncomfortably implicated in Janet's story, the narrator addresses them directly: "Like Janet, if you've been hospitalized with heart-related chest pain, or a certain type of heart attack, what doctors call ACS, chances are, you've had a clot." As the narrator speaks, the illustrated clot disappears and the audience witnesses, instead, the real-world effects of such pathology. Only now, rather than witness a clot forming in someone else's chest, viewers see what a clot could do to *them*. The next scene is almost instantly recognizable as the common nightmare of middle-aged American men. The camera forces each viewer into the role of the patient lying on the gurney. As they're rushed through swinging hospital doors we see the doctor running alongside them, the white walls of a long hallway, a seemingly coincidental *exit* sign flashing into view. Janet's face reveals even more tension than she displayed in the chaos of the waiting room. She's all action-she doesn't even look at her patient. Viewers focus on her urgency, watching as she yells orders and hurries the faceless others along.

Illustration 5.2: The first gurney scene.

The events witnessed from the gurney flash by in less time it takes for the narrator to finish his sentence. Yet that flash is all it takes to conjure up this particular fear, a fear which is common, well known, understood. Viewers know this story already–they only need a bit of prompting to allow their own anxiety, and/or memory, to fill in the details. "What a fearsome thing! To be American, male, in one's fifties, a compulsive worker–as who of them is not?–worried about cholesterol and unpaid bills, working under stress and watching old friends succumb, one by one, to that crisis of heart."[210] Martha Weinman Lear recalls the moment she received the phone call that American wives of a certain age dread so much. It is their generation's equivalent to the military telegrams sent to their mothers and grandmothers. This is how they expect to lose their men–husbands and brothers and fathers and friends. Mrs. Lear was overseas and there was a message, on a

[210] Martha Weinman Lear, *Heartsounds* (New York: Simon and Schuster, 1980), 18.

Sunday, at the hotel desk. "Hal was dead," she immediately thought, "or had had a heart attack. There were no other possibilities."[211] The sight of swinging hospital doors, of red lights and white uniforms–these pictures evoke a wealth of meaning that no medical journal could ever contain. Americans watch this scene, on this commercial, and instantly know what the subject is. They know what they're dealing with, what's at stake. For the millions of viewers with known cardiac disease, these few seconds recall the most terrifying moments of their lives. The recent finding that ten percent of heart attack survivors suffer from post-traumatic stress disorder underscores the power that these images might hold for their target audience.[212] And the power they hold for other viewers is in the reminder that everyone is, ultimately, included in that target audience. For the stereotypical "type A," overworked man (and now, increasingly, woman) this is the end that many viewers expect to face, the death scene to the story of the American dream. Start young with nothing, work hard, raise a family, buy a home, struggle with the mortgage, stay late at the office. Then, one Wednesday, in line at Starbucks, stand helplessly as pain rises up in your chest and down your left arm. Hear the clatter of your cell phone hitting the floor. Next thing you know–hospital doors, hallway …

The scene, mercifully, changes and viewers are afforded a reprieve. They watch Janet standing with two other women, also dressed in scrubs. She signs something on a clipboard they've handed her, perhaps medical orders. She hands the form back to them with a smile. Still shaken from the gurney trip, the audience is calmed by this display of medical authority and control. The narrator is only now at the end of his sentence, introducing a condition that "doctors call ACS." At the bottom of the screen, in white

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[211] Ibid., 17.

[212] Reuters, "Heart Disease Patients May Suffer PTSD," MSNBC News, August 10, 2006, http://www.msnbc.msn.com/id/1492498/ (accessed September 4, 2006).

text, the words “Acute Coronary Syndrome” explain the acronym that many viewers have never heard of. Janet stands next to another doctor, an Asian man slightly shorter than she, as they apparently discuss the images lit up on the x-ray screen behind them. Janet’s colleague watches her, takes her cues. They nod, as if they’ve agreed on a diagnosis.

At this point, the tone shifts. The music becomes lighter, more melodic, more heartening. The narrator’s voice bespeaks relief and hope: “But now …” The plot has turned. From behind a curtain, Janet appears. She seems relaxed, and even smiles slightly. From a close-up of her face, the camera pulls back to watch her approach a patient–a young man with his leg in a cast. Bright lights from behind the curtain give Janet a backlit, almost haloed effect, particularly in her white coat. What has changed? “Janet’s doctor is helping increase Janet’s protection against heart attack and stroke.” Again viewers are confronted with a gurney scene, although this one is quite different from the last. First of all, the perspective is not that of the patient being wheeled in. This time, Janet leads two paramedics and a nurse towards the camera. Janet’s expression, walking toward the viewer, is much calmer than it seemed from below. Previously, she was running, trying to keep up, racing against time. Now she walks, although quickly, and turns to hurry the others along with a wave of her hand. She has become the one to keep up with. In this scene, viewers are spared the image of the double doors (which the gurney may have already passed, or not yet reached) and the exit sign (visible only to the patient looking up.) The two images technically depict the same event, but the change in perspective, along with the change in Janet’s demeanor, make the first seem like a terrifying crisis and the second a well-controlled procedure. The next scene seems to offer an explanation of the change: “… by putting Janet on Plavix.”

Illustration 5.3: The second gurney scene.

Now Janet, the gurney, and the hospital disappear into a dark screen. Out of the shadows emerges a prescription bottle with the Plavix logo printed on the paper label. Just as it was with Janet in the waiting room, the camera is positioned below its subject, so that the bottle seems larger than life, especially as the camera zooms in for a closer shot. The Plavix bottle is brightly lit against a dark background with a few streaks of light behind it. The presentation is dramatic, like a star on stage with spotlights crisscrossing behind him, or perhaps lasers. The logo is simple and strong. "Plavix" appears in blue letters, with a wide, sturdy font. Later, the audience will see Janet stand with her hands on her hips, and this is the image that the logo brings to mind: the stable, confident stance of someone accustomed to their role as a human shield. Or, perhaps, a superhuman one. The dot over the "i" is red rather than blue, and three horizontal lines lie to the left of it, as if it is rushing through the air, as if it is trailed by a cape.

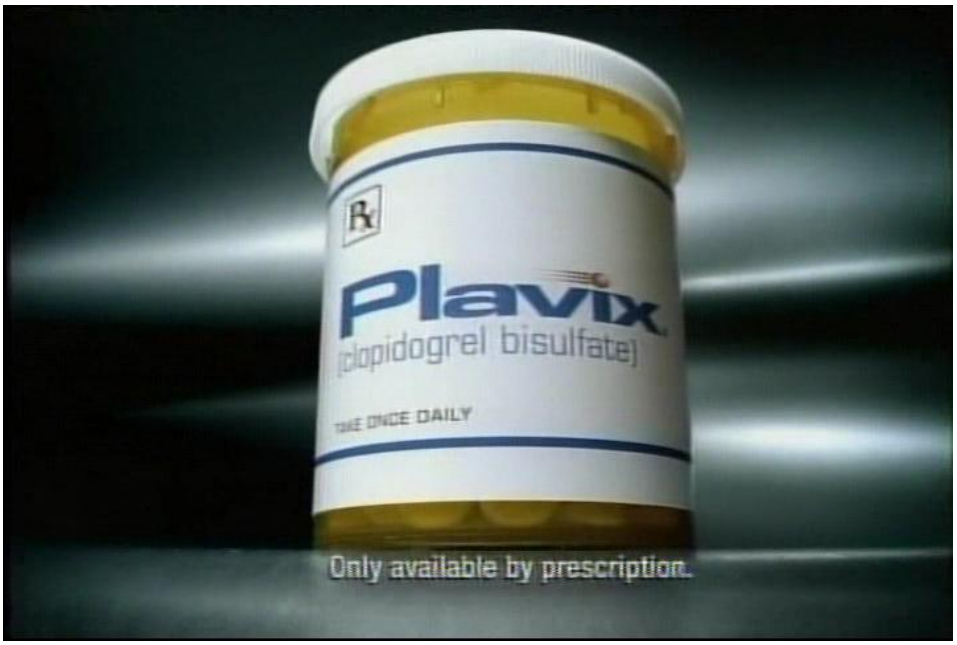

Illustration 5.4: Plavix bottle and logo.

Now that this new character has been introduced, quite dramatically, on the screen, the narrator begins to explain its role in the story: “Plavix, in combination with aspirin and other heart medicines, helps provide greater protection against heart attack and stroke than other heart medicines alone.” Just as viewers were presented with two differing images of cardiac events (the gurney scenes), they are now presented with a second cartoon of the internal events, this one quite different from the first. Again the camera travels into a network of translucent vessels until it peers into one. Again the lumen appears partially obstructed by a plaque and a clump of immobile platelets below those that stream through the vessel. Only this time, the few platelets that have accumulated seem nothing more than a thinly spread layer of cells that hardly affects blood flow. Viewers are told that this is the work of Plavix, which has lowered the risk of obstruction “by helping keep platelets from sticking together and forming clots.” And just

like a panel in a comic book, the "after" version of this "before and after" cartoon threat shows viewers that things are back to normal, that the hero has dealt with the danger, and that everyone is safe again, for now.

The music continues to carry us along with Janet's story–the story of how she is safer from calamity, from the threat that was looming within her, because of Plavix. Although the music is continuous, the narration changes abruptly at this point in the commercial. The previous narrator seems to have taken a short break, and instead a different voice-a woman's voice-informs the audience of the side effects and potential risks of the drug. "If you have a stomach ulcer or other condition that causes bleeding, you shouldn't use Plavix," she explains. During this segment, Janet stands in front of a dry-erase board, apparently explaining something to three other women, each in scrubs. Janet holds a marker, speaks, and gestures towards the board. The women, who are perhaps students or nurses, listen attentively. They hold their heads at a slight tilt. And they each hold a coffee cup. Perhaps they've found a rare break from their work in the ER and now have a chance to learn something from a senior physician. The pause in the story also represents a learning opportunity for viewers, who are given a website and an "800" number at the bottom of the screen with which they can learn more. This is the cue to fetch paper and pen–the break within the commercial break. It affords an intermission, a few seconds within which the attention of the audience, held tightly by the dramatic events portrayed so far, can wander, can rest. Before the side-effect profile ends, viewers are gradually drawn back into the story. Janet now walks down the hall with two male doctors in tow–still teaching, but once again on the move, perhaps now on patient rounds. The Asian doctor we saw earlier walks beside and slightly behind Janet. He looks up at her (the difference in their heights is even more pronounced in this shot) and nods as she speaks. Behind them walks another male physician, this one African American and bald.

He gives the impression of physical strength, of someone who would likely be quite tall, but because he follows Janet at a distance, he does not seem to reach her height. She turns back to him as she talks, as if to check that he is still following, still listening, still paying attention. Simultaneously we are drawn back into her story.

"Talk to your doctor before taking aspirin or other medicines with Plavix," continues the female narrator. "Additional rare but serious side effects could occur." White text appears at the bottom of the screen: "See our ad in Saturday Evening Post." The music by now has transitioned from its tense beginnings to an inspirational, triumphant melody. It is the soundtrack to the climactic finale of a story with a happy ending. And as it crescendos, viewers see Janet walk out of the emergency room, back into the waiting room where they first met her. She approaches a blonde woman, roughly her own age, who sits with her back to us so that our view of Janet is partially obstructed. As she walks nearer, the camera swings around to get a full view of Janet, who is smiling broadly, kneeling to hand the woman a cup of water. Their hands touch for a moment. With this simple act, Janet demonstrates more control over her emergency room than she did with her efficient patient triage in the first scene. She not only possesses the expertise to handle whatever comes through the door, as she has demonstrated to us in previous scenes through interactions with her peers, but she is now also in such full command of her environment that she has time to devote to the important, personal details of care that might otherwise fall to a nurse or clerk. Although viewers understood her to be in control before, they see now that she no longer has to fight as hard to maintain control–it comes more easily, leaving her attention open for things that she truly cares about.

Illustration 5.5: Janet with a cup of water.

"Ask your doctor about Plavix today." The male narrator has returned, still dramatic but now happy, hopeful. Janet stands outside in the ambulance bay. Again, she is seen from below, along with the reflections of flashing lights against the building behind her, and a red "emergency sign" just behind her left shoulder. She puts her hands on her hips and looks ahead, smiling slightly. She's ready to handle whatever comes next. The ominous edge to the narrator's voice doesn't stay gone long, however. It returns as he reminds us that Janet has not reached this happy ending alone. The Plavix logo materializes in front of her, highlighted against her white coat as it spans across her chest. Gradually, Janet's image disappears and the screen becomes white except for the logo. "No matter how formidable you are," concludes our narrator as his words appear in red across the bottom of the screen, "you're no match for a dangerous clot."

Illustration 5.6: Janet with Plavix logo.

This is the natural end to the commercial, and to Janet's story. Just as the music seems to fade into a final note however, it lifts back up again into a slightly different melody–an encore. We have been left with a white screen as a final image. Now, however, it comes to resemble a white piece of paper as its side edges roll back around a prescription bottle. With the logo remaining in place, our previous screen is now the label on a bottle of Plavix. The camera backs away from the bottle and begins to circle it. Our narrator returns. After explaining that "feeling better doesn't mean you're not at risk," and re-offering the phone number and website, the bottle rotates once more to reveal the words "Help Stay Protected." At this point, the narrator concludes, leaving us with the image of the Plavix logo and a final line, in which he accents the first word only slighty, so that two meanings can be inferred: "*Stay* with Plavix."

Both Janet and Plavix function as characters in this story. They're treated similarly by the camera, which personifies Plavix, especially during its spotlight debut against a dark screen, and they each act as the protagonist in their particular realm–Janet in the ER, dealing with the external events that surround a cardiac crisis, and Plavix inside the body, dealing with the microscopic events that trigger it. The relationship between the two is complex. Their parallel action in their respective realms, along with the implication of their power and even the similar sound of their names, intertwines their narrative personas. Yet the crux of Janet's story is the comparison of her power before and after Plavix arrives. From the beginning she has been "a formidable woman," a doctor, managing to maintain control of her chaotic surroundings. Yet it is only with the introduction of Plavix that she is seen as truly confident in that control rather than desperately hanging onto it. Without Plavix, she would not appear to us as she does in the last scene, smiling, relaxed, calmly waiting to overcome the next emergency. As the Plavix logo appears before her, highlighted by her white coat, the audience is left to wonder: who is the hero of Janet's story? If Janet is the hero, then what role does Plavix play? Perhaps her secret weapon? Her superpower? Without it she's akin to Clark Kent, successful but stumbling, unsure of herself. Protected and empowered with Plavix, however, standing proudly with its logo across her chest like a superhero's emblem, she can face whatever comes her way. Even a dangerous clot. Janet's story–the story of Plavix–is essentially a comic-book story. Closely related to the themes of rescue and restoration that often appear in medical fiction or memoir, but with a distinctive, cartoon drama, this is a story of heroes protecting people from dangerous enemies, from catastrophe and death. It's a thriller, to be sure, complete with suspense and even terror. It's a story that reminds viewers of the danger they're in, and comforts them with the image of a superhuman protector, a hero-savior "available only by prescription."

The narrative within this advertisement is a relatively simple one, although the skilful way in which it is told involves a sophisticated set of cultural ideas, each reinforcing and supporting the other in ways that make Janet's character and the events of her story seem so understandable, so natural, and so taken for granted that the narrative is presented less as a narrative and more as an accurate reflection of the way things are, or should be. This story oversimplifies the condition of heart disease and its appropriate treatment, encourages potentially damaging metaphors and hinders the adoption of other, more enabling narratives. It may function to raise awareness of cardiac risk in women and minorities but, I will argue, the relationship between the authors and their intended audience is more complicated than it may seem. Most importantly, this story exploits the fear of death all the while encouraging the specific tendencies of its targeted viewers to deny the possibility of their own mortality. It traps its audience into a cycle of fear and false control and, unless it is read carefully and questioned extensively, it will likely be adopted wholesale by many cardiac patients, both present and future. It is, after all, quite enthralling.

THE MYTH OF REBIRTH

Janet's story is offered to us as a suggestion, a possible way to understand what happens to those who suffer heart attacks. It is, however brief, a narrative of illness, and one that relies, primarily, on the image of the hero and the hope of rescue. Ann Hunsaker Hawkins, in her study of patient narratives, finds that stories of heart disease more commonly make use of another metaphor, however, one that she terms "the myth of

rebirth."[213] Because cardiac disease often brings itself to attention through a discrete event (a "cardiac crisis,") it resembles cultural understandings of spiritual rebirth, also commonly considered a discrete event wherein the Almighty confers knowledge, love, or a spiritual awareness upon an unsuspecting nonbeliever. People are thus converted, reborn, all in a moment. Knowledge of divinity reveals itself to them as suddenly and dramatically as chest pain and palpitations make heart patients aware of their previously hidden chronic disease. Hawkins notes that in both types of autobiographies, that of the religious convert and that of the coronary patient, the narrator sets out upon the task of reinterpreting his or her previous life, the time before the moment of conversion or crisis. The focus on one's previous life (the life, as Hawkins puts it, of a previous self) serves not only to make sense of the crisis but also to lay a foundation for the formation of a new life, a new self, which the metaphor of conversion demands. Through this particular narrative scheme, "the past is reconstructed in such a way as to make the heart attack intelligible, retrospectively 'expected,' and thus much less threatening."[214] Just as the "born-again" look back to their previous life and see, with the help of their newfound understanding, the depths of their sin, the heart attack victim reconstructs the time before his or her illness as a time of unwitting, unreflective self-destruction. Narratives of heart disease thus describe in detail the bad habits that led to disease and the acute attack that announced its presence. And the safety of the new self (the psychological security that the patient or convert needs to overcome the terror inherent in a moment of crisis) resides in its distance from the old. As the word *convert* implies, the moment of crisis represents a moment of re-birth, of re-creation. It represents a dramatic split between old and new, particularly when understood retrospectively by a patient or convert trying to make sense

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213 Hawkins, 39.

214 Ibid., 37.

of the event and his or her subsequent future. Therefore, religious converts look back at their former lives and see nothing but sin and depravity. Hawkins notes that the tendency to hyperbolize the extent of their previous debauchery has led several authors of spiritual biographies to refer to their pre-conversion selves using phrases such as the "chief of sinners."[215] Think how unusual a religious testimonial would sound if the "before" portion of the "before and after" story involved, say, a relatively normal person with relatively normal faults, someone who occasionally failed to report a few hundred dollars income on their tax return or told white lies to avoid hurting their spouse. A mild backdrop could not provide the stark contrast that a conversion story hinges upon. What is needed is a past so dark and deranged that not only are listeners amazed at the miracle of rebirth itself, but specifically at the extent to which the spiritual event altered the narrator. A similar tendency exists in narratives of heart disease. In order to make peace with the presence of a near-fatal crisis in their own lives, patients may find it easier to believe that they *really* had it coming. They were tempting fate and got their due. This is much more palatable than the alternative story: fate is capricious and we have little control over it. We could drop dead at any moment not because our behavior has led up to it but because we are human and therefore destined to die without knowing when or why or how. Luckily, the medical story of heart disease does not ask that we accept the latter. The former, in fact, fits in quite well with scientific knowledge about heart disease (and scientific aspirations to overcome death, thus mortality, thus fate) and so narrators are bolstered by the collaboration of their physicians in explaining their disease in terms of the bad habits of their former selves. This story is not only psychologically helpful for the narrator, but it also turns out to be medically helpful for the patient, since it requires that the new self be characterized by the opposite behaviors: healthy eating habits and

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[215] Ibid., 38.

exercise and conscientious attention to medication regimens. The "spiritual" knowledge gained by the survivor of a cardiac crisis, analogous to knowledge of everlasting life gained through a religious epiphany, concerns vulnerability. If the previous self did not understand that life is precious and delicate, the new self is painfully aware of it, and therefore lives accordingly.

Yet, even while the patient or convert must distance himself from his previous life, he finds it understandably challenging to completely dissociate himself from the person that he was only moments before the attack.[216] This difficulty could explain the trend described by Hawkins that in both spiritual and coronary autobiographies, the hyperbolic characterization of the narrator's errant former self ends up, "in a subtle way … self-congratulatory."[217] A certain note of pride is heard in the voice of a believer describing the utter wickedness of his old life, as if he must then have been the worst of the worst, a demon, a devil, in order to have become what he professes to be now–an angel, a lamb, an innocent child born once again through the grace of divine forgiveness. So, too, can a heart attack survivor's account of his former self be "self-aggrandizing," with an undercurrent of pride and bravado beneath the overt rejection. Hawkins draws a parallel between the image of the "chief of sinners" in religious narratives and the "type A personality" in stories of heart disease. Even while the narrator denounces his old self as "type A" or "coronary-prone," he simultaneously brags of it, since this rejection "castigates the self for precisely those traits that our culture values most: aggressiveness, competitiveness, the wish to achieve, and the ability to do so."[218] This misplaced

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[216] Although awareness of heart disease in women is increasing, the protagonist of a story of heart disease has traditionally been male, and it is in the context of cultural conceptions of heart disease, rather than contemporary epidemiological trends, that I use masculine pronouns in this section.

[217] Hawkins, 38.

[218] Ibid., 39.

fondness for the very lifestyle they renounce may pose a danger for converts to successfully create and maintain their new life. It may also reflect and exacerbate the difficulty in relinquishing the bliss of ignorance, the freedom of never having confronted one's own mortality. The transition that the crisis requires of a self-professed type A personality is understandably difficult, since the perception of control is the very thing that has been shaken. Hawkins quotes one such narrator who "remark[s] that cardiac disease destroy[ed] his 'myth of supercompetence.'"[219] Supercompetence is a particularly strong myth in American culture, and it very nearly defines the stereotypic type A personality–a man (usually) who pushes himself to do more than a man can do, to control more than a man can control, to be more than a man can be. Americans may grow out of the comic books and superheroes they idolized as children. But perhaps our culture has yet to grow out of its belief that we ought to be, each of us, supermen. Heart attacks, along with cancer and car wrecks and hurricanes, rob us of that fantasy. We're understandably desperate to find a story to replace it. And, notwithstanding its potential for self-aggrandizement and nostalgia, and its space for dodging, at least slightly, the reality of an uncontrollable universe, the image of conversion and rebirth works well for many people. Hawkins characterizes it as a powerful and enabling story, "a functional myth," that can help cardiac patients find their way to the next phase of their lives.[220]

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219 Arnold J. Mandell, *Coming of Middle Age: A Journey* (New York: Summit, 1977), 46, quoted in Hawkins, 39.

