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UNIVERSITY OF CALIFORNIA, SAN DIEGO

Curing Consumers: How the Patient Became a Consumer in Modern American
Medicine

A Dissertation submitted in partial satisfaction of the requirements for the degree

Doctor of Philosophy

in

Communication

by

Nancy Stark Lee

Committee in charge:

Professor Michael Schudson, Chair
Professor Daniel Hallin
Professor Robert Horwitz
Professor Richard Kronick
Professor Richard Madsen

2007

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The Dissertation of Nancy Stark Lee is approved, and it is acceptable in quality and form for publication on microfilm:

Chair

University of California, San Diego

2007

With loving gratitude to my Mother and Father,

李沈秀娟

李 品 禮

Lee Shen Hsiu Chuan and Lee Pin Li.

This is their work.

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Review of *Confronting Consumption*, edited by Thomas Princen, Michael Maniates, and Ken Conca. *Journal of Environment and Development* 12 (June 2003): 268-271.

ABSTRACT OF THE DISSERTATION

Curing Consumers: How the Patient Became a Consumer in Modern American
Medicine

by

Nancy Stark Lee

Doctor of Philosophy in Communication

University of California, San Diego, 2007

Professor Michael Schudson, Chair

This dissertation addresses the widespread practice of calling the patient a consumer in contemporary discourses about health and medicine in the United States. Despite its common usage, little is known of the historical origins of this construct, how it entered popular discourse, and the symbolic and social significance of conceptualizing the patient as a consumer to current health care debates. Through historical research that spans the years 1930 to 2006, this study traces the patient-consumer metaphor to the patients' rights movement of the 1960s. Ideas about patient empowerment and rights emerged only after that decade's social and cultural

transformations reduced the public's trust in traditionally authoritative and paternalistic institutions such as medicine. Calling the patient a consumer was a rhetorical tactic first popularized by the 1960s social movements involved in expanding patients' rights, including the consumer movement led by Ralph Nader. This periodization is supported by findings from a historical textual analysis of mainstream magazine articles on health and medicine from 1930 to 1969 that indicate the patient as an empowered health care consumer was not part of normative expectations of patienthood before the 1960s. Textual analysis of self-help literature, magazine and newspaper articles since the 1970s show how the patient-consumer metaphor's connotations of empowerment and personal autonomy in health decisions were co-opted and reduced to simple messages about consumer sovereignty by the 1980s as the US health care sector became increasingly corporatized under successive neoliberalist administrations. This dissertation's findings contributes to a more nuanced, historically based understanding of the ramifications of patient consumerism to better enable and support critiques of the American health care system.

CHAPTER ONE

Introduction

Americans today are reminded constantly by the media that individuals are the masters of their own health. Learning to make informed choices is the way to take control of health. And information is the key to making the best, most informed health decisions. That patients as “empowered consumers” have the right—and the responsibility—to make their own health decisions has become nearly taken-for-granted in American society. The patient is often called a consumer these days, yet the right to self-determination in health is a recent concept in the history of medicine in the United States, as is the idea that information and effective communication are central to making personal decisions about health.

This dissertation addresses how the widespread practice of calling the patient a consumer in both popular and expert discourses represents a profound transformation of American ideas about patienthood and expectations of professional authority in medicine. These changes correspond to larger cultural and social transformations of American society since the 1960s that reduced the public’s trust in traditionally authoritative and paternalistic institutions such as medicine. As a result, a new paradigm emerged of the patient as an active, empowered consumer that upended traditional ideas about the patient as a passive dependent of her physician. Given this

historical context, this dissertation argues that the rhetorical figure of the patient-consumer represents contemporary ideas and expectations of freedom, choice, personal control and responsibility in matters of health, not all of which resulted from the influence of neoliberalism. In the past 25 years, the consumer metaphor lent itself readily to neoliberalist health policies that have promoted market expansion in the health care sector on the basis of greater consumer sovereignty and choice in health services and products.

These developments, understandably, tend to obscure the fact that calling the patient a consumer was a rhetorical tactic first popularized by the 1960s and 1970s social movements involved in expanding patients' rights, including the consumer movement that aimed to protect consumers from the hazards of the marketplace. This linguistic turn was important symbolically in the struggle to diminish the physician's total authority over patients in the paternalistic model of medicine. Under pressure from various rights movements, including the consumer movement, the traditional medical model began to give way to a more patient- or consumer-centered model of care. Effective communication became the benchmark of doctor-patient relations under this new paradigm and access to information considered vital to patients' active involvement in their own health care. This shift towards greater patient autonomy is far from complete nor are its results uniformly democratic. But out of this development emerged a new awareness that individuals must take control of their health care decisions if they want to reap the benefits and avoid the pitfalls of modern medical care.

After the US political climate turned conservative in the 1980s, it took little imagination for free-marketers to adopt the consumer message of self-determination and choice, minus the core progressive objectives of patient-consumerism that rights groups on the political left championed. These goals involved securing greater legislation to protect patient autonomy and welfare in health care and to expand patients' rights to affordable health insurance for all Americans. Research for this dissertation supports the assertion that political conservatives have used the patient-consumer metaphor's principles of choice and self-determination to justify policies that favor private enterprise in health care over government-supported social provision. But my findings also uphold the case for a consumerism informed by political and social values of the left that has stimulated progressive political action and policies at certain historical periods, leaving an indelible impact on health care delivery and access in the US.

The Importance of Defining the Consumer – Conceptual Framework

This dissertation raises interesting questions regarding the patient-consumer metaphor's significance in shaping health care debates in the US. Two questions tend to stand out: First, why is it important to know when the patient became interchangeable with consumer and, second, why the word "consumer" instead of, say, "citizen"?

Why is it important to sift out the historical origins of the patient as consumer? If our understanding of reality is structured through the power of metaphor as Lakoff

and Johnson (1980) argue, then the next sensible step is to discover what the metaphor in question actually communicates. The patient-consumer metaphor is everywhere in present-day lay and expert health care discourses yet under-researched for its symbolic and sociological implications in health and medicine. More commonly, the patient-as-consumer paradigm is alternately hailed as a superior way to practice medicine or criticized as exemplifying the corporate takeover of the health care system. Little research on medicine in the social sciences, however, has examined precisely the historical origins of the concept and its influence on sociological outcomes in health and medicine. This dissertation places the patient-consumer in historical context to assess the issue from a position other than free-market boosterism or a perception of consumerism as purely an outgrowth of gross commercialism in the US health care system. These polarized interpretations tend to obscure the larger historical picture that shows how the meaning(s) of the patient-consumer metaphor and the impact of consumerism in health and medicine are contingent upon the ever-changing social, cultural, and political-economic context in which language and social action are embedded. In this dissertation I present historical evidence that contributes to a more nuanced understanding of the ramifications of patient-consumerism. I show how corporations are not the sole proprietors of market language and that citizen groups have a history of appropriating market language to fight corporate exploitation and the injustices of the free market. I show that the custom of calling the patient a consumer came into vogue only in the late-1960s and 1970s when various rights groups deliberately used the term to signify the rejection of medical paternalism through the

empowerment of patients. And just as activists appropriated the term consumer from market vocabulary, in the 1980s the health care industry started co-opting the patients' rights movement's message of the empowered patient-consumer to sell the public on the merits of consumer choice in a competitive, open-market health system. Health care corporations, however, fail to trumpet the fact that competition produces its own pressures (i.e., the need to stay commercially viable in an aggressive market system) that place constraints on the accessibility and quality of health care afforded to consumers. Knowing these developments, on one hand, should not obscure the real gains won by the patients' rights movement through empowering patients as consumers. On the other hand, understanding recent directions in the US's corporatized health care environment should complicate any easy claims that patient-consumers today face choices that are necessarily abundant or straightforward.

The second question—"why consumer and not citizen?"—is frequently asked of my work on the patient-consumer metaphor's influence on modern American health and medicine. This is a good question, often asked from the basis that consumer and citizen as concepts represent conflicting values and expectations of political participation. The point is reinforced by the example that in countries with state-supported universal health systems health care is considered a right of citizenship and not a consumer privilege dictated by income. Undoubtedly, at least from my experience of the Canadian system, health care is largely construed and debated within the framework of citizenship in countries with government-funded health care. But citizens in countries like Canada also purchase over-the-counter medications,

prescription drugs, vitamins, and assorted conventional and alternative health products and services that often are not covered under public health plans or receive varying degrees of subsidization. They also face the problem of choosing suitable physicians and other health care providers even when their choices are not limited to managed care networks and other private health insurance restrictions. That citizens are also consumers in modern capitalist liberal democracies is a fact that only recently has attracted serious intellectual attention. My work is informed by this emergent generation of consumer scholarship that focuses on the relationship between consumption and citizenship. This body of research moves beyond the politics of identity that frequently dominates consumer culture research to examine the political implications of consumption. Health care is well-suited to study within the consumer versus citizen debate because of its relationship to the market and its status as a right of modern citizenship. It is important to remember that citizens were purchasers of goods and services in the health marketplace long before health came to be valued as a human right and considered a responsibility of the welfare state. Medical care in the past could be considered a “luxury good” (Tomes 2001) that few among the ordinary classes could afford. Patients before the present day had to navigate the perilous waters of the health marketplace with few rights and even fewer protections against the ever-present hucksters and charlatans that preyed on their vulnerabilities. Gaining a perspective on the problems of the past in no way lessens the need to expand health care rights as a matter of social justice. It does, however, sharpen the questions that

need to be asked about consumption practices and the inequalities that beset the US health care system today.

The politics of consumption as a field of scholarship is not new: studies on disadvantaged consumers (Andreasen 1975), consumer boycotts (Friedman 1999), and consumer activist groups (Maney and Bykerk 1994) have existed since the early 1970s when scholarly interest in consumerism as a political movement was at its highest in the US (Maney and Bykerk 1994, 1). The resurgence of interest in “political consumerism” (Micheletti 2003) has been fueled by present-day developments in global consumer activism and protest against the transnational spread of neoliberal capitalism. European scholars have led the way in theorizing political consumerism as an avenue of civic engagement, as distinct from “economic” or “lifestyle” consumerism. Swedish political scientist Michelle Micheletti offers this definition of political consumerism:

Political consumerism concerns the politics of products, which in a nutshell can be defined as power relations among people and choices about how resources should be used and allocated globally. Political consumers choose products, producers, and services more on the basis of the politics of the product than the product as material object per se. Their choices are informed by political values, virtues, and ethics. They differ from economic consumers who are just looking for a good buy, that is a satisfactory relationship between material quality and economic costs. Political consumers also tend to differ from lifestyle consumers who shop for products with the sole aim of helping to define and enhance their self-identity. (Micheletti 2003, x)

Danish scholars Jørgen Goul Andersen and Mette Tobiasen offer a concurring definition of political consumerism:

We suggest that the criterion of a deliberative attempt to influence or change society . . . is the only possible way to distinguish between

“ordinary” consumption and “political” consumption. Whereas “ordinary” consumers are only concerned with satisfying a purely personal need, a political consumer must, at a minimum, be concerned about aggregate implications; that is be concerned about the possibility of deliberately using his or her “voting right as a consumer” to affect aggregate outcomes. This is what ultimately blurs the divisions between politics and economics; this consciousness about collective effects is what provides, in a minimalist version, a sense of “imagined community.” (Anderson and Tobiasen 2003, 205)

In a seminal collection of new research on political consumerism, Micheletti and colleagues Andreas Føllesdal of Norway and German-Canadian scholar Deitlind Stolle note that this blurring of politics and economics has played out in the market from early on in Western history, as “people who were not part of the demos of political life often chose the market as an arena for politics” (Micheletti, Føllesdal and Stolle, 2004, x). Historically, the market has served as an outlet for political action for people denied full citizenship rights and excluded from political life whether through marginalization, colonization, or enslavement. These scholars also point out that even people with full citizenship rights to political and economic participation have utilized the market as a political tool: “Empowered and embedded people use their purchasing choices to criticize the policies and practices of corporations in their own and other countries in situations where strong government regulation in domestic and export settings is absent” (Micheletti, Føllesdal and Stolle, 2004, xi). Micheletti’s study of political consumerism in Sweden is an example and offers some answers as to why political consumerism occurs in a country with few “governability problems” and where “collectivistic rather than individualized collective action” tends to be the norm of political involvement (Micheletti 2003, xii-xiii). Her findings suggest that political

consumerism offers “new opportunities for different kinds of political engagements and individualized collective action” that are emerging in response to the effects of globalization and postmodernization (Micheletti 2003, xiii).

Echoing the Scandinavian scholars, British consumer scholars Matthew Hilton and Martin Daunton (2001) also recognize the important role consumption has played in the political history of Western societies. They disagree with Jurgen Habermas’s explanation of consumption as a state-sanctioned distraction from meaningful political discourse and contend that consumption has always been a vital component of civil society. Referring to the 1999 World Trade Organization protests in Seattle, Hilton and Daunton argue that “the prominence given to consumer issues on the streets of Seattle was not so much the recognition of a new public sphere of political debate, more the confirmation that the public sphere of consumption has always existed as one of many forms of ‘civil society’” (Hilton and Daunton 2001, 12). Where Micheletti, Føllesdal, and Stolle focus on political consumerism spawned by the new realities of globalization, Hilton and Daunton address the concept of consumer citizenship itself and focus on the state’s historical role in the politics of consumption. They argue that the state is implicated in the construction of the consumer as much as it is in delineating the parameters of citizenship: “Defining the consumer interest, and speaking for the consumer, establishes both the extent to which the state can intervene in issues of consumption and the extent to which the consumer is active in the political process” (Hilton and Daunton 2001, 5). They maintain that through market regulation and the inclusion of consumer issues within government institutional agendas, states at

various historical junctures and through different political regimes have contributed to the production of two competing notions of the consumer: the economic “rational utility-maximizing individual,” or the model of consumer as customer, and a broader definition of consumer that encourages more political activism (Hilton and Daunton 2001, 5). But as much as states have determined the contours of consumption and citizenship, people have also defined consumer-citizenship on their own terms: “consumers have also created their own notions of consumer citizenship, often in opposition to and beyond the state as in the initial ambitions of the co-operative movement and the activities of recent NGOs” (Hilton and Daunton 2001, 5). In short, citizenship and consumerism are negotiated, not static, concepts and the dynamics between them perpetually yield new notions of citizenship. Thus, in these scholars’ estimation, current understandings of the public sphere would be better served by acknowledging consumption as a genuine site of political debate.

That consumption can act as a site for political disputation and action is a controversial idea in the social sciences. According to Micheletti, political consumerism is a contentious subject because it signals “that citizens are looking outside traditional politics and civil society for guidelines to help them formulate their more individualized philosophy of life and live as good citizens” and that “It challenges our sense that money and morality cannot be mixed, as it is in green businesses, socially responsible investing, codes of conduct, and general trends toward corporate citizenship” (Micheletti 2003, 3). Micheletti observes that many scholars, particularly in the US, consider political consumerism a “normative appeal for

neoliberalism, economic globalization, and market capitalism and a call for the rolling back of the state” (Micheletti 2003, 3). Other scholars see it in exactly opposite terms, i.e., political consumerism as a provocation by the political left in their quest for more government regulation of business and to curtail global free trade. Consumption can provoke such antagonistic responses because, as Hilton and Daunton remind us, “Consumption has always been a moral and political as well as an economic act” (Hilton and Daunton 2001, 14). They note, however, that consumption typically has been judged according to whether consumption practices and needs are productive or wasteful, rational versus irrational, “real” versus “false.” They point out that within liberal economic philosophy consumption traditionally has been considered a morally frivolous but necessary component of the capitalist economy. This explains why consumption was acceptable to the likes of David Hume and Adam Smith as a domestic activity in the private sphere of women but considered incompatible with the serious business of men in the public sphere (Hilton and Daunton, 2001 14).

In short, the new scholarship on political consumption is valuable for the way it challenges, through empirically based analyses, the entrenched biases on various sides of the consumption question to draw attention to consumption as a channel of legitimate political discourse. Informed by this body of work, this dissertation moves the debate on consumerism’s influence in health and medicine beyond the usual for-or-against judgments by first asking what have been the real advantages and disadvantages of this historical change. How have patients benefited from this shift to seeing them as consumers? What disadvantages, on the other hand, or risks did this

shift expose patient-consumers to? A careful assessment of the outcomes of patient consumerism in recent US history can better enable and support critiques of the troubles with the American health system in the long run.

Modern Medical Ethics and the Doctrine of Informed Consent

The larger theoretical context for this dissertation is the doctrine of informed consent that comprises principles of patient autonomy central to contemporary medical practice. As doctrines go, informed consent's history is brief. Its roots lie in the aftermath of World War II, specifically in the Nürnberg Trials (1945-1949) in which Nazi physicians who experimented on prisoners were punished for their experiments on captive subjects. Although the Nürnberg Code established the ethical importance of informed consent, it was basically ignored by the medical profession throughout the 1950s and most of the 1960s until the patients' rights movement promoted its tenets regarding patient autonomy beginning in the late 1960s. The patients' rights movement pressured medicine to adopt informed consent as a governing ethical principle, the result of which no physician practices medicine today without obtaining the patient's informed consent. While fierce debate rages around the protocols of acquiring informed consent and whether patients are truly informed before giving consent in most cases, the primacy of patient autonomy remains unchallenged as the guiding principle of modern patient care.

Historically, Western medicine has followed the central tenet of the Hippocratic Oath, namely, that physicians must never do harm and must actively

protect patients against harm whenever possible. The Oath regulated physician behavior but set no guidelines to accommodate the wishes of the patient. The Nürnberg Code did not dispel this basic rule that doctors must do what is right and best for their patients; however, the Code broke new ground by codifying patient autonomy as an ethical value above all others that govern physicians' actions.

Nürnberg was the first time in Western medicine's history that medical ethics stepped beyond regulating professional conduct to protecting the individual patient's right to give or withhold consent voluntarily. The Nürnberg Code's principles eventually formed the foundations of the UN's Universal Declaration of Human Rights in 1948 (Kagarise and Sheldon 2000, 42) and became the basis of the patient rights movement that sought to protect the individual's right to make her own health care decisions.

According to Faden and Beauchamp (1986), informed consent is theoretically and philosophically both an ethical and legal doctrine. The distinction between ethical and legal is crucial: while the law's intention is to uphold compliance to ethics, to genuinely carry out informed consent in medical practice is to prioritize the ethics above all other considerations, including the legal. In other words, doctors ideally should be motivated to disclose medical information to their patients not because they are afraid of malpractice lawsuits, but because they are professionals sworn to carrying out the ethical standards of their calling: "Notwithstanding the societal decision to resolve certain limited kinds of problems in the courts, informed consent in clinical practice should be first a problem of medical ethics, not of legal requirements. This judgment is of course primarily normative and sociological" (Faden and Beauchamp

1986, 141-142). In contemporary medicine this would mean upholding the patient's right to make voluntary, autonomous decisions about health. Three moral principles dominate informed consent: 1) autonomy, 2) beneficence, and 3) justice. Informed consent as an ethical principle is thus a concept rooted in the Western liberal philosophical tradition of respect for the autonomy of the individual. The legal doctrine of informed consent, on the other hand, exists to delineate the parameters of responsibility when medical care goes wrong. The legal dimension of informed consent concerns the boundaries of duty, responsibility, liability, and risk for both the patient and physician and to dispense justice where rights have been violated. The law historically has contributed more than medicine to the pragmatics of translating informed consent into practice:

In medicine, there was no ready set of internal principles that paralleled those of law. Developments in medicine therefore had to come from an external source or framework. There *was* an available moral framework in medicine, but it was entirely beneficence-based and ill-suited for grappling with problems of autonomous decisionmaking and informed consent [*italics in original*]. (Faden and Beauchamp 1986, 142).

Historically, two conflicting standards form the basis of legal theory on informed consent: 1) the professional practice standard and 2) the reasonable person standard. The first standard supports the rights of physicians to carry out their professional duties according to accepted medical standards. The second targets the problems associated with medical paternalism and sides with patients and their rights to make decisions in their own interests. Much controversy surrounds both principles. In response to the drawbacks of both standards, a third standard, the "subjective standard," emerged in legal theory. This third standard embodies the principle that

physicians ought to disclose information according to the particular needs of individual patients.

Today, the subjective standard is the ethical and legal gold standard in patient care. In medical language it is known as informed decisionmaking. The controversy arises when empirical research reveals evidence of frustration in both patients and physicians when the subjective standard of informed consent is translated into actual clinical practice (Braddock et al. 1999; Wade 1995). A key problem is the patient's level of desire to involve herself in treatment decisions. The patient's ability to consent to procedures in an informed way depends on factors such as the doctors' communication skills, the nature of the medical condition, the patient's personal cognitive and psychological makeup, age, gender, socio-economic and cultural background, and so forth. Thus, medical practitioners and theorists agree that, in principle, the practice of informed consent should constitute a process whereby doctors dialogue with patients from the outset of diagnosis and throughout treatment to ensure that patients are prepared to make informed decisions about their care. But the problems of translating the ethics of informed consent into practice are well-documented: in the clinic, informed consent all too often becomes a legalistic, administrative procedure involving reams of written forms difficult for patients to understand and time-consuming for harried medical staff to explain. Problematic as it may be, informed consent continues to be the accepted standard of medical ethics among medical practitioners, ethicists, and legal experts today. The consensus

continues that informed consent is an imperfect but necessary doctrine that protects the personal autonomy of patients in medical decisionmaking.

Plan of the Dissertation

Chapter two: A historical perspective on consumerism

Chapter Two examines the historical roots of consumerism in the United States. This chapter focuses on the history of consumer protest and activism that often is overshadowed by a cultural critique of consumerism grounded in a puritan or anti-materialist moralism. I construct an intellectual history through which to trace and analyze this tradition's basic suppositions about consumption. I compare these against historical scholarship based on empirical research of consumer behavior that calls into question some of these anti-consumer assumptions. This chapter also establishes the fact that medicine and consumerism share a long history in American consumer society, not only through advertising but also through the consumer or consumer protections movement that fought to safeguard citizens from fraud and harm of all sorts in the health marketplace. In the past, consumerism was a term mostly associated with the efforts of early consumer organizations that struggled to defend the interests of ordinary consumers against the corporate power of producers. Through advocacy, boycotts, consumer education, and other forms of activism, early consumerism added the dimension of active political consumer to the classic definition of consumer as a purely economic actor. Thus, the term consumer had taken on moral and political connotations early in twentieth century American consumer culture that injected the

spirit of citizenship into consumerism. The consumer citizenship model of advocacy groups and grassroots organizations contrasted with the customer model of a “purchaser consumer” that was favored by businesses (Cohen 2003).

Chapter three: Health care and the problem of communication

Chapter Three examines how communication is conceptualized in the field of health communication, specifically in the area of doctor-patient communication. It is common in health communication studies to speak of the “centrality” of communication to medicine and health promotion. But my textual analysis of health communication journal articles, articles from the *Communication Yearbook*, and health communication handbooks between 1977 and 2006 reveal that health communication scholarship has yet to address the sociohistorical context of how and why this concept called “communication” became central to health and medicine in the first place. The reason for this lack is due to the traditional dominance of what I call, for purposes of this chapter, the “information model” of communication. This model construes communication in a positivist manner as the transmission or exchange of information in the form of messages that affect behavior. This understanding of communication leaves little room to investigate the larger social, cultural, and historical context in which communication practices are embedded. This chapter offers a critique of health communication studies’ current approach to understanding communication in the doctor-patient relationship and informed decisionmaking in contemporary patient care.

Chapter four: “Be a good patient!”and other stories of medical paternalism, 1930-1969

Chapter Four analyzes normative expectations of the doctor-patient relationship between 1930 and 1969 to determine whether the empowered patient-as-consumer paradigm existed before the 1960s cultural changes revolutionized attitudes about patient autonomy in medicine. Recent historical scholarship in medicine reveals evidence that patients in the era of strong medical paternalism behaved more like active consumers than is conventionally assumed. This chapter’s textual analysis of mainstream magazine articles on health and medicine from before 1969 both confirms and contradicts this literature. My findings indicate that “shopping around” for physicians’ services did occur, at least among patients who could afford to. But shopping around for health care was frowned upon and vigorously discouraged by physicians, hence patients typically engaged in these activities covertly. Consequently, while some aspects of patient behavior before the 1960s could be considered consumerist, my evidence indicates that the patient as an empowered consumer, knowledgeable of her personal rights, was not the normative concept of patienthood. Patient autonomy had yet to penetrate medical ethics and public discourse was largely free of the term consumer or consumerism to represent patients and their health-related activities. An early and significant exception was in the 1930s debate over “socialized medicine” and the issue of universal health insurance. In this chapter I show how the patient was defined politically as a consumer by progressive consumer

groups like Consumers Union to challenge organized medicine in the policy domain. This fell in line with the movement's collectivist vision of consumer citizenship that included health care as a basic right of all consumers.

Chapter Five: “Patient power!”: the patient as health care consumer, 1970-2006

Chapter Five addresses developments since 1970 that have shaped the contemporary understanding of patient-consumer empowerment and how it is exercised. This chapter looks at how the direction of American health care and policy since 1970 has been driven by broader cultural ideas of personal responsibility and the high value placed on information to empower the individual. I examine the cultural, social, epidemiological, and political-economic reasons why the consumer was embraced by bioethicists, feminists, and other progressives supporting patients' rights in the 1970s but has fallen out of favor today among intellectuals on the left (though not among advocacy groups involved in health care activism). I show how the progressive message to take back control over health embodied by the patient-consumer metaphor was going mainstream just as the US was experiencing a vast political and economic climate change that brought conservative politics to power after the mid-1970s. These changes along with an array of developments in the past 40 years—the establishment of patients' rights, the expanding consumer health information environment, the growth of managed care, and, since the early 2000s, increased talk about “consumer-driven” or “consumer-directed” health care coverage

in a “post-managed care” era—have contributed to shifting attitudes for and against the consumer as a metaphor of the patient in modern American health and medicine.

CHAPTER TWO

A Historical Perspective on Consumerism

This chapter turns to the broader social history of modern consumer culture in the United States to gain a greater perspective on the historical developments that produced the patient-consumer metaphor in contemporary health care discourses. I construct an intellectual history that traces the shifting meanings of consumerism, which consumer historians generally agree is a term that tends to trigger competing definitions: “within any given era, ‘consumerism’ has had a plurality of distinct and not always consistent significations: sometimes defined as excessive materialism, sometimes as a political movement of organized consumers” (Glickman 1999, 1). As I shall discuss, a long intellectual tradition exists in the US that defines consumerism as unchecked consumption. This tradition often overshadows an activist interpretation of consumerism as a social movement, which at certain times in contemporary American history has compelled both the state and corporate America to concede more rights to citizens in a market society. By tracing the history of consumerism and its contested meanings, this chapter sheds light on the larger sociohistorical and cultural context of the patient-as-consumer metaphor that has shaped ideas about patienthood in the US since the latter half of the twentieth century.

Defining Consumerism

Historian Lawrence Glickman (1999) has noted that, until the 1970s and 1980s, American intellectual discourse on consumption and consumerism was characterized by a “binarism” that comprised either a moralistic denunciation or a “jingoistic celebration” of consumer society.¹ Consumer scholarship of the 1970s and 80s started to turn away from this binarism. But new research of that period largely focused on popular culture and “consumption’s more visible cultural manifestations—the amusement park, the department store, advertising—attending to the inequalities of power based on class, race, and gender” (Glickman 1999, p. 9).² Health and medicine was not a focus of this early body of work. According to medical historian Nancy Tomes, little research to date has been conducted on the connection between medicine and consumer society (2001; pers. comm. 2005; 2006). Consequently, most existing knowledge about consumerism’s relationship to patients and their medical care comes through scholarship on the civil rights movement, minorities and women’s health, the countercultural holistic health movement, disabled persons’ rights, welfare

¹ See Glickman’s summary points outlining the key events in US twentieth-century consumer history the introduction of Consumer Society in *American History: A Reader* (pp. 1-14), Ithaca, NY, and London: Cornell University Press.

² See Glickman (1999). Strasser, McGovern and Judt corroborate the relative newness of the historian’s interest in consumer society in both the US and Europe. For most of the twentieth century, historians on both sides of the Atlantic were preoccupied with politics and statecraft (1998, 1). The Annales school paid no attention to consumption despite its signature approach to history as one that “attended to the details and mechanisms of daily life in the evolution of economies” (Strasser, McGovern and Judt 1998, 1). Strasser makes an interesting observation that while earlier theorists like the Frankfurt School provided critiques of consumption and mass leisure in Weimar Germany and interwar Europe, none of the theorists offered any detailed historical account of actual consumption practices.

rights, and so on. These movements impacted every facet of American society and medicine as a social institution was no exception.

Literature on consumer culture and history often begins with Raymond Williams' seminal etymology of the word consumer.³ Originally from archaic French meaning wasteful or destructive, as a fire consumes something to exhaustion, consumer's modern usage is rooted in bourgeois capitalism. According to Williams, consumer came to reflect a more abstract economic relationship between producer and purchaser in a more abstract market as industrialization altered the structure of capitalism in the eighteenth century: "In the new predominance of an organized market, the acts of making and of using goods and services were newly defined in the increasingly abstract pairings of *producer* and consumer, *production* and consumption [emphasis in original]" (Williams 1985, 78). The contemporary meaning of consumer arose after 1890 during the period of American-led industrialization that saw bourgeois capitalism transformed into corporate capitalism through the development of mass production and an advertising industry geared to creating consumer desires (versus advertising that provided information on the price and supply of goods). Williams argues that the manufacturing and advertising sectors of the capitalist economy fashioned the modern sense of consumer and the idea of "consumer choice" to generate a perpetual demand by the masses for more consumer goods. Fittingly, says Williams, the term "consumer society" also emerged in this period of capitalist transformation as a critique of "a wasteful and 'throw-away' society" (1985, 79).

³ See, for example, Cohen (2003); Glickman (1999); Sklar (1998); Strasser, McGovern and Judt (1998).

Curiously, Williams does not include a definition of consumerism. According to the Oxford English Dictionary (OED), the word consumerism first appeared in the *New Republic* in 1944 to describe the early cooperative movement in the US. The OED defines consumerism as both the “protection of the consumer's interests” and an economic “doctrine advocating a continual increase in the consumption of goods as a basis for a sound economy.”⁴ The moral consequences of the latter definition, i.e., consumption’s potential for unchecked expansion, has fueled a great deal of critical commentary on consumerism and consumer society.

Critiques of Consumer Culture and Practices of Consumption

Historians of consumer culture by and large agree that consumption itself is an age-old practice but the nature and scope of popular consumption changed with the appearance of mass industrial society. When scholars speak of consumer culture they are usually talking about the society that arose out of late nineteenth century industrialization in the United States. Some historians argue that the social practice of consumption itself has been around much longer and that the roots of contemporary consumer culture in the US stretch back before the twentieth century.⁵ However, consumer historians generally concur that the shift from a producer- to a consumer-centered economy created the basic shape of consumer society as we know it today, i.e., the first mass-consumer society in history born out of the transformation from “simple” or bourgeois capitalism to mass industrialization and the rise of corporate

⁴ Oxford English Dictionary s.v. “consumerism”; see also Swagler (1994).

⁵ See chapters by Jean-Christophe Agnew, Joyce Appleby, and James Axtell in Glickman (1999).

capitalism. This consumer society was firmly entrenched by the 1920s and 1930s, and virtually every facet of American life was reshaped by mass-produced goods.

Since there is plenty to criticize about consumer capitalism, it is impossible to provide in this chapter a comprehensive review of extant critiques. A quick tour, however, shows that critiques proliferated from virtually the moment mass consumer society emerged in the late-nineteenth century. In 1899 Thorstein Veblen published his seminal *Theory of the Leisure Class* that criticizes American elites and their “conspicuous consumption,” which set an ostentatious example few among the lower economic classes could afford to emulate but tried nevertheless, due to the influence of advertising and consumer culture. In 1957, Vance Packard’s indictment of the mass media and advertising, *The Hidden Persuaders*, became a milestone in popular discourse.⁶ Another milestone, Herbert Marcuse’s 1964 *One-Dimensional Man*, introduced “the Frankfurt School of Hegelian Marxism to an emerging New Left” in American academia (Cohen 2003, 10). With *Captains of Consciousness* in 1976, Stuart Ewen injected a New Left critical perspective of consumption in the emergent field of social history (Strasser, McGovern and Judt 1998, 2). In 1978, Christopher Lasch published *Culture of Narcissism*, which determined that consumer culture’s instant gratifications distracted workers from taking action against their own proletarianization. These seminal critiques share what Daniel Horowitz has identified

⁶ It is noteworthy that during the Cold War, American historical scholarship on consumption started out as “consensus” history that celebrated consumerism as the “weapon” to strengthen the American nation and promote its foreign policy agenda (Strasser, McGovern and Judt 1998, 1). David M. Potter’s 1954 book, *People of Plenty*, placed consumption at the core of the American national identity and the source of its wealth and “inexhaustible abundance” (Cohen 2003, 10).

as “the persistent hope among intellectuals that Americans would curtail their spending habits and turn to loftier goals” (Horowitz 2004, 2).

Modern critiques of consumer culture are often conflated with an older, puritan critique against acquisitiveness. Criticism of this nature has been present in American intellectual discourse since the colonial era: “From early in the nation’s history, writers worried about the moral implications of consumers’ self-indulgence and the consequences of changing patterns of comfort and luxury” (Horowitz 2004, 2). Michael Schudson and Daniel Horowitz are scholars whose works address the dominance of the puritan, anti-materialist critique of consumption in the social criticism produced by American intellectual elites. This critique is prescriptive in nature, based on normative notions of culture and values that indicate a conservative (in the original sense of conserving traditional ways) concern for how modern consumer society has altered or obliterated “traditional” American society and culture, traditional in this case meaning early modernity before the advent of consumer capitalism. Both scholars interrogate the critics’ ideas about “good” versus “bad” ways to consume. Palpable in anti-materialist critiques is the sense that there is a right and a wrong approach to consumption, and that a manufactured culture of consumption has foisted the wrong way upon a gullible, vulnerable, or, depending on the critic’s perspective, feckless public. In other words, puritan, anti-materialist critiques share the supposition that there is an artificial versus authentic consciousness about material acquisition. If this is the case, then the question must be asked: who or what

determines the right way to consume if consumer culture creates a false consciousness that supports a wrong way?

Schudson addresses this question in *Advertising: The Uneasy Persuasion* (1984, 9): “Advertising, it is often claimed . . . shapes consumers’ desires and makes them feel a yearning for things they do not really need.” Schudson contends that for the most part people tune advertising out because they recognize it as capitalism’s “propaganda.” Therefore, he questions whether the power of advertising lies less in its obvious intentions—interpreted by cultural critics like Lasch as the drive to seduce the masses into profligacy—and more in its symbolic impact: “Advertising, whether or not it sells cars or chocolate, surrounds us and enters into us, so that when we speak we may speak in or with reference to the language of advertising and when we see we may see through schemata that advertising has made salient for us” (Schudson 1984, 210). In other words, as a capitalist symbolic system, advertising may be more powerful as an influencer of people’s values and attitudes and less successful as a hawk of specific products or brands in the mass media.

Schudson’s argument departs provocatively from conventional criticism of consumerism principally over the question of advertising’s “strong effects” on the public’s morality. Rather than assume that all advertising is harmful, his critique focuses on determining the historical and social factors that need to be present for advertising to adversely impact people. Departing from the standard cultural critiques of consumption, his analysis takes into account the broader sociological reasons for the transformation of the US into a consumer society. Late-nineteenth century’s new

industrial economy supported the growth of a national consumer culture via mass media and a nationwide transportation system. The industrial urbanization of this period unmoored stable social networks that anchored American identity in the values of Protestant Republicanism, as people left rural towns and their traditional institutions of church and family. With the demise of local cultures through social and geographic mobility, Americans turned to the new mass culture to root their sense of self and belonging. In contrast to traditional society in which identities were more or less fixed by relatively immutable social institutions, consumer culture introduced change through the element of individual choice where choice was formerly alien in the lives of ordinary Americans: “With a more mobile society and, to some extent, a more open social fabric, realms in which choice rarely figured become open to individual decision making. Most important decisions—who to marry, what career to enter, what religion to adhere to—become matters of selection,” for better or for worse (Schudson 1986, 154-155). In this way, choice became a tangible concept that pervaded all aspects of American life.

Anti-materialist critics, on the other hand, argue that the acts of choosing a toaster and choosing a spouse are qualitatively different and, hence, consumer choice ought not translate into other domains of life. Further, the question of whether consumer choice converts into authentic choice in domains outside material acquisition becomes irrelevant if, as many critics believe, consumption’s power lies ultimately in its capacity to seduce the masses and divert them from more meaningful practices. Schudson notes that “attacks on consumer culture are often linked with a

critical concern for the growing privatization of life and a decline in concern for the public good” (Schudson 1986, 7). The critics fear that people will become enslaved by material pleasures that cause them to abandon their civic duties, thus hastening democracy’s demise. This is a reasonable worry in a political tradition dependent on “a healthy civic culture,” says Schudson. But whether this fear is justified by a puritan “suspicion of pleasure” is a separate issue, one that empirical research in consumer history has made problematic.

Horowitz indirectly addresses the issue of pleasure by questioning whether ordinary people’s consumption habits are as corrupting or trivializing as the critics presume. In *The Morality of Spending* (1985), Horowitz examines who the critics are and what they assume “bad consumption” looks like. Analyzing how social commentators in the US have talked about consumption from roughly the mid-nineteenth to early-twentieth centuries, Horowitz asks: why do American intellectuals generally view consumption as a “social illness”? Decades before consumption became a mass cultural phenomenon, intellectuals like Francis Wayland, Henry Thoreau, Alexis de Tocqueville, and Daniel Webster were pondering the effects of a higher standard of living on spending habits. Horowitz argues that these antebellum social critics impacted nineteenth century debates over consumption and their influence continues today. Wayland voiced a conservative, Calvinist, bourgeois moralism critical of both the rich and the poor—but especially the poor—for their perceived lack of self-restraint. He feared that, with higher living standards, the working class’s profligacy and the wealthy’s ostentation would threaten social

stability. Thoreau worried about materialism from a romantic tradition that sought harmony with nature through “the simple life.” De Tocqueville offered a social analysis of American mass consumption that included a critique of excessive materialism. Webster contradicted the others by embracing consumption as an outgrowth of progress and morally elevating. Webster aside, all saw rising consumption as a moral threat. But how closely did their perceptions correspond with reality? Apparently, not close enough. The spending habits of workers were far from profligate, as Horowitz shows from his analysis of the 1875 statistics on Massachusetts laborers’ household budgets. Most families could barely scrape by on their incomes, the bulk of which went to food and shelter. Thus, Horowitz demonstrates how early-nineteenth century social commentators were judging poverty as a moral rather than a social-structural problem. These intellectuals never considered how working class’ habits of consumption were informed by a different set of values stemming from different cultural, ethnic, class, and religious traditions, especially in as much as the critics were likely to be middle- to upper-class native-born Protestants while those they criticized were immigrant ethnic Catholics and Jews. Although sympathetic towards labor, Progressive-era social critics still hoped workers would spend their money and time on loftier pursuits rather than patronizing saloons, dance halls, and movie theaters. By the 1920s, a “modern moralism” emerged criticizing mass culture and the new middle class’s consumption habits, replacing the older conservative moralism that was especially censorious of the working class. Modern moralism differs fundamentally from its predecessor because it targets the inhumane

working conditions of a rationalized industrial economy. According to Horowitz, however, it does share with the older critique the puritan hostility towards pleasure and consumption.

Where Schudson questions the anti-materialist critique from a sociohistorical perspective with an emphasis on institutions, and Horowitz dissects anti-materialist moralism through rhetorical analysis embedded in a history of ideas, Colin Campbell (1999) tackles the anti-materialist definition of consumer society by honing in on the nature of pleasure. Schudson has identified the puritan strain of cultural critique as a “bourgeois” critique against consumption in which “Goods . . . should be valued for their capacity to fulfill human needs but they should not be ends of desire in themselves” (Schudson 1999, 346). Campbell also objects to the puritan, utilitarian abnegation of pleasure and argues that puritanism’s legacy in American intellectual discourse obscures the long existence of an “alternative moral tradition” in Western culture, represented historically by Antinomianism and Romanticism, that places the highest moral and aesthetic regard on the emotions and pleasure. Campbell contends that the puritan critique overlooks the ideational dimension of pleasure and its function in consumer culture. Pleasure in the abstract can be present everywhere and in anything, including the emotions, and is not necessarily limited to the “‘baser’ appetites” (Campbell 1999, 23). The “last significant efflorescence” of this tradition was the 1960s counterculture. Counterculturalists, however, tended to adopt the same anti-materialist stance in puritan critiques—even as they defended pleasure-seeking—because they, too, misunderstood the nature of modern consumption as a “magpie-like

desire to acquire as many material objects as possible” (Campbell 1999, 26). Campbell argues, rather, that modern consumption is fueled by the dynamic interplay between imagination and reality along with the desire to experience the new—not for the sake of novelty itself, but for the purpose of encountering pleasure in reality that people have already enjoyed in an idealized form through daydreaming. Whether desire through the imagination is “good” or “bad” for us, Campbell cannot say since delusions can also be pleasurable. But what can be said is that both self-interest and idealism operate in consumer society. In this respect, consumption is morally no different than other modern social practices (Campbell 1999, 30).

Campbell’s analysis contributes to understanding modern consumption from outside the puritan intellectual critique of consumer society. His analysis accounts for pleasure and the heterogeneous nature of consumption but does not consider issues of power and class that are the focus of structural critiques of consumerism. In critiquing the critics, Schudson identifies two “anti-bourgeois” critiques, Marxist and aristocratic, that are similar only in that both are against bourgeois values and are rooted in class consciousness. The Marxist critique criticizes production in terms of justice for workers. The aristocratic critique, on the other hand, targets the objects of mass production from an aesthetic perspective, i.e. “mass produced goods are ugly” and do not conform to the elites’ sense of Culture (Schudson 1999, 342). Schudson objects to the aristocratic critique’s “anti-democratic bias” and its rejection of mass-produced goods in the name of beauty and taste (Schudson 1999, 352). He supports the Marxist focus on social justice but is critical of anti-materialist moralists like

Lasch when they “bootleg” the Marxist argument to forward their theories about consumerism as the opiate of exhausted, politically incapacitated workers. For Schudson, a Marxist critique differs fundamentally from an “anti-materialist Marxist” critique of consumer society because the latter assumes that Marx differentiated between artificial and necessary needs, i.e., that Marx held a purely utilitarian concept of goods. However, Marx’s sole criterion to distinguish material necessities from luxury goods is class, not utility—luxury goods are any goods consumed by the rich. In contrast, anti-materialists consider superfluous any consumption that is unnecessary to sustaining life. But this argument fails to account for the fact that human needs are both biological and social. Thus, there will always be the question of who or what determines the use-value of goods.

Schudson’s, Horowitz’s, and Campbell’s respective works could be considered representative of what Horowitz calls a new “post-moralism” in studies of consumer culture that rejects “the puritanical strain among American cultural critics” and their “top-down approach that emphasized unitary understandings of the meaning of goods” (Horowitz 2004, 255-256).⁷ Indeed, historical scholarship since the 1980s yields a decidedly more complicated picture of the human costs of consumption as well as the benefits. Elizabeth Ewen’s (1985) and Kathy Peiss’s (1986) respective studies on

⁷ In questioning moralizing critiques of consumption and coining the post-moralist term, Horowitz states that his intention is not to denigrate the necessity of making moral judgments or to imply that there is nothing to criticize about consumer culture: “We all do and should make moral judgments. Yet some moralism I find problematic because it seems to rest more on self-righteous judgments of people who are simply struggling to make ends meet than on an engagement with the moral implications of social conditions and analysis” (Horowitz 2004, 3). He points to the perspectives of Michael Harrington, Rachel Carson, Betty Friedan, Martin Luther King Jr. and, more recently, Juliet Schor and Eric Schlosser, as examples of moralism grounded in successful social critique.

working class immigrant women in the early twentieth century reveal complex socio-economic and cultural factors underlying their consumption practices. Consumer culture imposed new economic constraints on working women while offering new personal freedoms and independence for women non-existent in traditional society. The industrial economy liberated women from domestic drudgery and servitude by creating free time for women outside of work (although family obligations often consumed their off-hours). Commercialized leisure also gave working women a measure of freedom, though this was circumscribed by their low income. Lacking money, many single working women practiced “treating” in which they exchanged sexual favors for leisure activities they could not afford.

William Leach (1994) provides evidence of women’s importance to the history of the department store both as clients and employees. Department stores took care of their female clerks relatively well compared with the brutal working conditions in factories. Nevertheless, their wages remained low and they could not afford what they sold to their middle-class sisters. Leach casts a critical eye on the production side of consumption: it was no coincidence that the factory and the department store rose to form the twin institutional pillars of consumer society as the dehumanizing practices of the shop floor were increasingly hidden away from retail shoppers. Leach finds in the Wanamaker archives evidence that John Wanamaker pioneered the practice of removing the shop floor from the retail side of the “dry goods and sundries” business to make the shopping experience more attractive to customers. Thus, the department store was not an “organic” social institution but was created to advance profits through

mass consumption. Ewen and Peiss, too, are critical of the hidden costs of production for workers, especially women. However, they recognize from a feminist perspective that women have also benefited from mass consumption by forging new freedoms out of consumer culture.

This section has focused on untangling the critiques of consumption to gain a better understanding of the ways consumption has been studied and discussed in American scholarly discourse. In the next section, I present a brief history of consumerism as a social movement that emerged in the early decades of the twentieth century.

A Brief History of Consumer Activism in the US

The anti-materialist critics overlook the history of consumerism as a social movement when they insist that consumerism creates an “ethos of consumption” that causes people to invest their energies in acquiring goods rather than in authentic and meaningful social relations and political participation. At various times in the past century, consumerism spurred ordinary Americans into organized action against both business and the state in their interests as consumers and citizens. Consumerism as a political weapon has been deployed in radical social struggles such as workers’ rights, women’s liberation, and the civil rights movement. These social movements depended on an interpretation of consumerism quite different from the puritan, anti-materialist definition. Health care rights were intrinsic to these causes, particularly in the 1960s: “Demands for consumer control and consumer rights, which took hold in the health

care field in the late 1960s, were initially seen as an avenue for meeting the needs of the poor and ethnic minorities” (Ruzek 1978, 181). The new historical research on consumerism points out the different understandings of consumption by different publics within the larger polity: groups such as working class immigrants, female factory workers, middle-class housewives, African Americans, and others have mobilized politically to fight for their interests as consumers which, especially in the case of African Americans and the poor, are entwined with issues of respect and social justice. The history of consumerism as a social movement presents the complex ways class, gender, and race play out in modern consumer society, how sometimes consumerism produces powerful social reforms while at other times results in virulent regressive actions against groups, such as African Americans and immigrants, singled out to be excluded as consumers and citizens. Rather than an ethos of consumption conceived along puritanist lines, it has been argued that the history of “political consumerism” in modern American society represents an “ethics of consumption,” or consumer ethics, that builds its successes on the enlistment of personal responsibility for the greater good and social justice (Micheletti 2003). Moralists lament that the culture of consumption lacks these key civic virtues, yet evidence from American social history can be found to contradict this interpretation. On the other hand, historians have shown that even during the most radical period of political consumerism in the 1930s, ideological fissures already present within the consumer movement itself splintered the movement between those focused on protecting consumers as individuals in their personal shopping decisions versus those who saw

consumers as social individuals who were on “the leading edge of a revolutionary social movement” (Glickman 2001, par. 17). Consumerism, in short, “is an essentially contested concept” historically contingent upon the sociopolitical factors that shape the *zeitgeist* of a given era. The social history of consumption opens up space to rethink the dominant critique of consumerism in American intellectual discourse. It provides different ways to think about the tension between individual and collective interests and opens up a historical perspective on how ordinary Americans with no access to formal political power have exercised their collective will in a strong market society with a weak tradition of social citizenship.

Historians of consumer society generally identify three eras in the history of consumerism as a social movement, described by Lizabeth Cohen as “first-,” “second-,” and “third-wave” consumerism (Cohen 2003). The emergent consumer in the first-wave consumerism of the Progressive era represented “the development of a new understanding of market relations” (Strasser, McGovern and Judt 1998, 12) that structured not only the economic imagination of capitalists but the political and moral imagination of Progressive social reformers such as Florence Kelley of the National Consumers’ League (NCL). The NCL was one of the earliest and most powerful lobbying groups working on behalf of non-unionized, unskilled workers during the Progressive period. In her study of the NCL’s historic “White Label” campaign (1899-1906), Kathryn Sklar (1998) shows how Kelley absolutely saw the consumer campaign to promote fair wages and safe working conditions for women and children garment factory workers as a moral crusade against exploitative industrial practices

that contradicted Christian values. Kelley and the NCL deliberately adopted the term consumer, as distinct from buyer or purchaser, to cement the economic and moral connection between producer and consumer in the minds of middle-class women who bought white muslin undergarments with the NCL's label of approval: "For [Kelley] and for the league, knowledge of the centrality of consumers to the economic marketplace was valuable for one reason and one reason only: as a spur to moral action" (Sklar 1998, 27). Progressive era social reformers like Kelley displayed a singular astuteness by harnessing the economic power of consumer choice to their crusade to cultivate ethical consumption among consumers. As the White Label campaign educated more middle-class shoppers to exercise moral choice in their consumption of manufactured goods, Kelley believed that with this new-found knowledge came responsibility. As Sklar quotes Kelley from a 1901 NCL publication, "We can have cheap underwear righteously made and clean; or we can have cheap underwear degradingly made and unclean. Henceforth, we are responsible for our choice" (Sklar 1998, 27). Sklar describes the ideological and moral impetus behind the White Label campaign as an "informed morality" that aimed to stir outrage in middle-class consumers against household goods produced under vile factory conditions and to encourage socially responsible consumption. The success of the White Label campaign between 1899 and 1906 in numerous cities throughout the US indicated that Kelley's message of informed choice and personal responsibility as the basis for ethical consumption struck a chord with consumers at a time when American society was experiencing upheavals created by the rapid transition to a consumer-centered,

corporate capitalist economy. Kelley's vision "linked the White Label campaign with nineteenth-century reform traditions that emphasized the relationship between personal conscience and social salvation" (Sklar 1998, 27). For Progressive reformers like Florence Kelley, the conflation of moral responsibility with consumer choice was necessary and unproblematic.

The NCL's consumer movement displayed the sociological characteristics of the Progressive era's reforms, namely, a movement based on middle-class values that mobilized mostly white women who stoked grassroots support particularly among housewives, and who formed alliances with labor to abolish exploitative labor practices. The NCL bolstered women's public culture by raising their political prominence and clout as middle-class reformers and worker activists. However, in borrowing the label tactic from union workers, the NCL was also tapping into a distinctly racialized idea of an "American standard of living" that improved conditions for white women and children but did nothing for African Americans and other racial groups. African American women, for example, typically were excluded from jobs supported by the NCL in department stores and the garment industry. In this way, "the White Label campaign reinforced racial distinctions at the same time that it improved working conditions for white women and children" (Sklar 1998, 22). Nonetheless, the seeds of subsequent consumer social movements were sown in first-wave consumerism: the strong presence of women; consumerism's complex relationship to race; the economic power of consumer choice; the political mobilization of individual responsibility and morality for a larger collective cause; the connection between

consumption and production; and the power of consumerism to support progressive labor practices and greater workers' rights. The contours of the informed consumer model in later consumer movements were beginning to take shape during this period. Some scholars, however, have observed that to say this early consumer carried a consumer consciousness or was cognizant of consumer's interests would be an exaggeration as the nascent consumerism of the time was rooted in the "Progressive theme of the 'people' versus the 'special interests'" and "To the extent that people were beginning to recognize their distinct political interests as consumers, it was part of a more basic and in some ways reactionary critique of industrial capitalism" (Mayer 1989, 18). All the same, the first wave consumer movement managed to pass important consumer protection laws such as the Pure Food and Drug Act (1906), the Meat Inspection Act (1906), and anti-trust legislation in the Federal Trade Commission Act (FTC) of 1914.