220 Hawkins, 39.

PHYSICIAN-AMERICANS

Martha Weinman Lear's *Heartsounds*, a memoir of her physician-husband's experience with heart disease and what the couple came to perceive as the appalling systemic incompetence of academic medicine, contains elements of Hawkin's conversion structure. In one sense, the book can be seen as the painful process through which Dr. Lear leaves his old life of medical authority, intellectual control, physical prowess, and social ease for his new life as a cardiac patient. This new identity is one that he has extreme trouble creating and fulfilling, however, not only because the task is daunting under any circumstances, but because the setting for the transition is, ironically, the world in which his former self could exert the most control–the world of academic medicine. This unfortunate irony, along with the difficulty that his wife, the author, has in relinquishing her image of the "deliciously arrogant" doctor she married, hinders his transition and leaves him mired in a state of confusion and rage from which he only seems to emerge at the very end of the book (and one could argue that he never completely emerges at all).[221] Dr. Lear's story reflects that of many Americans who may be stereotypically labeled as type A or cardiac personalities. He faces his illness in the way that many of us would: armed with his resources (knowledge, power, money) and an iron-locked belief that his actions can and will make a difference in his fate. One can hardly fault him for this reaction. Who among us, particularly academics or professionals, would not do the same? Who would not go online to research conditions and treatment options? Who would not make phone calls to people whose influence may help secure the best doctor, the best hospital, the best treatment? Who would not sink their entire being into the project of their disease? A physician like Dr. Lear would find this process

[221] Lear, 256.

even easier. The line between the professional universe in which he works to treat and control disease and the personal tragedy over which he feels abjectly helpless all but disappears. Because his identity is so thoroughly invested in and intertwined in medicine, he is unable to gain perspective and see the irony of the cardiac personality attacking heart disease with all of its organizational power lust.

Because stories of heart disease so often involve successful, highly functioning and highly ambitious people, the role of the cardiac patient is one that suits physicians especially well. The type A character, after all, is reflective of a cultural faith in individual abilities. A top-notch businessman, a cutting-edge scientist, a CEO whose assistant keeps track of her children's soccer game schedule–all of these are living instances of the belief that Americans, if they work hard enough, can do it all and have it all. And this doesn't just mean juggling a family and a career. It means continually striving to push the limit of what has previously been done. The meta-narratives of American ingenuity, innovation, and progress depend on a particular type of character: the ambitious, optimistic, hard-working American, who spends his or her days not only providing for a family and accruing the personal wealth that characterizes the American dream, but also pushing the limit of what's considered possible, striving to be the first, to be the best, to step over the line that has always been thought of as the border of human capacity. Who better to epitomize this character than the doctor? For the doctor, this line is not simply the technological limit of contemporary machinery or financial strategy. The limits against which the doctor pushes are the limits of humanity itself, the limits of mortality, the extent to which sentient beings are able to control a capricious universe. In this regard, Janet's story is doubly powerful. Not only does Janet, as a physician, embody the cultural image of a cardiac patient, she also represents our culture's answer to such crises. Janet simultaneously reminds viewers of their vulnerability, ironically considered

greater the more "formidable" their personality, and reinforces their iron-clad confidence that they could overcome any obstacle, if not by acting as physicians themselves, then by using their material and intellectual resources to secure the very best medical care. As physicians, both Janet and Harold Lear occupy an unusual place in relationship to their own illness. Yet, in some sense, these doctors epitomize a stance towards mortality and personal capacity that characterizes the most typical American reaction to illness, or perhaps diversity in general. And although the Lears' memoir certainly contains elements of rebirth and conversion, and Janet's story relies heavily on the image of the superhero, both narratives also reflect and support a metaphor of illness which is perhaps the most common, and perhaps the most characteristically American: the war metaphor, or, as Hawkins refers to it, the military myth.

FINDING AN ENEMY

Whether the hero of the Plavix commercial is Janet or the drug itself, the identity of the villain is quite clear, and as Hawkin's reading of *Heartsounds*, along with a look at cultural conceptions of heart disease demonstrates, the ambiguous nature of the enemy represents a significant difficulty for cardiac patients who consider themselves to be fighting for their lives. As Susan Sontag emphasizes in her extensive discussion of the war metaphor in relation to cancer, the tendency to understand a disease as an other, an external enemy, may cause conceptual and emotional dissonance for those who, like cancer and cardiac patients, cannot attribute their condition to the kind of invading pathogen which plays a key role in the battle narrative of infectious disease.[222] A more

[222] See Sontag, 57-71.

complicated relationship exists between the pathological entity and the normal physiologic state in cancer and heart disease, so the line between the (healthy, normal) self and the (external, pathological) other becomes more difficult to maintain. One of the primary dangers inherent in war metaphor, so extensively used in American health care to understand conditions of all kinds, is the potential to conflate the disease and the self, and possibility to begin to act, think and speak as if the patient is the enemy to be attacked rather than the courageous soldier on the battlefield or the innocent citizen to be protected. Hawkins explores the trouble encountered by the Lears in their use of the military metaphor, which centers less on the tendency to identify the patient as the enemy and more with the patient/warrior's inability to identify an enemy at all. Hawkins attributes the "confusion and deep despair" which permeates the memoir to the use of this metaphor that she considers, at least in this instance, a "disabling" myth. She characterizes the book as a record of "Lear's 'fight' against heart disease–his attempt to continue the same 'battle' that he was involved in as a physician, but this time from the other side, as a patient."[223] As Martha Lear points out, and Hawkins corroborates, the military metaphor is a natural one for physicians and their families because it is so common in medicine itself. Due in no small part to the historical collusion between the wartime government and medical science in the battle against infectious disease, it is almost impossible to read a medical text, scientific research grant, or even a public health brochure without encountering words such as *fight*, *battle*, *enemy*, and *attack*. Undoubtedly many patient memoirs make use of these images, consciously or unconsciously, because their authors have picked up on the language of the medical system into which they have been thrust. And, certainly, the military metaphor has helped countless families find hope, courage, and dignity in the face of terrifying circumstances.

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[223] Hawkins, 68.

This imagery would not have become so prevalent if it did not work well for many people, not to mention the extent to which it has worked for American biomedicine to characterize its mission as a battle against the ever-present threat of disease. And yet, as Sontag insists, metaphors can trap people in negative roles as easily as they can offer helpful ways of understanding various situations. There is, for instance, the unrealistic expectation that often settles upon a patient who has been cast in the role of soldier to not only win the battle but to use every weapon available, to never give up the struggle, to go down swinging, etc. For a terminal patient who may want to forgo further treatment and face death with calm acceptance, these images may seem less than supportive.

Hawkins postulates that perhaps the military metaphor "requires certain conditions surrounding the illness." The list of requirements she posits includes the presence of "an adversary, an enemy 'other,' something that can be identified, measured, and then combated." She also believes that "the patient must feel that the physicians are allies in the battle against disease," and that "there must be some therapeutic agent or procedure that can act as weaponry."[224] I agree with her assessment that none of these things characterize the Lears' story, except perhaps a therapeutic procedure, a coronary bypass, which could have acted as weaponry had it not, like so many other things in Dr. Lear's case, gone horribly wrong. The surgery leaves him partially brain-damaged, and he must then suffer the loss of his mental acuity, which has served as his primary weaponry against disease and every other challenge that has confronted him throughout his life. His misery is heightened by the fact that his doctors either deny or skirt the issue, offering him no allies in the fight to understand what has happened to him, why he has lost control over not only his body, but even more tragically, his mind, and thus, from his perspective, his ability to overcome and deal with his disease. The ultimate weapon

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[224] Ibid., 69.

available to the bright, successful people that our society has come to consider cardiac-prone is intelligence, or, more specifically, intellectual control. They may not be able to beat their enemy in physical combat, they may have lost fist-fights on the playground, but they've always been able to outsmart their opponents, and they have to believe that their encounter with heart disease will be no exception. (No matter how formidable you are, you're no match for a dangerous clot. Unless you're smart enough to protect yourself with Plavix …) The alternative is to consider their own fallibility, their own mortality, the extent to which the control they so highly value is a façade. And for this to be a battle (albeit a battle of wits) there must be an opponent. There must be an "it" against which to struggle, to scheme. Dr. Lear calls out of his ICU delirium "Where is my adversary?" Hawkins believes that "the military myth fails" Lear "not because [he] dies … but because of the ambiguous nature of his medical problem."[225] She also postulates that the seething rage that sets the tone of the narrative results from Lear's anger against his disease having no appropriate target. He's not sure what to hate, what to fight. And so, according to Hawkins, "the energies aroused by [the military myth he evokes]… are displaced onto … the patient's physicians, or simply left without an object and released as a measureless rage or a profound bitterness."[226] While I have to wonder whether the medical blunders documented by Martha Lear would not have aroused a similarly "measureless rage" in any family, I do agree that heart disease did not offer the patient an easily identifiable adversary–"an enemy, a pathology… against which he might pit his own skills."[227]

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225 Ibid.

226 Ibid.

227 Lear, 152.

What is the enemy in heart disease, if in fact an enemy exists? In a question like this, the medical facts matter less than the common cultural perception, the layman's understanding of what it means to have heart disease. One way to approach the subject is to take a look at the language that people use to communicate and grapple with what happens when they or their loved ones fall ill in this particular way. *Heart attack* is perhaps the first phrase that comes to mind. While the military tone is hard to miss, the exact nature of the fight is ambiguous–thus the old joke about a patient's wife recalling to physicians the moment when her husband's heart "attacked him." Is the heart the enemy? Rising up within the chest to battle the patient? Is it an active attack, inflicting damage wherever it can, or a mutiny, a strike-a simple refusal to play its necessary part in the larger campaign and thus, out of stubbornness, risking the lives of those that depend on it? Or perhaps the heart is *under* attack and if so, from what? The suspects that come to mind are those things which we've all been told might *give* one a heart attack such as stress, fatty foods, a sedentary lifestyle. But none of these things makes sense as an immediate cause or a specific, identifiable adversary that suddenly *attacks*. Even if one of these risk factors could be considered the attacker, which among them is tangible enough to focus on as an enemy? The stress inherent in the patient's own lifestyle? The added weight that has accumulated with age? The relatives who passed on less-than-desirable genetic profiles?

Along these lines, one potential adversary has emerged in recent years: cholesterol. Although its precise relationship to heart attack may remain unclear to many laypeople, almost anyone can tell you that it is cholesterol one must fight against in order to prevent heart attacks. The fact that cholesterol-lowering medication has enjoyed the attention of perhaps the largest segment of DTC advertising has, no doubt, helped to solidify this belief. Thanks to these ads along with increasing attention to cholesterol in

the news media and, of course, education via doctors, family and friends, the common cultural perception of heart disease now involves, to some degree, the idea that healthy lifestyles (i.e., low fat diets, exercise, etc.) help to lower cholesterol which helps to prevent heart attacks. But it is not only "heart attacks" that concern us these days. It is "heart disease," a cultural and clinical entity much broader than a single heart attack. From the single event signified by heart attack, we have widened our understanding of cardiac pathology to include circumstances which elevate the likelihood of heart attack, or even heart-related chest pain.

The Plavix commercial offers the public an alternative conception of cardiac pathology by introducing viewers to a new disease: acute coronary syndrome, or ACS. It's a condition related to heart attack and stroke, which the ad also mentions by name, but not exactly equivalent. "If you've been hospitalized with heart related chest pain, or had a certain type of heart attack, what doctors call ACS, chances are, you've had a clot." Given the prevalent social conception of heart attacks and strokes being caused by a buildup of cholesterol, the concept of a blood clot suddenly causing these conditions doesn't immediately fit our current ideas about heart disease. The common story about heart attack is linear, with unhealthy lifestyle leading to high levels of cholesterol, which literally builds up to the climax: a heart attack, or perhaps a stroke. By focusing instead on the negative effects of a specific and potentially recurring culprit, a clot, Janet's story offers us an enemy. In addition to being clearly identifiable and externalizable (the clot, although made of platelets, is not really part of us in the same way that an organ like the heart is), it's also responsible for a wide range of suffering including, but not limited to, heart attacks. What we refer to as *heart disease* is actually the damage inflicted on heart muscles by a lack of oxygen flow secondary to what is really a vascular disease: a condition of the vessels that supply the heart itself. Understood in this way, the

distinction between an episode of angina, in which the heart muscle is temporarily oxygen starved but no damage is done, and a heart attack, in which the heart is deprived of oxygen for long enough to kill sections of tissue, is in fact one of degree. Yet for most Americans, whose understanding of heart disease is perhaps not this sophisticated, chest pain may herald a heart attack, but a heart attack seems to belong to an entirely different category of events, of crises, really, that resist being understood in terms of spectrums and shades of grey. For the target audience of the Plavix commercial (the specific intended audience of Janet's story), rethinking their condition in this way broadens the range of symptoms or events that they, according to the commercial, ought to fear and attempt to control. Now one does not only have to fear a heart attack, but in fact any episode of chest pain, any period of oxygen deprivation, any occlusion of blood supply. This may, of course, make sense medically. There's really nothing to tell us how fearful we ought to be of an episode of chest pain before we even know how long it will last. It's sort of like being held underwater: while it's happening, you don't know how long it will last, how dangerous it will be. You do know that you'd prefer to avoid the circumstance altogether, and this is what Plavix is offering to help you do.

Not only does ACS represent a new way to think about the spectrum of cardiac disease, it highlights the role of a single event (the formation of a clot) to provide not only a character to fill the villainous role that the story demands but also a focal point for the complicated pathological condition that ACS represents. Viewers encounter this commercial from a perspective already conditioned by their previous understanding of heart disease, and their previous exposure to various narratives about cholesterol, risk factors, genetic tendencies, obesity, exercise, clogged arteries, and oxygen supply. Even with the relatively sophisticated medical knowledge that comes from living with chronic

illness, the myriad of players and the complex relationships between them makes it difficult to focus on a key development, or pinpoint a specific culprit in heart disease. Is the real problem weakened cardiac muscle or the sudden sprint for a cab that increased its demand for oxygen? The cheeseburgers that increased cholesterol or the cigarettes that exposed the lining of the vessels to toxins making them more susceptible to atherosclerosis and obstruction? The stress that raises blood pressure or distant relatives that doomed their predecessors with unfavorable lipid profiles? There is no tumor. There is no germ. "Where is my adversary?"

Janet's story provides this crucial missing piece, and thus allows viewers to operate within the military metaphor, or at least one very close to it, that Americans in general, and cardiac-prone personalities specifically, are so comfortable with. We feel better when we know what we're up against. If we know what our enemy is, we can go about beating it, outsmarting it, controlling it. Which is all well and good, up until the point when the military metaphor leads us to the already tempting conclusion that *all* we have to do is outsmart this *one* enemy, or to false confidence in our ability to outsmart it, or to superhuman expectations of those whose heroic leadership we want to rally behind. What are the implications of telling the story of heart disease in this way? It simplifies things, certainly. But it also tends to devalue or ignore altogether important elements of the public's current understanding of cardiac health. Why, for example, does Janet's story not explicitly draw upon the public's current understanding of cholesterol? From a medical standpoint, the relationship between damaged, atherosclerotic vessel walls and the aggregation of platelets is quite direct. The cartoon views of clots inside the vessels notably (and accurately) depict platelets adhering to tissues on top of the fatty plaques which result from high levels of cholesterol in the bloodstream. Explicitly tying the drug into the public's existing understanding of heart disease might help audience members

place this new drug into the larger context of medications and risk strategies. The narrator does tell us that Janet's doctor, by putting her on Plavix, is "doing more" to reduce her risk of cardiac events, but never elaborates on what this might mean, and never explicitly mentions cholesterol or other lifestyle factors at all. It's true that Plavix works differently than cholesterol-lowering medications, and that anticoagulation (which is the end result of the drug) represents a different strategy for managing cardiac risk than the direct reduction of cholesterol. Yet it is the structure and nature of the story told by the commercial, even more than its failure to mention these other issues, that would deemphasize them the most. It's not, necessarily, troubling that a Plavix commercial fails to mention other strategies. What's troubling is that Janet's story doesn't depict Plavix as part of a larger strategy at all. Even if the narrator reminded the audience to eat right and exercise, to keep an eye on their cholesterol and their blood pressure, this advice would be given outside of the primary narrative, because it simply does not fit within it. The story of Plavix is the story of a superhero, and a superhero isn't simply one part of a larger effort. Although it facilitates the use of the military metaphor, this narrative differs from a narrative of wartime in this significant way: wars are fought by armies of men and women, using all the weapons at their disposal. A superhero represents, by definition, a power beyond that of mere men and women, a power that, by and large, operates alone and outside the system. A superhero gets called in when everything else has failed–just when we fear the worst, when the red ambulance lights are flashing and the hospital doors are swinging open and we see the exit sign …

WOMEN AND MINORITIES

Janet is perhaps not the leading character that we would expect from this story. On the one hand, she is a physician, an emergency physician, specifically, and therefore the epitome of our culture's quest for control over our own mortality. In this respect she is type A writ large. On the other hand, as an African-American female, Janet hardly fits the common cultural stereotype of a "coronary-prone" personality. Yet in this respect, Janet's story is on the cutting edge. Although not traditionally considered a women's health issue like breast cancer or osteoporosis, cardiovascular disease actually tops the list of fatal diseases in women.[228] In recent years, more attention has been given in medical circles and media reports to the rates of heart disease in women, and its tendency to go misdiagnosed by physicians who were trained to picture cardiac patients as white men. In actuality, nearly twice as many women died of cardiovascular disease than from all forms of cancer combined in 2003, and African-American women have a significantly higher mortality rate from heart disease than do white women.[229] Not only are women, particularly minority women, more likely to present 'atypically'-that is, with symptoms other than the classic textbook signs that doctors more easily recognize as heart attack, evidence also exists to indicate that women perceive the same symptoms, of the same severity, to be less concerning than do men, perhaps because they do not consider themselves at risk for a cardiac event. As a result of their underestimated risk, they may be less likely to present until their condition becomes much worse. Yet even when

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[228] American Heart Association, "Survey Finds Increased Cardiovascular Disease Awareness among Women but Plenty of Room for Improvement," http://www.americanheart.org/presenter.jhtml?identifier=3018814 (accessed September 3, 2006).

[229] American Heart Association, "Facts about Women and Cardiovascular Diseases," http://www.americanheart.org/presenter.jhtml?identifier=2876 (accessed September 3, 2006).

women do come to the emergency room with symptoms of cardiac disease, they are less likely to receive adequate care. Women and minorities are statistically less likely to be treated with aggressive measures such as catheterization than men, and while only twenty-five percent of men die within one year of a heart attack, the analogous mortality rate for women is thirty-eight percent. [230] Fortunately, public awareness of women's risk for heart disease is growing. First Lady Laura Bush currently serves as the "Truth Ambassador" for *The Heart Truth* campaign, a nationwide effort to educate women about their risk of cardiac disease. And surveys have indicated that cultural ideas about heart disease are widening to include groups other than the stereotypical white male patient. Forty-six percent of women in a 2003 study correctly cited cardiovascular disease as the leading cause of death among women, up from thirty percent in 1997.[231] Yet despite increasing awareness of women and minority rates of heart disease, and of the disparities in quality and access to care among these groups, the situation in emergency rooms across the country seems to be changing less than would be expected. A study published in the *New England Journal of Medicine* in 2005 found that despite increased medical and media attention to heart disease diagnosis and treatment in these populations, significant disparities continue to exist in treatment and outcomes.[232] As proponents of DTC prescription drug advertising have begun to recognize the role of this marketing technique in reaching underserved populations, it has become more common for women and members of minority ethnic groups to appear in these commercials. If regular broadcast of the Plavix advertisement reinforces, even subliminally, the idea that women and minorities are at risk for heart disease, or, for that matter, work as senior emergency

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[230] Ibid.

[231] Ibid.

[232] Viola Vaccarino et al., "Sex and Racial Differences in the Management of Acute Myocardial Infarction, 1994 through 2002," *New England Journal of Medicine* 353, no. 7 (August 18, 2005): 671-82.

physicians in the traditionally male dominated field of medicine, then the marketers are to be applauded. It makes sense, of course, that by reaching out to underserved populations, the drug industry not only performs a public service but also creates a new population of consumers to buy their product. I am willing to believe that this is true, to a certain extent, of DTC advertising in general. Janet's story in particular, I believe, is a bit more complicated.

One way to examine the particularities of Janet's character is to note the obvious differences between our formidable hero-physician and another African-American female character making a rare appearance in DTC commercials. A Crestor advertisement, running concurrently with the Plavix commercial, features a vibrant woman who greets viewers from a park bench where she is taking a break from her exercise routine. Her hair is stylish and worn loose, although one might expect it to be pulled back for her walk. It curls in ringlets and bounces slightly as we see her striding along the tree-lined path in a pink jogging suit, contributing to viewer's impression of her as both feminine and energetic. She addresses the audience directly, explaining, in a friendly tone, that her cholesterol "is all out of whack." One could wonder whether it is her professional status as a senior physician or her characterization as heroic, therefore both distant and powerful, that makes it difficult to imagine Janet trading places with this woman. Of course both of these factors contribute to the differences between them, but I would argue that both are also reflective of a larger, more fundamental difference, one that has to do with the portrayal of African-American women themselves.

SUPER STRENGTH

Whether Janet's character was created to address issues of cardiac health disparity or not, the story's authors have tapped into a cultural and narrative tradition quite appropriate to the story they wish to tell about Plavix. At first glance, a black woman seems antithetical to the tradition of American superheroes. Clark Kent, Bruce Wayne, Peter Parker–these characters seem as all-American (white, innocently boyish, farm-bred) as they come. Even the Incredible Hulk is white … until, of course, he turns green.[233] Yet even if the traditional American image of the superhero fails to include African Americans, particularly African-American females, the image of the African-American female has increasingly begun to resemble a superwoman. Trudier Harris has argued that the literary portrayal of African-American women in the last half of this century focuses, almost exclusively, on the virtue of strength, and has actually done so to a fault, despite the worthy intention of rescuing these women from images of servitude and ignorance. While Harris recognizes and reinforces the importance of portraying black women in a way that demonstrates their strength over and above the traditional conception of weakness, she argues that authors have focused so single-mindedly on this particular characteristic that "the landscape of African-American literature is [now] peopled with black women who are almost too strong for their own good."[234] While it may be difficult to imagine strength as a negative characteristic, Harris points out that, as "frequently the only virtue available to black women" characters, strength often overshadows other,

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[233] Of course there are notable exceptions to this trend, the earliest perhaps being Linda Carter as Superwoman, and, much more recently, Halle Berry as Catwoman in the 2005 movie *Batman Returns.*

[234] Trudier Harris, "This Disease Called Strength: Some Observations on the Compensating Construction of Black Female Character," *Literature and Medicine* 14, no. 1 (Spring 1995): 110. Subsequent references to this source will appear parenthetically in the text as *DCS* followed by the page number.

perhaps more complex personality traits, and has actually been cultivated to a point that surpasses, and often diminishes, the humanity of the characters themselves. "Against the backdrop of unwritten taboos and efforts to avoid stereotypes, black writers inadvertently created another stereotype: that of the black woman who was more suprahuman than human." (*DCS*, 111) Harris intends "suprahuman" to indicate at least two characteristics about these heroines. First, their strength, and the value they place upon it, tends not so much to celebrate their value as women, but more to diminish their femininity and reinforce the importance of masculine characteristics. Second, especially in recent years, the hyperbolic strength of black female characters has reached the realm of the fantastic, glorifying the heroine's powers–even superpowers–over and above their humanity.