If first-wave consumerism was characterized by social reformism through mobilizing personal moral action, second-wave consumerism, which lasted from the late 1920s until the end of World War II, was distinguished by "consumer citizenship." During the Depression, this model represented the growing centrality of consumption to the state as a tool for nation building. In this period the figure of the consumer transformed from a moral crusader into a citizen consumer, and consumption under the new paradigm became an entitlement of citizenship guaranteed by the state. According to Lizabeth Cohen and Charles McGovern, two types of consumerism developed during the 1930s: the "citizen consumer" (Cohen 2003), or

“consumer republicanism” (McGovern 1998), which signified the political power of consumerism and was the model for consumer movements during the Depression era, and the “purchaser consumer” or “corporate consumerism,” adopted by FDR’s New Deal administration to justify Keynesian economics and the aggregate economic power of consumers. According to McGovern, the language of consumer republicanism and of corporate consumerism both appeared first in the 1920s in the public discourses of two professions that emerged from mass consumer society: advertising and product-testing. By using political language and the electoral metaphor, McGovern argues that advertising in the 1920s tightened the connection between citizen and consumer, creating a public discursive environment that naturalized the association between politics and consumption for ordinary Americans. Advertising, for example, urged consumers to “vote” for their favorite consumer products to show brand-name loyalty. Voter sovereignty became associated with consumer sovereignty and citizens were encouraged to exercise their “franchise” by purchasing freely and often. McGovern labels this economic mode of consumer citizenship “corporate consumerism” because business favored this language in their efforts to expand profits. Consumer republicanism, on the other hand, rose out of independent product-testing discourse and was grounded in Jeffersonian ideals of citizenship and individualism. The ideas of consumer republicanism were “in some measure a response to national advertising, but they were grounded in long-standing popular suspicion of artifice, hostility to corporations, and a strong bias for the utilitarian and instrumental” (McGovern 1998, 51). Central to this model was the

informed citizen consumer who makes discerning choices in the marketplace independent of corporate manipulation. The electoral metaphor operated differently in consumer republicanism; i.e., if consuming were like voting, then the state must ensure that the process is “free and fair” for Americans to make independent and informed decisions. Lawrence Glickman’s study of the 1935 strike at Consumers’ Research (2001), the first and leading consumer advocacy and product-testing organization established in the late 1920s, shows how the ideals of consumer republicanism splintered into two factions as the consumer movement matured. One faction organized as Consumers Union and continued the Progressive tradition of consumer social activism on behalf of workers. The remaining group at Consumers’ Research concentrated on “individualist consumerism” by continuing to focus strictly on arming consumers with the necessary knowledge to make informed purchasing choices. The schism in the “temple of consumption,” as one trade journal dubbed Consumers’ Research, held repercussions for the political direction of consumerism as the movement matured and also for the larger arena of social activism in post-World War II American culture.

The two models of consumerism that emerged from 1920s advertising and product-testing discourses capture the changing relations between citizen, consumption, and the state that followed in the 1930s. Lizabeth Cohen (1999) shows how these ideas were cemented by the Great Depression’s social, economic, and political impact on American society. Contrary to conventional consumer history that looks at periods of economic growth to explain the expansion of the modern mass

consumer economy (i.e., the 1920s and 1950s), Cohen argues that consumerism became entrenched in American society not in the good times of the 1920s, but in the bad times of the 1930s. She argues that the New Deal state utilized consumption as a means to secure capitalism from the threat of socialism during a period of economic contraction. This threat was more real during the 1930s than at any time before or since. For example, Glickman shows how the era's left-leaning thinkers believed in the radical potential of consumerism to reorganize society:

The 1930s was perhaps the only decade in American history when commentators could speak of 'consumer society' as a potentially radical force; in the mid-1930s J.B. Matthews, using a term that we today take to be synonymous with the interests of hegemonic, global, corporate capitalism, defined a "Consumers' Society" as an 'alternative to the regency of business. (Glickman 2001, par. 8)

Intense grassroots participation in consumer organizations, cooperatives, and boycotts across the country in the 1930s bolstered this belief that the consumer will break the power of business in America.

In her book, *A Consumer's Republic* (2003), Cohen discusses how Franklin Roosevelt's New Deal government turned to consumption to pull the nation out of its economic mire. The notion of consumers' interests became a way for government to articulate a common good that can justify state intervention on behalf of ordinary people who, as citizen consumers, deserved strong social policies aimed at protecting their interests: "By the end of the depression decade, invoking 'the consumer' would become an acceptable way of promoting the public good, of defending the economic rights and needs of ordinary citizens" (Cohen 2003, 23). In the name of consumers' interests, many federal government organizations were prodded by a combination of

Washington lobbyists, consumer activists, and policymakers, with the blessings of Roosevelt's administration, to expand social goods to benefit more ordinary Americans. Notable examples include the establishment of the Rural Electrification Administration in 1936 to bring electricity to rural America; the offering of affordable housing loans through the Federal Housing Administration and the Home Owners' Loan Corporation; the guaranteeing of bank deposits through the Federal Deposit Insurance Corporation; and the passage of the Social Security Act in 1935. The glaring exception was health care, which the American Medical Association fought hard to block and succeeded. The model of consumer citizenship also established the principle that citizens have a right to a decent standard living so they can afford to participate in the market. To this end, organized labor received a boost when the Roosevelt administration passed the National Labor Relations Act in 1935 "that recognized workers' right to organize and bargain collectively" (Cohen 2003, 32). This legislation proved to be a major factor in the expansion of private health insurance after World War II when unions seized upon this right to bargain for greater coverage of workers and their dependents (Starr 1982; Mayes, 2004).

The New Deal's success in establishing a quasi-welfare state (minus the critical component of nationalized health insurance) overshadows the fact that Roosevelt also opened the way for the purchaser consumer to gain a foothold in the American economy. The roots of the purchaser consumer model lie in Keynesian economics. The Depression forced the state to institute Keynesian economics, which challenged classic economics' idea that the state play a minimal role in regulating free

market enterprise. The Keynesian premise was that the economy will be saved not by helping businesses produce more by producing more efficiently, but by increasing demand for their products through mass consumption. This model stressed the aggregate purchasing power of consumers and the resulting benefits to the greater society: “purchaser consumers were viewed as contributing to the larger society more by exercising purchasing power than through asserting themselves politically” (Cohen 2003, 18-19). Suspicious of increased government activism and spending, business nevertheless supported Keynesian economic policy under the premise that a citizenry satiated by consumer comforts was less apt to mobilize politically. The upsurge in grassroots consumer activism nationwide in the 1930s stirred business’s anxieties, making the sector prepared to adopt any means to kill what they perceived as the growing “communist” threat.

Second-wave consumerism, says Cohen, was a bona fide social movement that included the interests of social groups with poor political representation, such as women and African Americans. As in the Progressive era, women were prominent “as guardians of the public welfare” (Cohen 2003, 34) and female activists built a nationwide network of women’s consumer advocacy organizations, such as the 15,000 member strong American Home Economics Association. The spirit of the National Consumers League remained alive through groups such as the League of Women Shoppers, founded in New York in 1935, that supported workers’ strikes through boycotts and sympathy picketing. In addition to these mainly middle-class women’s organizations, thousands of women from different socioeconomic strata across the

country participated in consumer protests such as the 1935 meat boycotts that successfully shut down the retail butcher trade and wholesale meatpacking industries. These boycotts drew legions of women “more diverse in class, race, ethnicity, and political orientation than the women generally attracted to the established consumer groups” (Cohen 2003, 36). Grassroots alliances between the races were formed when African American women participated in the meat boycotts. According to Cohen, African American women were particularly effective in protests against unfair meat prices as they were already veterans of the “Don’t Buy Where You Can’t Work” boycotts of white-owned businesses in their own communities.

Consumer activism was a powerful weapon for economically disenfranchised African Americans in the 1920s and 1930s. African Americans suffered disproportionately high unemployment, which meant traditional labor unions did not help their situation (Byrd and Clayton 2002; Cohen, 2003). Consumer activism was the weapon of choice for a community long disenfranchised by white society. Blacks in the South protested the imposition of segregation laws through massive boycotts in the late nineteenth and early twentieth centuries. Beginning in the late 1920s, urban African Americans in the North organized successful “Don’t Buy Where You Can’t Work” boycotts that began in Chicago and spread to other major cities across the country. Although the campaigns created thousands of jobs, the downside was that hundreds of thousands of African Americans needed work. According to Cohen, the larger impact of the “Don’t Buy” boycotts was symbolic: “this very visible strategy had enormous symbolic impact. People became convinced that African-American

purchasing power truly meant power, and other efforts to tap it emerged. Most notable was a resurgence of interest in founding black businesses and a renewed confidence that black consumer spending could keep them viable” (Cohen 2003, 47). The boycotts inspired the growth of black businesses in Northern cities during the Depression despite widespread unemployment and poverty among African Americans.

Second-wave consumerism petered out as the purchaser consumer overshadowed the citizen consumer during the post-war economic boom. Grassroots consumerism faded away except within the African American community, which resorted to local-level consumer boycotts and protests throughout the 1950s. Black consumer agitation in the post-war years culminated in the Montgomery bus boycotts and lunch sit-ins of the late 1950s credited for launching the civil rights movement. The rest of America devoted itself to fulfilling the Depression-era vision of a Consumers Republic by buying consumer goods in greater quantities than ever before as the market and the middle-class expanded. Consumption during this period melded with Cold War politics and became a patriotic duty for the greater good of building a strong postwar nation: “Mass consumption in postwar America would not be a personal indulgence, but rather a civic responsibility designed to provide ‘full employment and improved living standards for the rest of the nation’” (Cohen 2003, 113). Not until after Kennedy declared a “Consumers Bill of Rights” in 1962 did political consumerism return as a full-blown consumer protections movement that contributed to transforming the American social landscape.

After the dormant 1950s, third-wave citizen consumers turned to the state once again to guarantee their interests and, as in the New Deal, the state turned activist on their behalf by toughening regulation of product safety and industry standards. The Great Society passed laws in the consumers' interest that far surpassed what was politically achievable during the Great Depression: "between 1967 and 1973, more than twenty-five major consumer and environmental regulatory laws passed, and hundreds remained under consideration. Regulation likewise increased noticeably. . . . Between 1970 and 1975 alone, expenditure by US federal agencies on "economic" regulation grew 158 percent, from \$166 to \$428 million" (Cohen 2003, 357). But for all its achievements, third-wave consumerism experienced notable failures; for example, the tobacco industry eluded regulation while the "100 most concentrated industries" targeted by the Consumer Federation of America in 1973 escaped anti-trust busting. The third-wave consumer movement came close to but failed at establishing a permanent, high-level consumer agency or department in the federal government, a dream of consumer activists since the New Deal era. In 1968, the federal government established the Consumer Protection and Environmental Health Service as an agency in the U.S. Department of Health, Education and Welfare. A few years later the Environmental Protection Administration evolved from this agency while consumer protections migrated to the Office of the Secretary of Health, Education and Welfare under a new sub-agency called the Office of Consumer Affairs (Cornacchia 1982, 3). The White House under Nixon and Ford showed no interest in supporting legislation introduced in 1973 to create a higher-level consumer agency. By the mid-1970s, the

political climate began to turn against political consumerism as business groups such as the Chamber of Commerce, the National Association of Manufacturers, the National Federation of Independent Business, and the Business Roundtable (founded in 1972) lobbied militantly against what they experienced as the “destructive tidal wave” of the consumer protections movement (Cohen 2003, 362).

Much as the Depression influenced second-wave consumerism, third-wave consumerism emerged in the 1960s when new demographic, technological, economic, political, and cultural factors shaped in the aftermath of World War II caused large scale changes in the structure and culture of American society. Sociopolitical developments that impacted third-wave consumerism include the new business practice of market segmentation, its influence on the evolution of interest group politics, and a new militancy in activism of every stripe. Ralph Nader and his Public Citizen organizations became the most formidable consumer watchdog over Washington and corporate America; Nader was the most public face of consumerism’s “explosion of organizations on the national, state, and local levels” (Cohen 2003, 364). Organized labor was a main supporter of the consumer movement as were older consumer groups such as the National Consumers League and Consumers Union. Both organizations continued their longstanding commitment to fair labor standards but also reconstituted their mandates to focus on consumer protections as much as worker protections, in line with the mainstream consumer movement. Mainstream consumer activism centered on acquiring more safety standards and fair pricing in the market, following more or less the product-testing tradition of Consumers’ Research that

distanced itself ideologically after 1935 from the then renegade, pro-labor Consumers' Union. Consumers Union in the 1950s and 1960s continued as a respected voice in product-testing and consumer safety advocacy, reaching a wider and wider audience through its flagship publication, *Consumer Reports* (Silber 1982). Elizabeth Cohen contends that the sixties' militant zeitgeist created crossover in political tactics between mainstream and more radical consumer groups. For the most part, radical politics played a minor role in influencing mainstream consumerism, but radical activism co-opted consumerist tactics to great success, as in the 1965 national grape boycott organized by César Chávez and the National Farm Workers Union on behalf of migrant laborers. Nowhere is the crossover between the militant and mainstream arms of the Sixties consumer movement more evident than when Nader served on Consumers Union's board of directors for eight years starting in 1967. Nader resigned in 1975 over his dissatisfaction with the organization's advocacy goals and tactics, which he considered too middle-of-the-road (Consumers Union 1975; Silber 1982).

In the civil rights movement, women and African Americans once again played momentous roles in consumer grassroots activism while the poor or low-income consumer became a new constituency in third-wave consumerism. Felicia Kornbluh's work on the welfare rights movement, coordinated by the National Welfare Rights Organization between 1966 and 1973, illuminates how consumer activists fought for the rights of poor people to decent living standards and to apply for consumer credit (Kornbluh 1997). Nowadays easy consumer credit is a serious problem causing the largest ballooning of personal debt in American history, but in the

1960s consumer credit was off-limits to low-income earners and those on welfare. The low-income consumer fought for these middle-class entitlements as a matter of respect as well as economic freedom.

Third-wave consumerism declined in the mid-1970s due to new sociological factors born out of the previous decade's massive social upheavals. Although grassroots support of consumer activism was strong, it was difficult to marshal consumers as a broad-based group due to the emergence of interest groups and, according to Cohen, the phenomenon of "narrow-cast marketing" in the media that contributed to splintering the movement into segments focused narrowly on female consumers, black consumers, working-class consumers, and so forth. In addition, factors such as inflation, the rise of neoliberalist economic policies after the mid-decade, and mainstream political culture's growing conservatism contributed to ending in many ways the most significant mass consumer movement in contemporary American history.

Health and Medicine from a Consumer Perspective

The connection between health and medicine and consumerism as a consumer protections movement can be traced through popular publications on health and product safety dating to the 1920s and 1930s. Frederick J. Schlink and Arthur Kallet, the founders of Consumers' Research, published in 1933 the bestseller, *100,000,000 Guinea Pigs: Dangers in Everyday Foods, Drugs, and Cosmetics*. In 1934, Mary Catherine Phillips published *Skin Deep: The Truth About Beauty Aides, Safe and*

Harmful. In 1935 Schlink followed up the success of *Guinea Pigs* with *Eat, Drink and Be Wary* that scrutinized the food industry over food adulteration and inspection methods. *Good Health and Bad Medicine* published in 1940 by Harold Aaron, chief medical advisor to Consumers Union, was a popular self-help handbook that dispensed advice on commercially available drugs to use or avoid in the treatment of everyday ailments. Mary Phillips published in 1948 *More Than Skin Deep*, a sequel to her first book on the cosmetics market. In 1958 Richard Carter's *The Doctor Business* critically examined the high costs of medicine and its impact on consumers. In 1961 Consumers Union published the first of its anthologies of popular health and medical articles from *Consumer Reports* under the title *The Medicine Show*.

In academic literature, Haug and Levin's 1983 *Consumerism in Medicine: Challenging Physicians Authority* uses consumerism as the framework through which to appraise power in the doctor-patient relationship. They argue that consumerism has helped patients to upset the balance of power in the doctor-patient relationship; however, Haug and Levin offer no historical insight on how and why consumerism came to represent patients in their drive for greater rights. According to Nancy Tomes, there are few examples of research in the vast history of medicine literature that directly address consumer history and health care consumerism. Noteworthy works include Rima Apple's *Vitamina: Vitamins in American Culture* (1996), a look at how vitamins became important in American culture through the interplay of science, politics, advertising, and consumer advocacy, and a number of Tomes' own works cited in this chapter and especially her work on patients rights in the mental health

movement (1999). Though not explicitly about consumer culture and medicine, works such as Steve Epstein's *Impure Science* (1996) and Barron Lerner's *The Breast Cancer Wars* (2001) trace the history of patient-consumer advocacy around specific diseases.

On the paucity of scholarship in consumerism and medicine, Tomes contends that part of the reason could be that the "canonical" history of medicine literature is doctor centered. The works of David Rothman, Charles Rosenberg, Paul Starr, and Rosemary Stevens, for example, focus on the institution of medicine and the professional dominance of doctors but do not take into account the patient's influence in shaping medicine in American consumer society (Tomes 2001, par. 3). Considering medicine in the context of consumer history can shed new light on the way patients have affected medical care. For example, Tomes argues that consumer culture establishments such as department stores, movie theaters, and hotels cultivated a new customer satisfaction ethos in the early-twentieth century that raised middle-class patients' expectations for personal comfort and service, which contributed to heightening the demand for greater quality of clinical and hospital care (Tomes 2001, par. 22). Tomes speculates that another reason scholars have been slow to study medicine through consumer history could be due to the American Medical Association's (AMA) success in disassociating medicine from commercialism in the early decades of the twentieth century. Medicine has had a long association with consumption and consumerism, first through advertising and later through the consumer protections movement. For example, Apple's study (1996) of vitamins as a

dietary supplement underscores the lengthy history of health marketing and advertising in the US as the patent medicine industry was one of the first to distribute and market its products nationally. The AMA regarded much of patent medicine advertising's "gaudy images and extravagant claims . . . a dangerous form of charlatanism" (Tomes 2000, 9) and it waged a successful war against the patent medicine industry through professionalization that distinguish scientifically trained doctors from the quacks and snake-oil salesmen that abounded in the health marketplace. The AMA became a natural ally of the consumer movement and collaborated with consumer advocacy groups to form the FDA in 1906 and the FTC in 1914.

Advertising's link to health care has been important, though problematic, to one of the oldest forms of medicine, self-care. As the consumer society matured in the 1930s, a thriving self-care industry emerged in the form of over-the-counter pharmaceuticals and all kinds of medical devices and health paraphernalia. The self-care market boom happened in the pre-health insurance era when patients paid out-of-pocket to see the doctor and the ensuing costs catapulted medical care into the category of a "luxury good." Since two-thirds of Americans could not afford to see a doctor, the emergence of new but expensive therapies as a result of rapid scientific discoveries escalated health disparities between the medical haves and have-nots during the interwar years: "the proliferation of effective but expensive hospital treatments—the tonsillectomies, appendectomies, and painless childbirths—accentuated the dire consequences of an unequal distribution of medical resources"

(Tomes 2001, par. 26). In 1928, the Hoover administration established the Committee on the Costs of Medical Care (CCMC) to determine how much Americans were spending on health care. The CCMC discovered that the wealthiest 10 percent accounted for 30 percent of spending on doctor's visits and drugs. The Depression worsened the already vast gap in medical care access between the affluent and the lower income classes. The AMA, however, vigorously disputed the CCMC's findings to strike down the efforts of labor, public health activists, consumer groups, and progressive policymakers to include a national health insurance plan as part of the New Deal. Concerns about the under consumption of basic medical services during the Depression fueled a new consumer activism in health care led by organizations such as Consumers Union and the National Consumers League. Where historians generally view the battles over health care during the New Deal as "evidence of the growing political power and conservatism of the AMA," Tomes argues that "interwar reformers' efforts to convert the new medicine from a luxury good to a basic necessity of modern life can also profitably be viewed as incubators for a new kind of consumer-oriented health activism" (Tomes 2001, par. 29). Though welfare reformers failed to win legislation for a national health insurance plan as part of the New Deal, they did succeed in raising health care as a consumer concern and legitimating consumers' interests in health and medicine as significant policy issues.

The Origins of the “Empowered” Patient-Consumer

Although the concept of consumer emerged in the 1920s and 1930s, it is hard to find scholarship that pinpoint when the word consumer became interchangeable with patient and why this linguistic correlation has become practically ubiquitous in recent decades. The health sociologist Leo G. Reeder was one of the earliest scholars to call attention to the connection between consumerism and the expansion of patients' rights at the end of the 1960s. In a 1972 article, he identifies “the growth of consumerism as a social movement” (Reeder 1972, 407) as one of three sources of structural changes in medicine that had begun to shift more health care control away from physicians into the hands of patients in the late 1960s. The other two developments were the increased focus on preventive care and the rise of medical services provided through bureaucratic institutions. Reeder lists a number of key developments led by consumer advocacy organizations and activists in the late 1960s-early 1970s that contributed to the growing prominence of the consumer in all facets of American society:

Indeed, it is now generally recognized that we are in the early stages of the “age of the consumer.” On a variety of fronts the voice of the consumer is making itself heard in a powerful way: for example, Ralph Nader is a symbol of the consumer movement; the executive branch of government has the President's Committee on Consumer Interests; the American Federation of Homemakers is prominent in various consumer legal actions; the National Welfare Rights Organization as a consumer group aims to be the spokesman for the welfare poor . . . and in the health field the consumer movement received particular impetus through OEO-sponsored Neighborhood Health Centers. . . . Indeed, the trend toward citizen control of Neighborhood Health Centers is well advanced and sometimes encouraged by officialdom. (Reeder 1972, 408)

Reeder goes on to note the linguistic power of the word consumer to change the relationship between professionals and their clients when the client adopts the consumer label:

The mere use of the term “consumers” to replace “clients” initiates a different perspective. . . . As a client, on the one hand, the individual delivers himself into the hands of the professional—who presumably is the sole decision-maker regarding the nature of the services to be delivered. On the other hand, when the individual is viewed as a consumer, he is a purchaser of services and tends to be guided by *caveat emptor*. . . . The social construction of the relationships becomes redefined by virtue of the realities imposed in the bargaining and negotiating between client-practitioner versus consumer-provider. (Reeder 1972, 408)

Reeder hypothesizes that because the patient-consumer’s power lies chiefly in “the expression of satisfaction and dissatisfaction” with the medical system, consumerism will contribute to more “citizen participation in health care” as more research will be devoted to discovering how patient satisfaction or dissatisfaction affects the quality of care and the nature of provider-client relationships in increasingly bureaucratic health care settings (Reeder 1972, 410).

If Reeder’s stance on consumerism’s effects on medicine does not sound suitably cynical or critical enough for our times, this could be because consumer as a figure of speech seemed, on the whole, less problematic and potentially more liberating back in the early seventies. George Annas, renowned bioethicist and medical legal expert, is currently one of the sharpest critics against conflating patients’ rights with consumer rights. Yet, as I shall discuss in more detail in chapter five, he himself used the term “patient-consumers” (Annas 1975, 3) explicitly in his opening chapter on the patients’ rights movement when he wrote *The Rights of Hospital*

Patients, published in 1975 by the American Civil Liberties Union as a self-help handbook to inform patients of their rights. Indeed, I have found that, generally, the word consumer has been used in more ambivalent and contradictory ways in intellectual discourses than in popular usage or consumer advocacy discourse,⁸ sometimes by the same author and within a single piece of work. This is evident in some of the literature on the women's health movement and its considerable contributions to the health care rights of women and all patients. Sheryl Burt Ruzek begins her 1978 book, *The Women's Health Movement: Feminist Alternatives to Medical Control*, by attributing the public's growing assertiveness against professional paternalism of all kinds to the success of social movements led by "organized consumer groups": "Disinclined to obey professionals simply on faith, clients openly challenge professionals, arguing that they can evaluate advice and make crucial decisions about their own lives. Many of these challenges to professional authority come from organized consumer groups" (Ruzek 1978, 1). Five pages later, Ruzek uses "consumer movement" as a generic term to describe disparate groups in the American public striving for greater social justice:

In the past decade, organized clients have expressed dissatisfaction through varied consumer movements: women, students, minorities, service workers, and some segments of the educated elite who are concerned with 'public interest' issues (for example, Nader's 'raiders'). Gartner and Riessman (1974) view these groups as a consumer vanguard—a potentially powerful force in transforming society. Since

⁸ My interviews with representatives from three consumer advocacy organizations confirm that consumer is an unproblematic term for their purposes that represents the interests of ordinary citizens. These groups are the Center for Science in the Public Interest, based in Washington, DC, Consumers Union's health policy division, also in Washington DC, and the Center for Medical Consumers in New York City. All three organizations were founded between 1970 and 1976 (Consumers Union opened its DC health policy bureau in 1973).

many such groups are relatively disadvantaged in American society, they stand to gain considerably by pushing for social change. (Ruzek 1978, 5).

On the next page, Ruzek uses consumer again unproblematically: “Since the mid-1960s, health care consumer and reform movements have grown in several directions” (Ruzek 1978, 6). Throughout her book Ruzek uses consumer often to describe grassroots social movements and as an alternate to patient, especially when discussing patients’ aggregate power to induce change in the health care industry when they express their demands for better procedures and services: “The eagerness of professionals to endorse these new procedures and practices is a good indicator of consumers’ real power in determining how, if not what, services should be available. To a great extent, obstetrician-gynecologists are economically motivated to provide what consumers demand” (Ruzek 1978, 223-224). However, in a subchapter called, “Health: Just Another Commodity?”, a critical perspective appears when Ruzek refers to Barbara and John Ehrenreich’s critique of what they saw back in 1971 as the contradictions of being the patient-consumer in a capitalist health system: “Under capitalism, they argued, health care is transformed into a commodity, but a commodity difficult to ‘purchase’ wisely, for although patients are ‘consumers,’ they have none of the rights or protections that consumers of other goods and services expect” (Ruzek 1978, 63).

Fast forward 20 years to Ruth Rosen’s history of “second-wave” feminism, *The World Split Open: How the Modern Women’s Movement Changed America* (2000), and we see the ambivalence over consumer and consumerism in high relief.

On one hand, Rosen uses consumer to describe a pseudo-feminist discourse created by the advertising industry in the 1970s to sell women harmful products such as cigarettes (referring to the famous Virginia Slims cigarette campaign, “You’ve Come a Long Way, Baby,” launched in 1970) and alcohol, and other money-wasters as the material symbols of liberation and sexual attractiveness:

A flurry of new magazines—New York Woman, Self, Working Woman, to name just a few—appeared during the 1970s, aimed at selling to young working women. Such magazines repackaged feminism into products and services and targeted the working woman, who supposedly needed these things to prosper. This new consumer feminism tended to equate liberation with the purchase of things—liquor, tobacco, vacations, stereos, cameras, and clothes. (Rosen 2000, 312).

On the other hand, Rosen uses consumer to describe the women’s health movement’s successful challenge to medical paternalism by redefining patients as active participants in their own care:

The women’s health movement taught many Americans—not only feminists—to view themselves as medical consumers, rather than as passive patients. Decades later, journalist Sheryl Gay Stolberg wrote in the *New York Times*: “it was feminism, most experts agree, that changed . . . medical paternalism. The 1973 publication of *Our Bodies, Ourselves* by the Boston Women’s health Collective was the turning point. This book taught women to distrust male doctors’ authority.” (Rosen 2000, 178).