Harris explores the ways in which characters such as Lissie in Alice Walker's *The Temple of My Familiar* and Minnie Ransom in Toni Cade Bambara's *The Salt Eaters* cross the limits of human strength and become "otherwordly" and "mythical." These women "defy spatial and bodily limitations, commune with the dead, or die and continue to be sentient." (*DCS*, 121) Viewed from a literary, rather than scientific perspective, Janet's work in the ER seems just as fantastic. What would literary critics from another time and culture have to say about a defibrillator? About shocking the heart back to life on a daily basis? Is this not what doctors do? Janet's world is both fantasy and reality, and by telling us her story, the makers of Plavix are bolstering our belief in the fantastical, our belief in medical magic. Whether it actually works is beside the point.

Harris does not argue that literary portrayal of African-American women as supernaturally powerful or masculine is, in and of itself, such a bad thing. Particularly given the scarcity of strong models for earlier generations of African-American readers, and in stark contrast to the often weak and overwrought portrayal of white women characters, the heroines of Toni Morrison and Zora Neale Hurston have an important

social and political role to play. However, in part because of their political utility, these characters have been pigeonholed, their development stifled, their potential untapped, as much or more as the stereotypes they were written to overcome. And the contemporary tropes often echo the older, less fashionable ones without our ever realizing it. Harris recognizes "reclaimed and often romantic ties to Africa" in the unending strength of these female characters: "images of African women who trudge for miles with heavy loads of wood across their shoulders, or of regal women carrying huge pails of water on their heads, or of warrior queens…" (*DCS*, 113) The Voodoo Queen of the deep South may function as a more contemporary, more American echo of these images, and contains the mix of strength and supernatural mystery that Harris calls attention to. The problem with being supernatural, super-feminine (or would a masculine female character be considered sub-feminine?) and, generally, superhuman is that it distances you from your own humanity. Harris claims that when we "romanticize strength" we "ignore its possible malignancy," the often violent, dysfunctional denial of our true nature, our true vulnerability. (*DCS*, 119) By forcing these women into the role of superheroines, or, to use Harris's language, of goddesses, we glorify the very traits that their human counterparts, who "still have feet of clay" can never hope to live up to. (*DCS*, 124) If this is the story we tell ourselves about how women–doctors–people–ought to be, then we're setting ourselves up for an infinite cycle of frustration and disappointment. What's more, we end up disappointed in, and embarrassed by, the very traits that define us as human. By tracing the relationships that many of these characters have with their lovers and children, Harris finds that the superwomen of African-American literature seem unable to show dependency, thus weakness, thus love. "They are nearly complete unto themselves." (*DCS*, 121) Children cower in fear of their mothers' limitless power. Lovers pull away under the pressure of impossible expectations and chronic disappointment. Yet

"what they miss in emotional relationships, they more than make up for in power and the satisfaction of transcending human limitations." (*DCS*, 121) This sentence could just as easily describe Janet's professional identity as her cultural or racial one, and her powerful, distant persona as an African-American superwoman is amplified by the trappings of the physician.

Janet's character joins the small group of black female health practitioners portrayed on popular medical television shows. Actress Gloria Reuben played Jeanie Boulet, a young African-American physicians assistant in the hey day of NBC's hit show *ER*, and the newly popular *Grey's Anatomy* features Chandra Wilson in the unusual role of a black female chief surgical resident, Miranda Bailey known for her unforgiving standards and referred to behind her back as "the Nazi."[235] Jeanie's role as a PA, one step closer to a more traditionally female (and traditionally black) image of the nurse, as well as her storyline as a woman whose unfaithful husband left her infected with both HIV and Hepatitis C, lent her character a vulnerability which was nicely off-set by her stoic, but kind, personality. Dr. Bailey's character, however, might be considered an explicit attempt to manifest one of Harris's black superwomen, and the difficulty in maintaining such a strict and, ultimately, untenable stereotype (here attributed more directly to the culture of surgery) makes her surprisingly likeable. Other, non-medical examples of African-American super-heroines can be found in film and television as well as works of literature. For although Harris examines the narrative tradition of this character, the dynamic interaction between novels and the culture they both spring from and reflect makes it no surprise that other scholars have identified the same trend in pop-culture portrayals of the strong black woman. Donald Bogle, who has written extensively about

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235 *ER*, National Broadcasting Company (NBC), 1994-present; *Grey's Anatomy*, American Broadcasting Company (ABC), 2005-present.

the evolution of African-American characters in American film, dates the "arrival of the black superwoman," in movies such as *Cleopatra Jones* and *Foxy Brown* in the mid-1970s.[236] Such women certainly represented "high-flung male fantasy" with their exotic glamour, but in many ways also took on distinctly masculine characteristics. "They lived in fantasy worlds," explains Bogle, "of violence, blood, guns, and gore," and seemed both cognizant of and unbothered by their status as sex symbols, recognizing and exploiting their power over men by "using them as playful, comic toys."[237] He offers Pam Grier's performance of Foxy Brown, who castrates the man who has killed her lover and personally delivers a jar containing "the poor man's most valuable parts" to his girlfriend.[238] It might seem odd that these superwomen roles "pleased, rather than threatened, male audiences," while "generally, black women found it difficult to relate" to them, unless they are understood, as Harris makes a persuasive case that they should be, as reinforcing the value of masculine traits rather than extending the available range of the feminine.[239] Bogle argues that the black superwoman developed from, and remains intricately connected to, the stereotypic image of the mammy: a strong, protective, no-nonsense nurturer who, while often cast in a servile role, rarely answered to a husband and in this sense could be seen as a self-sufficient, independent woman. Yet, for all their celebrated traits, mammies were often portrayed as fat and unintelligent, and much has been written, by Bogle and others, about the limits placed upon the development of black characters, not to mention real life African-American women, who struggle with this stereotype.

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[236] Donald Bogle, *Toms, Coons, Mulattoes, Mammies, & Bucks: An Interpretive History of Blacks in American Films*, 4th ed. (London: Continuum International Publishing Group, 2001), 251.

[237] Ibid., 251, 252.

[238] Ibid., 251.

[239] Ibid.

The authors of Janet's story may not be familiar with contemporary literary criticism concerning the characterization of African-American women, and they may not have read scholarly analyses of the development of racial stereotypes displayed in film and television. Both of these scholarly traditions, however, represent explorations of American cultural understanding of gender, race, strength, independence, and identity–all of which are reflected and reinforced in the various films, television shows and novels that literary critics and anthropologists take as the basis for their investigation. As such, these issues represent far more than academic theory or secondary considerations to the marketing experts whose task it is to create demand for these drugs. It could be that Janet's character was designed to increase awareness of heart disease in African-American women. Perhaps it was not an intentional effort to tap into the stereotypes discussed above, but rather simply a coincidence that Janet is portrayed as likeable but distant, female but not feminine, and above all, powerful, "formidable," even heroic. Given the skill of marketing experts, I tend to doubt it. In any case, Janet's character suits a superhero narrative quite perfectly. And her story, regardless of its origins or the intentions of its authors, says things, does things, works on us in ways that we must hold it accountable for.

THE REAL TARGET AUDIENCE

If Janet's story helps to raise awareness among women and minorities of their risk of heart disease, and I believe that it probably does, then it has served us well in that regard. However, given the overriding superhero myth, the fast-action cinematography, and the language (the clot "KOed" Janet…), I have to wonder if this commercial is really intended to target women. Even Janet herself, true to the tradition of superstrength that

Harris has identified, is, it seems, only coincidentally female or African American. Other than perhaps the image of her handing a cup of water to a patient in the waiting room, everything about Janet's appearance and characterization downplays her gender and race. Her plain appearance, while not necessarily unattractive, seems out of sync with a commercial targeted towards women, who would likely relate, or admire, a successful professional who has not completely relinquished her femininity. Part of the measure of success for working American women, and therefore part of the picture meant to represent it, is the graceful combination of beauty and power–the ability to succeed *as a woman,* to succeed without having to give everything that womanhood represents. Of course no sensible woman would wear expensive jewelry into the ER, and Janet's appearance rather accurately reflects the picture of a real life doctor. It is important to remember, however, that Janet does not operate in the world of reality, but rather the world of advertising, where people are portrayed not as they are but as they would like to be. Of course I cannot offer this as any kind of statistically significant or even verifiable empirical study, but for several months now, after noticing Janet's austere appearance, I have taken note of women physicians, both black and white, in commercials and on television. Janet is the only one I have seen without visible jewelry. Even The Nazi on *Gray's Anatomy* wears earrings. Other than her scrubs, white coat, and stethoscope, Janet wears only a mannish, black plastic watch. The authors of Janet's story, highly successful marketers, know this very well, and as good writers, they include no accidental detail in their text. It seems strange, then, that they would deliberately under-feminize a character that seems, overtly, to represent their efforts to reach a female population.

Another element to consider when identifying the target audience of Janet's story is the relationship of this particular commercial to the other advertisements in the Plavix campaign. Janet appeared on television in the early fall of 2006, along with a

complementary ad featuring a white man who coached his son's sports team. Since then several commercials in this series have come out, each with the same basic story but different lead characters. At least one other version features an African-American woman, a college professor whose appearance, like Janet's, seems deliberately stark, and two others feature white men. The interesting thing to note about this campaign is that, aside from the name of the protagonist and the details of his or her profession, the narration is exactly the same. In each case, the character is "a formidable" man or woman. In each case, "they were no match" for the clot that "KOed" them before they even had a chance. If audience members were to close their eyes and listen only to the narrated text, managing to ignore the names of the characters themselves, the individual advertisements would sound identical. And based on the word choice and intonation of the narrator, along with the overall structure of the narrative itself, I would argue that the commercials (all of them, regardless of the gender of the protagonists) are primarily intended to target men.

Janet is not designed to capture the attention and admiration of women. She functions as a politically-correct stand in for the stereotypical image of the cardiac-prone, type-A, overworked white American male who represents the intended audience. The beauty of this approach is that by making use of the cultural image of the African-American superwoman, a character which fits nicely in with the professional identity of a physician and which tends to highlight the masculinity of its female exemplars, the marketing team is able to accomplish seemingly contradictory goals. The makers of Plavix can use Janet's story to bolster their public image as scientists concerned about the common good and health disparities as they simultaneously target the population most likely to have access to regular health care and most able to pay for an expensive prescription. They get credit for targeting women, but even as they tell a story about a

woman, they do so in a way that quite effectively reaches men. Granted, the choice of an African-American character in the leading role may appeal to a relatively untargeted population–an untapped market for heart medications. I'm sure the makers of Plavix hope for this possibility, and that it had an important part to play in the decision to make this Janet's story. Nonetheless, the story is not primarily designed to reach women or minorities. If its consumer appeal extends to these groups, all the better for the bottom line. That's hardly the same thing as a campaign designed to remind women of their risk, to bring them into the fold of health care. In fact, once Janet's story is understood as being read to a male audience, by a male narrator, the delegation of the side-effect and risk profile to a female narrator seems less inclusive than dismissive, particularly when combined with the image of a coffee break discussed above. Janet's story is not told for women or African Americans. It is intended for white men–for all the Harold Lears out there, watching the evening news after a long, stressful day at the office.

THE CYCLE OF FEAR AND CONTROL

Although *Heartsounds* is, of course, only one narrative of illness, it seems a particularly appropriate one to compare to the story we're being offered by the makers of Plavix. Janet and Harold Lear are both doctors, and their stories revolve around their ability to control heart disease, whether walking beside the gurney or lying upon it. What *Heartsounds* can tell readers about Janet's story, however, is that it can't go on forever. Janet can be a superhero for thirty seconds, a minute perhaps. But those who accept her story must live with their disease for, hopefully, much longer than most superheroes grace us with their presence. Howard Brody attributes Dr. Lear's maladaptive quest for

control over his heart to, in no small part, the professional identity claimed by both Harold and Martha Lear, and in particular, Harold's medical training.[240] The old adage that physicians make the worst patients earned its cache precisely because of the expectation of control and the difficulty in relinquishing it. As Brody points out, rather understatedly, "physicians are trained to feel extremely uneasy if they are not in full control."[241] Full control, of course, is precisely what patienthood forces one to give up, because it forces one to face the vulnerability inherent in the life of a mortal, fallible, human being. Yet physicians are certainly not the only ones to successfully distance themselves from this humbling reality. As a successful journalist who defined herself largely in terms of her career and her intellectual prowess, Martha Lear also fell victim to a self-deceiving facade of control. As Brody explains, "they were two highly rational, upwardly mobile Manhattanites. They seemed never to imagine that there was anything one could not get if only one had the right connections and talked to the best people."[242] Of course it seems harsh that we should indict the Lears for reacting the way so many of us would. But, recognizing the suffering and frustration that accompanied the Lear's experience of disease, one has to wonder how we can learn by their example to "distinguish a health search for control from an overly obsessive search for control."[243] Brody attempts this by turning to a model described by James Groves as the "entitled demander."[244] By micromanaging every detail of his medical care, which in the case of heart disease can be quite complex and long-lived, Dr. Lear effectively drove his

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240 Howard Brody, *Stories of Sickness*, 2nd ed. (New York: Oxford University Press, 2003), 166.

241 Ibid.

242 Ibid., 167.

243 Ibid., 166.

244 James Groves, "Taking Care of the Hateful Patient" (1978), quoted in Brody, 169.

physicians into a constant state of defensiveness. Brody argues that because "the Lears pestered the physicians mercilessly with trivial details," and "devoted all their energies to finding the rational explanation for every trivial or random event," their fanatical demand for control undermined the very high-quality care they had rabidly sought after in the first place.[245] While Dr. Lear himself would likely have admitted to micromanaging his own care to a certain extent (drawing his own blood at the precise moment he suspected his potassium levels were off, for example), I don't necessarily recognize his concerns as mere details or his demand for medical attention driven by a feeling of entitlement. Perhaps Brody's own clinical experience lends him a perspective on the medical aspects of the story that I, as a student, don't yet have access to. Yet regardless of whether we consider Harold Lear a difficult patient, an "entitled demander," or even a type-A personality, the underlying point is well-taken: this was a man who desperately fought for control over a situation that was always, already, out of his hands. And the rage that resulted from his inability to regain control over his health and life pervades the memoir of his illness. Both Harold and Martha seem stuck, mired by details, unable to stop micromanaging long enough to see the big picture–that Harold is not getting better, that they are living the last months of their life together. "Don't worry," Harold says to his wife as she arrives at the hospital after his first heart attack. "It will be all right. It will be just like it was."[246] The remainder of the memoir can be read as the story of two people slowly accepting the extent of their joint self-deception.

While their adversarial relationship to their doctors certainly made this situation worse, it ultimately was not the physicians or the hospital or even the all-too-often blundering medical education system that took this fantasy away from them. What

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[245] Brody, *Stories of Sickness*, 167.

[246] Lear, 26.

prevented them from controlling their circumstances was the fact that Dr. Lear's heart tissue was finite, mortal, fallible, damageable. It was the fact that he was human, and therefore susceptible to tragedy beyond his range of control, no matter how much his previous professional life had led him to assume otherwise. Only at the end of the story, far away from the hospital and their professional identities, could Dr. and Mrs. Lear retreat to Provincetown. Here they finally accepted their own humanity, and finally allowed themselves to enjoy it. *Heartsounds,* read from the perspective of Hawkin's myth of re-birth, is a story about an extraordinary long and difficult labor. The Lears are trapped by their desire for control and their frustration at feeling powerless. The more complications arise in Dr. Lear's care, the more anger the couple directs at the physicians, and the more desperate they become to regain control the medical system they fault for the complications. And the more ferociously they cling to the details in an attempt to gain control, the more distance they place between themselves and their physicians, and the more distance they place between themselves and the acceptance of what is truly happening. They will never find satisfaction this way. Dr. Lear will never be the robustly healthy, powerful doctor he once was. Nothing will ever be the same again. The Lears can't seem to come to terms with this in New York. But finally, at the end of the book, they are able to leave town. They finally make it to Provincetown, and there they find peace.

Janet's story would not have allowed them to go. Janet's story wants to keep its audience, its characters, literally back at the hospital, at the Emergency Room. Janet's story is about regaining control–about fighting the enemy of disease and winning-not having to retreat from the battlefield. It's about superhuman strength, superhuman resilience. It's inspiring, to be sure. But Dr. Lear and others like him, others those who our society simultaneously shames and celebrates for being type A, fatally successful

personalities, do not lack for inspiration. They lack for insight. They lack for acceptance, for peace. Not that their peace has to mean death, or escape to some idyllic vacation home, or even retirement. Nothing about acceptance prevents people from taking the steps they need to take to maintain the lifestyle they want, to the extent that they can. But acceptance does, necessarily, involve moving beyond the cycle of fear and false control. And that cycle is what Janet's story perpetuates. It offers a medication not as one potentially useful step in reordering your life after a heart attack, in coming to terms with your vulnerability and doing what you can to protect yourself from further disease, but as a superpower-an elixir of strength, a shield to ward off the kryptonic weakness that characterizes the very nature of humanity. It's an entertaining story, and one we'd all like to believe in. And it may turn out to be extremely profitable for the people selling the elixir in question. But it's not a good story-not in the sense that I'd like to use the word. It doesn't offer a healthy or compassionate route through which people so recently subjected to terror and tragedy can see their way to the future. It exploits of our biggest weakness: our fear of weakness, and it does so for profit. It sends us chasing after a fantasy that we can't help but fall for because we were all raised on it, and because an innate (if irrational) belief in human immortality is what fosters the "type A" personality in the first place. The ad tells its viewers (commands them, really) to Stay. With Plavix. When in fact what they need is to learn to move on. Not to death, but to life–real life–with heart disease.

Chapter 6: Reflections of Responsibility (Nexium)

THE FINISHER

A man walks briskly down the hallway of his home. Lively music with a prominent drum beat begins to play. "They call me," says a male voice, "The Finisher." The commercial is framed with a lavender strip above and below, providing a cinematic wide-screen effect along with a convenient location for the text that will later appear. [247]

Illustration 6.1: The Finisher in the hallway.

Although the first line is delivered by a voice-over narrator, it becomes clear that this is the voice of the protagonist–the Finisher, as he has identified himself. Viewers look over his shoulder as he pauses in a bathroom doorway. Inside, a blonde girl in her early teens

[247] The images in this chapter were captured from a video recording of a television commercial for AstraZeneca's Nexium, broadcast on the American Movie Channel (AMC), on August 21, 2006, during the movie *Nine to Five* (Twentieth Century Fox, 1980), from 4 p.m. to 6 p.m.

stands in front of a mirror brushing her hair. “Finish up in there,” says the man in a fatherly tone. She sighs, obedient but apparently weary of this message. “Okay,” she says. Her father continues down the hallway and spots two younger boys playing video games in a darkened living room. “Finish your homework?” he asks. “Yes!” they respond quickly and in unison, as if they had been expecting this question.

The camera cuts to a kitchen table scene, where all three children are now seated alongside one another. Their father walks the length of the table in front of them. Purposeful but not rushed, he seems to be making his evening rounds through the house, a diligent father ensuring that everything is as is should be. “Finish your vegetables,” he says as he passes his children at the table. They seem slightly irritated but nonetheless resigned. They peer skeptically at their food but do as they’re told.

Illustration 6.2: “Finish your vegetables.”

The father walks into the master bathroom, now wearing a cotton T-shirt rather than the neatly pressed button-downs he wore in previous scenes. Here again he speaks

through voiceover narration, as if allowing the audience access to his thoughts: "something I thought *I* was finished with…." His voice lifts slightly towards the end of this line, as if it were a question. With a purple shower curtain draped behind him, he approaches the mirrored medicine cabinet over the sink and, finally, stands still before it. He pauses as he opens the cabinet door. Suddenly, the audience faces him directly and from close proximity. The camera positions viewers on the other side of the mirror, inside the medicine cabinet. As if acknowledging the unusually intimate view that this perspective affords, the protagonist leans in slightly and continues: "managing my acid-reflux disease." His tone and demeanor are confessional, although he couldn't be called sheepish. He is admitting to the audience that he failed to live up to his image and heed his own good advice. He quit before the task was complete. Yet unlike completing a homework assignment or clearing a plate, this chore is a long-term, perhaps even life-long project: managing his acid reflux disease. He does not say "treating my heartburn." He failed to finish "managing" this (apparently) chronic condition. Or, more specifically, he failed to realize that his condition was chronic and in need of continued attention.

Illustration 6.3: The view in the mirror.

Illustration 6.4: A visit to the doctor.

"I thought it was just bad heartburn," he admits, "but my doctor told me that over time, stomach acid was damaging the lining of my esophagus." Viewers are now afforded another rather intimate view – they witness a conversation between the protagonist, seated on an examination table and his physician, an Asian woman standing in front of him. She wears a lavender blouse under her white coat and although her words are not audible, the gist of her message is conveyed to the audience as her hand gestures from her chest up towards her throat, signifying the splash of stomach acid up into the esophagus. "She prescribed Nexium," continues the narrator, as the camera zooms into a close-up shot of the physician printing the name of the drug on her prescription pad.

The scene changes to a wide view of the examination room, with doctor and patient continuing their conversation on the right side of the screen. But the protagonist now appears superimposed on the left, facing the audience and addressing it directly as the now-embodied narrator. He summarizes the conversation taking place behind him: "She said I needed more than heartburn relief. My esophagus needed repair."

Both the narrator and the exam room are replaced by an illustrated image of a long purple cylinder. The camera gazes directly into it. Concentric rings appear on the inside surface of its walls as the tube narrows and fades into shadow. The Nexium logo appears printed in the center of this view, shown in white letters with its generic name (esomeprazole magnesium) in parenthesis below it. Emphasized by a high musical note, a brighter purple ring travels through the tube toward the camera, and closely following this pulse is a picture of a purple capsule with three yellow rings circling its left edge. The pill seems to fall, end over end, toward the audience. As the capsule continues forward, the logo appears to stick to it, so that the last view is that of a purple pill complete with name and trademark traveling closer and closer to the viewer until it falls off the bottom of the screen. While this is happening, the narrator continues: "One prescription Nexium pill a day not only relieves my heartburn, it healed my esophagus." Bright purple pulses continue down the tube, which gradually changes color from lavender to a brownish orange. Two dark, cragged areas representing esophageal erosions appear upon its inside walls. Within seconds, more purple pulses travel down the esophagus and the erosions shrink and disappear as the walls return to their initial, pleasant purple. The illustration disappears and the camera returns to the narrator, zooming in on his face as he lifts his head slightly. "So I don't just *feel* better," he says with a confident smile, "I *am* better."