That consumer continues to be used in contradictory ways within intellectual circles is not lost on Nancy Tomes. From her study of the mental health movement she provides more evidence that the contemporary notion of patient as an empowered consumer originated in the 1960s and 1970s (Tomes 1999). In recent work she has observed that a “visceral dislike of the term *health-care* consumer” exists among

many medical economists and physicians that is attributable to the growth of managed care in the past 20 years and the ensuing loss of professional autonomy for many physicians under the dominance of this system (Tomes 2006, 83; pers. comm. 2006). Her work confirms that it was indeed “patient activists, not market enthusiasts” who popularized ideas about the empowered patient-consumer back in the sixties and seventies (Tomes 2006, 84), but this history tends to get lost in the current climate in which the managed care industry is as much responsible for messages about making smart choices and being pro-active about health as the American Heart Association or a celebrity fitness guru. Tomes herself sees this current predicament as a shrinking or distortion of what consumer choice stood for in the heady days of the early patients’ rights movement (Tomes, pers. comm. 2006). She writes that the consumer health revolution of the 1960s and 1970s did expand important facets of patient choice, but “their decision making continues to operate within a uniquely constructed, highly specialized marketplace over which they have comparatively little control” (Tomes 2006, 88). This point I shall expand upon in Chapter Five. Nevertheless, consumer and consumerism are terms that continue to elicit in public discourse contradictory and competing assumptions about the choices and limitations realizable in a capitalist society.

Conclusion

This chapter begins to address the complex history behind consumerism and consumption in health and medicine in the US. It aims to untangle the competing and

contradictory strands of beliefs, ideas, and assumptions that form the intellectual history on consumption in American consumer culture. And it lays out the complicated social history that created the conditions for the patient-consumer paradigm to emerge in the latter half of the twentieth century. An important part of this process has been to take a hard look at a particular type of moralist critique of consumption dominant in American intellectual discourses about society. In so doing, my intention is to critically examine the rhetoric of this critique, which tends toward a supercilious tone that contradicts the good intentions of the substance of the critiques. I bring in the latest generation of research on consumer history to show that consumption ought to be interrogated first by considering the social, cultural, and economic contexts of people's lived experiences of consumer society. Until more is known about how everyday people actually engage in consumption and why, we cannot assume people are as gullible or vacuous as they can be made to appear. The analytical issue is to discern the social and human factors that cause people to be susceptible or not to consumer culture's excesses.

CHAPTER THREE

Health Care and the Problem of Communication

Health care in the era of the patient as informed consumer seems intuitively a subject for communication studies. Indeed, the study of communication in health and medicine branched off as its own subdiscipline in the early 1970s, during the same period when social and cultural forces shifted American medicine away from the traditional model of paternalistic practice and ethics to a more “patient-centered” or “consumer-oriented” model of care. Given the importance of health and information in modern society, “health communication” continues as one of the fastest growing specialties in communication studies.

Since health communication has claimed the study of communication in health and medicine as its natural domain, it is necessary to interrogate the subdiscipline’s basic assumptions about communication, health, and health care practices from outside its given maxims. This chapter provides a critical textual analysis of American health communication research published between 1977 and 2006. For my study I selected 50 articles from six main communication journals and the *Communication Yearbook* that I reviewed.⁹ I also reviewed five handbooks on health communication, published between 1990 and 2003, intended for students and practitioners of health

⁹ For my research I have focused on studies of doctor-patient communication and not on other areas of health communication research, such as mass communication in public health, and recent specialties such as risk communication and research on the Internet’s role in health care.

communication. My findings support my contention that health communication as an academic discipline lacks the necessary intellectual and methodological robustness to advance social scientific knowledge and moral-philosophical considerations about the intersections of communication and health practices in contemporary society. I argue that these limitations on health communication's intellectual reach and relevancy result from how the field conceptualizes communication and also the nature of social scientific inquiry itself. Communication has traditionally been theorized as information exchange or transmission along the lines of the sender-receiver/behavioral effects model of communication research. For purposes of this chapter, I call this the "information model" of health communication. This model is a result of health communication scholarship having been under the same grip of positivism that has encumbered the larger communication discipline for most of its history. These problems intrinsic to health communication have historical explanations as to how and why the information model of communication and positivist methodology continues to dominate health communication research and, for that matter, much of mass media, speech, and other areas in conventional communication studies.

If health communication was satisfied with its self-styled status as an "applied" social science, then my critique begins and ends here. My analysis of the literature, however, indicates otherwise. I have come across periodic appraisals of the field's standing as a discipline that indicate some within health communication studies do question the limitations of the dominant approach. I suggest that to credibly engage in larger moral-philosophical debates about the problems in contemporary health and

medicine, health communication needs an infusion of what C. Wright Mills has called the “sociological imagination” (Mills 1959), that quality of social science that produces greater insight into individuals and society through empirical observation grounded in social theory and historical knowledge. Health communication, as it stands now, practices a methodology prone to “abstracted empiricism,” another of Mills’s concepts that I turn to as a guide to assess how communication and health are conceptualized, discussed, and evaluated in health communication studies.

Abstracted Empiricism

In *The Sociological Imagination*, Mills is critical of “methodological pretensions” that threaten to make social scientific scholarship irrelevant (1959, 20). He was targeting sociology as it developed in the 1950s, but his critique is still relevant and extensible to the social sciences in general. Mills identifies two trends, “grand theory” and “abstracted empiricism,” that fetishize different aspects of the work of social science (1959, 50). Both lead to “obscurantist” scholarship, but from different paths: grand theorists start at a level of theoretical abstraction so high as to be unintelligible whereas abstracted empiricists never get beyond their myopic fixation on methods, generating data with no broader conception or theory around which to cohere.

Abstracted empiricists suffer from a “methodological inhibition” resulting from the study of the quotidian from within “the curiously self-imposed limitations of their arbitrary epistemology” (Mills 1959, 55). A slavish preoccupation with “The

Scientific Method” in particular limits the kinds of questions and problems to be studied. This, says Mills, resulted from a misguided belief that social science must emulate the natural sciences in the way it gathers and processes knowledge about the empirical world: “abstracted empiricism often seems to consist of efforts to restate and adopt *philosophies of natural science* in such a way as to form a program and a canon for work in social science [italics in original]” (1959, 57). And although the work of abstracted empiricism is recognizable for its minutiae, Mills insists that rarely does any of it add up to new or substantive insights about humanity:

As a style of social science, abstracted empiricism is not characterized by any substantive propositions or theories. It is not based upon any new conception of the nature of society or of man or upon any particular facts about them. True, it is recognizable by the kinds of problems its practitioners typically select to study, and by the way in which they typically study them. But certainly these studies are no reason for such celebration as this style of social research may enjoy. (Mills 1959, 55).

Abstracted empiricism’s other major weakness is its capacity to become “administrative” or “bureaucratic” research that supports large institutions such as corporations, the military, the state, and, yes, universities. These are the only organizations that can afford this type of “applied social science” because the scale of research typically demands the deployment of research teams and access to facilities that only larger organizations can support or provide. The effect of abstracted empiricism’s rise in the university has been to replace its traditional organization as “a circle of professional peers, each with apprentices and each practicing a craft” with “a set of research bureaucracies, each containing an elaborate division of labor, and hence of intellectual technicians” (Mills 1959, 103). This, in turn, ensures the further

perpetuation of the theoretically limited research abstracted empiricism calls for, since according to Mills, “for the efficient use of these technicians, if for no other reason, the need increases to codify procedures in order that they may be readily learned” (1959, 103).

To summarize, C Wright Mills’s concept of abstract empiricism describes a particular style of research in the social sciences that eschews social theory in favor of data aggregation to answer questions about social phenomena. This style of research is often employed in the applied social sciences, which too often end up as administrative research in the service of bureaucratic organizations. For these reasons, Mills doubts abstracted empiricism’s ability to produce knowledge that enables new insights on the significant social quandaries of our day. Mills’s model of abstracted empiricism essentially captures the problems with health communication’s research methods and its development as an academic specialty. In the next section, I examine how health communication studies traditionally has conceptualized communication as the transmission of information and why this “information model” is an example of abstracted empiricism’s limitations.

The Information Model in Health Communication

My sample of health communication articles and handbooks published in the past 30 years confirms that the information model has and continues to be the dominant paradigm in health communication studies. Although starting in the early 1990s the field began to entertain other ideas about communication, such as the

construction of illness through language and narrative, the positivist paradigm of communication as the flow of information through different channels (e.g., face-to-face, telecommunications and mass media, the Internet), in different settings (e.g., doctors' offices, hospitals, schools, households), and at different levels (e.g., interpersonal, group, organizational, societal) continues to exert an unmistakable influence. Channels, settings, and levels are important words in the health communication lexicon as they are the source of the variables that affect how health information content is transmitted or received. Quantitative methods and tools with impressive names such as linear regression analysis, discriminant analysis, the "Perceived Confirmation Scale" (Grant, Cissna and Rosenfeld 2000), and the "Health Belief Model" (Fishbein and Yzer 2003) are employed to measure information's variables and outcomes.

The information model in health communication is best summed up as the fetishization of all aspects of information as an object of quantification. This positivist conception of information in health communication is evident in several articles published in the International Communication Association's annual *Communication Yearbook* between 1978 and 2001.¹⁰ For example, in a 1978 *Yearbook* article on the state of health communication research, Daniel Costello argues that "doctor-patient interactions can be comprehended using the traditional S→M→C→R→E [sender-message-channel-receiver-effects] communication model" (1978, 558). He maintains

¹⁰ I judge these articles reasonably definitive examples since *Yearbook* monographs are considered representative of the communication field either because they derive from noteworthy papers presented at the ICA annual conferences or are essays that "have something to say to the field at large" (Anderson 1988, 11).

that “if *communication* is defined as the process of an individual acquiring and converting event data into meaningful or consumable information, the ends served by communication are those of adaptation [*italics in original*]” and therefore “the link between health and communication is of a fundamental nature” (Costello 1978, 58).

Costello casts communication in the traditional effects model of information transmission that constructs a one-way flow of messages from sender to receiver. A study published in the 1980 *Communication Yearbook* is considered an improvement over the older model because it takes into account “the human side of information” in the doctor-patient relationship (Dervin et al. 1980). It does so by debunking the commonly held assumptions at the time about the nature of information in health communication. In a nutshell, the authors critique the old model of communication for being “absolutist” because it assumed information was transferable from doctor to patient “as if it were a brick” (Dervin et al. 1980, 592). Instead, the authors propose a “relativistic” model that considers information useful only if it means something to its targeted audience: “information does not inform unless the individual can make personal sense of it, and personal sense can only be made when information can be processed” (Dervin et al. 1980, 592). This study’s focus on “*the receiver construction of reality assumption*” over the old “*the observor construction of reality assumption* [*italics in original*]” (Dervin et al. 1980, 592) represents the first inklings of a move towards more patient-centered research in health communication studies that gained momentum in the 1990s (Sharf 1997). Nevertheless, the study’s underlying model is still firmly grounded in a concept of communication as “information transfer” except

the patient at the receiving end of the transmission is discovered as an important variable:

The basic idea of a relativistic, situational approach is that it will provide, in the long run, an entry point for the improvement of communication. Thus, for example, it is suggested that if one understands something about how a patient sees a situation, a degree of power will be achieved in predicting the nature of the patient's information seeking and use" (Dervin et al. 1980, 594).

Gary Kreps establishes information as "a central element of health care" in a 1988 *Yearbook* article entitled, "The Pervasive Role of Information in Health and Health Care: Implications for Health Communication Policy." "Health communication is pervasive," says Kreps, "because human communication is the critical process that enables participants in health-care delivery systems to seek and send timely and relevant information that is crucial to evaluating health complaints, determining appropriate health-promoting and preserving activities, and eliciting cooperation" (1988, 239). The language throughout the article is characterized by the vocabulary of the information model. For example, the author describes "health-care relationships," such as the all important doctor-patient relationship, as "primary channels for acquiring and seeking health information, and as such are crucial delivery vehicles for a wide range of health-care services" (Kreps 1988, 242). Information's power is so pervasive that it shapes even the roles assumed by the "interactants" in these health care relationships:

Interpersonal communication provides interactants with information about the kinds of roles expected of them by relational others, and the actual performance of these interpersonal roles directs the ways interactants interpret each other's messages. . . . When a consumer asks a doctor to help with a health problem, the consumer is not only

communicating on a content information level about his or her health condition, but is also providing relationship information that defines the doctor's "helper" role and his or her own "helpee" role. (Kreps 1988, 242-243).

Kreps's assumption that information equals communication, which in turn forms the foundation of good health care practices, has not gone unquestioned from within the health communication discipline itself. An early critique is Loyd Pettigrew's critical response to Kreps in the 1988 *Communication Yearbook*. Pettigrew questions Kreps's premises on two points: a) using information synonymously with communication, and b) the lack of hard evidence for the connection between communication-as-information and health. Pettigrew argues that by associating information with communication uncritically, Kreps contributes to the "conceptual fuzziness" that besets health communication research and undermines its credibility as a social scientific discipline. Furthermore, Pettigrew notes that "although the association between communication and health has yet to be tested rigorously, Kreps prescribes more and better communication. If we are as yet unsure of the question, how credible can communication answers be?" (Pettigrew 1988, 301). An early adherent of narrative theory, Pettigrew sees an important role for communication in health and medicine through narrative as a way to learn how patients construct meaning out of health and illness. Narrative theory offers a means to greater understanding of the social context in which health care is delivered, which would help create more effective communication at all levels—intrapersonal, interpersonal, organizational, and mass media/societal—to help more of the population achieve better health. Pettigrew is skeptical about Kreps's assertion that health outcomes can

be improved by simply providing more and “better” communication by enhancing the channels of information since billions are spent by local, state, and federal governments on health promotion campaigns with no clear evidence that they are effective (1988, 307). Pettigrew therefore asks for stronger empirical evidence to support the claim that information is central to communication and health or else health communication risks its credibility as a discipline.

A 1994 *Yearbook* article by Eric Zook echoes Pettigrew’s critique against the model of communication as information. Zook goes a step further than prescribing narrative theory as a means to break away from the dominant information model by attempting to articulate a new “ontological” theory of health communication. Zook’s chief complaint is the paucity of genuine communicative theory on the nature of health and communication, and on the latter’s importance to the former. This theoretical void has allowed non-communication experts, namely, medical professionals, to define health and communication biomedically, which explains why health communication scholars fall into the trap of positivism and why their work never rises above instrumentalist, administrative research that perpetuates the biomedical definition of health. Zook proffers a theory of health and communication in which health is “embedded” and communication “constitutive” of an “authentic conceptualization of health communication.” By embedded, Zook means that health is ontological rather than purely biological, and the study of health necessitates a holistic approach that accounts for the non-biological, psychosocial factors that comprise a person’s wellness. By constitutive, he means that communication in the form of language is

elemental to how humans experience phenomenon like health and construct personally meaningful knowledge from their experiences. As for authentic, it is difficult to grasp what Zook precisely means as he tends to fallback on dense philosophical language to define the idea, as in this example:

The particular threat to which Heidegger (1962) alerts us is the omnipresent tendency and temptation to live inauthentically, that is, in accord with the “dictatorship” of mass opinion that shapes one’s choice of being-in-the-world. To live thus is to experience but a derivative world provided by an unquestioned, unappropriated tradition. To live authentically, Heidegger argues, is to (a) freely choose the situations in which we find ourselves (i.e., accept our “thrownness”), (b) possess authentic (i.e., personally derived) understanding of these situations, and (c) express this understanding in authentic language . . . For Heidegger, authentic living (i.e., “being-in-truth”) is *the* project of human existence. Inasmuch as we begin life inauthentically, relying on others to provide us with initial representations of meaning as well as material and emotional sustenance, authentic existence must be wrested from the grip of historicity. Further, there is never a point at which we may be said to have finally and fully achieved authenticity; rather, Dasein must constantly protect itself from the temptation to “fall” (i.e., descend) into taken-for-granted commonness [*italics in original*]. (Zook 1994, 361-362)

Zook’s efforts to move the field away from its theoretical barrenness and the positivism inherent in the information model of health communication is commendable but rife with its own shortcomings. In his desire to define health communication as “*the study of personal and sociocultural symbol usage for purposes of developing, maintaining, and adapting ontological health* [*italics in original*]” (Zook 1994, 367), Zook depends upon the opaque language and concepts of metaphysics that detracts from his intention to redefine health communication in more humanistic terms. Furthermore, how can a concept of health communication that purports to examine “personal and sociocultural symbol usage” fail to account for

social structures and historical change? Nowhere in the article does he discuss social theory or point to the impact of political, economic, and social institutions on individual and group behaviors. This omission is due to his conceptualization of communication purely in terms of language and individual psychology rather than communication as a sociocultural practice. But in his effort to define how communication and health ought to be conceived, Zook gives his readers an accurate picture of the dominant paradigm of communication as information in health communication:

communication lies in the very midst of health and illness, providing constitutive as well as instrumental force. Rather than serving merely as a conduit for the passage of “objective” knowledge and intentional states, communication is *the* means whereby we pursue authenticity, whereby we construct our world and our being-in-the-world [*italics in original*]. (Zook 1994, 367)

Or, to put it another way: “it is both inappropriate and irresponsible to view communication as merely the jug that transports objective knowledge from the distilleries of logic and/or scientific empiricism” (Zook 1994, 349).

Zook’s ontological definition of health communication represents an emergent culturalist or constructionalist critique of the biomedical model of medicine in health communication studies in the 1990s. Health communication studies before that decade focused entirely on improving physician communication to achieve greater compliance among patients. By the 1990s, this orientation was critiqued as perpetuating the biomedical construction of health and privileging physician paternalism in the clinical setting. Health communication articles from this period show that researchers began to investigate the communicative processes involved in

the patient's experience of illness, which paralleled developments underway in medicine that accelerated the trend towards a patient-centered model of care (Frederikson 1993; Lambert et al. 1997; Sharf 1993; Sharf and Street 1997). The psychosocial and cultural dimensions of health and patient care became important research foci, reflected in the growing appreciation of narrative theory (Sharf, 1993; Sharf and Vanderford, 2003) and the introduction of cross-cultural communication into health communication research (Ford and Yep, 2003). These promising developments did not purge the discipline's tendency towards abstracted empiricism. But it did introduce a new concern with the two-way flow of information between patients and physicians or, in the new vocabulary, consumers and providers, that modified the traditional sender-receiver model of testing the effects of health messages on patient behavior. This is reflected in how words like "dyad," "integrative," and "agency" slipped into the vocabulary of health communication research, and also in the greater utilization of behaviorist theories such as "uncertainty management theory," "problematic integration theory," and "agency restriction theory" to explain the patient's perspective (O'Hair et al. 2003). The new emphasis on information's two-way flow is exemplified in this definition of communication from a well-cited handbook on health communication theory and practice:

Human communication occurs when a person responds to a message and assigns meaning to it. The two key parts to this definition of human communication are the message and meaning. Messages are anything that people attend to and create meanings for in the communication process. . . . No one individual is only a sender or a receiver in human communication. In human communication we simultaneously send and receive many messages on many different levels. [italics in original] (Kreps and Thornton 1992, 14 and 19)

In another example, from an 1993 article on the “Development of an Integrative Model for Medical Consultation” (Frederikson 1993), we see how the shift to patient-centered research sensitized health communication scholars to the effects of personal thoughts and feelings upon the information exchange that is central to the medical encounter:

In medical consultation, the flow of information should include insight to attitudes, feelings, fears, desires, expectations, and anticipations. From this wider perspective it is clear that information exchange is central to medical consultation. The proposed model develops this theme of functional information exchange as the basis of good clinical practice and proposes that all other aspects of medical care flow from this central tenet. (Frederikson 1993, 226)

Another example from a 2001 *Communication Yearbook* review article by Kreps, entitled “The Evolution and Advancement of Health Communication Inquiry,” illustrates the persistence of the information model up to current times: “Health care providers and consumers depend on communication to generate, access, and exchange relevant health information for making important treatment decisions, for adjusting to changing health conditions, and for coordinating health-preserving activities” (2001, 237). And in a December 2004 review article in the *Journal of Communication* that assesses advances in health communication research, Roxanne Parrott writes: “information exchange in medical interaction is a primary focus when messages are evaluated, focusing on how patients describe illness . . . and demonstrating information’s role in reducing uncertainty” (Parrott 2004, 763). Even with illness narratives and studies of cross-cultural communication in health care settings becoming less of a rarity in the early 2000s (Sharf and Vanderford, 2003), the

information model and its associated positivist methods and research mindset continues to be an overriding interpretive frame. As health communication studies enters its third decade, the information paradigm remains an enduring influence on how communication in the domain of health and medicine is conceptualized and researched.

In brief, health communication studies is dominated by the information model of communication, which has traditionally conceptualized communication as both information conduit and content. This objectification of communication results in the discipline's preoccupation with measuring the effects of communication on behavior in various health care settings. Although critiques of this quantitative approach started to appear in the 1990s, the dominant information paradigm is far from dead in contemporary health communication research. As I shall discuss in the next section, a significant reason why the dominant paradigm persists can be attributed to health communication self-appointed status as an applied social science.

Health Communication as Applied Social Science

Health communication scholars consider its applied focus on communication in health care as its mark of professional distinction. The specialty was formally established as an applied communication discipline in 1975 in Chicago at the International Communication Association's annual conference. At that convention, scholars working under the category, "Therapeutic Communication," replaced the term therapeutic with health to better reflect research interests that were broadening

beyond interpersonal communication in the medical setting to include health promotion through the mass media (Sharf 1993; Smith 1989). In the 1989 debut issue of *Health Communication*, the first of two peer-reviewed journals established in health communication, Kreps argues that, as an applied social science, health communication can increase communication's credibility in general because the sub-field can "help legitimize the social value of communication research and education by demonstrating the practical applications of communication knowledge in improving the public's welfare and increasing the effectiveness of the health care system" (Kreps 1989, 12). Health communicators consider their work important for directly addressing real-life problems in health care:

Health communication inquiry has emerged as an exciting applied behavioral science research area. It is an applied area of research not only because it examines the pragmatic influences of human communication on the provision of health care and the promotion of public health, but also because the work in this area is often used to enhance the quality of health care delivery and health promotion. To this end, health communication inquiry is usually problem-based, focusing on identifying, examining, and solving health care and health promotion problems. (Kreps, Bonaguro and Query 1998, 2)

But in the shadow of the celebratory rhetoric exists a measure of doubt as to the real extent of the discipline's influence. Leading scholars in the field have voiced concerns in the past that health communication scholarship has a modest intellectual reach outside the discipline. In the first *Health Communication* issue in 1989, Jon Nussbaum comments on the findings of several review articles on the state of health communication and concludes

Perhaps more important, these reviews have made it quite clear that many of the most intriguing communication questions are asked by

scholars who do not have an advanced degree in communication. Although many of us feel insulted by this fact or somehow feel that the research question under investigation must somehow be flawed because it was not generated by an alumnus of a debate team, the research addressing communication within the health setting by “noncommunication scholars” is to date more extensive and enlightening than the communication research conducted by those of us who call ourselves communication scholars. This statement is not meant to insult the many excellent scholars who produce fine health communication research . . . it is made merely to point to the fact that any researcher who makes the mistake of reading only in his or her discipline has made an enormous, myopic error and will ultimately be misinformed. (Nussbaum 1989, 36)

Writing in 1995, Gary Kreps and Dan O’Hair allow that “health communication research and theory has not dramatically influenced the training of health care providers, the introduction and implementation of health care policy, or the delivery of health care services” (Kreps and O’Hair 1995, 2). In a special 1997 *Health Communication* issue on “the patient as a central construct,” Keith Bennett and Harry Irwin ask

Who else is interested in and cares about this work? Who listens, and who applies the insights and outcomes of our applied research? An outsider to the field glancing across the bibliographies of the articles in this issue, but also in the field more generally, could be excused for thinking they had stumbled across a small but dedicated group of core converts happily massaging one another’s egos. (Bennett and Irwin 1997, 84)

And a 2004 study in *Health Communication* reveals that less than 25 percent of health communication articles are published outside the subdiscipline’s two journals: of the 850 health communication articles published between 1989 and February 2001 surveyed for the study, 638 of them were published in either *Health Communication*

or the *Journal of Health Communication*, the second peer-reviewed journal established in 1996 (Beck et al. 2004).

This is not to say that health communication's influence has been nil. Perhaps problematic is the best way to describe its impact. On the one hand, more and more communication departments are establishing health communication as a research specialty and in the past decade or so several universities, including Tufts, Michigan State and Northwestern (Rogers 1996, 18), have instituted specialized programs leading to graduate degrees in health communication. Emerson College in Boston, for example, offers a masters degree in Health Communication through its Department of Marketing Communication, in collaboration with the Tufts University School of Medicine. Health communicators are involved with national health organizations such as the National Cancer Institute and the Centers for Disease Control and Prevention (CDC). Gary Kreps has served as the chief of the Health Communication and Informatics Research Branch at the National Cancer Institute since 1999. Cynthia Bauer is the current director of Health Communication and Marketing Strategy at the National Center for Health Marketing (NCHM) at the Centers for Disease Control and Prevention (CDC).¹¹ And the *Journal of Health Communication* is listed on the NCHM's website alongside academic and trade journals on health such as the

¹¹ Information on Gary Kreps from the National Cancer Institute website at <http://cancercontrol.cancer.gov/od/glk.html> and Cynthia Bauer on the CDC website at <http://www.cdc.gov/healthmarketing/aboutnchm.htm>.

American Journal of Public Health and the Public Relations Society of America's *Health Academy Newsletter*.¹²

On the other hand, some health communication scholars have questioned the discipline's intellectual relevancy and its ability to advance critical knowledge about health and communication precisely because of its close connections with state-supported institutions. Deborah Lupton criticizes health communication for its lack of critical social analysis and attributes this to its "close links with health promotion agencies largely funded by the state" (Lupton 1994, 57). Consequently, "theory in health communication is too often limited to individualistic models of knowledge and behavior, whereas the cultural (and less easily measurable) dimensions of health communication are frequently ignored" (Lupton 1994, 57). In a 1997 article Barbara Sharf and Richard Street wonder whether the field's lack of professional credibility is due to its theoretical limitations:

Perhaps because the scope of health communication research has been so broad as to eschew conceptual coherence, the work in our field has produced few, if any widely acknowledged models and theories within the larger discipline of communication, nor recognition of a distinct professional specialty by health practitioners or the general public. (Sharf and Street 1997, 3)

Lupton is correct to trace the lack of critical theory back to health communication's focus on applied, positivist research methods that measure individual health behaviors without addressing the larger sociocultural dimension of health. And Sharf and Street are on the right path by pointing out the lack of theory as a source of conceptual incoherence in health communication, although, as I have been arguing, it is not a lack

¹² The National Center for Health Marketing website is at <http://www.cdc.gov/healthmarketing/research.htm#journals>.

of theory per se but the way the dominant methodological model has perpetuated research in the vein of abstracted empiricism. The end effect of this type of research is a sense of conceptual hollowness as a result of the small-scale questions that are asked. A lot of data on health behaviors gets produced but fail to add up to any substantive answers to “big picture” questions about health and communication in society. “The details no matter how numerous,” as C. Wright Mills commented on the results of abstracted empirical research, “do not convince us of anything worth having convictions about” (Mills 1959, 55).

In the next section we shall see that there is historical precedence to the critique that health communication research operates in a theoretical vacuum. Communication scholarship in general has a history of indictments for intellectual thinness attributed to the absence of coherent theories and the administrative origins of its research.

In Search of Theory

The critique that health communication lacks distinctive theories about health and communication echoes a similar critique that has circulated for decades regarding the larger field of communication’s struggles with conceptual coherency. Charles Berger (1991) suggests the reason for communication’s conceptual fuzziness results from a lack of communication scholars who “do theory.” The problem lies in the discipline’s fixation on methods and an over-reliance on theories borrowed from “cognate” fields such as linguistics and psychology. As a result, “there is no particular

theoretical paradigm or touchstone theory around which communication researchers might organize their efforts” (Berger 1991, 101). Furthermore, this development has “Balkanized” communication studies into many different subfields, each searching to define itself through “context-specific theories” to explain the uniqueness of its particular area of specialty. Brant Burleson (1992) quibbles with Berger over the type of theory needed to explain communication, but he, too, argues for some kind of overarching theory to guide empirical research. Burleson believes that what is needed is not more communication theories authored by authentic communication scholars, as Berger argues, but more theories about “the nature of human communication” (Burleson 1992, 79). What exactly is the nature of human communication he leaves unclear, presumably because no theory exists to provide the answers. Burleson leaves his readers hanging over this question and moves right to suggesting a “philosophy of communication” that can guide empirical research:

A philosophy of communication needs to provide the big picture about what communication is and how it works. In so doing, a philosophy of communication suggests which aspects of communication warrant empirical examination and further provides a framework for coordinating insights from empirical investigations of specific communication processes and structures. (Burleson 1992, 84)

Neither Berger nor Burleson reference critiques proffered by Peter Golding and Graham Murdock and John Durham Peters on the trouble with theory that has plagued communication studies since its beginnings. These authors critique the discipline’s difficulties with achieving intellectual relevancy from different perspectives on the issue of communication’s quest for theory.

In their 1978 article, “Theories of Communication and Theories of Society,” Golding and Murdock argue against seeking a unifying theory of communication as the “holy grail” that will end the methodological crisis in communication research. The problem is not the lack of a unifying theory, they contend, but the erroneous idea that an all-encompassing theory of communication can be found to cover the vast range of human experience that is studied as problems of communication. Just because “symbolic interchange” is present in human interactions to a significant degree does not mean that communication lies at the heart of social relations or that a unifying theory of communication will unlock the secrets to solving society’s issues. Furthermore, interpreting the meaning of messages should not be the purpose of communication research; in the context of mass media, Golding and Murdock argue that “the primary task of mass communications research is not to explore the meanings of media messages, but to analyse the social processes through which they are constructed and interpreted and the contexts and pressures that shape and constrain these constructions” (Golding and Murdock 1978, 352). They propose, instead, a critical theory of society that looks at “the relations between cultural systems and economics and social formations, questions about the dynamics of social and cultural reproduction, and sources of change and contestation” (Golding and Murdock 1978, 354).

John Durham Peters argues that the trouble with communication studies and theory lies in its institutional history. In his 1986 article, “Intellectual Sources of Intellectual Poverty in Communication Research,” Peters argues that the field of

communication is conceptually inchoate because, historically, more energy has been spent on establishing communication as a field, i.e., an “institutional entity,” than on achieving theoretical clarity around the idea of communication, i.e., sorting out what is and is not communication. Because communication lacks defining theories, what qualifies as communication is determined on an “*ad hoc* basis” depending upon the proclivities of individual communication departments: “Because the only principle of conceptual organization that really works in the field is administrative, each department comes up with its own definitions, depending on its own peculiar historical and curricular accidents (though the variety is by no means infinite; it is arbitrary)” (Peters 1986, 547). Nevertheless, a dominant conception of communication did emerge after 1949 following the publication of Shannon and Weaver’s *Mathematical Theory of Communication* and the introduction of “information theory.” Information theory “rocked the academic world” of the Cold War era and seemed to offer the “positivist hope” of bridging the chasm between the natural and social sciences (Peters 1986, 538). According to Peters, “Information theory was a science made for its time; it fit a world of space, sputniks, and surveillance” and its vocabulary—“*noise, redundancy, channels, transmission, messages, senders, receivers, signals, and entropy* [italics in original] (Peters 1986, 538; 539)—quickly spread throughout the intellectual world of the natural and social sciences in post-war America. The theory came into vogue at precisely the same time Wilbur Schramm was seeking to establish communication as a new social science. Communication as a young discipline quickly adopted the language of information theory in its quest for academic legitimacy: “the

field tried to erect a permanent edifice around a highly fashionable set of terms. Little justification was demanded for the creation of communication departments in the 1950s because the *Zeitgeist* seemed to sanction it [italics in original]" (Peters 1986, 540). Information theory's legacy in communication research is felt in the way the discipline still talks in the language of information theory, which represents a throwback to the 1950s institution-building era when communication was synonymous with information. As Peters puts it: "Nobody believes in *senders* and *receivers*, *channels* and *messages*, *noise* and *redundancy* anymore, but those terms have become a permanent part of the fabric of the field, in textbooks, syllabi, and literature reviews [italics in original]" (Peters 1986, 540). Thus, information theory helped to bolster communication's institutional growth in the mid-twentieth century but, in Peters' estimation, has hindered the field's theoretical development ever since.

Communication – “Central” to Everything?

The critiques of Golding and Murdock and Peters can be profitably applied to the problems with methodology in health communication studies that created the information paradigm and the emphasis on applied research. I want to return to Golding and Murdock's point about the significance of symbolic interaction in human activity and why this does not justify the belief that communication is central to society. By now it should be clear that health communication research is driven by the belief that "communication is central to health." The centrality of communication thesis typically revolves around the fact that most human experiences are articulated

through language. Hence, aside from content, it is often difficult to differentiate between health communication research's methodology and that of speech or mass communication research because all are attuned to the psychological effects of messages and message-making, to which language is essential. Indeed, Berger criticizes this tendency to organize along content lines for fragmenting communication studies unnecessarily when the methodology from one subspecialty to another is virtually indistinguishable:

when one critically examines research reported on the convention programs of some of these contextually defined sub-areas, one wonders why that research could not just as plausibly have been presented on the programs of another sub-area. Many, and perhaps most, of the research reports presented under the rubric of health communication, for instance, could be accommodated within the domains of interpersonal and mass communication, and there are numerous examples of potential opportunities for the integration of research done in interpersonal and mass communication contexts themselves..."
(Berger 1991, 101-102)

Berger's observation is astute, as is his other remark mentioned earlier that much of what passes for communication theory has been imported from other social sciences and especially from psychology and linguistics. His perceptions of the discipline's weaknesses serve his argument that, to cultivate credibility, communication studies must develop and cohere around authentic, unifying theories of the nature of communication. Golding and Murdock, however, dispute the need for an overarching theory of communication because this argument is predicated on "the idealism inherent in the idea of communications as the stuff of human relations" simply because humans are a talking species (Golding and Murdock 1978, 346). Golding and Murdock are critical of the centrality of communication thesis because it is

reductionist and too easily confers “an unwarranted and unsupportable significance” to communication that “distorts beyond reprieve a balanced view of social structure and process” (Golding and Murdock 1978, 347).

Faith in the centrality of communication to health has driven the growth of health communication research. But, as I have shown, the discipline’s heady development masks questions about its theoretical substance and whether its scholarship has anything meaningful to say about the broader social issues of health. Part of the problem is this unquestioned orthodoxy about communication’s essential role in health. Communication under this doctrine is reduced to its functional element of message-making, hence the discipline privileges studies of language and human cognition with little regard for social theory. Constructing communication this way obstructs health communication from cultivating the sociological sensibility advocated by Golding and Murdock—the same quality that Mills deems the “sociological imagination”—that regards communication as a practice interrelated with other cultural practices, operating within social structures, and impacted by politics. Not that the functional dimension of health communication should be entirely dismissed—it is well known that doctors are notorious for their inability to engage patients verbally. There is a need to teach health practitioners effective communication skills to the extent that medical diagnosis and the modern ethical requirements of consent depend on connecting with patients through conversational skillfulness and empathy. But “patient-provider” communication is a practice that happens within the institutional structure of medicine which, in turn, is embedded within the larger matrix of

institutions, culture, and politics that constitutes society. Health communication's rubric of "channels," "settings," and "levels" where communication takes place fail to add up to a social theory of communication that can engage with issues of health and medicine in intellectually engaging and substantive ways.

Communication as a Historical Construct

In *The Sociological Imagination*, Mills devotes an entire chapter on the "Uses of History." Along with biography and society, Mills considers history part of the three "co-ordinate points of the proper study of man" (Mills 1959, 143). History is "the shank of social study" and "without use of history and without an historical sense of psychological matters, the social scientist cannot adequately state the kinds of problems that ought now to be the orienting points of his studies" (Mills 1959, 143). There is little of the historical imagination to be found in health communication research and this becomes part of the reason why the work is criticized for its general banality and deficiency of critical social analysis. The first place to start applying history is to interrogate the assumption that communication is central to health. I turn again to John Durham Peters for a historically based theory of communication from which a very different picture of communication emerges to contest the dominant information model in health communication research.

In his 1999 book, *Speaking Into the Air*, Peters lays out a theory of communication that defines communication as a historically shifting social and cultural construct, a concept that changes across time and space. According to Peters,

the centrality of communication to human behavior and social processes is a notion that appeared only with the development of mass media in the late nineteenth century. While humans have always had language, the urge to define humans by our capacity to dialogue is a quintessentially modern understanding of the idea of communication: “Though humans were anciently dubbed the ‘speaking animal’ by Aristotle, only since the late nineteenth century have we defined ourselves in terms of our ability to *communicate* with one another” (Peters 1999, 1). Mass media caused communication to become loaded with ideas about mutuality and interactivity because the new technologies made possible the connection of people across traditional obstacles of time and space (Peters 1999, 5). Prior meanings of communication had little to do with connection and mutuality, such as the notion of communication as “imparting” exemplified in the partaking of holy communion: “here ‘communication’ suggests belonging to a social body via an expressive act that requires no response or recognition” (Peters 1999, 7). Another definition is the archaic concept of communication as physical transfer or transmission, as in the communication of “heat, light, magnetism, or gifts” (Peters 1999, 8). The meaning of communication as exchange, saturated with ideas about mutuality and reciprocity, became popular in the twentieth century; whether by telephone, in writing, or face-to-face discussion, successful communication is “distinguished by intimacy and disclosure” in modern times (Peters 1999, 8-9).

Thus, the idea that communication lies at the heart of human experience represents the aspirations and longings of modern times, says Peters. Communication

has moved to the center of how people come to terms with social, political, and moral issues that arise out of the conditions of our day, becoming “central to reflections on democracy, love, and our changing times” (Peters 1999, 1). Communication has been invested with such “moral privilege” that “the term evokes a utopia where nothing is misunderstood, hearts are open, and expression is uninhibited” (Peters 1999, 2). But because communication is as much about the gaps in communication as it is about the successful achievement of mutual understanding, a pervasive sense of communication breakdown or failure taints modern attitudes about communication: “Some of the chief dilemmas of our age, both public and personal, turn on communication or communication gone sour” (Peters 1999, 1). Seen in this light, health communication’s focus on the failures and successes of interpersonal discourse in the medical encounter reflects this modern interpretation of communication’s fundamental importance. Peters, however, believes communication’s significance lies less in the way messages are sent and received, that is, communication as a semantic or psychological problem of the individual, and more in its importance as a moral and sociological concept through which to understand the political and ethical dilemmas of our day. Peters sees communication as one of the most recent branches of philosophical and political inquiry in Western intellectual history. Therefore, the focus should be on how to achieve “just communication” as a measure of the good society: “We ought to be less worried about how signs arouse divergent meanings than the conditions that keep us from attending to our neighbors and other beings different from us” (Peters 1999, 269). Based on this conception, a theory and philosophy of

communication in health communication would conceptualize the problems of communication in health and medicine as more political and ethical than semantic or psychological.

Why does it matter to know that communication as a concept changes as history changes? From an applied perspective, historical knowledge of the kind Peters imparts seems, well, academic. But knowing that communication's centrality to society is a recent historical construct opens up the orthodoxy of health communication, i.e., good communication begets good health, to closer scrutiny of its basic assumptions about the nature of communication and its role in health care. In the next section I present a history lesson of sorts to illustrate how historical knowledge contextualizes taken-for-granted assumptions about communication in the doctor-patient relationship and why this is important as part of cultivating the sociological imagination in health communication studies.

A History Lesson for Health Communication

The purpose of conversation in the medical relationship is shaped by differences in social organization and cultural practices at different times in Western history. In past eras, expectations of medical practices and good health were fundamentally dissimilar to those upheld by modern standards of good communication in health care. This perspective, however, is not present in two examples from the health communication literature I have studied that specifically reference classical Greek history to support the claim that communication in the form of dialogue has

been central to the doctor-patient relationship for thousands of years in Western medicine.

Silence as the soul of medicine

In the first issue of the *Journal of Health Communication*, Scott Ratzan, Gregory Payne, and Carol Bishop write:

The methodological study of *communication and health* in the social sciences is principally a contemporary phenomenon. However, isolated references to the relationship between these vital aspects of the human experience date back to ancient Greece. The most notable of all physicians, Hippocrates, cited a nonmedical rationale for health in *Precepts*: “Some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician”...

To the Greeks, being of sound mind and body was an essential ideal of the polis and a prerequisite for the citizen orator. A symbiotic relationship between effective and persuasive communication and good health was a Homeric ideal for those in pursuit of *areté* (excellence). Yet, inherent in Hippocrates’s comment are the roots of the tradition of a unidirectional communication flow from the powerful physician to the passive patient that persists today. Also evident is the omission of any sense of the physician’s obligation to society, a questionable communication norm still in widespread practice. [italics in original] (Ratzan, Payne and Bishop 1996, 26)

While the authors are correct that the study of communication and its role in health is a modern pursuit, their use of historical evidence shows a misreading of communication’s place in Western medicine and concepts of health before the twentieth century. First, Ratzan, Payne, and Bishop assume that in Hippocrates’ time the patient’s recovery without medical intervention was rooted in the doctor’s ability to communicate effectively to his patient. Second, they are quick to generalize from Hippocrates that scant attention was paid to physicians’ moral obligations to society in

ancient times and that the nature of moral obligations in ancient Greece paralleled those expected of physicians today. Perhaps the authors are referring to the way the Hippocratic Oath continues to represent the core values of medicine in the contemporary period. If this is the case, then they overlook the fact that the Oath itself has undergone numerous translations and revisions as medicine developed over the course of Western history (Markel 2004). If, on the other hand, they are referring to the symbolic value of the Oath irrespective of how it has changed over the centuries, then they fail to realize that “the ethos [of medicine] is not immutable but, in fact, is malleable. It can be shaped by the priorities of the state, personal agendas, careerism, the profit motive, and deep biases in society and in ourselves” (Barondess 1998, unpaginated electronic source). To their credit, Ratzan, Payne, and Bishop criticize the “questionable communication norm” of ignoring medicine’s larger social context, a norm that has dominated health communication studies for most of its history. But historical evidence contradicts their assumptions that good communication constitutes open and equal dialogue and that this has been the essence of practicing good medicine since Hippocrates’ time.

It is now accepted lore in health communication research that communication in the form of discourse lies at the heart of Western medicine, with authentic dialogue between doctor and patient as the gold standard of care. In reality, however, *silence* has been the soul of medicine as practiced for more than 2000 years in the West. On this point, medical and legal historian Jay Katz writes in *The Silent World of Doctor and Patient* (1984, xvii): “The human care that physicians have extended to patients

throughout the ages rarely has been based on the humaneness of consensual understanding; rather it has been based on the humaneness of services silently rendered.” In so far as humans talk, language has always been important in medicine. If, however, as Peters claims that the gaps in communication are as important as the connections between people, then silence and not dialogue has been the dominant mode of communication in the history of Western medicine. Katz provides evidence that Hippocrates’ idea of the purpose of conversation between physicians and patients did not mirror today’s expectations of communication and ethical conduct in the medical relationship. Hippocrates, in fact, is silent on the place of conversation in the physician-patient relationship. But he is explicit about the physician’s moral responsibility to exercise his own medical judgment on behalf of his patients:

The Hippocratic Oath makes no reference to physicians’ obligation to converse with patients. The specified duties were of a different nature: “[to] follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.” (Katz 1984, 4).

There was no moral value attached to dialogue in the medical encounter in Hippocrates’ time and no ethical requirement that physicians were obligated to disclose information to their patients. There was also no expectation on the patient’s part for open and honest conversation. It is arguable then that Hippocrates would have recognized the modern interpretation of communication, which, at its most distilled, is about a desire for mutuality and perfect understanding between self and others ideally achieved through dialogue (Peters 1999). Plato in the *Dialogues* provides a detailed portrait of medical practices in classical Greece but never mentions the importance of

dialogue between physician and patient (Katz 1984, 4). Although the elevation of dialogue as the noblest form of connection between souls originated in ancient Greece, dialogue had no place between physicians and patients because the medical relationship was not an association of equals. The patient was expected to place unquestioning faith in the physician's authority and would have considered the doctor a quack if he did not perform his duties with complete authority. Silence therefore was intrinsic to sustaining faith among patients in the healing powers of physicians. When he observed that patients sometimes recovered "through their contentment with the goodness of the physician," Hippocrates was probably referring to faith and not, as Ratzan, Payne, and Bishop assume, the communication competencies of the physician.

Medical uncertainty provided another powerful motive for physicians to maintain a degree of silence in their relationships with patients. Western medicine for thousands of years was more art than science, and what science existed was mostly unreliable. Hence, medicine's capacity to cure depended on the physician's ability to inspire unquestioning faith in his skills: "Historically, surrender to silent and blind trust in the physician was to a considerable extent compelled by the state of the art—by medicine's uncertainties that could not be explicated easily" (Katz 1984, xvi). It may seem counterintuitive today, but with most patients Hippocrates instructed doctors *not* to talk. Talk, for instance, was unnecessary when treating slaves or citizens who were "free but poor":

While they were not to be treated "tyrannically," they were to be worked over resolutely with "an emetic or a purge or cautery or the knife," for they could not be expected to heed a physician's advice to

undergo a complicated course of treatment. They have “no time to be ill”; therefore it was a waste of time to talk with them. (Katz 1984, 4-5)

But polite conversation was appropriate in cases where patients were free citizens and rich. Physicians were instructed that conversation was fitting with this class of patients to cultivate friendship, or *philia*. *Philia* was encouraged between physicians and upper-class patients not in the modern sense of open dialogue between equals, but rather as a means through which the physician can bolster his authority over the patient. Conversation was “important not for the sake of sharing decision-making burdens but for the sake of friendship that, in turn, led to trust, obedience and then to cure” (Katz 1984, 7). In fact, Katz notes that the Hippocratic Corpus only addresses the role of conversation in medical practice to advise *against* disclosure. Revealing too much to patients would expose how uncertainty was more the rule than the exception, and that doctors really had little control over the effects of disease. In *Decorum*, Hippocrates instructed physicians to perform their duties

...calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and serenity, turning his attention away from what is being done to him; sometimes reprove sharply and emphatically, and sometimes comfort with solicitude and attention, revealing nothing of the patient’s future or present condition. (Katz 1984, 4)

Hippocrates thus advised physicians to maintain silence whenever possible as the best means to cultivating trust among patients. This is precisely the opposite of what physicians are taught in modern medical ethics about “the facilitation of trust” through disclosure and dialogue. The practice of sharing knowledge with patients, however, was not possible until the onset of biomedicine: “Only during the last 150 years,

thanks to the unprecedented advances in medical science, have physicians begun to acquire the intellectual sophistication and experimental tools to distinguish more systematically between knowledge and ignorance, between what they know, do not know, and what remains conjectural” (Katz 1984, xvi). Disclosure and consent became “viable alternatives to keeping patients in the dark and making decisions on their behalf. Without the emergence of medical science, the legal doctrine of informed consent probably could not have been promulgated” (Katz 1984, xvi). In short, history indicates that faith, not communication, was central to good medicine in ancient Greece.

Hippocrates’ doctrine influenced all of Western medicine but his tenets were interpreted differently in different historical periods. During the Middle Ages faith in the physician was cultivated not through *philia* as it was in classical Greek society (at least for the upper classes), but through the belief that the doctor’s authority came from God. As was the case in ancient Greece, the Medieval physician’s demand for their patients’ faith and obedience was not entirely motivated by the desire for status and power. Cultivating the patient’s unwavering trust in the physician’s powers was believed to be intrinsic to the cure. This belief is expressed by the ninth-century Jewish physician Isaac Israeli: “Reassure the patient and declare his safety even though you may not be certain of it, for by this you will strengthen his Nature” (Katz 1984, 9). Faith in the physician took another turn during the Enlightenment as reason became the font of trust in the therapeutic relationship. In accordance with the spirit of the times, physicians opted for greater candor to enlighten their patients on their

conditions. But this newfound belief in reason and truthfulness did not equalize the balance of authority between doctors and patients. Doctors of the Enlightenment “believed instead that patients, once they appreciated the true nature of medicine, its great promise to alleviate suffering, would make common cause with their doctors and accept their doctors’ authority” (Katz 1984, 13). Reason and truth therefore substituted faith as the means to fortify the physician’s authority to decide what is best for their patients’ welfare.

The dubious place of dialogue in Plato’s *Gorgias*

With this history in mind I turn to my second example, a quote by Debra Roter and Kelly McNeilis from a chapter in the *Handbook of Health Communication* (Thompson et al. 2003) on the nature of discourse in patient-physician encounters in which they, like Ratzan, Payne and Bishop, illustrate communication’s historical decline in medical care by invoking ancient Greek history:

In one manner or another, the construct of the physician-patient relationship and its expression through the medical dialogue has been described or alluded to in the history of medicine since the time of the Greeks (e.g., Plato’s *The Gorgias*) . . . Nevertheless, historians of modern medicine have tracked an undeniable decline in the centrality of communication to the care process [*italics in original*]. (Roter and McNeilis 2003, 121)

The idea that there has been a historical “decline in the centrality of communication” in medicine must stem from a misinterpretation of *Gorgias* and a general misunderstanding of the values that governed patient care historically in the West. For starters, dialogue as the expression of the physician-patient relationship was not what

Plato had in mind in *Gorgias*. Plato in fact was warning *against* the powers of rhetoric; the “ignorant,” i.e., the politically and culturally naïve *hoi polloi*, could be wrongly influenced by unscrupulous rhetoricians or, in the case of medicine, by silver-tongued physicians with the gift of persuasion. The power of rhetoric is illustrated when Gorgias boasts that many times he was successful at persuading non-compliant patients to submit to treatments where their physicians had failed:

On several occasions I have been with my brother Herodicus or some other physician to see one of his patients, who would not allow the physician to give him medicine, or apply a knife or hot iron to him; and I have persuaded him to do for me what he would not do for the physician just by the use of rhetoric. And I say that if a rhetorician and a physician were to go to any city, and had there to argue in the Ecclesia or any other assembly as to which of them should be elected state-physician, the physician would have no chance.¹³

In *Gorgias*, Plato’s concern was about the danger of rhetoric overriding genuine expert knowledge in fields where rhetoricians have no expertise. If anything, *Gorgias* stands as a warning against the dubious influence of verbal communication in the medical relationship and not, as Roter and McNeilis believe, an endorsement of speech as representing “the construct of the physician-patient relationship and its expression through the medical dialogue.” Plato recognized that some verbal interaction between physicians and patients was necessary for physicians to gather information for diagnostic purposes and to “teach the sick under what treatment they might get well.” But nowhere in *Gorgias* is there an endorsement of dialogue as the foundation of patient care.

¹³ Plato, “Gorgias”, translated by Benjamin Jowett, Internet Classics Archive, <http://classics.mit.edu/Plato/gorgias.html>.

Conclusion

Does knowing that communication has not been considered central to health for most of Western history make a difference to the work of health communication? I believe it can chiefly by reducing the tendency towards a deterministic mindset that believes “better” communication skills or processes or systems are the key to solving most problems in health care. This would in turn decrease the overabundance of research in the vein of abstracted empiricism that produces a lot of data on minute aspects of health behaviors that fail to add up to substantive answers to questions about health and communication in society. Health communication needs to examine the ways in which its applied focus and the persistence of the information model of communication prevent the field from adequately addressing the problems of power and ethics in medicine, which are sociohistorical, political, and moral philosophical in nature and not curable simply by clearing the communicative pathways for more two-way exchange between health “providers” and “consumers.”

CHAPTER FOUR

“Be a Good Patient!” and Other Stories of Medical Paternalism, 1930-1969

A widespread belief exists today that information “empowers” the patient as a consumer to become “active” in his or her own health care. There are persuasive arguments in recent historical scholarship that the patient as an active consumer of health products and medical services was already commonplace by the 1920s, the first efflorescence of the modern consumer society in the United States. However, at issue is whether active patients in the early twentieth century could be considered empowered in the same sense as the ideals embodied by the patient-as-consumer today, that is, one who is expected to seek out information necessary to take personal control over health decisions and is accorded this right to personal autonomy in health care by law.

From my analysis of print media from 1930 to 1969, I have found that information on health and medicine was widely available in early-twentieth century mass media, indicating that this knowledge was popular with the American public, or at least the segment of the white population that was educated and could afford newspaper and periodical subscriptions. But did this lay information impact the balance of authority in the doctor-patient relationship? I have found evidence that patients, as purchasers of patent medicines and consumers of health information in the

mass media, did behave in ways that could be considered “consumerist.” Public discourse, however, was largely free of the term consumer or consumerism to represent patients and their health care-related activities. This would be only a matter of “linguistic fashion” if not for the evidence I shall present that consumerism was not a prevalent way of conceptualizing the patient’s entitlements and responsibilities as medicine was organized before the mid-twentieth century. At a time when good health care was synonymous with finding a good doctor, patients lacked what Albert Hirschman (1970) calls “voice” through which to register their frustrations and grievances when the doctor-patient relationship ran afoul. This, however, did not stop some from exercising the economic option Hirschman describes as “exit,” which in the medical context meant leaving one doctor’s care for another or even renouncing mainstream medicine altogether by pursuing self-care or alternative medicine (Goldstein 2004). Since patient dissatisfaction is as ancient as medicine itself, the existence of exit at a time when “strong paternalism” (Hayry 1991) dominated medical practices does not necessarily indicate that patients were behaving as consumers with a sense of rights. In fact, I have found evidence that patients typically engaged in exit surreptitiously, behind their physicians’ backs as it were. I propose that the lack of patients’ rights to make medical choices in their own best interests was one of the chief reasons that patients resorted to exit in this manner.