Viewers now see the Finisher back at home, this time in the kitchen, apparently cooking dinner with his daughter. Brightly colored vegetables are strewn about the countertop. Together, father and daughter consult the recipe in a glossy pamphlet. "And," the voiceover narration continues, "with the Purple Plus Program I get advice on nutrition, exercise–even ways to save on Nexium."

Illustration 6.5: Cooking dinner.

The narrator again appears superimposed on the left side of the screen, only this time the scene over his shoulder is a somewhat blurry image of himself walking back down the hallway. “My doctor did say headache, diarrhea, and abdominal pain could be side effects of Nexium,” he says. The camera cuts to another close-up shot of his face, this time on the right of the screen. The blue background displays a pattern like the concentric rings of the illustrated esophagus, only now they are oriented vertically. The pattern fades as he continues: “and other serious side conditions may still exist.” The camera cuts to a nearly identical scene, in which the protagonist smiles at the audience from the left side of the screen, although his face is initially blurry. It comes into sharper focus as the background pattern again shifts from a pattern of alternating lines to a smooth blue surface. A second narrator, also male, tells audience members to “talk to your doctor about the healing purple pill.”

The final scene shows the Finisher standing with his three children, traditionally posed, as if for a family portrait, with his hands on their shoulders in the lush grass of a spacious backyard. A large oak tree behind them supports a sturdy tree house made from

unfinished lumber. “I tell them you shouldn’t do anything halfway,” says the father to the audience. Then he looks down at his children. “Let’s finish up!” he says, and playfully races them back to the tree house.

Illustration 6.6: The backyard.

Ostensibly, this is an advertisement for heartburn medication. Yet the Finisher plays a much more important role in the story, and the success of the commercial, than the pills he has been reminded to take. The main character in this story is both accessible and enviable. The audience is made to simultaneously relate to him and aspire to resemble him even more. He is not only the main character but also the narrator and, in some respects, the product for sale. The Finisher is a social role offered to the audience over and above, although connected to, the medication being advertised. Because the story is told without alternative points of view and with no sense of irony, viewers are not encouraged to question the first person narrator or adopt a perspective other than his own. In fact they are actively encouraged to adopt his viewpoint and picture themselves cast in his role. His characterization and the structure of the story would be enough to effectively

accomplish this, but the point is driven home by the image of the mirror over his bathroom sink. The Finisher looks into the mirror at the audience. The juxtaposition of the medicine cabinet in the same space helps to tie the medication into the identity that audience members are invited to share. In this narrative, Wayne Booth's notion of implied audience is, literally, the mirror image of the protagonist.[248]

This character exists in a state of tension between the contemporary image of an active, accessible, endearing dad and the cultural icon of the stern, righteous, authoritarian father. Even as he accepts good-natured ribbing from his kids and actively involves himself in their everyday lives, he still deserves (and receives) a level of respect that relates directly to the moral values he exemplifies. The Finisher is inextricably connected to notions of personal responsibility, consistency, and follow-through. He represents an old-fashioned morality in a modern family, and he tells an old-fashioned story through modern means: a television commercial with a straightforward, didactic structure and even an explicit "take-home moral."[249] Through his story, this father instills a renewed appreciation for the value of responsibility in the audience, but he also leads viewers to understand a medical condition in a particular way, and to respond to it with a prolonged course of a particular medication. He teaches his audience that to do anything else is not only medically inappropriate, but also bad parenting. It is morally, as well as medically, irresponsible. It sets a bad example and is personally hypocritical. Which is perhaps appropriate, given the political and financial context of the product being advertised. Hypocrisy turns out to be a central theme when the story of The Finisher is read alongside the story of the Purple Pill.

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[248] Booth, 125-53.

[249] Chambers and Montgomery, 77.

THE NEW OLD-FASHIONED DAD

The principle conflict of The Finisher's story is one of identity. He has managed to create a stable place for himself within the boundaries of his family, a contemporary American family living their daily lives in the context of rapidly changing cultural ideas about gender roles and parental responsibilities. Luckily, the producers of a brief television commercial don't need to explain the complexity of these larger cultural and historical shifts, or the evolving moral status of the family unit. All they have to do is set the scene.

A particular theatrical form known as *tableaux vivants*, or living pictures, gained popularity in the late 1800s. Roland Marchand describes these "elaborately costumed staged representations of familiar scenes" such as a city street or café, as stylistic devices intended to instantly convey a great deal of information about the characters and their social situation before the action on stage even began.[250] The curtain often rose to reveal the actors posed motionless in the midst of mundane actions, such as holding a fork to their lips or taking a step. Beginning with a silent snapshot and maintaining it for several dramatic moments, plays featuring tableaux vivants highlighted "the atmosphere … and implications of the depicted social situation."[251] This technique not only "convey[ed] an immediate impression of the characters" and their social situations, but also emphasized the intimate view that the audience was granted into the daily lives of those onstage.[252]

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250 Roland Marchand, *Advertising and the American Dream: Making Way for Modernity, 1920-1940* (Berkeley and Los Angeles: University of California Press, 1985), 166.

251 Ibid.

252 Ibid., 165.

Marchand recognizes the use of a similar technique in advertisements, one that became increasingly prominent in the 1920s and 1930s. These early advertisements, like the theatrical tableaux vivants, involved scenes that were "sufficiently stereotypical to bring immediate audience recognition."[253] Yet while playwrights and actors often created living pictures of well-known biblical or historical scenes as well as those from everyday life, the "social tableaux" found in advertisements most often depict one of two scenes, both heavily laden with social and moral meaning and each, at the time, exclusively associated with a particular gender: the domain of the home and the domain of the office.

Although the Nexium commercial does not begin with still-life image, it nonetheless functions as a snapshot of the American home. Interestingly, the house itself is never shown, even from the final shot in the backyard. Viewers find themselves instantly dropped inside of it, and not into a foyer or even a living room but into the hallway, and soon thereafter, two different bathrooms. These are the intimate spaces of daily life, into which only family members and close friends ever venture. Viewers are not treated as guests. There is no formal introduction or even any sense that the characters realize they're being presented. The Finisher addresses the audience through voiceover narration, but otherwise he goes on about the mundane tasks that viewers encounter him in the midst of.

While the image of a father in the household, actively involved in parenting, is not new or surprising to contemporary audiences, it does provide a stark contrast to the traditional portrayal of the bread-winning career man in the domain of his modern office and the softer, gentler wife and mother at home with the children.[254] The story of the

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253 Ibid., 166.

254 See Kathryn Kish Sklar, *Catherine Beecher: A Study in American Domesticity* (New Haven, Conn.: W. W. Norton, 1976), and Paula S. Fass, *The Damned and the Beautiful* (New York: Oxford University Press, 1978).

Finisher is one of two Nexium commercials that ran simultaneously as part of the same marketing campaign, and both are quite similar in their depiction of nontraditional gender roles. The other commercial features a woman who identifies herself as a "Problem Solver" and is seen engaging in traditionally masculine chores, such as helping her child repair a broken bicycle. Like the Finisher, she is featured without a spouse and, like the Finisher, she is portrayed as someone who has managed to balance traditional and nontraditional aspects of her gender. Both commercials are framed in purple, the signature color for AstraZeneca's line of heartburn medications, and both characters wear clothing that both complements the color of the Nexium tablet and depicts them as more traditionally gendered than the tasks that they perform. The Problem Solver wears a silk lavender blouse which, along with a close-up shot of the flowers in her yard early in the commercial, conveys to the audience that she has not relinquished her femininity even though she can confidently repair a bicycle or a ceiling fan. Analogously, The Finisher's neatly pressed dress-shirts serve as a clue that although he may be home in the evenings, he has presumably spent most of the day at office, where he functions in a more traditional male role. Once in the house, however, he demonstrates his willingness to take on more stereotypically feminine chores like cooking dinner and checking on the kids.

The interaction that the audience witnesses between this father and his children is not only evidence of contemporary, shared parenting roles, but also plays a key part in the development of his character. The Finisher bears his nickname proudly. He begins his story with something he might say to other neighborhood fathers over a backyard grill: "They call me The Finisher." This is both self-effacing and also a point of pride. It invites sympathetic responses from other fathers of teenage children, other parents who suffer sarcastic nicknames and not-so-subtle teenage sighs. Yet the specific way in which his kids tease him reflects his commitment to an old-fashioned parenting style and his

insistence on family values such as responsibility. His nickname acknowledges his parental success in two ways: it reflects his uncompromising moral standards and simultaneously demonstrates his youthful sense of humor. He may demand the same behavior from his children that his father demanded of him, but his kids can joke about it, and he's hip enough to laugh along with them–as long as they do as they're told.

In a contemporary advertising text, William Leiss emphasizes the role of the icon in publicity, and although he notes that the word originally referred to a visual image of "a venerated figuring in a religious setting," he explains its current use as connoting visual "representations of those secular values that have a special place within our culture."[255] He offers *father* as one example of such privileged concepts, yet he quickly qualifies it by its applicability to "older times," rather than current culture. Although I disagree with Leiss that the icon of the father is no longer applicable to today, I do agree that today's idealized image of fatherhood, which The Finisher is intended to represent, is a far cry from the more traditional (and perhaps more easily recognizable) father figure of generations past. The image of the father as loving yet stern, distant, authoritative, morally righteous and uncompromising remains in film, television, and literature, but it is increasingly identified with an older generation, often veterans with a military style of parenting, and portrayed in contrast with their famously easy-going sons. The old-fashioned father was to be feared and respected. He spent most of the time at the office but his presence at the dinner table was nonetheless one of primary authority. And even if his grown children make good on their adolescent vows to raise their children differently, they nonetheless grow up to appreciate the value of his lessons, if not the unforgiving style within which he delivered them. Dads these days involve themselves in parental

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255 William Leiss, Stephen Kline, and Sut Jhally, *Social Communication in Advertising: Persons, Products & Images of Well-Being* (New York: Rutledge, 1997), 286.

activities that were previously the sole purview of their wives. They go to teacher-parent conferences and play dates. They hug and kiss their children in public. They build swing-sets and tree-houses in the backyard and then play along with the kids. They get muddy, they cause trouble. They are young at heart, and they demonstrate it often enough to prompt the common complaint of sitcom wives and mothers–the trope that their first child is really their husband. Would June Cleaver ever have said that? Claire Huxtable would have, although she may have been among the first. And Deborah Barone rarely says anything else.[256] But along with a more active, affectionate, approachable image of fatherhood often comes a perceived lack of authority and respect. Even while contemporary, forward-thinking dads view corporal punishment as barbaric and want their kids to feel comfortable with them, they find themselves in an odd position, both nostalgic and disapproving, when comparing their own parenting style to that of their fathers. Thus the clichés that get bandied about in conversations about how to deal with a disobedient child ("I would never have gotten away with that," "my father would have worn me out," and so on) join the litany of paternal tropes about making do with less, the value of hard work, and the inevitably snowy uphill walk to school.

The Finisher has managed to navigate the difficult terrain of contemporary parental authority, and several aspects of his story demonstrate the balance he has found between the iconic authority of the father and the endearingly fallible image of the contemporary dad. Most obviously, his explicit attempts to instill the traditional value of personal responsibility in his children, as well as the nickname that such attempts have earned him, speaks to his character as well as the more traditional aspects of his parenting style. And although his children tease him, the audience understands this to be a sign of

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256 Female characters intended to represent typical wives and mothers in popular prime-time sitcoms of various periods: *Leave it to Beaver* ran on CBS from 1957 to 1963; *The Cosby Show* ran on NBC from 1984 to 1992; *Everybody Loves Raymond* ran on CBS from 1996 to 2005.

endearment rather than a sign of disrespect. His daughter sighs but stops just short of rolling her eyes before she agrees to "finish up" in the bathroom. His son peers warily at his vegetables but appears resigned to eating them anyway. Both boys turn to face their father when he asks them if they're done with their homework rather than calling out "yes" without taking their eyes from the video game. These gestures are all small but significant, especially in the context of a sixty-second commercial. The kids may feel free to tease their dad, but they certainly treat him as an authority figure who commands obedience and respect. Even the musical background to this story reflects the balance in his character. It begins reminiscent of a military march–the appropriate soundtrack to his no-nonsense walk around the house. Yet although the backbeat is prominent, the melody is light and upbeat, and as the story continues, the jazzy overtones become more frequent until the overall effect is that of a marching band backing a rock-and-roll group.

Perhaps the most significant evidence of The Finisher's successful negotiation of traditional and contemporary fathering styles, however, is, ironically enough, his admitted failure to live up to the standard he sets for his kids. He preaches the values of responsibility and follow-through: "never do anything halfway," he tells them. Yet he understands that they learn not only from his explicit instructions but also, and perhaps primarily, from the example he sets. Therefore, he tries exemplify the values that his children have come to associate with him. But when he is safely out of their earshot he admits to the audience (through the mirror) that he can't always live up to his image. Just as his good-natured response to their teasing and his active involvement in their lives softens the hard-line image he presents to his kids, his frank admission of fallibility softens his idealized character in the eyes of the audience. Viewers admire him for striving to maintain his image as the impossibly infallible father, and yet find themselves

able to relate to him as he admits to his own imperfections-something that a traditional, authoritarian father would never do.

THE MORAL OF THE STORY

Through its confessional, intimate tone as well as its didactic, almost "Aesopian" structure, the story takes on an explicitly moral dimension.[257] The context within which Americans are most used to telling and receiving stories about the experience of illness is characterized by a particular relationship between the storyteller and the listener. Illness is a personal topic, often times an intimate and potentially embarrassing one. The tradition of doctor-patient confidentiality both reflects and reinforces the idea that we usually tell our stories of sickness to those who we know and personally trust. The Finisher is not a physician, yet his role as the first person narrator, along with several other stylistic aspects of his story, creates a seemingly intimate encounter between himself and his audience. The exclusive view into the inner workings of the home, the privacy of the setting, the frank confession in the mirror, and the superimposed image of the Finisher narrating the events of his own medical visit while the audience looks on all contribute to the overall tone of the ad-one that brings the narrator, protagonist, and implied audience closer and closer together.

The sense of intimacy conveyed by this story not only provides an appropriate tone for the discussion of explicitly moral content, it also allows the audience to receive a didactic message without feeling overtly patronized. This story is told as a lesson to be learned, and although viewers are meant to relate to the father figure himself, he is

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[257] Chambers and Montgomery, 77.

nonetheless treating them much like he treats his children: he instills traditional values through his own example. And although the commercial is, literally, paternalistic in this way, the didactic edge is softened by the fact that the viewer finds the protagonist not only a legitimate source of moral authority, but also an accessible (and likeable) peer. For pharmaceutical marketers, this character serves as a convenient device to deliver a moral message that might otherwise sound authoritative and condescending. Imagine a commercial where a doctor looks directly at the camera and tells audience members that they ought to take their medicine, and that forgetting or discarding it, even because their symptoms disappear, is both medically and morally irresponsible. Such a story could only feature a traditionally paternalistic physician-an old-fashioned icon as outdated as the stern, authoritarian father upon which its primary metaphor is based. Pharmaceutical marketers know full well that such direct instructions coming from an authority all too often inspire a rebellious contempt, if they result in any long-lasting impression at all. Many people shrug off or forget medical advice to eat well and exercise. Or they commit to lifestyle changes only to encounter disappointment in the face of seemingly impossible expectations and standards. By delivering their message through The Finisher, however, marketers make it more likely for viewers to heed the advice for at least three reasons. As mentioned above, it is precisely his own fallibility that makes this character such a good role model. He offers an identity that is both realistically adoptable and aspirational at the same time. He also reminds viewers that the risks they may be willing to incur for their own health may not be examples they are willing to set for their children, and in this way the ad represents an interesting twist on public health strategies to quit smoking or reduce cardiac risk, if not out of personal concern, then for the sake of loved ones. Additionally, the Finisher not only represents not only the kind of dad that (male) viewers want to be, but also the kind of *guy* they want to be. He offers an "identity matrix" that goes beyond

his role as a parent.[258] A *Finisher* is not only a father insistent on follow-through, commitment and responsibility. He's also a guy who can get the job done, once and for all. He's a relief hitter, a "go-to" guy. He's a guy who can close a deal. And into the midst of these masculine aspirations, pharmaceutical marketers have cleverly positioned the medicine cabinet. Taking pills, particularly for a chronic condition requiring medication every day, may seem unmanly. Viewed from a certain light, even the idea of protecting yourself from potential future harm seems less than masculine. The makers and marketers of Nexium have cleverly turned that relationship on its head. Instead of compromising his masculinity by admitting the possibility of future illness and frailty, the Finisher is actually demonstrating and solidifying his masculinity by playing the role of the good, consistent, never-say-quit father. The act of taking Nexium leaves the category of medical care and relocates itself in a more acceptable framework. Men no longer need to see a patient (a sissy, a neurotic, a Woody Allen character) in the mirror as they open the medicine cabinet. Instead, they see a Finisher. They see themselves cast in a role somewhere between Atticus Finch and Joe DiMaggio.

The placement of the mirror in this story is key. The Finisher is the image that viewers actually see in the mirror–it is an identity held up for them to try on and admire. The connection of the mirror to the medicine cabinet makes explicit the connection between the role of The Finisher and the medication for sale. It visually echoes the scene in which the teenage daughter stands before her own reflection, and functions as a metaphor for the extent to which the father's behavior should reflect his values, and the extent to which his children's behavior and upbringing are a reflection of his own parental success. He is responsible not only for his own image and moral character, but

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[258] Leiss, 251.

also for those of his children, just as he is responsible not only for keeping his own house in order but helping them learn to build their own (if only in an oak tree, for now.)

A common visual element in film as well as advertisements, the mirror reminds viewers "of the relationship between the 'antecedent' and 'idealized' representations of [the] human personalities at play."[259] The motivation for purchasing the product (or, in this case, for asking a doctor to prescribe it) revolves around self-transformation and identity change. And in the brilliantly crafted visual spacing of the bathroom mirror scene in this story, the only thing between the viewer and The Finisher is what lies in the medicine cabinet-a purple pill called Nexium. Which, appropriately enough, turns out to be the mirror image of the previous generation of heartburn medication.

THE PURPLE PILL

While over-the-counter and folk remedies to neutralize stomach acid help to relieve the discomfort associated with acid-indigestion and heartburn, most Americans can testify by experience that they don't necessarily relieve all of the pain and do little for the long-term problem. In 1977, "the Tagamet revolution" began, and the public was offered, for the first time, a medication that did more than neutralize excess acid meal by meal. Cimetidine (released by Smith Kline as Tagamet) and well as Ranitidine (released by Glaxo as Zantac several years later) work to block the histamine receptors in the lining of the stomach wall. Not only did these agents, known as H2 blockers, provide better symptom relief than antacid tablets, they were to be taken daily rather than immediately after an indulgent meal. They were kept in the medicine cabinet rather than the coat

[259] Ibid., 254.

pocket or desk drawer. Compared with a half-chewed roll of Tums, these drugs seemed more like a legitimate medication for a serious health problem. Many can recall the clever commercials for Zantac, (which ran years later after it became available over the counter) featuring a man complaining of his acid indigestion to the unassuming yet confident fellow sharing his cab. The second man produces a box of Zantac and offers it to his suffering companion, along with a brief statement about the power of the drug. Grateful and almost sheepish, the first man counters with humor. "What are you, a doctor?" he quips, riding a brilliantly choreographed line between white and blue collar characterization. At which point the unassuming man admits, with a chuckle, that yes, in fact, he is. In these ads, Zantac was portrayed as the smart man's antacid–medication that ranks a cut above the chalky tablets endorsed by aging blonde waitresses in greasy spoons across America. While the ruddy-complexioned, working-class men seen at diners in commercials for Tums and Maalox are depicted as having regretted ordering the Salisbury steak, the white collar yuppie in the cab is presumably hurrying to make his next high-powered sales meeting on time. The etiology of heartburn therefore shifts from overeating to overworking as the target audience of the new heartburn medication becomes increasingly affluent. And the significance of the condition shifts along with its risk group and etiology, from everyday discomfort to a harbinger of a serious illness requiring medical attention. The guys in the diner will always have heartburn. The man in the cab, if he doesn't slow down, could give himself an ulcer.

As a significantly more serious health condition than heartburn, stomach ulcers represented both the danger of ignoring a frequently sour stomach and the importance of choosing a powerful medication rather than a few chewable antacids. Lowering excess stomach acid became an important preventative measure for those leading a stressful, "ulcer-prone" lifestyle as well as a treatment for those already suffering from stomach

ulcers. Yet even as more and more Americans began taking Zantac and Tagamet for their acid-reducing (thus, ulcer-preventing) properties, medical research was underway that would threaten the belief that excess acid necessarily lead to any significant pathology. As early as 1983, an Australian researcher named Barry Marshall had isolated a bacteria commonly found in the human stomach but present in excess in patients with frequent gastritis and stomach ulcers. *Helicobacter pylori*, as it was called, would revolutionize the understanding and treatment of ulcers, and as Marshall came to the United States to create an NIH-funded research center at the University of Virginia, the explanatory model upon which the drug companies had been successfully selling their H2 blockers was in jeopardy. Ulcers continued to represent a serious medical condition, of course, but not one caused by excess acid, which was "the problem that Zantac treated so well." [260] Ulcers, as it turned out, were most often due to a bacterial infection, treatable with a simple course of antibiotics. This discovery, of course, helped physicians treat patients with ulcers and prevent those at risk from ever developing. It hardly represented good news for the pharmaceutical companies, however. Although H2 blockers could certainly still be marketed and used to relieve the unpleasant symptoms of gastritis and heartburn, the irritation of the stomach lining and esophagus, respectively, they could no longer claim to prevent or treat the more medically significant condition through which they had earned not only profit but also medical and cultural significance. "The negative sales implications were huge."[261] Of course, this new explanation of ulcer pathology also called for pharmacologic treatment but, unfortunately for drug companies (and, ultimately, perhaps, for the public), the appropriate treatment simply did not have the

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260 Greg Critser, *Generation Rx: How Prescription Drugs Are Altering American Lives, Minds, and Bodies* (New York: Houghton Mifflin, 2005), 71.