The consumer movement was the exception to this general absence of consumer as a signifier of the patient in popular health discourse. Consumers Union published articles on health insurance in its magazine, *Consumer Reports*, in which

patients appeared as citizen-consumers who deserved health care as a basic right of citizenship. *Consumers Reports'* early articles on health insurance are the only examples I have found in which the *patient*—as the doctor's dependent or ward—was construed explicitly as a consumer. This linguistic move was particularly significant at a time when the medical profession had successfully disassociated the economics from the practice of medicine by focusing on the moral dimension of healing. The emphasis on trust as the soul of the doctor-patient relationship also meant that patients must trust physicians to set their fees based on moral and ethical considerations and not on pecuniary motives. The debate over “socialized medicine” and the issue of universal health insurance was the first example of the patient defined politically as a consumer to challenge organized medicine in the policy domain. In this debate, the American Medical Association exploited moral and patriotic language to argue that compulsory health insurance was “un-American” because the state would rob the patient of his or her freedom to choose a physician. In line with leftist critiques, Consumers Union countered that this contention was moot when millions of Americans cannot afford a doctor in the first place. Though the two sides argued from contrasting ideological positions on how to pay for physician services, they shared the underlying assumption that doctors were indispensable to making health care choices for patients. Consumers Union's position in the 1930s and 1940s was grounded more or less in the prevalent paternalistic paradigm of the day: the goal was not to secure rights for patients to make health care decisions in their own interests but to secure for every American the right

to see a doctor, regardless of income. Patients had to wait another thirty years before their right to self determination would be recognized.

This chapter presents a history of consumerism as it evolved in medicine during the period 1930 to 1969. I turn to the print media to ascertain the common ideals, assumptions, and practices of the time that influenced the way patients and doctors interacted in mainstream medicine. I have examined hundreds of articles from this period in newspapers and popular periodicals of different genres. Newspapers I have studied include the *New York Times* and four metropolitan dailies that were selected based on different ownership and regional representation: the *Chicago Tribune*, the *Dallas Morning News*, the *Philadelphia Inquirer*, and the *San Diego Union Tribune*. Popular weekly and monthly journals in print in the first three decades of the twentieth century that I have reviewed include *Harper's Monthly Magazine* (1850-present), *Scribner's Magazine* (1887-1939), *Newsweek* (1933-present), and *Time* (1923-present).¹⁴ My sample also includes three types of specialty magazines: consumer journals (*Consumer Reports*, 1936-present), lay health periodicals (*Hygeia*, 1923-1950 replaced by *Today's Health*, 1950-1976; *Health and Hygiene*, 1935-1938), and women's magazines (*Good Housekeeping*, 1885-present; *Ladies' Home Journal*, 1889-present).¹⁵ There are good historical and sociological reasons to start in the 1930s to look at how consumerism contributed to the emergence of the patient as a

¹⁴ I also reviewed several year's issues of *Collier's Weekly* (1888-1957) from the 1930s and 1940s, but did not find any articles on medicine or health.

¹⁵ I have also looked at *Delineator* and *Harper's Bazaar* as part of my review of early women's magazines, but textual analysis is largely focused on *Good Housekeeping* and *Ladies Home Journal*. I also had the opportunity to review several months' worth of early volumes of the men's quarterly, *Esquire Magazine* courtesy of the Mandeville Special Collections Library at UCSD.

“rights-bearing” consumer by the end of the 1960s. It was in this decade that key factors pertinent to the shaping of modern American medicine and health care emerged out of the confluence of a maturing consumer society, the consolidation of medicine as a profession, cultural faith in science, and the emergence of health care as a critical issue of state social policy. Second-wave consumerism gained momentum in the 1930s and new organizations appeared, such as Consumers Union, that were dedicated to protecting the public’s health through lobbying for tighter regulation of the health care market and equity in health care access. These were the seeds that germinated into conditions ripe for consumerism to join the civil rights movement, the women’s movement, and other rights movements of the 1960s to challenge organized medicine’s dominance of mainstream health care practices in the US.

This chapter begins with an overview of the historical origins of the “consumer’s information environment” (Schudson 1986) in health and medicine in American mass society.

The American Lay Health Information Environment

Lay health and medical knowledge before the twentieth century

The interplay of consumption, lay health information, and medicine is older than modern American consumer society itself. Two popular vehicles for lay health information were patent medicine advertising and self-help manuals.

“Proprietary” or “patent” medicines existed since the colonial period and were part of the common arsenal of home remedies and folk cures most Americans relied

on long before the arrival of modern scientific medicine and organized medicine's professional dominance of health practices in the early twentieth century. The patent medicine industry was one of the earliest to establish a nationwide distributing and advertising presence (Tomes 2000). The earliest colonial newspapers included patent medicine advertising (Young 1985), which spread with the proliferation of newspapers and popular journals after the mid-nineteenth century. For example, shortly after it debuted in September 1851, the *New York Times* began to publish its first medical advertising in the classified section for such nostrums as "Dr. Hastings' Compound Syrup of Naptha" that claimed to cure the common cold and tuberculosis or "Dr. S.P. Townsend's Sarsaparilla," described as "the Great Elixir of Life" and "Blood Purifier."¹⁶ Patent medicine advertising was a source of medical information to a lay mass audience, but the information was often either of dubious quality or served to promote the fortunes of the producers, usually both. For example, the *New York Times* in 1865 ran a full-page column by a "Dr. Schenck of Philadelphia" ostensibly to educate readers on symptoms of the common cold and pulmonary consumption while promoting the sale of his "Pulmonic Syrup" and "Seaweed Tonic and Mandrake Pills." Dr. Schenck may have been a bona fide doctor and not one of the countless charlatans operating in the patent medicine market; up until the early twentieth century, many legitimate physicians sold their own medicines before commercialism was prohibited by the medical profession (Young 1985). However, with proprietary drugs the line between the genuine article and quackery was fine since medicine before germ theory

¹⁶ All medical classified ads included here are from the Proquest Historical Newspapers database, The New York Times (1851-2003), <http://proquest.umi.com>.

offered few effective cures. Even at the beginning of the twentieth century, a person under a physician's supervision stood as much chance of dying as recovering. For the most part, what health information contained in patent medicine advertising was largely exaggeration and hype that producers hoped would distinguish their brands from their competitors'.

Self-care or self-help manuals were also popular in the seventeenth and eighteenth centuries. Susan Cayceff notes that in the eighteenth century self-help handbooks written by lay people were less common than physician-authored manuals but some became quite popular:

The more popular manuals offer valuable insight into the directives and values extant in domestic medicine. In 1742 Mrs. E. Smith's *The Compleat Housewife*—the first cookbook in America—was published. Its combination of medicinal as well as food recipes became typical of a large number of books by both women and men in the seventeenth and eighteenth centuries. Smith's book provides recipes for the cure of specific diseases and conditions using herbal and distilled drugs, many with a high alcoholic content [*italics in original*]. (Cayceff 1990, 312-313)

The tension between doctor's versus lay medical knowledge was evident as far back as the eighteenth century in self-help manuals such as Dr. William Buchan's *Domestic Medicine: Or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines* (in Cayceff, 1990). First published in 1772, Buchan's handbook represented complex intersections of popular ideas about medicine and health at a time when "allopathic" medicine was only one form, and not necessarily the dominant one, among numerous medical practices prevalent in American society. Buchan's manual reflected both a popular belief in the body to heal itself as well as the idea that lay

people required guidance from doctors to properly discern what was effective and what was not. Manuals like Buchan's aimed to increase the lay public's knowledge about medicine with the added goal "to enhance their trust and faith in physicians and to dispel quackery" (Caycleff 1990, 313). Other self-care handbooks were not so kind to physicians. John Wesley's *Primitive Physic* (1747), for example, "denounced doctors much more vehemently than did Buchan and fostered the belief that commonfolk were capable of treating their illnesses" (Caycleff 1990, 314). Much of medicine and healing traditionally has been practiced in the home and largely by women who relied on time-honored folk medicine. As with patent medicines, doctors involuntarily helped to sustain the enduring popularity of self-care. Until the arrival of scientific medicine in the latter half of the nineteenth century, "doctors had not progressed all that much beyond their counterparts of the Middle Ages" (Turow 1989, 4). Physicians relied chiefly upon "heroic" interventions such as bloodletting. As

Turow describes:

It isn't hard to understand, then, why a great many nineteenth-century Americans cringed at the thought of asking help from a physician. "Regular" doctors looked on in chagrin as millions of people eschewed them in favor of patent medicine vendors, who promoted sometimes harmful elixirs for self-medication. Millions also turned to relatively benign forms of healing—Thompsonianism, the Hygienic Movement, Eclecticism, Homeopathy. While not necessarily more effective than "regular medicine," these approaches at least had the benefit of not leaving the living patient permanently scarred and pained. (Turow 1989, 4)

Thus, the fact that patients had as much chance of dying under a doctor's supervision as they would without a physician's services explains to a great degree the popularity of self-help manuals and patent medicines before the arrival of scientific medicine.

Lay health information in consumer society and the age of scientific medicine

Self-care and patent medicines continued to be popular subject matter of lay health information after the arrival of the modern consumer society. Together with scientific and technological developments in medicine, changes brought on by the shift to a consumer economy altered the nature and scope of the lay health information environment after the 1890s. The spread of mass media in a rapidly expanding national consumer culture brought not only growth in patent medicine advertising but also an increase in health information available to the public through the proliferation of books, periodicals, and newspapers. Health and medical information and advertising also spread to radio and film as early as the 1920s.¹⁷ My review of four metropolitan newspapers and five general interest and current affairs periodicals in circulation before the mid-1900s¹⁸ show that health and medicine articles were ubiquitous in mainstream print media but usually occupied only a small percentage of a newspaper's or magazine's overall page count. Nevertheless, health information turned up fairly consistently in all the newspapers and magazines sampled. Health information appeared most commonly in the form of doctors' advice columns. All four newspapers I sampled carried daily or weekly doctors' columns that dispensed what

¹⁷ According to an October 1935 editorial in *Hygeia*, AMA was one of the first organizations that used radio for health education. It began broadcasting radio shows in 1923. The editorial included an estimate that there were more than 7,000 radio talks on health broadcasted by state and country medical associations and the AMA nationally in a given year.

¹⁸ Newspapers: the *Chicago Tribune*, the *Dallas Morning News*, the *Philadelphia Inquirer*, and the *San Diego Union Tribune*. General interest and current affairs periodicals: *Collier's Weekly* (1888-1957), *Harper's Monthly Magazine* (1850-), *Scribner's Magazine* (1887-1939), *Newsweek* (1933-present), and *Time* (1923-present).

amounted to medically endorsed self-help advice to readers' questions on diet, how to recognize disease symptoms, home treatments for common maladies, and best childrearing practices. Advice columns with headings such as "How to Keep Well" (*Chicago Tribune*), "Diet and Health" (*Dallas Morning News*), and "That Body of Yours" (*Dallas Morning News* and *Philadelphia Inquirer*) were published daily or weekly and sometimes over extensive periods by different doctors. "How to Keep Well," for instance, first appeared in the *Chicago Tribune* in 1916 and still existed as late as 1966.

Specialty versus general interest magazines carried lay health information differently. Current affairs weeklies such as *Time* and *Newsweek* published more "hard news" style medical reporting on the latest developments in medical science. *Time* and *Newsweek* provided weekly reporting on the latest scientific medical developments; *Time* carried a medical science column from its first issue in March 1923 while *Newsweek* included medical news in its science section from its earliest issues after debuting in 1933. The science and medicine sections typically appeared towards the back pages in both magazines and were about a page in length. As medical science became increasingly newsworthy after World War II (by 1945 medicine had its own section in *Newsweek*, for example), medicine and health policy were reported regularly in feature articles. Popular general interest monthlies such as *Harper's*, *Collier's*, and *Scribner's* typically featured extended essays that provided analyses and opinions on current health, medical, and policy issues. For instance, from *Harper's* and *Scribner's* I have found a few examples from the late 1920s and early 1930s of

first-hand patient accounts of their experiences with doctors. Articles written from the patient's perspective were harder to find than the contributions of medical experts. That physicians supplied much of the health information available in the popular media reflected their "cultural authority" (Starr 1982) as a profession.

Health information was a staple in women's journals, mainly as doctor's advice columns or feature articles about diet, disease, and other health-related issues written almost exclusively by physicians especially in the decades between the wars. Health economics and policy issues were less frequently reported, but examples did exist. *Good Housekeeping* and *Ladies Home Journal*, for instance, published articles that addressed health insurance and policy issues, though infrequently compared to the regular appearance of information that educated readers on the causes of common health conditions, diseases, and proper food safety and nutrition. In women's magazines, health was often associated with beauty and maintaining youth and articles detailing methods towards achieving these goals exist as far back as the mid-nineteenth century. For example, the October 1848 issue of Godey's Ladies Book (1848-1898) carried an article entitled "Health and Beauty" that expounded on the benefits of moderate exercise for women and included diagrams that illustrated how to perform the exercises.¹⁹ Illustrated "how-to" articles on exercising continued to be popular in early twentieth century women's journals such as *The Delineator*, which included topics such as "exercises for middle age" (F. Yost 1923) and how to avoid the "aggressive tummies of old age" (Cole 1929, 42). Beauty advice also appeared in

¹⁹ Godey's Ladies Book, "Health and Beauty," American Periodicals Series Online 1740-1900, <http://proquest.umi.com>.

newspapers and were sometimes paired with doctor's advice columns, such as in the *Philadelphia Inquirer*: "Your Figure, Madame!" was a daily beauty column that included advice on diet and exercise and appeared in November 1936 with "That Body of Yours," a health and medical advice column written by a physician.

Health journals geared for a popular audience also appeared in this era with titles such as *Life and Health*, *Everybody's Health*, *Health and Hygiene* (1935-1938), and the American Medical Association's publication, *Hygeia*, first published in 1923 and replaced by *Today's Health* in 1950 (1950-1976).²⁰ *Hygeia*'s articles more resemble those found in women's magazines than that of the general interest periodicals and news weeklies; early *Hygeia* included the typical question-and-answer advice columns and health education articles on diseases and illnesses. *Hygeia* before the 1940s also included short stories that romanticized physicians, excerpts from popular books on health, (e.g., the *Eye Book*, Dr. Hyman Cohen, 1935), the occasional script for plays ("The Medicine Man," March 1935; "Eavesdropping on the Doctor," June 1935), and also full scripts of the AMA's radio show, "Your Health," which was popular in the 1930s ("First Aid to the Unconscious," October 1935). The earliest volumes of *Hygeia* from the 1920s and 1930s included poems and nursery rhymes about hygiene and good health habits (e.g. "Around the Clock with Baby," 1923; "The Vitamin Elves," 1937), and even musical scores to songs about health, presumably to be sung by parents to their children ("Milk Song," 1923). The AMA's monthly lay health journal also included reviews of current books and magazine articles on health

²⁰ Note: these are a few of the titles from *N.W. Ayers' Directory of Newspapers and Periodicals* (Philadelphia: N.W. Ayer) I selected between 1935-1945 that provided actual circulation figures.

and medicine for popular consumption. Romanticizing the physician was the farthest thing from *Health and Hygiene's* goals, the lay health magazine published by a group of left-wing physicians and dentists that circulated between 1935 and 1938. *Health and Hygiene's* socialist perspective on the state of health care during the Depression was evident in the numerous articles that addressed workers' occupational health and safety, public health measures for the indigent, and the lack of affordable health care insurance for the majority of Americans. *Health and Hygiene* also included articles against quackery in the health marketplace, how to recognize and treat everyday ailments, and editorials that championed progressive positions on birth control, abortion, and sexual health. *Health and Hygiene* naturally supported the inclusion of health insurance in Roosevelt's New Deal plan and the AMA's position against "socialized medicine" was regularly and roundly critiqued in every issue during the journal's short existence. In perhaps a sarcastic dig at *Hygeia* and the AMA, a poem on the back cover of the November 1938 issue of *Health and Hygiene* mimics the type of poetry often included in *Hygeia* right down to the cartoon illustrations. But unlike *Hygeia's* poems about vitamins and encomia to the family physician, the poem, entitled "The Poor and Pulseless Patient and the Hard and Heartless Doctor," pokes bitter fun at physicians and the AMA's obdurate opposition to national health insurance, as in this excerpt:

Oh doctor, my doctor, but something must be done!
 My malady is getting worse, my pulse is down to one;
 I have no thought or wish, sir, to cut into your fee;
 Let those who have it pay it—but that still leaves me.
That still leaves him, says he;
And with that we must agree

Oh, is nothing to be done for the patient SANS a fee? [italics in original] (Health and Hygiene, 1938)

Doctor-patient articles in popular periodicals

Articles about patient-physician relations comprised only a small portion of the health and medicine articles in the popular journals included in this study. *Hygeia* published the most material addressing aspects of the doctor-patient relationship, as would be expected from the lay publication of the AMA. A Readers' Guide Retrospective database search for feature articles under the subject-heading "physicians" for the period 1930 to 1969 produced 185 articles in *Hygeia*, 24 in *Good Housekeeping*, 15 in *Harper's Magazine*, and 12 in *Ladies' Home Journal*.²¹ A similar search in *Scribner's*, which ceased publication in 1939, produced four articles. A textual analysis of these doctor-patient articles gives clues about patient-physician interaction and also provides evidence of how the values, assumptions, and expectations of a paternalistic system were communicated in print media to lay audiences. I have categorized my findings according to the following themes: how to choose a doctor, the importance of having a personal physician, the family doctor versus specialist debate, and proper patient behavior. These themes appeared regularly in many of *Hygeia's* doctor-patient articles from the 1930s and 1940s and are echoed in the few articles on that dealt with physician-patient relations in *Good Housekeeping*

²¹ Further searches using the terms "physicians and patients" and "medical ethics" produced articles that were already included in the results for "physicians."

and the *Ladies' Home Journal*.²² The issues captured in these themes also appeared in articles from *Harper's* and *Scribner's* but were more often than not critiqued from the lay or patient's perspective as aspects of the American system of medical care in need of reform. *Health and Hygiene* is the outlier to the mainstream magazines as it did not carry articles on the doctor-patient relationship. The socialist health magazine focused not on the doctor-patient relationship but on the fee-for-service payment structure that created hardship for patients. *Health and Hygiene* excepted, from the themes found in doctor-patient articles, it is possible to gauge the normative assumptions about values and ethics that governed doctor-patient relations in the decades between 1930 and 1969. My discussion will first address articles from 1930 and 1949 and then 1950 to 1969.

How to choose a doctor

The influence of science on medicine after 1900 profoundly altered how medicine was taught, organized, and practiced (Bonner 1995; Ludmerer 1996; Rosenberg 1987; Starr 1982) The intensification of science in medicine in the decades before World War II led to viable treatments for diseases previously considered incurable. This bolstered the public's faith in science and transformed the medical profession into one of the most trusted institutions in American society. By the 1930s, these factors helped boost the public's confidence in physicians and its acceptance that access to medical care was key to good health. These developments in medicine combined with factors created by the transition to a consumer society to influence the

²² Hygeia achieved circulation figures of 71,169 in 1935, 110,188 in 1945, and by 1949 an estimated 195,387 (Source: *N.W. Ayer and Son's Directory of Newspapers and Periodicals*, Philadelphia: N.W. Ayer).

type of knowledge about doctors and health care available in the lay health information environment. Increased social mobility and urbanization after the 1890s caused many Americans who migrated to the cities to lose their traditional social networks that once served as a source of experiential information about health care from family members and acquaintances.

Articles on how to choose a doctor appeared frequently in journals such as *Hygeia* and sometimes in popular magazines such as *Good Housekeeping*, and the *Ladies Home Journal*. These articles offer glimpses into the circumstances surrounding people who have moved to unfamiliar cities and are in need of medical services. A 1930 article in *Hygeia* depicts this scenario through the story of the “Joneses,” a fictional family in search of a physician shortly after relocating to a new city when little “Johnny” contracts measles. The article educates readers that the proper way to select a family physician is to seek expert recommendations from the local medical society, hospital, Chamber of Commerce, or the AMA directory at the public library. Only doctors are qualified to judge other doctors and this point is stressed in every article on how to choose a physician reviewed from this period. The wrong way to choose a doctor was to rely on the advice of laypersons or advertising. For instance, Mrs. Jones’s first inclination was to ask their neighbors. However, Mr. Jones felt this to be too risky and they wound up rejecting referrals to several different doctors in the community, two of whom were recommended by the butcher and Mr. Jones’s boss. Although physician advertising was against the AMA’s code of ethics by the 1920s, apparently the practice failed to disappear entirely as Mrs. Jones

discovered: “Mrs. Jones blacklists also the Westside Clinic, which carries a daily ad in the Hodge City *Sentinel*, and a Dr. Forest who inserts a weekly one, and is addicted to handbills” (Fortune 1930, 228). The Joneses’ rejection of their lay acquaintances’ recommendation serves to illustrate a common sentiment in *Hygeia* that “the average layman’s advice is not worth much” because lay people lacked expert medical knowledge to credibly judge a physician’s professional worth (Williams 1942, 439). Mrs. Jones’s rejection of doctors who advertised was meant to illustrate the AMA’s strictures against this practice. Plenty of *Hygeia* doctor-patient articles from the 1930s and 1940s carried warnings to its readers that credible doctors do not advertise, such as “Never employ or consult a doctor that advertises” (McFarland, 1931, 747), “A good doctor does not advertise his name, specialty, methods, cures or low fees in any commercial way” (Williams 1942, 432), or “Reputable doctors of medicine do not advertise spectacular cures” (McKeever 1948, 701). The AMA’s anti-advertising message reflected its efforts since the early 1900s to consolidate the medical establishment’s authority over health care practices by creating standards that would distinguish reputable physicians from quacks in the medical marketplace. From a symbolic perspective, the message that real doctors do not advertise accentuated the reputation of physicians as the antithesis of businessmen and the image of medicine as an institution powered by altruism rather than profit. This anti-commercialist message played a key part in fostering the ethical ideal that reputable physicians are professionally and morally obliged to always act in their patients’ best interests.

That patients have an obligation to remain loyal to their physicians once they have made their choice is a persistent message in *Hygeia*'s doctor-patient articles. After hearing about a "physician exchange" and calling the doctors recommended by this officially sanctioned referral service, the Joneses settled on "Dr. Blodgett" who cures Johnny. The moral of this story was that young Johnny's recovery resulted from his parents' intelligent actions: they consulted wisely on their choice of a physician and they chose to stick with their new doctor: "Mr. Jones knows it doesn't pay to change horses in midstream, and he has a notion many patients are delayed of recovery or actually endangered because they are unwilling to give their physicians sufficient time to get results" (Fortune 1930, 230). This type of informed "shopping around" for a physician was acceptable—and even prudent—since it was assumed that most people invested more time and scrutiny on household purchases than in selecting a personal physician: "Choosing a doctor . . . is at least as important as buying a new car" (Fortune 1930, 229). However, the shopping behavior must be informed by credible sources on physicians, such as official medical organizations. Once a choice is made, all shopping around for a family doctor was to cease.

The importance of having a personal physician

The fictitious Mr. and Mrs. Jones's efforts to find a suitable doctor immediately after relocating to a new city was meant to illustrate the unpredictability of illness. Hence, finding a family physician with whom to build a lasting relationship should be a top priority in any household and must not wait until a medical emergency. But a rare first-hand patient account from 1930 in *Harper's Magazine*

presents some of the everyday contingencies that prevented individuals to retain personal physicians in an increasingly urban and mobile American society. The anonymous author of “A Patient Looks at Doctors” (Anon. 1930) provides a glimpse into how the circumstances and expense of big city life can affect a patient’s ability to find suitable medical care when needed. The author describes herself as a professional worker, originally from a small town, who lived a life she considered typical of many young New Yorkers of her day: “Like thousands of other young men and women who pour into New York each year, I lived by myself in a modest apartment. I had the usual Manhattanite’s wide circle of acquaintances, but my intimate friends were few and busy” (Anon. 1930, 713). Her salary was “decent,” especially for a woman, but with “the cost of living in New York being what it is, my bank balance never exceeded three hundred dollars, and after some such expense as a heavy dental bill or new winter coat it occasionally descended to zero” (Anon. 1930, 713). After three years in the city, she had little reason to become acquainted with doctors until she found herself seriously ill one day. In great pain, she called a gynecologist she met once at a party:

In two hours, despite hot-water bottle and aspirin, I was clenching my fists and tensing every muscle to keep from screaming. I realized then that I needed a doctor and that I didn’t know one. There was, I remembered, the gynaecologist I had met just once, socially. The thought of rousing a prominent gynaecologist from his slumbers at daybreak to ask his advice about an earache would have normally outraged my sense of fitness, but finally in desperation I telephoned his home. There was no answer. (Anon. 1930, 713)

Desperate for a physician, the author turned to her friends for help. One instructed her to check-in to the local hospital after the specialist recommended by another friend

could not book her. Despite the hospital's AMA accreditation, "Doctor Brown," the specialist assigned to her case, turned out to be inexperienced and caused her further pain and grief after refusing her request to have another specialist operate on her ear. She subsequently spent many painful months recuperating and struggling to pay the bills for the botched operation.

After her ordeal, the author was told by "an official of a medical association" that her situation could have been avoided had she considered that "One of my first duties after settling in the city was to have made a contact with a neighborhood doctor to whom I could have turned to in an emergency" (Anon. 1930, 716). In other words, she was to blame for her predicament because she did not make finding a physician a top priority before illness struck. The author was rudely introduced to the underlying reality of the paternalist model of medicine: because she was not under the guidance of a personal physician, she was at the mercy of a medical system that, unbeknownst to the patient, adhered to rules of conduct that ensured the professional entitlements of doctors over the wishes and demands of patients. One of these was that doctors must not treat other doctors' patients without expressed permission. In the author's case, this was doubly forbidden because the second specialist—the one she requested to operate—was not affiliated with the hospital she had checked herself into. A 1941 article from *Good Housekeeping* echoes the recommendations in *Hygeia* and the advice given to the anonymous author in *Harper's* after her misfortunes in the hospital: the best way to find a suitable doctor was to contact "the nearest county medical society" and "the proper rule and the etiquette on consultants [specialists] are

that your doctor calls them in on the case, and not you” (Potter 1941, 31). In these ways, patients could not avoid institutional paternalism as reinforced through the professional conduct of physicians with their patients and their peers.