261 Ibid.

profit potential that long term acid-reduction (continually necessary within the lifestyle of stress and poor eating habits that Americans were not likely to abandon) had promised. Despite possessing the knowledge and resources with which to do so, the pharmaceutical companies demonstrated little interest in addressing the real cause of ulcers "with a short, cheap course of generic antibiotics when they could make billions of dollars treating their chronic recurrence with expensive prescription antacids."[262] Although clinical research eventually demonstrated a significant benefit to adding an acid reducing agent to a course of antibiotics against H. pylori, the foundation upon which the pharmaceutical "cash cow" of H2 blockers had been growing was irreparably shaken.

The medication, however, was too powerful and too profitable to abandon. The pharmaceutical companies were unwilling to allow the cultural and medical importance of Zantac and Tagamet to disappear or even significantly decrease. What they needed, in order to recover from this new understanding of ulcer pathology, was to shift the focus of their H2 blocker marketing techniques away from ulcers and towards something else. Industry critic Greg Critser offers the following explanation for the pharmaceutical companies' approach to keeping Zantac sales high-an approach that radically shifted the cultural and medical use of the terms used to understand and describe acid indigestion and its consequences:

> What did Zantac do, and whom would it benefit? The answer came in the form of a disease that almost no on ever got: GERD, short for gastroesophageal reflux disease. GERD is, in essence, heartburn that gets so bad and so chronic that it causes damage to the esophagus. True GERD is rare, but the precondition for it, a weak esophageal sphincter (the muscle that shuts off the esophagus from the lower gut acids) is part of the natural aging process. That is why almost everyone gets heartburn, and why almost everyone's heartburn gets worse with age. The business question was: How could you convince a lot of people-and a lot of physicians and insurers–to pay for an expensive prescription medication drug

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[262] Goozner, 220.

> when most people saw heartburn in a benign way and treated it with a 49-cent roll of Tums? Worse … much of the resistance to any anti-GERD medication populist, the outgrowth of long-held folk wisdom: people felt that heartburn was, at least in part, their own fault, either from eating too much or from eating the wrong foods at the wrong time. How do you sell around that? The answer was to medicalize–and thus to popularize–GERD.[263]

If Critser's explanation of how the pharmaceutical industry medicalized heartburn to "reposition" their most profitable drug sounds like cynical exaggeration, consider the following quotation from a medical marketing journal praising the success of this very strategy. By equating heartburn with gastroesophageal reflux disease (GERD), marketers

> elevated the medical importance of this condition by presenting it as an acutely chronic 'disorder' with the underlying physiological etiology and the potential for serious long-term consequences if left untreated – a far cry from the 'plop plop fizz fizz' perception of heartburn.[264]

Frequent heartburn, a ubiquitous consequence of the American lifestyle, was now not only increasingly synonymous with a serious medical disorder, it was also understood as "an acutely chronic" condition. The explanatory model of excess acid leading to esophageal reflux and (rarely but potentially) esophageal erosion combined the urgency of an acute problem (damage to the lining of the esophagus) deserving prompt attention with the long-term economic benefits (for the drug companies, of course, not the patient) of a chronic condition (frequent heartburn) that must be continually treated to keep more serious sequelae at bay. As the line between heartburn and GERD became increasingly blurry, and as the medical profession as well as the public began to focus on the potential esophageal damage associated with acid indigestion, a drug came along that was able to use this new perception of heartburn to launch pharmaceutical profits to unprecedented

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263 Critser, 71.

264 *Medical Marketing & Media* (March 2003), quoted in Critser, 72.

levels. And DTC advertising had everything to do with its success. A feature article on pharmaceutical costs in the Boston Globe reflects upon the relationship between mass media and what has become perhaps the most famously advertised prescription drug:

> Prilosec was the perfect drug to market on TV. Millions of people have gastric problems, and many were no doubt feeling the pain right as the commercial flashed on the screen in front of them. Here was this incredibly effective new medication waiting to change their lives. And when they later found themselves sitting on a doctor's padded exam table, they didn't even have to recall the drug's name. All they had to remember was its color.[265]

The Purple Pill surely represents one of the great success stories not only in pharmaceutical marketing but in product advertising generally. Not only is this phrase instantly understood in households and exam rooms across the country, it has successfully withstood a challenge that, logically, no advertising campaign ought to be able to withstand. The Purple Pill has taken on an identity and sales potential almost unrelated to the actual product it represents–it remains as a constant cultural entity despite the product it originally referred to having been replaced by another. But before this switch took place, back when the Purple Pill was still Prilosec, several factors ensured the stability and success of the product. As the first of the proton pump inhibitors, or PPIs, Prilosec represented a huge improvement over Zantac and the other histamine blockers, because it actually decreased the amount of gastric acid produced in the first place rather than attempting to neutralize the excess production after indulgent meals. Its power as an acid-reduction agent was such that, without the marketing work of the pharmaceutical industry, many of us would never have heard of it. Tim Ferris, a family practitioner at Massachuttes General Hospital, explains that "PPIs … were

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[265] Neil Swidey, "The Costly Case of the Purple Pill," *Boston Globe*, 17 November 2002, 4(C).

originally intended to treat [a] very rare condition."[266] But because the public, along with the medical profession, has come to associate frequent heartburn so closely with "serious esophageal disease," and to consider it a "harbinger" of potential damage to come, the line between everyday heartburn and true gastresophageal reflux disease (much less erosive esophagitis, which can only be diagnosed with endoscopy) is increasingly difficult to locate.[267] Prilosec became available in 1989. Five years later (and three years before the FDA broadcast guidance allowed for the dramatic increase in television drug commercials) *Harrison's Principles of Internal Medicine*, a classic diagnostic and therapeutic reference text, devoted the first paragraph of its discussion of esophageal reflux treatment to lifestyle modifications such as weight loss and elevated sleeping positions. The second paragraph discusses treatment of "moderate to severe cases" where these lifestyle measures "are more strictly enforced" and combined with H2 blockers. Only at the end of that paragraph is omeprazole (Prilosec) mentioned, and then in reference to "resistant cases."[268] In the 2006 edition of this manual, lifestyle modifications along with histamine blockers are recommended for mild cases of reflux. This is immediately followed, however, by the statement that "PPIs are more effective in symptom relief and more commonly used." In fact it is difficult to imagine how other medications are ever used since the diagnostic section instructs physicians that "a therapeutic trial with a proton pump inhibitor … provides strong support for the diagnosis

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[266] Tim Ferris, MD, quoted in Swidey, 4(C).

[267] Angell, 86.

[268] Raj K. Goyal, "Diseases of the Esophagus," *Harrison's Principles of Internal Medicine*, 13th ed., ed. Kurt J. Isselbacher et al. (New York: McGraw-Hill, 1994), 1360.

of GERD."[269] As a result of changes in both medical and public perceptions of heartburn and esophageal reflux, "there are tens of millions of people taking this medicine (Prilosec and, later, Nexium) that was never intended to treat an entire population," insists Dr. Ferris.[270] Whatever pharmaceutical critics have to say about the Purple Pill, almost no one would contest its strength as an acid-reducing therapy. "Prilosec is a wonder drug that actually deserves its title… But that doesn't mean a slew of people couldn't do fine on something much cheaper."[271]

As H2 blockers became available in generic formulations and even over-the-counter, most patients could effectively treat their heartburn for less than a dollar a day. Prilosec, sold at about six dollars per tablet when first released, certainly offered a substantial benefit in efficacy but it was one that the vast majority of heartburn sufferers could not appreciate simply because their symptoms were not severe enough. Most people are able to control their symptoms very well with Zantac. But many people never experience the slightest twinge of heartburn on Prilosec. Perhaps the difference would be worth it were it not for the dramatic cost associated with the latter drug. But most patients never see the full cost of their medication, and most doctors don't even know the cost of the medications they prescribe, so the cost/benefit ratio is hard to appreciate. It becomes even more difficult when a multimillion dollar marketing machine has hired the best and the brightest to convince both parties within the doctor-patient relationship that the more expensive, more powerful drug is infinitely superior to its cheaper competitors. As one gastroenterologist explains the difference, "You go to the rental car counter, and the

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269 Raj K. Goyal, "Diseases of the Esophagus," *Harrison's Principles of Internal Medicine*, 16th ed., ed. Dennis L. Kasper et al. (New York: McGraw-Hill, 2005), http://www.accessmedicine.com.libux.utmb.edu/content.aspx?aID=89425 (accessed February 15, 2007.)

270 Swidey, 4 (C).

271 Ibid.

company's paid for it, and you can get a Hyundai or a Cadillac. So you take the Cadillac."[272]

To be fair, the pharmaceutical companies didn't have a very difficult time convincing doctors that their drug was, in fact, a Cadillac. Or, as many physicians came to refer to it behind closed doors, "purple crack." "Prilosec gave physicians a sense of power, a sense that we can cure you," explains another gastroenterologist.[273] A powerful drug–one that can almost guarantee the complete relief of a patient's symptoms–is a difficult thing to resist, regardless of cost, and especially when costs don't seem to matter to the insured patients requesting it. "This might be the only problem that the doctor can satisfactorily solve today," so the impetus to write the prescription for the Purple Pill (despite the effects on larger health-care costs if not the patient's pocketbook) would be strong even without the extensive advertising campaign.[274] The medical superiority of Prilosec, combined with a multimillion dollar marketing strategy that further cemented the conception of frequent heartburn as a harbinger of, or even the same thing as, GERD, made the drug an astounding financial success. By the time Prilosec approached the end of its patent, it was the top-selling drug in the world, worth $6 billion in annual sales. The loss of patent protection would be "devastating" to AstraZeneca.[275]

The twenty years of patent protection afforded to a company for each medication it develops were intended by the authors of the Hatch-Waxman Act to protect the intellectual property of the pharmaceutical companies by allowing them the opportunity to adequately profit from the result of an enormous investment in scientific research.

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[272] James Richter, M.D., quoted Swidey, 4(C).

[273] James Reichheld, M.D., quoted in Swidey, 4(C).

[274] Swidey, 4(C).

[275] Angell, 77.

If a competitor could immediately begin selling and profiting from a drug that a company had spent decades and millions of dollars to create, the financial incentive for innovative pharmaceutical research would disappear. There has been much debate among the industry and its critics about the actual ratio of research costs and sales profit, and the point at which a company has enjoyed its fair share of a monopolized market is debatable. Yet with the cost of health care growing to unmanageable proportions, and more and more Americans struggling to afford medication that they simply cannot, many within and outside medicine have become frustrated with the now-common practice of "evergreening" a drug. A multifaceted strategy to extend patent protection and thus profits, evergreening consists of a variety of corporate tricks and regulatory loopholes, such as filing lawsuits against soon-to-be generic competitors and making slight changes to a product and reintroducing it as a new chemical entity with a brand new patent term, even when the alteration represents no real innovation. To maintain the record-breakinng profits it was earning from Prilosec, AstraZeneca effectively stalled the arrival of a generic PPI for nearly a full year after the initial patent would have stopped, and limited its potential pool of eventual competitors significantly. Like other pharmaceutical companies, AstraZeneca had "become increasingly savvy in obtaining patents for every conceivable feature of a drug, from its coating to how it combines with other drugs to its color."[276] This provided the company amble opportunity to sue its potential competitors whose generic products might resemble, in any patentable way, the original name-brand drug. For instance, AstraZeneca had patented "the idea of combining Prilosec with antibiotics," a practice that became commonplace when the medical strategy against ulcers was to decrease acid while targeting the bacteria. AstraZeneca then "argued that a generic drug would infringe on the patent because doctors might prescribe it with an

[276] Swidey, 4(C).

antibiotic."[277] Additionally, it patented one of Prilosec's metabolites, a substance produced in the body once the drug is ingested, "and claimed people would infringe on the patent if they swallowed a generic drug," explains Marcia Angell, noting that in these scenarios, it is either the doctor prescribing the generic drug or the "hapless customer" swallowing it to produce the metabolite who truly violate the patented feature, but the lawsuits were filed against the generic competitors who "would be guilty of contributing to the offense."[278] Most of the patent lawsuits filed against generic competitors are frivolous and lost, but pharmaceutical companies expect this and don't mind; the costs of filing the suit dwindle in comparison to the sales profits made while the patent extends over the period of time the competitors are tied up in court. Often, with both parties anticipating this state of affairs, a pharmaceutical company will simply offer the competing firm an agreed upon sum not to produce a generic drug. Financially, both companies benefit. Patients and consumers, of course, do not. In the minority of cases, when the court decides that a patent has actually been infringed upon, the generic competitors are blocked from releasing their product at all, or at least until they redesign it to avoid the infringement. In the case of Prilosec, AstraZeneca won three of the lawsuits it brought against potential competitors, each of which was found to have used a patented subcoating found between the purple shell and the pill it surrounded. The ruling was a surprise to industry critics and insiders alike, since numerous medications make use of some sort of subcoating and many are quite similar to the one that AstraZeneca had been forward-thinking enough to patent. The corporation AstraZeneca hailed the ruling as

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277 Ibid.

278 Angell,184.

"a vindication" and praised the judge for "defending [its] intellectual property," all the while working on a more long-term strategy for protecting its record-breaking profits.[279]

Drugs like Prilosec don't come around very often, and one might expect a company to have to endure the loss of profit when it went off patent without being able to immediately release anything bigger or better. AstraZeneca, however, was determined to do just that. Yet given the efficacy and financial success of Prilosec, the company had a predictably difficult time trying to best it. With patent time running out, and billions riding on their ability to replace Prilosec, AstraZeneca decided to release Prilosec again, under a different name, with a chemical structure both identical to the original in terms of activity and different enough to warrant a new drug application to the FDA. Many chemical compounds exist as a mix of two isomers: two mirror-image copies of the same molecule. One way to visualize this is to imagine a giant shipment of a particular tennis shoe. All the shoes are the same, except that some are for right feet and some are for left feet. In most cases, the "handedness" of the molecule doesn't make any difference in terms of its effect. In some cases, however, one isomer alters the chemical activity to the extent that the medicinal properties are affected for better or worse. The makers of the prescription decongestant Seldane were able to take advantage of this fact when their drug was pulled from the market because of its association with heart palpitations and sudden cardiac death. After further research, the manufacturers determined that only one isomer was responsible for the cardiac effects of the drug, which disappeared when they separated the compound and discarded that particular "half." The remaining isomer was packaged and released as Allegra, which is chemically identical to Seldane except for the separation. This simple and clever strategy takes advantage of a chemical quirk to produce a second compound that is both different from and identical to the first. In the

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[279] Jim Coyne, spokesperson for AstraZeneca, quoted in Swidey, 4(C).

case above, the new product was significantly different because it did not carry the risks associated with the original drug, even though the chemical action producing the clinical benefit was unchanged. When the makers of Prilosec separated their blockbuster drug and re-released it in a form containing only one of its isomers, however, there were no risks or even pesky side-effects that the separation was believed to improve. The only reason for the separation was to develop a chemical entity technically different from the parent drug in order to qualify for a new drug application to the FDA, a new patent, and thus the continuation of the exorbitant profits that Prilosec had produced. The company had no reason to fear that isomer separation would decrease the clinical effects of its star drug because, in the case of Prilosec, both isomers are quickly activated to form an identical molecule upon ingestion. The drug, therefore, only exists as a mixture of the two isomers for minutes. After that, Prilosec is Prilosec. Or, now, it is Nexium. Thus the New Purple Pill was born. As Marcia Angell has cynically remarked, "it wouldn't have done to call it 'Half-o'-Prilosec,' but that's what it was."[280]

Although the isomer separation itself was enough to grant Nexium status as a separate entity and allow for FDA application and approval, AstraZeneca had to show that it was superior to Prilosec, at least in some way, in order to maintain the market share it had established under its Prilosec monopoly. The company undertook what critics have described as "wildly expensive" and "medically irrelevant" research studies comparing the two drugs, in addition to the placebo trials that demonstrated, to no one's surprise, that Nexium controlled heartburn quite well when compared to nothing at all.[281] The study most commonly cited in the company's later marketing campaign found Nexium to be significantly better than Prilosec at relieving and preventing heartburn

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[280] Angell, 77.

[281] Goozner, 222.

symptoms as well as healing esophageal damaged caused by gastric acid. The statistically significant difference demonstrated in this trial, however, was between a forty milligram per day course of Nexium and a twenty milligram per day of Prilosec. Of the three trials that compared the drugs at equal doses, two showed no difference between the compounds and were never released to the public. The third, however, demonstrated that ninety percent of patients with endoscopically confirmed esophageal erosions were healed after an eight week course of Nexium, while only eight-seven percent of similar patients were healed after eight weeks on Prilosec.[282] "The logical conclusion" of this research, according to Angell, "might have been to simply double the standard dose of Prilosec, allow generic competition, and forget about Nexium," which appeared to offer very little, if any, clinical benefit over the existing therapeutic options. But as Angell points out, that was not in line with AstraZeneca's goal of maintaining its record-breaking profits from the sale of PPIs, although it would have done quite a bit of good for "people with heartburn who object to paying $4 a pill." At that price, Angell comments, the drug might cause more heartburn than it relieves.[283]

As the Prilosec patent approached its end in October of 2001, AstraZeneca worked through legal strategies to hold its generic competitors at bay, and in the meantime undertook a massive marketing campaign designed to transfer patients, and profits, from its original blockbuster drug to its new prescription purple pill. In the year 2001, the company spent $478 million dollars advertising Nexium. Over a thousand new sales representatives were hired specifically to market this one drug. By the end of the year, an investment firm tracking AstraZeneca's progress and future earnings potential

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[282] P. J. Kahrilas et al., "Esomeprazole Improves Healing and Symptom Resolution as Compared with Omeprazole in Reflux Oesophagitis Patients: A Randomized Controlled Trial," *Ailmentary Pharmacology & Therapuetics* 14 (October 2000): 1249.

[283] Angell, 77.

reported to prospective stockholders that forty-two percent of Prilosec patients had "been converted to Nexium."[284] Right from its debut, Nexium was heavily and directly promoted to the public, at times topping the charts for the most-advertised drug in the world.[285] In television ads that mirrored earlier Prilosec commercials, men and women stood scattered about on rocky cliffs separated by deep crevices meant to represent, presumably, esophageal erosions. As purple pills fell from the sky, the land seemed to heal and the people were brought together again. The narrator instructed the audience to ask their doctor about "the new purple pill called Nexium." As time went by, this phrase was once again shortened to "the Purple Pill"–a cultural entity that remained constant even while the object that it referred to switched from one drug to another. The ease with which AstraZeneca's marketing team was able to insert Nexium into the spot that Prilosec occupied in people's mind was certainly made easier because it was, basically, the same drug, a fact that the company thus capitalized on even while insisting on its difference and superiority to the FDA. But the strength of the advertising campaign was such that the drug itself really didn't matter at all. Americans were sold the color and the connotation and the cultural entity of the Purple Pill. On the one hand this represents a brilliant marketing strategy by AstraZeneca, a synthesis of modern pharmaceutical manufacturing and marketing that identified and took advantage of regulatory loopholes as well as public and medical perceptions. On the other hand, it's the same sleight-of-hand trick that sold patent medicines by the shape of the bottle rather than the composition of the liquid inside.

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[284] Data from Dresder Kleinwort Wasserstein, Inc, quoted in Swidey, 4(C).

[285] Leonard J. Weber, *Profits before People? Ethical Standards and the Marketing of Prescription Drugs* (Bloomington, Ind.: Indiana University Press, 2006), 171.

Finally, even as Nexium slid into Prilosec's spot as the powerful prescription medicine for GERD, AstraZeneca successfully petitioned the FDA to allow Prilosec itself, now off-patent, to be sold over the counter with minor chemical changes as "Prilosec OTC." Those patients who could not be persuaded to switch to the new brand-named prescription drug could continue to purchase the old brand-name drug, as could all of those people who had heard miraculous things about the Purple Pill but had never asked for or received a prescription for it. The OTC formulation allows AstraZeneca to continually profit from the name it made for Prilosec, and now from a potentially infinite market with no necessary intermediate, and for a potentially infinite amount of time. As a pharmaceutical marketing textbook puts it, "the patent runs out on new drugs after a finite period of time, but successful brand names can go on forever."[286] And although the OTC price would need to be significantly less than the prescription price, the would-be-competitors frustrated by lawsuits and delays had yet to launch a PPI into the prescription market, much less offer a generic OTC option. The final result of these varied and coordinated strategies to avoid the profit loss associated with the end of a patent was that "AstraZeneca preserved its monopoly in the prescription market with Nexium, and with Prilosec it accomplished the same thing in the OTC market."[287]

The story of the Purple Pill, once Prilosec and now Nexium, prompts several questions that go unanswered by the continuing marketing campaigns for heartburn medication. If Americans can purchase Prilosec in a drug store and treat their medical condition without the guidance of a physician, how can the same medication under a different name be intended for a serious medical condition diagnosable only with high-tech imaging techniques such as endoscopy? The Finisher must have submitted to this

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[286] Mickey C. Smith, 126.

[287] Angell, 185.

medical procedure in order to be aware of his esophageal erosions, but although the audience is allowed a cartoon illustration of the esophageal lining, the protagonist does not include that detail in his story. He commands the viewer's attention by facing the camera directly and from close proximity (once on the other side of the mirror and again from his position in front of the examination room) at the exact moments when text appears beneath the scene to provide required information about the actual indication of the drug. "Persistent heartburn, 2 or more days a week, despite treatment and diet change, may be acid reflux disease," appears in small to medium sized white font against the bottom portion of the ad's purple frame. A few moments later, it is followed by another message: "Erosive Esophagitis may affect 1 in 3 acid reflux sufferers." Apparently, the Finisher belongs not only to the subset of heartburn suffers who qualify for a diagnosis of true GERD, and additionally to the one third of this group who have experienced actual erosion of their esophageal lining. Much more than "just bad heartburn," indeed. Then how, if the extent of his pathology was this great, did he ever think he was "finished with" his condition? The protagonist never explicitly says that he forgot to take his medication, which would seem unlikely if the symptoms are as bad as those described above, or that stopped taking it because his symptoms went away, but this last scenario is what the story leads viewers to believe. He "thought [he] was finished" with the medication, but his doctor reminds him to continue taking it because he needs "more than just heartburn relief," he needed esophageal repair. Despite the attempt to technically locate the protagonist in the discrete population of patients with confirmed erosive esophagitis, the characterization of the Finisher and the larger moral message of the story seems more plausibly addressed to the larger population of those who suffer from GERD, and even common heartburn, and it serves not as a reminder to comply with a six or eight week course of Nexium to heal erosions but to vigilantly treat their heartburn, even when

they are not bothered by symptoms, so that they won't have to face the consequences of irresponsibility. The Finisher thought he was finished with Nexium. He thought he simply had heartburn. But his condition turned out to be much more serious. And now that he has learned his lesson, and is faithfully taking the Purple Pill, he appears in the homes of millions of other Americans so that they might learn from his example.