The family doctor versus specialist debate

By the 1930s, the role of specialists became increasingly instrumental in medical care. The rapid disappearance of the “old-time family doctor” was already evident in the lay health literature at this time. Many of the doctor-patient articles I have analyzed show that nostalgia for the old-fashioned family physician, who knew his patients personally and made time for house calls, was a prominent and persistent leitmotif in the lay health information environment. Although the author of the *Harper’s* article claims that her account “is no attempt to draw an idealized portrait of the ‘old-time family physician’ or to sentimentalize over his rapid disappearance from the medical scene in our larger cities” (Anon. 1930, 710), there is more than a hint of nostalgia in her fond description of her childhood doctor:

During our rare periods of affluence his bills were inclined to be large. But during the more frequent periods of depression they were either small or non-existent. . . . But his chief virtue, I think, was his accessibility. Except in the periods of his short yearly vacations, when an associate attended to emergencies, he was always to be reached somehow. (Anon. 1930, 710)

This author believes that people were nostalgic for the traditional physician because of his personal touch and his availability. In *Hygeia* the issue of the disappearing family doctor was placed within the context of the growth of specialization within the medical profession. “What has become of the old family doctor?” is a question frequently heard, often with an intonation of regret,” according to a 1942 article in

Hygeia: “In small towns he still exists, but in metropolitan districts he is almost extinct” (Nutt 1942, 814).

This article offers some clues as to what experts of the day considered to be the reasons for this decline. Higher salaries was one factor as was the specialist’s greater prestige: the specialist evolved from the role of a consultant to general practitioners to that of an expert who accrued more cultural capital within the medical establishment and also among the lay public: “The layman began to think of him [general practitioner] as inferior to the specialist in all branches of medicine and consulted specialists without seeking his family doctor’s advice as to the necessity of the special examination or in the selection of a specialist” (Nutt 1942, 814; 878). The supposed ignorant willfulness of patients was also blamed for inflating the numbers of specialists at the expense of the family physician: “the layman . . . wanted the best of medical service and went directly to a specialist for whatever examination he felt he needed. . . . The family physician, in the larger cities at least, passed almost completely out of the picture” (Nutt 1942, 814; 878). The article concludes that “the specialist should be a tool of the family physician” and patients need to rediscover and place their trust in the general practitioner as the best person to determine their medical needs. Lay people ought to “accept no advice regarding health unless it has received the endorsement of our family physician” (Nutt 1942, 814; 879). This reiterates the message from an earlier *Hygeia* article from 1930 that there will always be a place for the family doctor because the increase in specialties meant a greater need for general practitioners who have the expertise to know which specialists to

direct their patients to (American Medical Association 1930). This is the same message found in the many “how-to” articles on choosing doctors that only physicians have the credentials to assess the skills of other physicians.

Proper patient behavior

The common themes found in the doctor-patient articles I have reviewed show an unmistakable paternalistic understanding of the roles, entitlements, and responsibilities of physicians and patients. Patients were to ignore any information on physicians and health care not vetted or authored by the medical profession. Patients must find themselves a physician in whom they should place their unwavering trust. And problems in the doctor-patient relationship were assumed to originate with patients: non-compliance was considered a matter of errant patient behavior due to ignorance, superstitions, laziness, and malingering. A 1930 article in *Hygeia*, “How Much Should a Patient be Told?”, details the ideal qualities of a patient from the doctor’s perspective:

The good patient, and he is the one who has by far the best chance of recovery, is he who obeys his medical adviser, seeks from him and not from his neighbors or from books in the library whose terms he does not understand the answer to his questions. . . . Confidence in one’s physician is almost as important as confidence in one’s confessor or in wife or husband. (Stifel 1930, 819).

Other articles ask patients to “Be a Good Patient!” (Trehella 1943) or to “Give Your Doctor a Break!” by following doctor’s orders “to the last and most minute item” (Richardson 1934, 12). Articles with titles such as “Are Doctors Human?” (American Medical Association 1934) and “Are Doctors People?” (Haardt 1934; Lee 1945) are not questioning the physician’s humanity, but rather painting the doctor as a noble,

hardworking, and selfless hero who deserved well-behaved patients who did not burden him unnecessarily. In another article, a physician classifies his patients into the following types: “suspicious,” “overanxious,” “indifferent,” “ungrateful,” “unstable,” “impatient,” and the “professional invalid” (Whyte 1935). There exists also the “ideal” patient who exhibits loyalty, trust, and consideration, as well as intelligence:

the ideal patient will select his family or personal physician with great care, will let him know that he is regarded as chief medical adviser, with the privilege of calling all the skilled assistance needed, and then will trust this doctor as long as he shows himself worthy of confidence. (Whyte 1935, 497)

A 1943 *Hygeia* article on “Choosing a Doctor” provides a self-quiz for readers to assess how well they measured up as patients, with questions that reflect the expectations of proper patient behavior common at the time, including: “Do you select your doctor on the advice of neighbors?”, “Do you shop around from one doctor to another?”, and “Do you carry out your doctor’s instructions faithfully?” (Zeligs 1943, 107). The quiz questions are similar to those included in a 1948 article entitled, “How Good a Patient are You?” (Thumim 1948) that instructs patients to assess their own behavior by asking questions such as:

- “Do you have confidence in your doctor? Or do you visit your physician, pay for his expert advice, then follow the inexpert advice of your neighbor?”
- “Do you approach the doctor without fear? It is difficult for him to examine a nervous patient.”

- “Do you take the doctor’s advice and make an honest attempt to follow it? It is surprising how many individuals willfully retard their own progress simply by failing to take the doctor’s advice.” (Thumim 1948, 562-563)

The patient’s perspective

Only a small number of articles from the 1930s-40s that present the patient’s perspective were found for this study. The patient stories from this sample tended to be critical of doctors and the medical system. The 1930 *Harper’s* article, “A Patient Looks at Doctors,” discussed earlier is a first-hand account of the disastrous outcomes for the patient when medical paternalism meets incompetency and the patient is powerless to override her physician’s orders. Another article I discovered, a 1931 article in *Scribner’s* entitled “Unfit Doctors Must Go” (Halle, 1931), illustrates how nearly impossible it was for patients to seek redress in cases of physician negligence and incompetency in that era: a doctor had administered a drug overdose to a child and the family spent months bouncing from one medical society to the next in its efforts to strip the physician of his license to practice. The medical societies, it turned out, had no power to revoke his license: “The board, which had power to issue licenses, like those in almost all of the States, had none to take them away for such an act as this, no matter how complete the proof” (Halle 1931, 515). To add insult to injury, the family was advised by a medical society not to pursue matters further as they would then be open to a libel suit:

They could revoke a license for excessive personal use of narcotics, and they confidentially said that this man was undoubtedly an “intermittent drug fiend” who administered overdoses when himself under the influence. But it could not be proven, and almost in the same

breath they warned the family not to repeat this lest they be sued for libel! (Halle 1931, 515)

The family eventually took the physician to court, but the criminal action was dismissed and the physician continued to practice. The author asserts that the medical profession's silence over malpractice—"a strange unwritten code among them . . . that compels them to remain silent about such cases" (Halle 1931, 514)—was ultimately to blame. This article highlights the difficulty of prying open the medical profession for greater public scrutiny at a time when doctors in the US achieved the highest degree of autonomy in the history of their field. Eliot Freidson, the eminent scholar of the professions, characterizes American medicine in the mid-twentieth century as exemplifying the quintessential nature of professionalism: "In the most elementary sense, professionalism is a set of institutions which permit the members of an occupation to make a living while controlling their own work" (Freidson 2001, 17). The expertise of physicians was considered so specialized that they were able to command great discretionary freedom and the only people who could judge their work were their peers. Except for the most egregious cases of negligence and incompetence, few doctors ever attracted disciplinary action. Even then, the chances were slim that a physician would lose his license to practice. State licensing boards and medical societies did not monitor doctors and most physicians refused to testify against other physicians if cases went to court (Freidson 2001, 184). The family who tried to sue their doctor in the *Scribner's* article was thus a textbook account of futility faced by patients seeking redress in an era wherein doctors exercised "virtually complete control over the terms, conditions, and content of their work" (Freidson 2001, 184).

A *Scribner's* article from 1936 is another bitter critique of medical paternalism based on the author's personal experiences with physicians. The author characterizes the medical profession as tyrannical in its demand for patients to show "a blind, unintelligent faith and obedience that smacks of the Middle Ages. (E. Yost 1936, 47). She criticizes the profession for propagating an ideal patient model that infantilizes patients and robs them of their intelligence, even specifically rebutting the passage describing the ideal patient quoted earlier from the 1930 article, "How Much Should a Patient be Told?":

I am told in a recent issue of a medical journal, the "good patient" is one who is willing and able to return to the dependence of childhood when "we are nursed as infants in arms," with as much "confidence in one's physician as in one's confessor, one's husband or wife. (E. Yost 1936, 47)

The author's main concern is how the paternalistic model of care gave doctors the authority to silence their patients. Patients—especially female patients—who spoke up and refused to be treated like children risked having their concerns ignored or downplayed. This, says the author, could potentially endanger their health and even their lives: two of her women friends who were "told to get off their tension" who later died of cancer (E. Yost 1936, 47). She herself was told by different doctors she consulted for a physical ailment that her problems were psychological:

Possibly women suffer more often than men from this willingness of doctors to shrug shoulders and do nothing but pass out pills with a superior condescension. I do not know. But I do know that it is next to impossible for a woman who happens not to be of the placid, bovine type to undergo any illness which fails to respond favorably to the doctor's first prescription with out being handicapped at this point by the doctor's quick willingness to name some nervous and emotional

condition rather than a primarily physical source as the more likely cause. (E. Yost 1936, 47)

After three years and several physicians, she finally received serious attention to her condition—but only after she lost her patience and made it plain to her physicians that there would be no more cooperation on her part if her affliction continued to be written off as a symptom of neurosis.

Where was the Consumer?

It is possible to assume from the articles I have reviewed that patients were generally an irresponsible and difficult lot. Since most of these doctor-patient articles were published in *Hygeia*, the lay health journal of the AMA, and many were written by doctors, the portrait of patients as wayward children in need of remedial education seemed the prevailing sentiment of the medical establishment. But were patients disregarding their physicians and taking their health decisions in their own hands to such an extent that organized medicine, like a beleaguered parent, felt compelled to repeatedly remind patients to obey “doctors’ orders”? Historical research of the past 20 years addressing lay health care practices in the US have shown that Americans in the past were far more active in taking care of their health needs than was previously assumed. Research into caregiving and “scientific” childrearing practices of the early twentieth century (Abel 2000), self-care and complementary or alternative medicine (Goldstein 2004), and doctor-patient relations before the 1920s (Crenner 2005) all challenge the assumption that lay people were more passive about taking control of their health than they are today. But what is unclear in the literature is to what extent

can this active behavior of the past be considered consumerist in the modern sense, that is, motivated by ideas of empowerment based on the idea of rights and personal responsibility for one's own health, that have become normative ideals associated with patients as consumers in modern American medicine.

My research presents evidence that not all patients under traditional paternalist medicine were stereotypically submissive and compliant, but neither did this mean that the dominant cultural mores of the day, in both medicine and the broader culture, encouraged patients to be active as empowered consumers of health care with rights. One indication of the lack of the patient-as-consumer concept in pre-1960s mainstream health care discourses is how the term consumer is noticeably missing as a synonym for patient from the 77 doctor-patient articles and four first-hand patient accounts from the 1930s and 1940s that I reviewed. Instead, “intelligence” appears to be the catchword of the times. The doctor-patient articles frequently appealed to the innate intelligence of patients or asked patients to exercise their intelligence by following their doctors' every word. A good patient was an intelligent patient, someone who had the good sense to recognize that, in matters of health, doctors always know best and to actively follow their directives and seek their advice over those of friends, neighbors, or quacks advertising sure-cures in the media. For instance, a 1940 *Hygeia* article on “How to be an Intelligent Patient” (Reichert 1940) discussed the “training” of intelligent patients that included tips such as not to play coy with the doctor when he asks for information, and “to go to your doctor before he must go to you” to avoid costly house calls. Since it was assumed that they were to

blame for most problems occurring in the medical relationship, it was up to patients to learn how to cooperate intelligently with their doctors:

Surely, it is obvious that an unsatisfactory result in the unique relationship between doctor and patient is precariously easy: it is far more likely to be due to the unintelligent cooperation of the patient than to the experienced direction of the physician. (Reichert 1940, 109)

Those who criticized the medical profession also framed their grievances in terms of insults to their intelligence and not, as under a consumerist model, attacks against their rights. This is not to say that rights was an alien concept before the 1960s, but the use of rights language to assert personal entitlements was not common in everyday discourse. The family in the 1931 *Scribner's* article, "Unfit Doctors Must Go," was described as "a family of sufficient intelligence" perfectly capable of recognizing professional negligence when faced with it (Halle 1931, 514). And in "A Patient Wants to Know," the word intelligence appears at least 25 times throughout the article to describe the capacity of normal, adult patients to think for themselves. The author believes this innate faculty is suppressed and harmed when the doctor-patient relationship forces adults capable of normal reasoning into a state of dependency: "For neuroticism is a logical result in a person of intelligence who attempts to co-operate with doctors by reverting to an adolescent attitude of dependence—if the doctor happens to be wrong too long and the illness to be of a non-fatal nature" (E. Yost 1936, 48).

That consumer was not a commonplace synonym for the patient during the 1930s-40s is not, in and of itself, evidence enough that expectations of patienthood back then were qualitatively different from today's expectations of the patient as a

consumer who is ultimately responsible for making decisions in his or her own best interests. For though consumer did not appear in common usage as a substitute for patient,²³ recall that references to consumption and consumer culture did exist in the form of the phrase “shopping around,” as in articles with titles such as “Shopping Around for a Physician” and “Shopping for Health,” or in self-quizzes that asked the patient, “Do you shop around from one doctor to another?” (Zeligs 1943, 107). To the degree that an intelligent patient was expected to exercise her judgment in the choice of a physician, shopping around was acceptable in the context of selecting the right doctor to form a lasting relationship in which to invest complete loyalty and trust. Patients were expected to “apply at least as much time and intelligence to shopping for the family physician as to buying the family automobile” (Fortune 1930, 230). But to the degree that shopping around was taboo after the doctor-patient relationship was cemented, it is evident that the figure of the intelligent patient did not embody notions of rights to personal autonomy found in the modern patient-as-consumer concept. Once a patient decided on a personal physician, all shopping activity must end and health decisionmaking dutifully relinquished: “Let us scratch health off our shopping list and accept no advice regarding health unless it has received the endorsement of our family physician” (Nutt 1942, 879). The limited applicability of consumerist metaphors to doctor-patient relations was perhaps also due to the strict ethical proscriptions against associating business with medicine. In addition to having it restricted to the one-time process of choosing a physician, the use of the shopping

²³ My review of several years of *Index Medicus* and the *Ayers Directory* from the 1930s and 1940s confirms that the category of “consumer health” did not exist at that time.

metaphor was further constrained through the distinction made between shopping for consumer goods versus shopping for medical care:

When a man sets out to buy a chair or an article of clothing or food, he reads the advertisements and visits the shops until he finds what he wants. He considers the quality and the price . . . When a man wishes to consult a physician in this country he finds it difficult to apply the same method. Ethical physicians do not advertise; they do not want publicity. Their fees cannot be used as a measuring rod of their skill, since there are many factors entering into the setting of fees. (Nutt 1942, 814)

Whether shopping for products or choosing physicians, the inference here is that both consumers and patients need to make informed, intelligent decisions. But since a physician's skills are determined by medical and not commercial criteria, such as price, the message is that there is little about the process of consumption that is analogous with the nature of the doctor-patient relationship once the choice of a physician is made. The limited and ambivalent application of the shopping metaphor to the medical relationship suggests that the medical profession was eager to control the only exit strategy patients had when they were dissatisfied with their physicians, which was to take their money somewhere else. This coupled with the general absence of the word consumer suggest that normative ideas about patienthood embodied in the intelligent patient of the paternalistic era were far removed from the autonomy model of patient care that appeared after the late 1960s.

A second indicator that patients could not be the ultimate judge of their own best interests is that patients who sought information and tried to make decisions for themselves did so only by feigning passivity or through stealth. Physicians often complained in *Hygeia* that patients pretended to comply with their directions only to

seek out second and third opinions behind their backs. The author of “A Patient Wants to Know” (the one who lambasted the medical profession for its medieval attitudes towards patients) articulated the problem as a matter of suppressing the patient’s intelligence, which she believed ultimately interfered with the therapeutic process. She described how she did things that seemed to her “highly unintelligent” in retrospect, such as taking medicines that she already knew failed to alleviate her symptoms and was actually making her feel sicker. She tried hard to cooperate, but she grew tired of having to play stupid if she wanted treatment from her physician: “Time and again I used my intelligence to stifle my intelligence because of the tension that arose when I tried to use it in any way that did not fit the doctor’s pattern” (E. Yost 1936, 48). In another example from *Scribner’s*, the author of “A Woman and Her Doctors” consulted several surgeons without her family physician’s knowledge before submitting herself to surgery: “Instead of accepting the diagnosis of one physician and one surgeon, as most patients do, I decided that my life was sufficiently important to justify me in consulting several eminent surgeons, each unconscious of the others’ diagnoses” (Purcell 1933, 101). This woman’s strategy was apparently all too familiar to physicians: doctors commonly complained in *Hygeia* that patients would pretend to comply with their prescriptions only to surreptitiously seek out second and third opinions. This type of patient behavior was routinely described as disloyal, ungrateful, and selfish. In “A Doctor Looks at His Patients” (Whyte 1935), a physician writes about his experiences with patients and one of them was a young woman whom he examined and determined that her appendix had to be removed. “She left without

much ado” and shortly after he received a call from a surgeon asking to see if he could administer anesthesia in an appendectomy the next morning:

He [the surgeon] was greatly surprised to learn that she [the patient] had just left my office. She had consulted him the day before and had received the same advice I had given, but she was not willing to trust one man’s opinion. She may have seen several others, for all we knew. This happens so often that doctors of experience usually learn to “spot” such patients. (Whyte 1935, 497)

A cartoon accompanying the article illustrates the “problem” of the sneaky patient: a man tiptoes between three office doors with three different doctors’ names, looking furtively over his shoulder to see if he is being watched. A caption reads: “he does not accept the opinion of one doctor: hence he often secretly visits two or more doctors in succession and compares their opinions” (Whyte 1935, 496).

That the AMA found it necessary to repeatedly remind its lay readers to trust their doctors, to ignore their neighbors’ advice, to not secretly see multiple doctors, et cetera, indicated that undetermined but significant numbers of patients engaged in these “delinquent” actions during the era of strong paternalism. The first-hand patient accounts in *Harper’s* and *Scribner’s* magazines from the 1930s would seem to bear this assessment out as they are remarkable for their outspoken documentation of patient dissatisfaction with the paternalistic status quo. They are striking in the way they show their authors disregarding physicians’ diagnoses, confronting their doctors with questions, and generally refusing to keep quiet about what they considered condescending treatment, and outright negligence and incompetence in some cases, at the hands of medical men. If we consider these personal stories alongside the numerous doctor-patient stories that aimed to educate patients on bad versus good

patient behavior, it is possible to conclude that, even in the era of strong paternalism, the “problem” of patients who ignored doctors’ orders was a significant one despite the messages about cooperation and trust that were prominent in the lay health information environment.

However, it is impossible to ignore the descriptions of doctors’ authoritarianism in the *Harper’s* and *Scribner’s* articles that were consistent from story to story, making it safe to surmise that patients’ individual acts of resistance did not add up to a system-wide diminution of the physician’s professional autonomy and expert authority. It would be difficult to say from the small sample I have found whether these first-hand reports of patients’ experiences can be generalized to the larger patient population. Further, the authors of these articles were more than likely white, from the better educated classes that had the resources to see doctors and write about their bad experiences—and have them published in prestigious magazines with nationwide audiences. Their willingness to speak up, and publicly, about their ordeals in the doctor’s office almost certainly was not the typical response since most Americans during the Depression could not afford to see physicians in the first place. Patient activism was limited to the white middle classes who, in comparison to the working class, the indigent, and blacks, were educated and well-off enough to create choices for themselves even within a paternalistic medical structure.²⁴ Black Americans and other racial minorities, in contrast, faced endemic discrimination that

²⁴ I have found examples in *Harper’s* illustrating cases of wealthy patients who held no compunction against ordering their personal physicians around and treating them as employees at their private disposal, which sometimes was the case according to one 1936 account in *Esquire* magazine by a physician to the rich (Anon. MD 1936).

denied them primary care and hospital services that whites of means enjoyed (Byrd and Clayton 2002).

My analysis of the messages about doctor-patient relations from popular magazine articles of the thirties and forties concludes that institutional paternalism was strong in American medicine at that time but not all patients were behaving passively as conventional accounts would have it. Paternalism seemed to succeed only when the patient acquiesced to playing what Talcott Parsons has described as a “sick role.” However, while some patients may have willingly played the role, my evidence indicates that others may have actively decided to play passive knowing that this was the way to obtain treatment from doctors. Patient activism thus was circumscribed within a medical system based on cultural expectations of deference and trust in the expert. Active patient behavior was acceptable only if it built good cooperative habits with the doctor. To that end, it was even tolerable to employ a consumer analogy as a means to get the message across:

Let me address myself now to your most selfish instincts of shrewd purchasing that you might apply to any other commodity. If you knew that by some miraculous means you could greatly multiply the value of every dollar that you gave your doctor, wouldn't you consider it utter waste to neglect that means? That miracle is to train yourself to be a patient, to think seriously of your own role in the drama of your illness. Once you have given him the responsibility of making you well, he plays the lead with the confidence bestowed by learning and experience. You must play your part to support the lead; remember it is your own play! (Reichert 1940, 109).

In contrast, the rhetoric found in the modern lay health information environment indicates a qualitatively different orientation for patients. As I shall discuss in chapter five, contemporary discourses on health care teach patients about “sharpening your

consumer skills in choosing medical care” (Clarke and Evans 1998, 92) and to “remember that it is your right to know and make choices about what is happening and that information will empower you” (Oster, Thomas and Joseff 2000, 21). The assumption here is that no one but the patient is ultimately responsible for obtaining the best care possible, a message that had no equivalent in the lay health information environment decades ago.

Second-Wave Consumerism’s Impact on Health and Medicine

The consumer movement and health information

The patient-as-consumer was a concept missing from early health care discourses, but consumerism as a protectionist movement in health care was alive and well in the 1930s and 1940s. Commercialism was also at full bore during this time as the patent medicine market had never been more robust. Advertising for patent medicine accelerated as the number of nostrums available in the consumer health market grew at a bewildering rate. By the 1930s, patent medicines were an established target in the popular media. The era of muckraking journalism first arrived in health and medicine when Samuel Hopkins Adams published in 1906 a special five-part series in *Collier’s Weekly* that exposed the dangers in the myriad pharmacological concoctions available on the market. Around the same time, the *Ladies Home Journal* also carried an exposé on patent medicines’ threat to public health and safety. Popular response to muckraking exposés on food and drug safety in the mass media attested to the public’s desire for information that they could trust on everyday foods and

medicines. In the same year, Upton Sinclair's novel, *The Jungle*, shocked the public with descriptions of the unsanitary and dangerous conditions workers in the Chicago meatpacking industry faced. Although Sinclair's book was a critique of capitalism that created the inhumane working conditions he described, the public honed in on the health and safety aspect of his story.²⁵ The furor caused by *The Jungle* directly led to the passage of the Meat Inspection Act in 1906, a response by government and the meatpacking industry to allay the public's concerns about the safety of the nation's meat supply. The Pure Food and Drug Act was passed concurrently to restrict patent medicine manufacturers from producing fraudulent and dangerous pharmaceuticals by forcing them to reveal the drug content level of their products. Various groups representing the consuming public, such as the National Consumer League, the General Federation of Women's Clubs, and the Women's Christian Temperance Union (Food and Drug Administration 1981), were credited with the victory. The Pure Food and Drug Act represented a singular victory of Progressive era, "first-wave" consumerism in the early 1900s but the fact that consumer groups did not achieve tighter regulations on behalf of consumers was also testimony to the relative weakness of the consumer lobby against the power of the food and drug industries. Nevertheless, it was a sizable victory for these early consumer groups. The growth in patent medicines continued unabated into the 1920s and 1930s, and advertising persisted with its hyperbole even as the Act controlled some of the more egregious examples of fraud in the industry. It was in response to these developments that a pioneering and

²⁵ About the impact of his book, Upton Sinclair famously declared, "I aimed at the public's heart, and by accident I hit it in the stomach."

leading organization of the consumer movement in the 1930s published a book that captured the attention of the American public facing an uncertain consumer health market.

In 1933, Arthur Kallet and Frederick J. Schlink of the consumer advocacy organization, Consumers' Research, published *100,000,000 Guinea Pigs: Dangers in Everyday Foods, Drugs, and Cosmetics*. The book was an instant national success that remained a bestseller for a decade (Silber 1983, 18). *100,000,000 Guinea Pigs* aimed to both educate consumers and to shock the public into petitioning the federal government to take more stringent action against the food and drug industries. Kallet and Schlink charged the mass media and advertising with creating a climate of hype and fear ideal for food and drug manufacturers to exploit at the expense of consumers:

Using the feeble and ineffective pure food and drug laws as a smoke-screen, the food and drug industries have been systematically bombarding us with falsehoods about the purity, healthfulness, and safety of their products, while they have been making profits by experimenting on us with poisons, irritants, harmful chemical preservatives, and dangerous drugs. (Kallet and Schlink 1933, 4)

The impact of Kallet and Schlink's bestseller has been compared to the book that spearheaded the second-wave consumer movement of the 1920s and 1930s, *Your Money's Worth*, published by Stuart Chase and Schlink in 1927 (Katz 1977). Popular response to *Your Money's Worth's* call for product information to be made more available to everyday consumers through "the open dissemination of scientific data" (Katz 1977, 65) inspired Chase and Schlink to form, also in 1927, the Consumers' Club, which later became Consumers' Research in 1929. Consumers' Research was innovative for its time: it was the first consumer's organization to engage in

independent product testing with the aim of providing unbiased product information to “ultimate” consumers (Katz 1977; Silber 1983). This may sound pedantic to us today, but the only organizations in the late 1920s that engaged in product testing were either government or business, such as the Bureau of Standards and the American Engineering Standards Association (AESAs).²⁶ Schlink “spent his early career working for organizations created by business and government to evaluate their own consumption and production habits” and brought this expertise to Consumers’ Research (Katz 1977, 51; Sorenson 1941). The aim was to establish a testing organization that served only the interests of consumers and was not beholden to business. Consumers’ Research published a magazine, *Consumers’ Research Bulletin*, that provided testing information on common brand-name goods, including patent medicines, as well as political editorializing for stricter legislation on behalf of consumer health and safety. Food and drug legislation was a top priority for Consumers’ Research as well as the consumer movement’s holy grail, “the establishment of a Department of Consumer Interests” in the federal government (Silber 1983, 19). Such a department was never achieved. This was considered a great failure by second-wave consumer activists.