FATHER KNOWS BEST

The character developed in this story is a brilliantly placed to deliver a message that doctors must find a way to deliver everyday. As a candidate for the contemporary version of the iconic father, The Finisher manages to portray a gentle, respectful figure of paternalistic authority. The character, I believe, has the potential to embody the best of the traditional father and the contemporary dad, and to provide a positive and productive framework within which American men of all ages can rethink the relationship between masculinity and medical care. The values he advocates are laudable, and the image of masculine responsibility in the context of health care could be quite empowering and useful for encouraging middle aged men to pay more attention to their health. Unfortunately, this brilliantly balanced character has developed to represent a particular product and company-one which fails to live up to the standards of its spokesperson and, thus, makes their upstanding father figure nothing more than a hypocrite. The Finisher's story is one that tells men to do the right thing, to be a responsible father and an admirable guy. If the story continued by telling them to watch their blood pressure, or go get their annual colonoscopy, or even finish a round of antibiotics, I would argue that this narrative be embraced and adopted. Unfortunately, that's not what the story says. Instead, it tells viewers to ask their doctor for an outrageously overpriced medication (intended

for a rare condition that the vast majority of the target audience does not have) rather than make do with a second line drug or an over the counter product (which is exactly the same chemical) and thus avoid unnecessarily driving up medical costs and further denying basic health care to the millions of American uninsured. What would Atticus say?

In the meantime, physicians and other health-care professionals continue to walk the delicate line between the traditional medical authority figure and the contractual partner in care, doing their best to deliver necessarily didactic messages in ways that will be acceptable to contemporary patients. The tone they must adopt is intimate, honest, and respectful. It must convey that they are open to discussion but nevertheless privy to greater experience and knowledge, that they respect the patient's autonomy but also care enough to be deeply invested in the decisions that are made. The marketers of Nexium have brilliantly achieved this tricky balance, and tell a story that perfectly demonstrates its potential to reach an American audience. They have also usurped it, however, in order to maximize profits from a drug that would not even exist if the drug industry were forced to behave by the ethical standards set forth in this narrative.

Chapter 7: A Battle Cry (Gardasil)

ONE LESS

A teenage girl holds out her right hand, palm down, and watches as athletic tape is wound around her knuckles. She is Caucasian, and wears her blonde hair pulled back. Viewers see her resolute expression in profile, her lips slightly parted in concentration, only a moment after the commercial opens with a close-up image of her hand. Someone else is doing the taping, and although the shot is brief and the motion quick, her hands identify her as another young woman, probably African American. She deftly wraps the protective tape around each knuckle, preparing her friend for the fight.

"I want to be one less." The two images described above, of the girl's hand being taped and then of her tough expression, flash by in quick succession, with the transition timed so that viewers see the close up of the girl's face as the voice (also understood to be hers) clearly speaks the word *one*. In the beat just after the word *less*, the scene switches quickly and the audience watches her deliver a surprisingly violent blow to a punching bag hanging from the ceiling of what appears to be an urban gym. The camera treats her as honestly as it would any man in the ring; her skin shines with sweat, her mouth falls open and her face is distorted from the force of the punch. No one would dare accuse this young woman of hitting "like a girl."

Before the audience recovers from the previous image, another female narrator is already speaking: "I want to be one less woman who will battle cervical cancer." The scene again switches in the middle of a sentence (as it will continue to do throughout the commercial) and in this instance, the face of another young woman appears in time with the word *woman*. Also Caucasian but with a slightly darker complexion, dark hair and

dark eyes, this woman does not smile but is not frowning. She looks directly into the camera with an earnest, disarming expression. Moments later she is shown leaning over a sewing machine, and then the camera switches to a close-up view of her hands as she cuts appliqué letters from a piece of fabric. She soon faces the camera again, this time smiling, as she models a grey, zip-up sweat shirt onto which she has sewn the words "one less." The letters are large and yellow, each one capitalized, and span across her chest. The sweat shirt is reminiscent of high school gym clothes, although it shares a hip, retro style with the fashions sold at high-end, urban boutiques. [288]

Illustration 7.1: Sweat shirt.

As viewers admire the shirt, another woman is already speaking: "One less family turned upside down." On the word *family*, a third young woman's face appears. She wears her light blonde hair very short and spiky. Her lipstick is bright but not quite

[288] The images in this chapter were captured from a video recording of a television commercial for Merck's Gardasil, broadcast on Comedy Central on December 12, 2006, during *The Colbert Report,* from 11 p.m. to 12 a.m.

garish, and her eyes are accented by dark makeup. The camera zooms in on her profile as she brushes dark red paint in broad, curving strokes onto an exterior wall. Viewers are then shown her finished work: a large mural in an alleyway. She leans on a ladder towards the bottom right of the screen, wearing a tight red t-shirt under black denim overalls, cut off or rolled up to her knees, and bulky black high top tennis shoes. A large, rectangular boom-box stereo, identified with the image of punk-rock youth of the 1980s, rests among paint cans in the foreground of the shot. The mural is a stylistic rendering of the phrase repeated by all of these narrators: one less. The letters connect to one another and display artistic embellishments reminiscent of gender symbols.

Illustration 7.2: Mural.

A fourth female narrator begins speaking as the camera continues to focus on the mural: “Because now, there’s Gardasil.” The fourth narrator is soon pictured to be an African-American girl, probably in her early twenties. As she finishes her sentence, the

screen is momentarily covered by large white letters that seem to fall in a rapid jumbled motion away from the audience, quickly landing to spell the word "Gardasil" across the screen (and across the face of the latest narrator). The narrator's face disappears and a black background highlights the text that is now part of the Gardasil logo. The font is stylized and blocky, and the text is accented by an attractive design that seems like a nontraditional interpretation of an archery target. The smallest, central circle is dark and lower than center. The wider circle above it is colored red on the left side and yellow on the right, split by the edge of another half circle in blue which invokes the image of a force-field or protective covering over the yellow portion of the middle circle. Just below its trade name, Gardasil is identified as a "Quadrivalent Human Papillomavirus (Types 6, 11, 16, 18) Recombinant Vaccine." Smaller text, also white but less brightly so, tells the audience that the product is intended "for girls and young women ages 9 to 26."

Illustration 7.3: Gardasil logo.

As all of this appears on screen, the narrator continues. Gardasil, she says, is "the only vaccine that may help protect you from the four types of human papilloma virus that may cause seventy percent of cervical cancer." She and her fellow narrators speak directly to their peers: to the girls and young women who may benefit from this vaccine. As the commercial continues, however, they make it clear that women of all ages ought to be listening as well.

The black background fades away, a city street appears, and the latest narrator runs alongside another girl in race. As she rounds the corner to head straight for the camera, the audience can clearly see the number one pinned to her shirt. Her long braids swing behind her as her muscular legs carry her forward in long, confident strides. Like her fellow athlete in front of the punching bag, she displays a look of intensity and resoluteness.

The scene changes and yet another young woman appears, this one with dark hair swept up in a graceful, casual style. Her eyes are dark and her skin tone is tan. She could be of Asian or Middle Eastern descent, although she does not necessarily portray any specific ethnicity. "I want to be one less patient," she says, and the camera leaves the close-up of her face to show the entrance to a subway station at street level. The woman appears, from this angle, only from the shoulders up, and seems to be standing on the stairs as they descend down into the subway. Above her head, she holds a hand-made sign that says "less" next to the number one, circled in red, on the station identification sign behind her.

This circle foreshadows the appearance of Gardasil's logo, which the audience now sees on an information pamphlet being read aloud by another female voice, this one belonging to an older woman than those previously pictured. "It says here that, like all

vaccines, Gardasil may not fully protect everyone," reads a middle-aged woman in the passenger seat of a moving car. A girl in her late teens is driving, and she turns, smiling, to glance at the woman next to her, presumably her mother. Text at the bottom of the screen reinforces the narrated message: "Gardasil may not fully protect everyone."

The next voice is also that of a mother, and the voices are similar enough to make the transition quite subtle. From the image of the teenage daughter driving in the car, the scene switches to a close-up of a younger girl who is also listening with her head slightly titled. Viewers may assume her to be a younger sister riding in the backseat until the camera identifies her as part of another family, this one seated around the breakfast table of their mobile home. The second mother, who wears a blue robe and her long hair loose, appears to be reading from a magazine (perhaps a print advertisement for Gardasil), and her daughter seems to be the youngest of the girls pictured so far. Although he is positioned with his back to the camera and the lighting makes him visible only in silouette, a father is apparently also present at this table, watching and listening as the mother addresses her child. The daughter is then seen, posed and smiling as if in a snapshot, standing outside the mobile home next to a hanging basket of yellow flowers.

The audience then encounters a much older girl with a horse, first in a close up shot of her face and then a wider shot, taken from inside a barn, of the young woman leading the horse inside. With jeans and a white t-shirt under a plaid flannel shirt, and her long blonde hair worn in an elaborate braid, the girl's appearance matches her rural setting. She seems to smile at the viewers from middle America, from the front porch of the farmhouse next door. "Gardasil is not for women who are pregnant," she tells the audience, and the same line appears in white text beneath the scene.

Illustration 7.4: The breakfast table.

"Gardasil does not prevent all types of cervical cancer," says the artist with the blonde spiky hair pictured a few moments ago, "so it is important to continue routine cervical cancer screenings." This message is also reinforced with text before the scene changes again, this time picturing two women, both with dark hair and tan complexions, overlooking a beach scene. One is a young girl of perhaps eleven or twelve years old sitting on a bench and the older one, perhaps her mother, stands behind braiding the girl's hair. The two are positioned on a boardwalk or seawall, and a horizontal guardrail running just in front of the young girl separates them from the water in the distance.

A soft voice with a slight Spanish accent continues the narration: "Gardasil will not treat cervical cancer," as her words appear in while letters beneath the image.

As if to confirm the audiences' presumption that the voice belonged to the older of the women, the next line is delivered in a recognizably girlish tone: "With Gardasil," and here the perspective changes so that the younger girl looks back over her shoulder

and says to the viewer, who now seems to stand in her mother's place, "I could be one less."

"*You* could be one less," says a young Asian woman looking directly into the camera. Her hairstyle, features, and tone of voice seem softer and more traditionally feminine than some of the other women featured. The tough, assertive edge immediately returns to the narration, however, as viewers watch four African-American teenagers in what seems to be a high-school gymnasium practicing a step routine. The girls, who appear to be about fourteen or fifteen years old, stand in a square formation. Each calls out a line in the rhythmic sequence of a drill or cheer.

"One less daughter."

"One less sister."

"One less friend."

Illustration 7.5: The step routine.

As the girls chant these lines, one after another, they each perform the same motion: stepping energetically into a wide stance with their left hand on their hip and their right held out beside them, bent at the elbow in what starts as a snap and ends with a fist in the air. The movement is forceful, defiant, and sassy.

But lest the audience lose sight of the seriousness of the issue, the camera returns to the earnest brunette seamstress, who finishes the sentence and reminds viewers of what is really at stake. The one less woman that all these girls have referred to is one less woman "whose life might be affected by cervical cancer."

Together, all the women pictured so far have contributed to the energetic, assertive momentum of the commercial, which culminates with four fists in the air and is then put into perspective by the brunette. The narrated text has actually consisted of several sentences, but the cinematic patterns, as well as the content of the message, unifies all of these various images into one coherent segment. This moment marks what would be a paragraph break, were the commercial a written text. It allows the audience a brief moment to process the compelling message just presented, as well as the defiant energy of the commercial's tone, all in terms of this closing reminder of what is really at stake. The next scene suggests a particular response to the powerful narrative underway.

"GET VACCINATED." This message appears in white letters that tumble down from the screen at the moment the first narrator, now seen in the boxing ring, delivers a forceful punch. Viewers are given a few moments to admire this young athlete, captured at the moment her blow would have found its mark. Seen from the perspective of someone standing ringside, looking between the two horizontal guard-ropes that surround the ring, she stands with her feet firmly planted and staggered on the mat, turned toward the screen but facing her would-be opponent in front of her. Both hands are gloved, her right held protectively close to her face and her left extended and pictured just at the

climax of a forceful punch. Her arm extends perfectly parallel with the two guardrails, the top one red and the bottom one blue, as well as the white text running the length of the screen just over the surface of the ring. This was a hard hit, and the immediate appearance of the white letters initially eclipsing the screen, along with a sudden, powerful note in the music subtly invokes the cartoon image of a knock-out punch. Everything goes white, and the letters fall down like little stars.

Illustration 7.6: The boxing ring.

The original narrator's voice follows the sound of the knock-out. "Ask your doctor about being vaccinated with the only cervical cancer vaccine," she says, as the camera returns to the four girls in the auditorium, while text below their image tells viewers that Gardasil is "only available through your doctor or healthcare professional."

The girls are now fully absorbed in their step dance. They turn and clap and chant in exact unison, keeping the beat that they are creating together. The sound of their feet

and hands and voices grows louder and its rhythm becomes increasingly prominent as it blends into the soundtrack, perfectly matching the rapid tempo that the commercial has held all along. Their words are indistinct at first, but with careful listening, audience members understand that they are chanting the letters to spell the phrase "one less."

"Gardasil," says the farm girl, as she smiles at the camera.

"Gardasil," says a young black girl standing in front of a blackboard where the word "less," written in chalk, appears next to a notebook-paper drawing of the number one.

"Gardasil," says the boxer, holding her taped hands to the audience, her right index finger extended to represent the number one and held close to her left fist, where the word "less" is written on the tape across her knuckles.

Meanwhile the beat from the step routine has grown louder, more insistent. The camera cuts suddenly to a close up shot of the step-leader's face as she performs the final climactic move in her dance. The audience hears her voice distinct from, and yet in perfect unison with, the girls around her. Viewers see the quick, sharp motion of her right arm crossing her body as she snaps her fist into the air. Her eyes are bright and her focus sharp. She looks beyond the camera with the intense concentration of someone fully engaged in her task. "One less!" she yells, and the screen goes black.

A beat goes by in silence and then the white letters fall from the screen again, as if knocked loose by this verbal blow instead of a physical one. They separate and fall into place within the Gardasil logo while the sound of energetic, excited applause grows louder and then fades away.

The applause at the end of this commercial seems appropriate. The ad is engaging, energetic, and quite surprising in the context of DTC drug commercials that increasingly strive to be seen as sober and informative. The Gardasil ad is informative,

certainly. But the experience it offers the audience is distinctly unlike that of reading a patient education brochure or having a calm, rational discussion with a physician. Watching this ad is like being swept along in a political march or rally, or like attending a live performance so moving that audience members sit in stunned silence as the curtain closes before leaping from their seats and calling for more. Wayne Booth argues, in terms that mimic the hermeneutic insistence on connection as well as critique, that before a reader can explain or evaluate a text she must surrender to it–she must temporarily disavow herself of any skeptical or self-protective attitudes and allow herself to fully experience the story. Only once we allow the narrative to work on us-to completely dictate our experience for the time during which we are involved with it-can we step back to critique and evaluate from a place of honest understanding. In the case of the Gardasil commercial, the first step is easy. It would be difficult not to surrender to these young women. And that realization makes the second step–a critical analysis of their story-all the more important.

This commercial depicts a generation of young women poised to inherit the images, narratives, and norms of the feminist tradition. Its characterization, tone, structure, and metaphors all function as suggested strategies to reinforce and re-appropriate pieces of the tradition. The ad features a host of diverse women engaged in a variety of athletic and creative activities, two of which stand out as key thematic elements: the image of the step-dance and the image of the boxing match. Both of these activities serve as metaphors through which young women are encouraged to understand their place in the context of a community of fighters, and both sets of imagery suggest particular ways of understanding the Gardasil vaccine in relationship to the cultural and political framework of women's health.

THE ONE AND THE MANY

Rather than follow the experiences of one primary character, the Gardasil ad features eighteen women: athletes and artists, mothers and daughters, blondes and brunettes, Asians and Hispanics and African Americans, city girls and country girls, preteens and teenagers and twenty-somethings, schoolgirls and young women starting out on their own. The number of scenes in the commercial is high, even for a minute-long ad, and camera moves from scene to scene, and from woman to woman, quite quickly. The images change in the midst of a line, so that the voice transitions overlap the scene changes as more and more women come together to narrate the story. These stylistic elements, along with the impressive diversity of the women involved (in terms of not only age and race but social and economic status, interests, and even personal style) give the commercial a mosaic character. The protagonist of this narrative is both an individual and a group: it is every woman and women in general. And the complicated relationship between the two lends the ad much of its power. As Susan Sherwin explains,

> Many feminists favor a more community-based conception of the self as the bases for moral value than what is assumed in traditional ethical theorizing. They seek a conception of self in which individuals strive to determine norms for themselves within their communities.[289]

The Gardasil commercial features a variety of women who are pictured, most often, alone, and portrayed as unique individuals. Yet the cacophony of individual portraits functions as the picture of a community. And while the commercial does not rely upon the verbal rhetoric of community and, in fact, the narration in the Gardasil ad seems to

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289 Susan Sherwin, "Feminism and Bioethics," in *Feminism & Bioethics: Beyond Reproduction*, ed. Susan M. Wolf (New York: Oxford University Press, 1996), 53.

focus on individual decisions in the context of individual lives. The slogan for the ad is "one less," a phrase that not only connotes individual choice and responsibility but also the value of each particular woman protected from cervical cancer. Yet the stylistic unity of the ad, the way that nearly every woman repeats the phrase, the way their voices overlap, the way the very diversity of the characters underscores gender as the one characteristic they all share, and the way in which the mother-daughter scenes make it clear that these decisions are made in the context of relationships with other women all combine to transform the explicit slogan (one less woman) into an implicit ideal (none of us at all.) And, even while the commercial addresses the issue of women's health through individual treatment decisions, it revolves around a powerful image that provides conceptual coherence between the realm of the individual and the realm of the community.

Step-dancing, or stepping, involves "elaborate synchronized group routines" that combine elements of "cheerleading, military, and drill-team moves, especially the call-and-response element inherent in those forms."[290] Closely associated with "the African heritage of speech, song, and dance," stepping is believed to have originated in the 1940s on college campuses, and has been developed and popularized by African-American fraternities and sororities.[291] As an activity that creates, reflects, and depends upon the social cohesion of a group, stepping is associated with the community bonding experiences of pledging and initiation rites. Step competitions have become increasingly popular as a cross between performance art and competitive sport, and have recently been dramatized by the movie *Stomp the Yard*. The film received mediocre reviews, but critics

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290 Wikipedia contributors, "Step dance," *Wikipedia, The Free Encyclopedia,* http://en.wikipedia.org/w/index.php?title=Step_dance&oldid=103023758 (accessed February 15, 2007).

291 Elizabeth C. Fine, *Soulstepping: African-American Step Shows* (Chicago: University of Illinois Press, 2003).

and audiences previously unexposed to the "charismatic movement" of the tradition came away inspired by the energy and synchronicity involved.[292] Stepping demands that several individuals, and sometimes large groups, occupy an almost trance-like state of communal awareness and precision. It is not enough that the individuals keep the beat in order to stay in sync with the group. The individuals, moving together, actually create the rhythm that defines the group. Historians and scholars have described the phenomenon as the almost telepathic connection between group members which allows them to keep a beat that "only they can hear."[293] One film critic characterized the effect it in simpler, although perhaps more accurate terms: "Boomlay, boomlay, boomlay, BOOM!"[294]

The four girls engaged in their step routine literally set the rhythm of the Gardasil ad. And their dance represents the sophisticated relationship between the individual women featured in the midst of their individual lives and the community which both consists of and provides the structured rhythm of their activities and choices. The liberty to design your own life as an artist or a seamstress or an athlete is not seen in this context as freedom from the group. The very activity of realizing your own potential and forging your own way as a talented young woman represents the adherence to and reinforcement of a community norm. Viewed in isolation, these lives seem disparate. It is only with a wider perspective that the mosaic can be seen, that the rhythm can be heard.

And just as each woman is understood living her own life within the supportive structure of the larger group, she simultaneously undertakes the responsibility of living her life in ways that will keep her in sync with it. The Gardasil ad portrays vaccination as a group responsibility as well as an individual opportunity, and this is particularly

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[292] Stephen Hunter, "The Story's in the Stepping," review of *Stomp the Yard* (Sony Pictures Movie), *The Washington Post,* 12 January 2007, 4(C).

[293] Fine.

[294] Hunter, 4(C).

emphasized in to older women cast here in the role of encouraging their daughters to receive the vaccine. Individual responsibilities towards others in the community are much more explicit, however, in the disease-awareness commercials run by Merck before Gardasil was approved by the FDA.

TELL SOMEONE

The previous campaign never mentioned the name or even existence of the vaccine. It was intended primarily to educate viewers about the link between cervical cancer and the human papilloma virus (HPV). But like all informative or educational campaigns, the information was presented not only to educate but to thereby alter the public's understanding of a particular disease state. For the Gardasil vaccine to be an effective and widely utilized public health tool, and for Merck to market it as such, cultural ideas about infectious disease and malignancy would have to be related in new ways. The anticipatory campaign, which also featured several women of various ages and ethnicity, revealed to its audience the little-known link between cervical cancer and HPV. It then asked viewers to spread the word, to "tell someone." The women in these commercials seemed to be stopped spontaneously on the street and given the facts about HPV and cervical cancer. The audience witnessed their "stunned" reactions and their response to the news, which took the form of a pledge to tell as many people (and, specifically, as many women) as possible. One of the characters addresses the camera directly as she explains "I feel like it's my responsibility to tell whoever I can."

"I want to tell my sister, my mother, my friend," says another of the female characters, and text at the bottom of the screen instructs viewers to enter a specific text message into their cellular phone in order to send the message to the women in their

lives. The commercial thus becomes the literal embodiment of the "call to action" metaphor, and its identification with the women's health movement is striking.

OUTSIDERS

Television commercials for drugs targeted at women, such as the osteoporosis drug Boniva as well as the new generation oral contraceptive called Yaz, have tapped into the cultural history of the women's health movement by picturing a group of women sharing health information and advice outside of traditional medical settings. Although the "tell someone" commercial does feature a female physician, she addresses viewers from the street, with a hospital building behind her, rather than from inside the clinic itself. The tendency for women's health issues to be culturally located outside of the medical establishment dates back to the origins of the women's health movement, which took as its founding principle the idea that traditional medical authority was insensitive to the needs of women and a key source of gender oppression. The perceived conflict between women's health and medical authority is not only reflected in the women's movement of the 1960s and 1970s, but also played an important role in the development of the patients' rights movement of the same era, and continues to represent a central concern of contemporary scholars:

> A principal characteristic of feminist bioethics is the critical interest it takes in oppressive aspects of medical organization and practice. Feminist historians and sociologists of medicine have collected a great deal of data showing that medical authority has frequently been invoked to support discriminatory programs against women and to deny women's credibility in both medical and non-medical contexts.[295]

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[295] Sherwin, 54.

In addition to serving, in many ways, as the launch pad for bioethics concerns about abuse of medical authority and paternalism, the sense of alienation from traditional health-care systems led to the creation of a social and political movement for women to take control over their own health. The landmark work *Our Bodies, Ourselves* epitomizes the conception of women's health as not only inextricably bound to the political movement for gender equality but also the creation of an extensive cultural network of information, advice, and support available to women through nontraditional health sources.[296] Now a global non-profit organization, Our Bodies, Ourselves (OBOS) continues to serve as a clearinghouse of information and support services for women seeking health information and advice. Yet despite having become a well-established and well-respected organization, OBOS continues to frame its work as outside the system. The point, after all, is the creation and support of a self-sufficient community of women, most of whom continue to utilize the medical system, and many of whom are nurses or physicians themselves, but all of whom interact with this system from a newfound position of power, and the power is rooted not within the system but outside of it–in groups of women from small circles of friends to support groups to international organizations. The women's health movement is based on the idea that women don't need traditional (male) medical authority to take care of them. As the introduction to the latest edition of *Our Bodies, Ourselves* puts it, the women's health movement continues to function as it has since its beginnings in the 1970s, "offering information, stories, and resources so that we can take care of ourselves–and one another."[297]

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296 The Boston Women's Health Book Collective, *Our Bodies, Ourselves: A Book by and for Women* (New York: Simon and Schuster, 1973).

297 The Boston Women's Health Book Collective, *Our Bodies, Ourselves: A New Edition for a New Era* (New York: Simon and Schuster, 2005), xi.

The importance of both a supportive feminist community and alternative avenues of medical care cannot be denied, even four decades after the women's health movement began. Yet women comprised the majority of medical students as far back as 2000, and given the increasing presence of the women's community itself within the traditional medical system, both in the growing number of female practitioners and the increasingly common inclusion of alternative therapies, such as birthing centers run by midwives inside hospitals, it may be time to re-evaluate the relationship between women and medical authority.[298] Of course, gender inequality still exists, and medicine continues to be, generally, a conservative system. Yet the ramifications for continuing to reinforce the "outsider" image to young women may prevent them from seeking out the many like-minded advocates and role models within the medical system itself. The Gardasil ad does not explicitly enforce the sense of alienation from traditional health care, and as a commercial for a pharmaceutical product, of course, it actively encourages young women to visit a health-care professional. Yet it also encourages them to continue the fight that their mothers and grandmothers began, and it does so without encouraging them to pause and reevaluate the identity of their oppressors.

THE GOOD FIGHT

Not only does the characterization in the Gardasil commercial differ from most drug advertisements, its narrative structure differs as well. The ads for Plavix and Nexium, for example, clearly identify a leading character and then follow that character

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[298] Association of American Medical Colleges (AAMC), "Number of Female Residents Increases Over the Past 10 Years," http://www.aamc.org/newsroom/pressrel/2000/001215.htm (accessed February 15, 2007).

through a relatively traditional plot structure; a problem or conflict is developed and resolved, and the story highlights the contrast in the character's circumstances before and after the introduction of the product advertised. Gardasil certainly could have been marketed this way, in a commercial about a woman who initially feels vulnerable and then, after receiving the vaccine, possesses a newfound security and confidence. The young women in this commercial, however, are never pictured as vulnerable. If this were a before and after story, each of the women would be "afters."[299] And, in a certain sense, the scenes in the Gardasil ad do represent the second portion of a before and after story, even if audiences don't see the first part of that story in the commercial. While the commercials for Plavix and Nexium certainly interact with larger cultural narratives, they simultaneously function as free-standing stories. The Gardasil ad, however, may be more appropriately viewed as the continuation of an established story rather than a discrete narrative in and of itself. Therefore, much of the its structure (particularly the introduction and specific conflict) are implied rather than explicitly discussed. The Gardasil commercial functions as a resolution–a particular candidate ending–to a story that viewers already know: it is the story of how women, fed up with their social status as the weaker sex and the social structures that oppress them, draw strength from each other to fight injustice and to "transform their positions of vulnerability."[300]

Although women's struggle against social oppression dates back to at least the suffragettes of the early twentieth century and probably long before that, the most significant point of historical origin for the narrative at hand can be found in the women's

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[299] The current advertising campaign for Weight Watchers encourages women to "be an after," in the context of the frequently told before-and-after stories of diets and weight loss. As the imagery of the Weight Watchers ads imply, an "after" is not only someone who has lost weight, but someone who feels self-confident because she has set a goal and successfully accomplished it. See www.weightwatchers.com (accessed February 15, 2007).

[300] Sherwin, 62.

liberation movement of the 1960s and 1970s. The women of this generation fought historical battles not only for the opportunity to choose a career outside the home, but the right to high quality education and equal compensation. They fought for reproductive freedom and respect within the traditionally paternalistic medical system. They fought to bring about social conditions that would allow their daughters and granddaughters more opportunity than they themselves enjoyed, and although gender oppression is far from extinct, especially from a global perspective, the young women born to this generation of feminists have, more or less, enjoyed a level of freedom and equality that bespeaks the success of the feminist movement. The girls and young women featured in the Gardasil commercial are likely two, and perhaps even three, generations removed from the marches and rallies of the 1960s. And as they inherit this tradition from their mothers and grandmothers, they find ways to apply one of its central narrative themes-the fight for women's rights-to their own contemporary circumstances.

Alongside the image of the step routine and its implications for the relationship of the individual to the community, the image of a boxing match also weaves its way through the Gardasil, reinforcing the ideas of struggle, conflict, and self-defense as a principle way for these women to understand the activities and ethos of the feminist community. The commercial begins with the symbolism of one young woman helping the other to protect herself and prepare for the fight. The boxer is emphasized again at the break in the narration, as the camera freezes on the image of her in the ring delivering the powerful punch she had practiced for with the punching bag. The text below her ("get vaccinated") identifies the product, and the act of requesting it, with the act of delivering a blow to the would-be enemy. Additionally, the repeated image of white letters suddenly covering the screen in jumbled chaos before they fall back to form the Gardasil logo, when timed along with the sound of a forceful punch, continues the boxing-ring image

throughout the commercial even when other activities are pictured on screen. The ad makes it clear that this is a fight. But who or what do these young women face in the ring? The opponent is never pictured.

By framing this commercial as the ending to a story, and therefore leaving the audience to imaginatively reconstruct the principle conflict that precedes it, the marketers of Gardasil ensure that their product will be understood in terms of a fight, but leave the specific reasons for the fight and the identity of the antagonist open. Viewers can quickly, and probably without realizing it, fill in the beginning of this story with based on the pervasive, well-known story of women's fight against sexism in general. Or they can choose from a myriad of specific manifestations of that fight, several of which fit seamlessly into the Gardasil commercial even if they are never explicitly included. The audience supplies the setting for the conflict and the nature of the foe without being encouraged to reflect upon their choices, or being made explicitly aware that the choice of these narrative elements belongs to them at all. Because the metaphor of the fight is so pervasive and has been used in the context of so many specific issues and controversies, its vague application in a powerful ad not only runs the risk of conflating feminist politics with corporate interests but also fails to encourage young women to think carefully about who, and what, they understand themselves to be fighting.

The commercial could be convincingly portrayed, for example, as a continuation of the fight against cancer, specifically in the context cultural of the widespread and well-organized activism undertaken by women's groups in response to breast cancer. The cultural visibility of organizations like the Susan J. Komen Foundation and its now famous fundraising event, "Race for the Cure," reflects the "notable advances in women organizing themselves to make changes in policy, health care, and research related to this

disease."[301] Images of women walking en mass may recall the political marches of the 1960s but are now more often associated with the annual fund-raising races that have become increasingly popular and increasingly recognizable, along with the associated pink ribbons, pink hats, and matching t-shirts, as symbolic of the political, social, and physical strength of the female community. These images, and the social movement they refer to, represent a response to disease which combines the image of a fight with that of a race. It draws on the feminist narrative of fighting against oppression but yet simultaneously tempers the language of fight with other images, perhaps to avoid embracing wholeheartedly the war metaphor that theorists such as Susan Sontag consider potentially damaging, specifically as it has been traditionally applied to cancer patients.[302] The breast cancer movement, or at least the fundraising campaigns that represent its most culturally recognizable manifestation, explicitly relies on the metaphor of the race, which lends positive images of physical strength and endurance, individual determination in the context of a supportive, cheering community, and healthy, active lifestyles. The Gardasil ad could certainly be viewed as an attempt to position Gardasil within this well-established response to women's health and to cancer. It frames the image of the fight within its more general depiction of young women as athletes, and the image of the marathon runner is prominently placed in relationship to the timing of the ad and the introduction of its logo. It also makes use of the relatively recent but now well-understood cultural significance of clothing as a symbol of identity, community and cause. The women in the disease-awareness ads that preceded the Gardasil commercial don matching t-shirts with "tell someone" printed across them. Placing the campaign

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[301] See Susan J. Komen Foundation, www.komen.org (accessed February 16, 2007); Barbara F. Sharf, "Poster Art as Women's Rhetoric: Raising Awareness about Breast Cancer," *Literature and Medicine* 1, no. 1 (Spring 1995): 73.

[302] See Sontag, 57-72.

slogan in the context of the ubiquitous "Race for the Cure" t-shirts helps to elevate the message from a sales pitch to a rallying cry and a show of support for the community at large. The grey sweat-shirt with "one less" stitched across the chest functions similarly in the Gardasil ad.

In addition to conceiving the fight depicted in this commercial as a fight against cancer, it can also be read more generally in terms of the women's fight to reclaim control over their own health and well being from the dominating structure of traditional health care. The women's health movement, discussed above, represents the perceived need to seek supportive care from outside the bounds of a medical system which has long been seen as an important source of the systemic oppression. Feminist scholars have explored the ways in which medicine uses its cultural and scientific authority to "[seize] control over all aspects of women's reproductive lives," "alter women's attitudes towards their own bodies [by] transforming them into objects to be constantly monitored and regulated," and reinforce images of women as "immature, ignorant, nervous, and dependent."[303] This portrayal of medicine as a paternalistic and oppressive force denying women the right to control their own bodies is, of course, especially relevant to issues of sexual health. From this perspective, the Gardasil commercial could be understood as reflecting the fight not only against a paternalistic health-care system, but against conservative policies regarding controversial reproductive rights issues like abortion and contraception. Even if medicine has been understood as a relatively conservative institution, particularly by feminist scholars who attend to the power dynamics within it, its relationship to scientific research and its respect for empirical evidence has represented an important form of protection for those who fear the intrusion of socially conservative and sexist values into medical care and health policy. And yet while

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[303] Sherwin, 55.

feminist scholars would likely be the first to question the supposedly absolute objectivity of scientific investigation, the extent to which federal research agencies have lately appeared to be under the direct influence of conservative politics is especially alarming to those who rely on evidence and data to guard against the intrusion of oppressive forces into women's health. The Centers for Disease Control and Prevention (CDC) has been a valuable resource for scientifically validated information and recommendations concerning sexuality education and contraception use. Yet political changes made by the newly elected Bush administration were reflected in a dramatic change in the content of the CDC website. Empirical results regard condom efficacy, for example, were removed along with instructions for their proper use. A handbook for community organizations and schools that outlined the most effective sexuality education curricula was removed and never replaced. Susan F. Wood, former director of the FDA's Office of Women's Health, resigned her position after she learned that the agency had rejected an application to allow Plan B, an emergency contraceptive medication made by Barr Pharmaceuticals, to become available over the counter. [304] The decision surprised many agency officials, and particularly the members of the scientific advisory committee which had recently voted, twenty-three to four, to approve the application. Never before had senior-level officials at the FDA contradicted the position of the scientific advisors, and the decision was interpreted by Susan Wood, among others, as a signal of the increasingly powerful influence of a conservative administration.[305] Feminists have much to fight against, in fact, when it comes to current health policy. One-third of all federal money spent on HIV prevention is currently reserved for abstinence-only education programs, despite an extensive empirical literature and clear scientific consensus that these programs are not

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[304] Michael Specter, "Political Science," *New Yorker* March 13, 2006, 58.
[305] Ibid.

only ineffective at delaying sexual initiation but actually lead to higher rates of unprotected sex. International health organizations are forbidden to even discuss abortion with any of the women they serve or risk losing all of their federal funding. And conservative resistance to any sexually transmitted disease (STD) prevention strategy other than abstinence implies that, in addition to barrier methods like condoms, vaccines, even one that could protect against cancer, might create a false sense of security and therefore promote promiscuous behavior. While it seems as if a cancer vaccine with almost no reported side effects would hardly be controversial, Gardasil involves not only protection from cervical cancer, but from a virus which is exclusively transmitted by sexual contact. The vaccine must therefore traffic not only in the meanings associated with public health and vaccination, but also in the controversial context of reproductive health and safer sex.

SEX, CANCER, AND CONTROVERSY

HPV is the most prevalent sexually transmitted infection in the United States. The CDC estimates that about half of all sexually active Americans are infected with the virus.[306] Several stains of the virus exist within the population, and although the vast majority of cases are asymptomatic, several of the strains can lead to genital warts and other strains have been conclusively linked to malignant changes in cervical tissue. Because the normal physiology of cervical tissue changes in significant ways during the decade or so following puberty, girls exposed to the virus during their teenage years are more susceptible to infection and its negative consequences. Gardasil protects women

306 Centers for Disease Control and Prevention, "HPV Vaccine: FAQs," http://www.cdc.gov/nip/vaccine/hpv/hpv-faqs.htm (accessed February 16, 2007).

from becoming infected with HPV, but is not effective if the virus has already come into contact with cervical tissue. Therefore, it is recommended that girls receive it before the initiation of sexual intercourse. Because sexual initiation most often occurs during the teenage years, the CDC's Advisory Committee on Immunization Practices recommends that it be given to girls eleven to twelve years of age, just before they start high school.

Recommending a vaccine that could be understood as safer sex strategy to school children across the nation becomes even more controversial when the younger part of the target population are young girls who may not yet have even reached puberty. Right-wing and conservative religious objections to sexuality education and safer sex methods have often centered on the idea that the promotion of condoms and other prevention methods send mixed messages to young people about the safety and appropriateness of teen sex. "I personally object to vaccinating children when they don't need vaccinations, particularly against a disease that is one hundred percent preventable with proper sexual behavior," Leslee J. Unruh told a reporter for *The New Yorker*.[307] Unruh founded and runs an educational supply company called Abstinence Clearinghouse, so perhaps her position on the matter is not surprising. Yet the same argument has been forwarded by congressmen and even members of the Centers for Disease Control's Immunization Committee. Reginald Finger, who was appointed to that committee following his stint as the medical advisor for the right-wing organization Focus on the Family, has voiced his concerns about any strategy other than abstinence to protect against STDS. When asked, hypothetically, about the case of an effective HIV vaccine, he replied that the committee would have to "look … closely" at the potential negative effects, such as "disinhibition" before supporting such a measure.

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[307] Specter, 58.

It was into this social and political milieu that Merck introduced its cervical cancer vaccine, and both the disease-awareness ads and the Gardasil commercial itself represent not only an attempt to educate women about the nature and availability of the vaccine, they also offer women a specific frame of reference within which to understand, and then, ultimately, to support and even fight for, its availability. These ads are certainly about women and women's health, but they present the Gardasil as, first and foremost, a novel way to prevent cancer. The women who pledge to "tell someone" that cancer can be caused by a virus, as well as the girls who resolve to be "one less" woman affected with the disease, present the vaccine as having important implications for their health and lives as a whole. Gardasil is not depicted, in either campaign, as having anything to do with sexuality in particular. Certainly it has to do with gender, and relates not only to women's health but to the women's movement, but it is never presented in the context of romantic relationships or sexual behavior. The only image in either campaign which evokes any notion of sexuality are the stylized letters in the "one less" mural that hint at the symbols for male and female. Yet these symbols typically indicate gender, and it is only when they are seen in close proximity or connected to one another that a sexual meaning is usually inferred. Although there may not be enough evidence within the ad to support this, it seems as if the nontraditional interpretation of these images within the mural is meant to clue viewers into the sexual orientation of the painter herself, which would then function to widen the already diverse community of women featured in the commercial. Other than the hint of sexuality or sexual orientation in the mural, no element the Gardasil commercial would lead an otherwise unknowing viewer to conclude that HPV is sexually transmitted. This is not about sex, at least according to the ad. This is about young women who deserve every opportunity to lead healthy, active, productive lives. Even the images of the youngest women featured in the commercial, which might

represent the most controversial element of the ad, function to evoke a protective, maternal instinct in older women viewers. Combined with the image of the fight, the commercial thus equips women not only with information about the vaccine, but also with a particular response to the conservative forces who resist it. This is perhaps most dramatically achieved in the snapshot image of the young blonde girl outside her mobile home. She looks young, but her youth is both suggestive of her future potential as well as a powerful call for a communal, maternal commitment to protect her by fighting for her access to the vaccine.

The strength of this message and the power of the fight narrative within the ad combines with the energetic and participatory tone of the commercial to transform it from a product advertisement to a battle cry. It is not only a public health message but also a recruiting tool for a political cause. Which is not necessarily new–certainly other products and pharmaceutical agents, such as the birth control pill, for example, simultaneously function as a consumer good to be bought and a political symbol to be rallied around. And certainly the political cause at stake in the Gardasil commercial (access to STD prevention strategies) is an admirable one. Yet viewers swept up in the passion of this narrative might be surprised by an important feature of the cause they've been recruited for: young women don't really have to fight for access to Gardasil. At least, not in the way the campaign has framed that fight. Despite the social and political controversy, and the continuing disapproval of conservative groups, the FDA approved the vaccine in June of 2006. Soon there after, CDC recently issued a recommendation that all school age girls be vaccinated against HPV. Young women across the country are not only able but encouraged to follow the example of the girls in the commercial and get vaccinated with Gardasil. If they can afford it, that is.

The vaccine is administered in a series of three injections, each one at a cost of around $120, and many insurance companies either don't cover it at all or reimburse physician groups only a fraction of the price. An associated press reporter interviewed several pediatricians and gynecologists, everywhere from Arizona to New Jersey, who don't feel that their practice can support the cost of offering the vaccine.[308] Cost is an especially important in this case because of the age groups for which it is recommended. When adolescents can be persuaded to seek care, they often do so at confidential clinics that can't expect their patient population to file insurance claims or cover the costs themselves. Many young adults do not have insurance of their own and are no longer covered by their parents' plans. And for families with multiple daughters who fall within the nine to twenty-six year old group, the costs for three shots each can quickly add up, even if they can find a doctor willing to cover the costs of stocking and providing the vaccine.

This situation is rapidly changing, however, as the CDC's recommendation forces states to consider the controversial step of mandating the vaccine as a requirement for school attendance. Texas Governor Rick Perry recently issued an executive order making his state the first to require all girls entering sixth grade to have begun the series of injections.[309] As the policy will go into effect for the coming school year, state-funded programs and private insurers alike are quickly responding, and the financial obstacles to receiving the vaccine are expected to decrease dramatically within the coming months. Washington State legislators recently considered and rejected a similar measure, voicing

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[308] Linda A. Johnson, "Cancer Vaccine Faces Cost Hurdles," February 2, 2007, *Houston Chronicle*, http://www.chron.com/disp/story.mpl/ap/business/4522628.html (accessed February 6, 2007).

[309] Janet Elliot and Todd Ackerman, "Perry Orders Cancer Vaccine for Young Girls," February 3, 2007, *Houston Chronicle,* http://www.chron.com/disp/story.mpl/front/4523211.html (accessed February 6, 2007).

concerns about the potential risk of requiring an entire population of children to receive a vaccine which (although it has been thoroughly tested) is brand new to the population as a whole. Recent scandals, such as the one surrounding Vioxx, have demonstrated the need for caution in encouraging the widespread use of new drugs, and similar concerns underlie the recent Congressional calls for a required waiting period between the release of a drug and the marketing efforts to increase public demand through DTC advertising.

The controversy over requiring schoolgirls to be vaccinated against HPV continues to unfold as this is being written. Conservative groups opposed to Gardasil have been vocal in their opposition to Perry's executive order, and have accused him of making the decision based not on public health concerns but on financial ones instead. Merck has made sizable contributions to the political campaigns of Perry and other Texas lawmakers over the past few years, and Mike Toomey, the Merck lobbyist most involved in the Texas government, worked as Perry's chief of staff during the last gubernatorial term. "This is 'follow the money' if I've ever seen it," said Cathie Adams, president of a conservative political group, to local reporter.[310] Certainly there is a lot of money to be made. But it is also possible, as Merck maintains, that what's good for the company's bottom line is also good for public health–and, specifically, for women's reproductive health. This may turn out to be the case, and if corporate profits and political payoffs result in greater access to important preventative strategies, young women have no less reason to take advantage of them. They do have good reason, however, to examine the issue carefully, especially given the possibility that their interests and those of the pharmaceutical industry may not turn out to be in sync after all–if not now, then perhaps later. At the very least, the presence of a mammoth corporation in the midst of a political

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[310] Ibid.

and medical controversy ought to prompt a careful analyses of the power relationships at play, which is precisely the kind of analysis that feminist scholars and activists have worked to develop and popularize. If a new generation of young women is looking to inherit the feminist tradition, I would suggest starting here. Let's be careful who we're fighting for.

Conclusion: A Reader's Response

REFLECTING AND RESHAPING

An interpretive approach to direct-to-consumer advertisements reminds us that individual commercials draw their meaning from the larger web of collective understanding. But rather than simply reflecting culture, these advertisements also work to shape it by suggesting new connections between existing ideas and reinforcing particular viewpoints. This argument has been cast by social critics, particularly those who espouse some form of Marxist theory, as an accusation of systemic deception and manipulation of consumers. "Advertisements," according to media theorist Judith Williamson, do not really sell consumer goods, or at least not only consumer goods:

> In providing us with a structure in which we and those goods are interchangeable, they are selling us ourselves … We feel a need to belong, to have a social place; it can be hard to find. Instead, we may be given an imaginary one.[311]

In answer to such claims, marketers have denied the intention or even ability to deliberately create social conditions that would maximize their profit. Advertising does not force culture in new directions, according to this position. Instead, it "works within and reproduces the general normative order, responding to it and only slowly reflecting broader changes" that come not from television commercials but from the consumers they target.[312] It is the "rational consumer," after all, that advertisements are created to serve, and they do so by informing and persuading, but never deceiving or manipulating.

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311 Williamson, 13.

312 Leiss, *Social Communication in Advertising*, 35. Subsequent references to this source will be made parenthetically in the text as *SCA* followed by the page number.

According to a strict reading of "classic liberal theory" applied to the role of advertising, "the market behaviour of consumers is based upon deliberate and calculated action."[313] This viewpoint focuses on the individual's capacity for reason, which is not only the fundamental characteristic of the consumer but also what protects him or her from the possibility of deception. "It is assumed" by marketers who understand their work in this way "that rational man [*sic*] will be able to detect truth in the clashing views of … the marketplace." (*SCA*, 44) Just as framing the specific issue of drug advertising in the context of patient education and autonomy skews the argument in favor of the pharmaceutical industry, framing the general practice of marketing in terms of a rational, intelligent, savvy consumer positions critics in a rhetorically disadvantaged role. To disagree with the argument (and yet still work within its terms) marketing skeptics must insult the very consumers they seek to protect. Within the narrative of the free market, advertisers accuse their critics of underestimating the average American, who is "not the 'bewildered' but the 'rational' consumer," and therefore in no danger of being duped or misled:

> The consumer is not manipulated and controlled, but rather is a free agent who searches the market for suitable means to satisfy his or her own needs and desires. The producer of goods tries not to create wants but to discover what wants exist and to design and manufacture products to respond to those wants. Advertising informs consumers about the result.[314]

Businesspeople, policymakers, and citizens groups have been debating the role of advertising since the earliest days of the American free market. And from early attempts at regulation to contemporary accounts of the effect of publicity on culture, both those who defend and those who criticize the practice of marketing continue to struggle with

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313 Ibid.

314 Ibid., 36.

words like *persuasion*, *manipulation*, and *deception*. No one expects a commercial to tell "the whole truth and nothing but the truth," (at least, not anymore.) (*SCA*, 36) Yet the line between "outright manipulation" and persuasive "embellishment" is difficult to define, and rarely agreed upon by those on opposite sides of the debate. (*SCA*, 45) Even while advertisers admit that "as a system," publicity "may well anticipate and amplify certain value changes" already underway in the "real world" of culture, the common conception of marketing as a public discourse addressed to a society of rational consumers necessarily casts doubts on the power of advertisers to actively control culture. (*SCA*, 271) Bruce Morrison, a well-known marketing executive, offers this expertly framed response to industry critics: "To anyone who truly believes he can manipulate consumers, I would offer this humble advice: try it."[315]

As the debate is currently framed, advertisements are either manipulative lies representing imaginary versions of reality of they are simply a form of fair persuasion, kept in check by the intelligence of the consumers themselves (excepting, of course, those consumers who are such irrational idiots that they can't tell the difference between fact and fiction.) Are these the only conceptual choices with which scholars and consumers alike can understand the role of advertising in American culture? I contend that the only rational response to mass marketing begins by questioning the idea that fact and fiction represent an exhaustive list of categories available, as well as the assumption that they reflect a mutually exclusive, strict division between what is real and what is not. An interpretive approach to advertising (not only DTC drug commercials but all forms of marketing and even public discourse in general) asks us to consider the possibility that *everything* is fiction, which is not to say that it is false or unimportant or unreal, but

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315 Bruce Morrison, quoted in J. Moskin, ed., *The Case for Advertising* (New York: American Association of Advertising Agencies, 1973), 38.

rather that it is authored, stylistic, and revisable. Perhaps the word *fiction* has become too loaded with connotations of falsehood for it to serve us well in this context. The choice offered by contemporary debates surrounding advertising, and by the modern worldview in general, might be seen as a choice between truth and narrative. I refuse to choose between the two, and the interpretive framework described in this project, I hope, allows for rigorous analysis without the distortion of strict and, at times, unproductive divisions.

INTERPRETATION IN PUBLIC POLICY

Like those in the advertising industry, policy makers in the U.S. have generally relied upon modernity's classic liberal theory, which conceives of society as an aggregate of autonomous individuals making choices and negotiating compromises according to their own rational best interests. This understanding of society seems to require that public (as well as legislative) discourse rely heavily upon an objective, consensus-based method of arriving at collective decisions. Therefore, despite the frequent appearance of narrative in legislative and public discourse, storytelling is generally considered to be outside the proper realm of responsible policy making, which ought to be based on well-considered factual evidence.Yet as scholars in bioethics and the medical humanities have begun to explore the social, political, and economic problems of medicine using a variety of academic traditions, narrative scholarship has found its way into policy debates over resource allocation, access to care, and the proper role of the pharmaceutical industry.[316] This has come as no surprise to Deborah Stone, who claims that narrative has always played a central role in legislative discourse. Although policy discussions often explicitly

316 See Fitzhugh Mullan, Ellen Ficklen, and Kyna Rubin, eds., *Narrative Matters: The Power of the Personal Essay in Health Policy* (Baltimore, Md.: Johns Hopkins University Press, 2006).

addresses facts and data, Stone elucidates the ways in which "debates about values" often "[masquerade] as debates about facts and data."[317] A given argument may seem to consist of data and evidence, but the choice of what counts as evidence, and why, as well arguments about the implications of the evidence presented, are all necessarily tied to particular human perspectives.

Policy debates, like pharmaceutical commercials or political statements or scientific articles or spy novels, are therefore susceptible to narrative interpretation, even when (or perhaps especially when) they might otherwise enjoy the status of absolute truth. The only thing threatened by the introduction of narrative and interpretive thinking into policy debates is the false idol of objectivity in collective decision-making. Once this idealized neutrality, along with the other tenets of modernity, is seen as a story itself (not as the necessary condition for human interaction and progress but, rather, as one alternative understanding of knowledge and communication among others), the strict separation of narrative from reality becomes unnecessary. "The challenge is not to get narrative and storytelling out of policy making," says John E. McDonough, because these elements "cannot be eliminated." Instead, "the challenge is to raise everyone's skill level–officials and citizens alike–to be more intelligent consumers of stories."[318] While it would be naïve and anachronistic to ignore the power and expertise that separates these two groups in contemporary society, a discussion of the nature of policy debates may be well served by the reminder that originally, and ideally, the distinction between American citizens and American (political) officials was understood as temporary and functional.

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317 Deborah Stone, *Policy Paradox* (New York: W. W. Norton, 2001), quoted in John E. McDonough, "Using and Misusing Anecdote in Policy Making," in Fitzhugh Mullan, Ellen Ficklen, and Kyna Rubin, eds, *Narrative Matters: The Power of the Personal Essay in Health Policy* (Baltimore, Md.: Johns Hopkins University Press, 2006), 11.

318 McDonough, 13.

Policy makers represented the larger pool of active citizens not only through their status as elected officials but also, and perhaps more importantly, in their similarity to, and connection with, the larger pool of active citizens participating in a democratic culture. The specific ways that interpretive thinking can aid those men and women whose job it is to draft and enforce the federal regulations represents an important topic for interpretive scholars to explore. Within the scope of the project at hand, however, I am more concerned with the broader application of an interpretive paradigm, and with the ways in which interpretive and narrative thinking can offer average citizens new ways to respond to, and participate actively in, collective culture–not only mass marketing campaigns for prescription drugs, but public discourse of all kinds.

CULTURE AS NESTED NARRATIVES

To clarify how an interpretive understanding of pharmaceutical commercials (or any other form of public discourse) encourages a broad and participatory response from average citizens as well as experts and officials, I want to briefly return to the relationship between advertisements and the culture that they simultaneously reflect and reshape. Roland Marchand sees several dominate narratives at work in the print advertisements of the 1920s and 1930s which function as "the great parables" of a new, modernized lifestyle.[319] He describes how early advertisers believed themselves to be not only making use of established cultural ideas, but also carefully encouraging the adoption of new ones. They explicitly identified themselves as the "apostles" of the new century, deliberately guiding American society toward innovation, mass production,

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[319] Marchand, 233.

consumerism, and an increasing dependence on technology in daily life.[320] These parables worked on culture in subtle ways, and his description of their relationship to existing social structures is as applicable to television drug commercials as it is to early print advertisements for home appliances available through Sears, Roebuck & Company.

> In each case, the parable so succinctly and vividly encapsulated widely accepted ideas that it propelled them back into the society with a more compelling force and a more entrancing ambiance. Advertising parables did not challenge the society to overturn conventional ideas, but they did facilitate the spread of those subtle formulations of old ideas and values endorsed by the most "modern" segment of the population. Frequent reiteration of each parable by a number of advertisers gave the pattern of thinking it embodied an aura of inevitability so that fundamentally different viewpoints became impossible to imagine. Popularized for a widening audience, the parables acquired the status of social clichés – notions with the quality of 'givens' that established the ideological framework within which other ideas could be explored.[321]

By referring to the ideas conveyed by the ads as "parables," Marchand characterizes them narratively. And while his discussion of their power to reflect, shape, and eventually become the larger "social cliché's" and "givens" represents an insightful understanding of interrelated contexts, reframing this interaction in terms of hermeneutic culture and narrative theory allows for a significant gain in clarity: the "clichés" and "givens" that these advertisements simultaneously mirrored and molded were, and are, narratives themselves. Individual stories told by advertisements interact with broad and well-established forms of cultural understanding that might be called meta-narratives, and the complicated relationships between narratives of various power and sizes can be understood through a hermeneutic conception of culture. Advertisements do not simply reflect or redirect the ideas that form the larger social context. As narratives, they

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[320] Ibid., 167.

[321] Ibid., 233.

participate in (which is to say, operate according to, reinforce, reiterate, and, in important ways, retell) the larger stories that consumers already live according to.

Taken together, hermeneutic anthropology and narrative ethics provide the basis for a conception of culture as a series of interrelated, nested stories, ranging from an individual memoir of illness to the history of collective experience and values that define a nation. The candidate meanings available to each individual are those supported and reinforced by various levels of community, and the authorial power of the individual to not only accept or reject various alternative narratives but also to rewrite them, from her own perspective, in dialogue with others, leads to the gradual revision of culture.

My intention here is not to provide a narrative taxonomy by designating each consecutive "level" of storytelling and defining its scope. The terms we use to distinguish the size or influence of a particular narrative are less important, to my way of thinking, than a recognition of the overall structure, and an understanding of the way in which every narrative both supports and depends upon the stories above and below it. For example, an individual cancer patient who thinks of herself as a fighter may plot the story of her life as a battle with cancer. Her family members, responding to her language (and, since they presumably share similar backgrounds and beliefs, perhaps adopting a war metaphor on their own accord) begin to talk to her and to each other, as well as to friends and to health-care professionals, about her fighting spirit, her bravery, and so on. Because the military metaphor is well-established in American medicine, this patient's individual story will find support and reinforcement in the hospital and, simultaneously, the institutional and professional narrative will be reinforced by one more patient who characterizes her physicians as generals and her treatment options as weapons. This particular story has found cache in nearly all levels of health care. It pervades even scientific journals, and eventually reaches its way to health policy debates. Meanwhile,

the continued acceptance and increasing adoption of the narrative by individual patients and families becomes evident in support groups, church congregations, and disease awareness organizations. Patients, physicians, politicians, and, of course, pharmaceutical companies, share the same story, retelling it countless times in the context of countless lives, and reiterating its basic structure while altering it, slightly, with each iteration. Eventually, a powerful narrative becomes, as Marchand puts it, a "given," and that's when we run into trouble; we forget that it is a story at all.

So when a commercial for Nulasta appears featuring men and women of various ages confidently stating that they are "ready to fight" cancer, we forget what kinds of questions to ask. The information presented in the ad must be accurate according to the available scientific literature, of course, but questions about the facts do not necessarily challenge, or even call attention to, the larger narrative in which they are being framed. In this case, for example, questions about risks and benefits can easily be fit into the military myth offered by the commercial. Is Nulasta safe and effective? Is it a good weapon? Is it time to employ it? Drug information can be evaluated within this narrative, but using the informational paradigm alone, viewers are not prompted to question the narrative itself. Am I at war with cancer? Do I experience my disease in this way? Do I want to?

POWER AND PARTICIPATION

Recognizing social discourse as fundamentally narrative highlights issues of cultural power and offers everyday citizens novel ways to reclaim it. By exploring narrative issues of plot and point of view in terms of authorial power, Tod Chambers and Kathryn Montgomery assert that "every plot is a bid to establish a vision of the truth," and thus an attempt, implicit or explicit, to control the possible structures of

understanding for readers who accept the story as it is told.[322] Since every story has an author, and every act of authorship is an act of control, narrative can never exist separately from the exercise of power. Along with this realization, however, comes the democratizing corollary that every story can be read critically and potentially rejected with issues of authorial power in mind. As Chambers and Montgomery insist, "every story can be retold, replotted, and reinterpreted" from a different point of view.[323] Every narrative, no matter how grand, is susceptible to thoughtful critique and revision, and while many laypeople might consider themselves far removed from overwhelming social issues such as access to health care, the only authority required for active participation in the interpretation and revision of culture, from this perspective, is the *author*ity of experiencing and describing the world from a specific point of view. You don't have to be a legislator or multimillionaire or even a health-care professional to challenge the narrative authority of the pharmaceutical industry, or of the medical profession in general. By recognizing the ways in which larger social systems attempt to structure an individual's experience by narrative, the individual can take control over her own experience by critically receiving the stories offered to her and then, if she chooses, retelling them to exercise the power of her own point of view. This is not to say that anyone can narrate themselves out of terminal illness. But a patient can choose which metaphors, which imagery, which narrative structures and, importantly, which characters will occupy her story and therefore shape her experience. An interpretive approach allows a patient to recognize, for example, that her physician has adopted the rescue narrative, and rather than passively submit to becoming part of a story she does not feel comfortable with, she can exercise her own authorial power, a power that allows her to

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[322] Chambers and Montgomery, 78.

[323] Ibid., 81.

respond to the medical system in ways that have not traditionally been available. ("This character you're playing? He doesn't fit in my story…")

How does claiming authorial power over our own lives and experiences translate into active participation in an interpretive culture? The cultivation of critical reading skills and the experience of deliberately accepting or rejecting candidate narratives allows individuals direct interpretive access to critically evaluate larger stories that might otherwise seem out of our reach. For example, many laypeople might feel intimidated by the complex debate over access to health care, and consider it completely outside the bounds of their understanding and purview. To a certain extent, of course, some people are better placed to read and respond to particular stories than others. Just because every individual has the authorial power to plot his or her own experience doesn't necessarily mean that everyone's story will be equally received. The idea is that no one perspective can claim exclusive narrative authority, and everyone, no matter how unqualified they believe themselves to be, has a stake in issues of health and disease and therefore has a unique and important contribution to make to the public discourse concerning those issues. This task becomes less daunting when an individual can start by evaluating a more circumscribed narrative such as her own particular experience of illness, or perhaps even a television commercial for a particular drug. By thinking critically about the ways in which an individual narrative connects with and participates in larger cultural stories, individuals can find their way to evaluating the most systemic of shared narratives, such as the story of the autonomous rational individual or the story of the free market.

COAUTHORING CULTURE

A participatory democracy depends upon an educated population that understands the system well enough to take an active role in it. For most of us, that role extends no farther than casting a vote, although school children continue to watch the ubiquitous cartoon starring Bill who becomes a Law. I would not argue that these lessons are unimportant, but in the contemporary age of mass media, where consumer goods (as well as political causes) are sold over the television screen, I would argue that what may be more important for effective citizenship–for responsible participation in the collective task of creating and maintaining a moral culture-is the cultivation of critical reading skills. Future citizens need an education that will prepare them for the onslaught of mass media communication, for the complex interplay of shared narratives, and for the significance of their own personal investment in, and responsibility for, the stories they choose to live according to. Individuals participating in a culture such as ours need to know more than how to evaluate the accuracy of factual information. They need to know how that information is presented, what contexts it belongs to, and what purpose its author had in mind. They need the kind of education that will help them recognize which details are significant and which questions are not being asked. They need, in other words, a humanistic education focused on the rigorous interpretation of texts, the connection between language and experience, and the relationship between the self and the stories it is cultivated through.

The move toward interpretive thinking, specifically in response to pharmaceutical advertising but more generally in response to public discourse as a whole, must take place as a widespread, popular shift in the way that citizens of all levels of authority and expertise understand both their relationship to, and responsibility for, culture. In an age of

mass media, the temptation is all too great to sit back and passively receive the messages of public discourse as if we're not being directly addressed or influenced, as if culture has nothing to do with us and is the sole product of those with power and influence. This will (and may have already) become a self-fulfilling prophecy unless we adopt a framework which asks citizens to operate as active, thoughtful members of a participatory culture. Most of us, admittedly, do not have the millions of dollars required to tell or retell stories through television commercials or other public media outlets. I don't intend to deny or make light of the logistical and financial structures that allow some stories to be heard loudly and often, and others not at all. Yet I would argue that most individuals are not aware of their own authorial power, and don't recognize the various audiences available to them. From dinner-table conversations to support group meetings to sermons to social clubs–Americans do, in fact, talk to each other the old-fashioned way.

Only one subset of these nearly infinite opportunities for conversation involves health-care professionals. In clinical encounters with patients, professional meetings with colleagues, and medical school lectures to students, physicians enjoy more than their share of authorial and communicative power. Intersubjective meanings of illness are negotiated in each of these contexts, and given the profession's ethical commitment to serve as patient advocates over and above financial interests, the demand for careful, critical attention to the meanings adopted is even higher. Even physicians who do not believe themselves well-connected or particularly powerful within the health-care system have dozens of opportunities, every day, to engage patients in thoughtful conversation concerning the meanings conveyed by DTC marketing. What's more, the physicians themselves don't even have to broach the subject. Patients, after all, have already been told to "ask their doctor" about the prescription drugs advertised on television.

REFRAMING OUR RESPONSE

This dissertation is intended to explore and advocate an alternative way of understanding the issue of DTC advertising, one which allows average citizens to respond to and participate in public discourse in fresh and novel ways. It does not attempt to provide a step-by-step legislative or regulatory plan of action concerning pharmaceutical marketing. While such a plan may well be needed, it is not the specific project undertaken here. I applaud the efforts of those whose political and scholarly work aims to more immediately influence policy. However, the inadequacy of our conceptual framework for understanding and debating the issue of DTC advertising is, I believe, broad and deep enough to require a more thorough and theoretical reorganization than any specific policy suggestion can involve. What I have attempted to provide within the scope of this project is an alternative way of looking at, thinking about, and negotiating between the meanings conveyed by pharmaceutical commercials and DTC marketing as a whole. By taking this comprehensive, theoretical approach, I do not mean to imply that specific policy change cannot or should not be implemented, but only that the categories of thought and action that we bring to policy debates ought to be carefully examined as part of the issue as well. Without taking a step back to look at the ways in which we think about these commercials, we can never escape the specific assumptions and biases of the framework which currently shapes our personal, political, medical, and legislative responses to drug advertisements–a framework which slants the entire issue in favor of the pharmaceutical industry.

Certainly, specific changes in the legislative and medical arenas could facilitate the interpretive approach described in this dissertation by lessening the authority of the

pharmaceutical industry over health care. I agree with Howard Brody's call for a "divestment" of pharmaceutical interests from the medical field, and also support current Congressional efforts to impose further limits on drug marketing, including a mandatory waiting period before a newly released drug may be advertised to the public.[324] And while I recognize the difficulty in altering federal regulation over advertising in order to account for more interpretive analysis, I do believe that behind any code, law, or policy is a group of people whose job it is to interpret those rules in the context of specific instances. Because even code and regulation is ultimately based on, and applied within, human understanding and communication, I do believe there is room for a narrative consideration of these ads alongside the current efforts to ensure the accuracy and fairness of the information provided.

But, ultimately, an interpretive framework acts to redistribute cultural power from federal officials and pharmaceutical executives to the patients and caregivers whose individual and collective experience of illness is at stake. The idea is not (or not only) to rewrite the rules for pharmaceutical advertising. The idea is to change the way we think about and respond to the commercials themselves. There is no set of regulations or standards that can take the place of careful, critical reception of the message at the other end of the process–once an ad has met all the rules and appears in living rooms across the country. Citizens rely on the FDA and other regulatory agencies to protect them from false advertising, exploitation, and harmful products. The mindset that must be changed is the idea that, once these federal protections are in place, an individual viewer has no responsibility for any kind of critical evaluation of the message as she receives it-that the only relevant evaluation is an evaluation of the facts, and this is done by experts, not

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[324] See Brody, *Hooked*, 287-98.

average citizens. The power of bringing this interpretive, critical tradition to bear on the issue of DTC advertising is that it democratizes the process of advertising regulation.

When we think of these ads as stories, we pay attention to them, and we learn to ask the right questions about them. We must continue to ask if pharmaceutical commercials are presenting factual, balanced information, and to what extent its presentation lends itself to patient education. Yet we must also ask questions that will help delineate the nature and implications of the narratives conveyed through these advertisements, the way in which they support and or revise other cultural narratives, and the implications of the candidate meanings that they offer. Why is this story being told in this way? Do I want to live according to it? Why or why not? These are the questions we ought to be asking ourselves, as well as our doctors, about the prescription drugs we see advertised on television.

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Vita

Angela Lea Scott was born January 11, 1977, in Midland, Texas, to Luther and Kathryn Lea. She attended the University of Texas at Austin, graduating *magna cum laude* from the Plan II honors program in humanities. She received special honors for oral defense of her senior thesis, titled "Adolescent Confidentiality and Issues of Sexual Health." As an undergraduate, Angie received the College Scholars' Award for Outstanding Academic Achievement and was inducted into several academic honor societies including Golden Key and Alpha Epsilon Delta. After graduation, she spent one year as a health educator for a nonprofit organization in inner-city Houston, conducting HIV prevention classes for a variety of populations, including school children, drug rehabilitation groups, and the incarcerated. She was also appointed to the Houston Community Planning Group, a group of local health professionals charged by the Centers for Disease Control and Prevention with the fair and effective distribution of federal HIV prevention funds to the Houston area.

Angie entered the M.D./Ph.D. combined degree program at the University of Texas Medical Branch (UTMB) in 2000. During her graduate studies at the Institute for the Medical Humanities, her coursework focused on her major and minor areas of concentration, Health Care Ethics and Narrative Studies in Health Care. She has presented her research at both national and international conferences, as well as to faculty and students of the University of the Transkei (UNITRA) school of medicine in Umtata, South Africa, where she spent three months conducting a phenomenological study of crosscultural beliefs about HIV. Her teaching experience includes ethics and humanities courses for medical students at UTMB and Baylor College of Medicine, as well as a

survey course on medical humanities for undergraduate students at Rice University. She has received numerous awards while at UTMB, including two Blocker Scholars Fellowships and a National Institutes of Health infectious disease fellowship to study beliefs about HIV in rural South Africa. Angela plans to finish medical school in 2007 and then enter a pediatrics residency program. She lives with her husband, Corey, and her son, Holden.

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This dissertation was typed by the author.