The rise of Consumers Union

Two years after they co-published their bestseller, Kallet and Schlink parted ways during the bitter 1935 strike at Consumers’ Research. Schlink published *Eat*,

²⁶ According to Helen Sorenson’s 1941 study of the consumer movement, only one other testing organization, the Intermountain Consumers’ Service founded in 1932, existed prior to the formation of Consumers Union after the 1935 strike at Consumers’ Research.

Drink, and be Wary in that same year, written in the “guinea pig” genre of attacks started by *100,000,000 Guinea Pigs* against patent medicine manufacturers and the flawed 1906 Pure Food and Drug Act. Kallet led a group of pro-labor employees, supported by like-minded subscribers, to form a new testing organization, Consumers Union (CU), which was instrumental to the passage of the 1938 Food Drug and Cosmetics Act that instituted greater regulation of food and patent medicines. Although the two organizations carried out essentially the same work of product testing and consumer health and safety advocacy, they were worlds apart ideologically. Whereas Consumers Union “sought to link consumer issues with broader social concerns and showed a strong desire to cooperate with labor interests” (Stole 2006, 80), Consumers’ Research under Schlink’s directorship became increasingly anti-labor and let no opportunity pass to publicly accuse CU of communist activities. Schlink and other Consumers’ Research executives became prominent supporters of the House Committee on Un-American Activities (HUAC); J.B. Matthews resigned from Consumers’ Research to become the director of research for HUAC and submitted a report in 1939 that “accused fourteen consumer organizations—all social movement groups, including the LWS [League of Women Shoppers] and CU—of being a ‘Consumers Red Network’ of Communist “transmission belts” (Glickman 2001, par. 38). Despite the constant attacks from its right-wing enemies, Consumers Union quickly overshadowed Consumers’ Research in popularity, becoming the leading product testing agency largely through its high-profile success with the publication of *Consumers Union Reports* in May 1936. Unlike

the *Bulletin* with its dry presentation of technical information, CU's flagship magazine was designed to attract readers and its style was as Helen Sorenson, a contemporary scholar of the consumer movement, described, "lighter and numerous photographs and cartoons are included. In interest and readability it compares with many popular magazines" (Sorenson 1941, 48-49). The popularity of the magazine contributed to CU's rapid growth. Within its first year of operation, CU membership and circulation figures of the *Reports* soared from approximately 4,000 in May 1936 to 37,000 by May 1937 (Consumers Union 1937a). By 1946, Circulation for CU's magazine, now titled *Consumer Reports*, hit 100,000.²⁷ As measured by circulation figures, the early *Reports* did not achieve circulation numbers comparable to *Good Housekeeping* (2,536, 559 in 1945) or *Ladies Home Journal* (4,090,659 in 1945), but the *Reports'* popularity in its first decade was comparable to general interest periodicals available in the mid-1940s such as *Harper's Magazine* (115,033) and lay health journals such as *Hygeia* (110,188) and *Life and Health* (134,646);²⁸ CU remained a staunch supporter of labor and its advocacy for better wages and working conditions on behalf of workers was strikingly evident in the *Reports* up until the end of World War II. Articles on common household products and foods reported the results of CU's testing and also included sidebars that detailed the labor situation behind the products. It was telling, however, that by 1943 CU decided to change the magazine's name to *Consumer Reports* and by 1945 regular reporting of labor issues largely disappeared. While the organization continued to support left-wing causes and CU's leaders and

²⁷ Figure from the Consumer Reports website at <http://www.consumerreports.org/cro/aboutus/history/>.

²⁸ These figures are from the *NW Ayers and Son's Directory of Newspapers and Periodicals*, 1945.

staff's support of labor issues remained unbroken, several factors steered CU away from overt alignment with labor, including the experience with red-baiting in CU's first 10 years, the perennial problem of sustaining membership, which skewed towards the middle class despite CU's efforts to target the working class, and, perhaps above all, the need to reinforce its reputation for unbiased and objective product testing information (Katz 1977; Silber 1983).

***Consumer Reports* – how did it stack up as a health journal?**

Health was a category of public welfare important to Consumers Union from the very beginning. Kallet—who had previously written for *Health and Hygiene*—carried on the muckraking tradition of *100,000 Guinea Pigs* into *Consumer Reports*. At *Health and Hygiene*, the socialist health magazine, Kallet frequently collaborated with Dr. Harold Aaron who became *Consumer Reports*' first medical advisor and editor and held that position for many years. Aaron made it his mission to demystify complex medical information for the magazine's lay readers as he believed that consumers had as much right to knowledge about health issues as physicians (Katz 1977, 122). The presence of health and medical articles reflects both the personal concerns of Kallet and Aaron but also the general importance of health care to the consumer movement. As Norman Katz explains, the consumer movement saw consumption as a practice not limited to the purchase of merchandise. Because patients must pay for the services of physicians, the economic dimension of medical care naturally turned health care into a consumer service. In addition, “A singular

dislike for the patent medicine vendor, combined with a belief that adequate health care and maintenance were crucial variables in evolving a humane definition of living standards, made the topic of prime concern to most consumerists” (Katz 1977, 120). Although *Consumers Reports* today is known more for its consumer product testing and its annual new car ratings, articles on health and medicine have been a staple since its May 1936 debut issue, which included a searing critique of Alka-Seltzer’s claims to cure everything from the common cold to “morning misery” (Aaron 1936, 6). From my content analysis of every issue since May 1936, I have discovered that in its 70-year history, aside from the periods 1964 to 1975 and 1979 to 1983 in which about half of the yearly issues did not contain articles on health or medicine, the vast majority of CR issues contained at least one health article and/or an advice column on health and medicine.

Doctor-patient issues were not a focus of early *Consumer Reports*. Between 1930 and 1949, only five articles remotely addressed aspects of physician-patient relations. Most *Consumer Reports’* health and medicine articles were comparable to the types of articles on everyday health concerns found in *Hygeia* and women’s journals. The *Reports* provided information on health through a combination of feature stories explaining particular diseases or medical procedures and therapies, question-and-answer advice columns, nutritional advice, and discussions about health care economics. The magazine’s earliest medical articles were written by Harold Aaron himself or excerpted from the works of prominent physicians of the day, such as Dr. Walter C. Alvarez, Chief of Medicine at the Mayo Clinic. Often the *Reports’* medical

articles included information from the latest research published in prestigious medical journals such as the *New England Medical Journal*. But where *Consumer Reports* differed from the mainstream magazines was in its orientation toward the socioeconomic causes of disease and poor health. In keeping with its campaign against advertising, CU often targeted the advertising industry as the culprit behind many modern-day afflictions. For example, a critically acclaimed series on constipation by Aaron that ran monthly between May and November 1937 argues that the popular obsession with proper bowel function and the resulting overuse of laxatives were the unfortunate consequences of “Modern high pressure advertising, concerned rather more with profits than with health” and thus the industry was “in large part responsible for this terrorism against the bowels” (Aaron 1937a, 3). Another perpetrator was simply the everyday stress of modernity: “We are living in a period of great social changes wherein most of us are subject to tremendous emotional and physical stress. It is not likely that these stresses will suddenly subside so that all of us will be able to enjoy normal [bowel] activity” (Aaron 1937b, 30). In contrast, early *Hygeia* articles on disease and illness tended to focus on individual behavior as the cause of everyday ailments, as we see in this 1935 article also on constipation: “Most constipated persons prefer to think their colons are lazy, whereas in reality it is they, the persons themselves, who are lazy; or they may be misguided for the vast majority of those who suffer from this disorder do not have lazy colons” (Cady 1935, 586-587). The *Reports*’ early health articles provided information with the goal of helping

consumers to be less vulnerable to the hard sell of advertising and to become better educated on the social and economic origins of disease and illness.

Consumers Union's chief focus of course was to protect consumers by publishing the results of their tests for quality and safety of the leading brands of patent medicines, health products, and cosmetics. The consumer movement's goals intersected with the AMA in their respective crusades against quackery in the patent medicine business. While the consumer movement was motivated by safeguarding consumers' health and pocketbooks, the AMA's motives to protect the public were complicated for reasons of professional legitimacy and economic control.²⁹ But in their publications, CU and the AMA presented differing philosophies when it came to advertising. Consumers Union did not accept advertising in *Consumer Reports* (and continues to shun advertising revenue to this day) as its credibility depended on lay audiences trusting their information to be unbiased and un beholden to the advertising industry.³⁰ The AMA's attitude towards advertising was less straightforward. While the AMA unreservedly attacked patent medicine advertising and its code of ethics forbade physicians to advertise, advertising in *Hygeia* was apparently acceptable. In 1935, advertising was limited to 10-15 back pages of each month's issue; by 1945, more than half of the journal was taken up by ads—a quick count of the January 1945

²⁹ These motives have been amply documented and discussed by Starr (1982), Tomes (2000) and others who have argued that the AMA discredited patent medicine to establish the medical profession's credibility and to ensure physicians "wrest control of the flow of pharmaceutical information" (Starr 1982, 129) away from manufacturers.

³⁰ Inger Stole writes on how consumers were far from the naïve audience that advertising agencies made them out to be and that the advertising industry in the late 1920s "was forced to contend with a full-fledged consumer movement that challenged the industry's view of consumers as helpless and irrational and called for a discontinuation of advertising that played too heavily on emotions" (2006, 20). For their efforts to be taken seriously by the public, Consumers' Research and later Consumers Union were careful to remain untainted by any association with the advertising industry.

issue produced 46 pages of advertising out of a total 79 pages. A January 1935 back-page editorial in *Hygeia* justified publishing advertising by rationalizing that there was good versus bad advertising: benign advertising was of “truly educational and beneficent nature” while “the most quackish sort of patent medicine advertising” fell in the iniquitous category (Mohler 1935, 98). The health information benefits of many of *Hygeia*’s ads were certainly questionable as advertisements for nail polish, deodorants, light bulbs, baby shoes, women’s brassieres and girdles, life insurance, exotic vacations, and beauty “institutes” became ubiquitous in the magazine. Advertising revenue was perhaps the real reason the AMA justified carrying advertising. According to Inger Stole (2006), middle-class women comprised a significant percentage of magazine readership nationwide and this group was precisely the demographic coveted by advertisers. Women were the principal consumers in households and were generally the overseers of consumption in the domestic sphere. National brand names such as Coca-Cola, General Electric, and Horlick’s, “The Complete Malted Milk—Not Just a Flavoring for Milk,” were fixtures in *Hygeia* by the early 1940s, alongside ads sponsored by industrial lobbying organizations such as the “Council on Candy” of the National Confectioners’ Association, the Cereal Institute, and the American Meat Institute. The latter were often full-page ads that presented “facts” ostensibly health-related but in reality served as publicity for the various industries paying for the advertising space. These ads often included scientifically-sounding information on, for example, “The Nutritional Platform of Candy” (that claimed “Candies in general supply high caloric value in small bulk”),

or carried the AMA's "Seal of Acceptance" to legitimize a particular industry's claims about the salutary benefits of its products. In effect, the AMA's endorsement of products was a form of branding that aimed to distinguish one product from the next in a market overcrowded with competing brand names. *Good Housekeeping* also devised a "Seal of Approval" endorsement that relied on the magazine's own product testing and rating system. Consumers Union disputed *Good Housekeeping's* methods and criticized the Good Housekeeping Seal for misleading consumers. In the late 1930s, Consumers Union waged a long battle against the Hearst Corporation, the publisher of *Good Housekeeping*, for its questionable advertising practices (Consumers Union 1937b; Stole 2006, 164).

Consumers Union's socially conscious and anti-advertising focus for consumer protections in health care was in line with the progressive perspective represented in the socialist magazine, *Health and Hygiene*, that Kallet and Aaron also wrote for in the late 1930s. *Health and Hygiene*, however, often took the socioeconomic critique of disease a step further by targeting the motives of the medical elite, represented by the AMA. Taking again the problem of constipation as an example, a 1937 article in *Health and Hygiene* blames the advertising industry for turning Americans into an "especially bowel-conscious" people, "due probably to the extensive advertising propaganda which has made them the greatest consumers of cathartics in the world" (Health and Hygiene 1937, 21). The article went on to accuse the medical profession for its part in creating undue anxiety about improper bowel movements: "the medical profession has contributed its share to American bowel-consciousness by its

acceptance of the theory of auto-intoxication” (Health and Hygiene 1937, 21). Nancy Tomes (2006) has attributed the consumer movement’s reluctance to challenge the medical profession’s authority to the limitations of their testing methodology: “In private, consumer advocates expressed great resentment over what they perceived to be physicians’ professional arrogance . . . Yet they had no independent, scientific testing process with which to measure and critique the increasingly specialized, technical world of medical practice” (2006, 94). Because it did not have the means to test drugs and medical procedures, Consumers Union “had to rely on the testing of drugs and devices done by other groups, such as the AMA (one reason they could not afford to antagonize that group) and the FDA” (Tomes 2006, 94).

Second-Wave Consumerism confronts the AMA over socialized medicine

The lack of affordable health insurance for the majority of ordinary Americans was a central concern of Kallet and Consumers Union, following the consumerist’s philosophy that access to good health care was part of “evolving a humane definition of living standards” for consumers, particularly those in lower economic classes for which medical care was difficult to afford. This is reflected in the number of articles *Consumer Reports* devoted to coverage of health insurance and policy debates. The *Reports* carried the most material on issues pertaining to health insurance of all the monthly-circulating general and specialized periodicals that carried health articles reviewed for this study. Between 1936 and 1949, *Consumer Reports* published 45 articles and editorials addressing health insurance in some way (i.e., national health

insurance, voluntary hospital plans, medical cooperatives, etc.). For this same period, I found 21 articles and editorials on health insurance in *Hygeia*, four in *Harper's Magazine's*, two in *Good Housekeeping*, and one in the *Ladies Home Journal*. *Health and Hygiene* published 10 articles and editorials on health insurance between 1935 and 1938. Out of this sample, *Consumer Reports* was the only publication that used the word consumer in health insurance and policy articles to signify the patient. This in and of itself is not necessarily significant because the idea that medical service can be considered a consumer commodity was not limited to second-wave consumerism. Tomes (2003) notes that along with the consumer movement, a new type of “institutional” economics emergent in the 1920s and 1930s also started to consider the patient as a consumer in a health care market. As well, *Health and Hygiene* never explicitly used consumer language, but its critiques of organized medicine utilized consumerist arguments to draw attention to the pitfalls of the fee-for-service payment method that barred workers from seeing physicians or placed them in undue financial hardship when a serious illness made a visit to the doctor unavoidable. Because of its Marxist focus on class-based injustices, *Health and Hygiene's* central concern was the interests of workers and the underprivileged. As a worker's health magazine, *Health and Hygiene* presented health care as an entitlement of labor whereas *Consumers Reports*, as a magazine of the consumer movement, depicted affordable health care as a basic consumer need that was going unmet in a market environment geared to exploiting consumers. Particularly in its first decade, Consumers Union championed efforts to help those at the bottom of the economic ladder who were least able to

participate freely in the market. This meant support for labor's goals of achieving livable wages and better living standards that included affordable, quality health care. But neither were the middle classes protected from the often prohibitive costs of health care under a fee-for-service system: "Poverty and low income are the chief causes of insufficient medical care, but sickness costs are a serious financial problem for families far above the poverty level" (Consumers Union 1939a, 18). While the rich have always been able to take care of their needs, and the poor have been dependent on limited charitable care provided by municipal hospitals, in a fee-for-service structure, the majority of Americans in the middle and working classes found it difficult to budget for illnesses that could bankrupt them. Because Consumers Union was a consumers' organization first and foremost, dedicated to protecting the rights and entitlements of citizen-consumers in a market society, it named the fight for socialized medicine as both a consumer entitlement *and* a right of citizenship and thus defined health insurance important to the welfare of all Americans as consumers, not just a problem of the working class.

Consumers Union was ideologically in step with leftist, pro-labor groups like *Health and Hygiene's* publishers, the Daily Worker Medical Advisory Board, over the issue of national health insurance: Consumers Union favored a redistributive approach to financing compulsory health insurance through the federal government. Taxation of higher income classes would ensure Americans contributed to a national health insurance plan relative to their ability to pay; citizens toward the lower end of the economic spectrum would have access to decent health care services without means-

testing and without having to shoulder costs greater than their personal incomes would allow. The AMA successfully blocked health insurance from Roosevelt's program for Social Security in 1935, but the problem of affordable health care only worsened as the Depression wore on and the cost of medical care increased as rapidly as new therapeutic methods and technologies came on the market.³¹ Numerous *Consumer Reports* articles and editorials between 1936 and 1949 spelled out Consumers Union's position against the AMA's defense of fee-for-service, which CU considered an exploitative practice that permitted physicians too much fiscal discretion over price and typically constrained patients' ability to pay for the medical care they needed. These conditions caused increasing numbers of Americans—including many rank-and-file physicians hit by patient attrition during the Depression—to favor some kind of legislative provision to help ordinary citizens afford the services of physicians. The failure of the New Deal to secure a national health insurance plan forced the creation of grassroots solutions to help bring down the cost of medical care to affordable levels. Medical cooperatives and group health plans to cover hospital bills for catastrophic illnesses emerged across the country as local solutions to the gaping national problem of health insurance. Not all of these plans were consumer-friendly or socially just, and *Consumers Reports* carried extensive articles explaining the differences between the numerous voluntary plans that sprouted after 1935. For example, CU reluctantly supported the "3-Cents-A-Day" hospital plans only because these pre-paid plans were the only form of insurance available in most communities and at least protected

³¹ The AMA's aggressive opposition to the New Deal and subsequent efforts to introduce federal health insurance right down to Medicare in 1965 is well-documented in the historical scholarship on health insurance in the US. See Starr (1982), Oberlander (2003), etc.

consumers against bankrupting hospital costs. But CU's chief criticism of these hospitalization plans was that basic medical care was excluded and subscribers had no direct representation in these group plans. Once again, the AMA proved to be the obstacle against any progressive steps towards improving the affordability of medical care: "Organized medicine can, by withholding approval and cooperation, "break" either a hospital or a hospital service plan" (Consumers Union 1939b, 18).

To summarize, consumerist organizations like Consumers Union supported socialized medicine because health was considered a crucial issue fundamental to the consumer movement's goals to improve living conditions for "ultimate" consumers, especially the lowest wage earners in American society. Medicine increasingly was considered a vital social good because of the efficacy of new scientific treatments relative to the limitations of allopathic medicine before germ theory revolutionized medicine after the 1880s. The public's faith in science and doctors increased as medical research developed new ways to cure diseases formerly considered intractable scourges upon society, such as polio, and manage conditions like heart disease and diabetes that were at one time a certain death sentence. The physician was increasingly important for his highly specialized skills and, as a result, medicine gain great social prestige and professional independence.

At the same time, medicine's economic dimension became a central concern of scholars, policymakers, pro-labor organizations, consumer activist groups, and ultimately the state. By honing in on health care economics and social policy, consumerism focused on the political economy of medicine at a time when the

medical profession regarded the cost of care as strictly an individual matter between doctor and patient, determined by the professional ethics and personal morality of doctors as they assess their remuneration on a patient-by-patient basis. From the AMA's perspective, the economics of medicine must be controlled and determined by physicians—fee-for-service was considered by organized medicine the only method of financing that secured trust in the doctor-patient relationship. Organizations like Consumers Union helped open the fee-for-service system to public debate by defining medicine as a social good or service that must be *purchased* at a *collective* cost to consumers, ideally as taxpayers via the state or, failing that, members of medical cooperatives or other group care organizations. At issue was how to create a system in which the increasingly expensive costs of medical care would be spread across the population rather than leaving patients and their families to shoulder the burden individually. Organized medicine warned that socialized health insurance would spell the death of a cherished American value, the freedom to choose his or her physician. The consumerists countered that the freedom of choice is disputable when millions cannot afford a doctor in the first place. Consumers Union thus used market language to articulate citizenship rights to health care as a social good and to counter the AMA's moral defense of choice and individualism as cherished American values.

Consumers Union recognized that medicine is an “imperfect” market and that it was difficult to put a price on trust in the doctor-patient relationship. In fact, the connection of the patient to the consumer was less about “buyer beware,” although *Consumer Reports* did carry articles cautioning against doctors who advertised, than

about citizenship rights to health care. For instance, nowhere in the early years did the *Reports* carry articles on how to take action if a physician treated a patient badly, displayed incompetence, or negligence. The *Reports* did not carry stories instructing patient-consumers on how to report physicians, how to choose doctors, and nowhere did it spell out rights in health care to its readers. Rather, CU's focus, similar to *Health and Hygiene's*, was clearly on the economic dimension of medical care to fight for citizenship rights to health care. The "buyer beware" dimension to consumerism is evident in CU's articles on food, drug, and cosmetic safety, but the demands for health insurance was articulated in the language of citizenship rights that recognized that all citizens were also consumers. Second-wave consumerism in this way contributed to the collectivist critique of the individualist values upheld by organized medicine at a time when, as reported in *Consumer Reports*, "tens of millions of Americans get little or no medical care, and . . . millions of others get restricted care only at the price of major upsets to their budgets" (*Consumer Reports*, June 1945, 26).

Medical Paternalism in the 1950s and 1960s

The 1950s is considered the apex of physicians' cultural, political, and economic power and authority as a professional class. Yet evidence from my study of mainstream magazines indicate that fissures were starting to appear in medicine's lock on influence over public opinion. Patient dissatisfaction as expressed through malpractice suits crept into the public discourse on health care in this decade, evidenced in a number of stories on malpractice that turned up in my sample of

popular magazines. For example, articles entitled “Legal Rash,” “Surgeon in Court,” and “Sue the Doctor?” appeared in *Time* and *Newsweek* during this period. A 1953 *Ladies Home Journal* article, “Can We Trust All Our Doctors,” discusses the problem of “a rash of malpractice suits against doctors” as symptomatic of a “sickness within the medical profession itself” (Shalett 1953, 53). A 1959 article in *Good Housekeeping*, “When Your Doctor Fears His Patients,” points out that malpractice suits went “from an almost negligible problem 40 years ago” to becoming “a major concern of the medical profession today” (Peters 1959, 130). A 1959 *Ladies Home Journal* article on “Medical Care and Its Discontents” paints a picture of a profession under siege: “Recently the medical profession and its institutions have come in for a considerable drubbing . . . one finds critical articles nearly every month” (Thompson 1959, 11).

Not only were stories about malpractice beginning to show up in popular media in the 1950s, but the medical profession itself was starting to worry publicly about the reported increase in litigation against doctors and its potential to erode the public’s trust. An article in the AMA’s *Today’s Health*, which replaced *Hygeia* in 1950, notes that “Doctors themselves agree that the medical profession has slipped in public confidence” (De Kruif 1953, 22). Organized medicine considered malpractice the result of a few bad apples that were tainting the profession’s reputation for high standards of ethics and expertise. A top official of the AMA was quoted in the *Ladies’ Home Journal* confirming that physicians as a whole “usually are reluctant to take firm, positive action to purge their own ranks of the relatively few incompetents” but

“the malpractitioners must be expelled before there is further loss of public confidence in the medical profession (Shalett 1953, 53). This was usually because physicians, out of “professional courtesy,” never testified against their professional brethren and the courts tended to consider physician-defendants’ expert accounts over the grievances of their patients (Shalett 1953). Another popular explanation for growing malpractice suits was the shortage of physicians relative to patients’ and their escalating demands for medical care: the *Ladies Home Journal* reports that medical colleges were turning out about the same number of physicians in 1959 as they did 25 years before despite phenomenal post-war population growth (Thompson 1959, 11). An article from a special October 1961 issue of *Harper’s*, “The Crisis in American Medicine,” states that Americans were seeing physicians at double the rate in 1930, “But in the face of this rising demand the ratio of physicians to population has remained static” (Greenberg 1961, 134). The rise in litigation against doctors was also attributed to the rapid pace of specialization resulting in the loss of the old-time general practitioner and the familiarity and trust that came with an older way of practicing medicine: according to a 1953 article in *Today’s Health*, the “Age of Specialization” was truly upon American medicine by the 1950s as “the kindly old man of medicine, ever at our service in time of need, is gone—shoved out by a scientific but not quite human being who awes us with rays, ballistocardiographs, needles for shots of every antibiotic, a tinkling cash register...” (De Kruif 1953, 22). In a similar vein, the 1961 special *Harper’s* issue attributes the growing patient dissatisfaction to the “atomization of knowledge” resulting from increased specialization and how “as a succession of

specialists splinter the patient into separate ailments, he often finds that no one doctor regards him as a person with a unique set of problems and anxieties” (Greenberg 1961, 134).

At the same time malpractice entered the public spotlight, there was a noticeable change of tone in the articles of the AMA’s lay health journal. After 1950, no longer prominent in *Today’s Health* were the stern and at times condescending warnings that patients should “be a good patient!” and should act “intelligently” by heeding only the advice of physicians and sources endorsed by the AMA. It was still the rule in the how-to articles that a patient’s choice of physician should be guided by the recommendations of the local medical society, hospital, or other creditable medical sources. But consulting lay persons for their experiences with physicians was no longer completely anathema, as illustrated in this piece of advice: “You’ll probably want to ask around about the doctors. Their patients and businessmen in the neighborhood can help you decide which M.D. is best suited to your family” (American Medical Association 1956, 29). Nevertheless, the message to invest complete faith in one’s doctor still appeared frequently, such as “Don’t question the doctor’s diagnosis. If the doctor tells you that you are free from organic disease after thorough examination, be assured that he is right” (Swartout 1957, 30), or “more and more doctors are giving patients interpretive information about their physical condition, but it must be left to the judgment of your doctor as to how much he tells you” (Richardson 1959, 35). The most significant indicator of change was the disappearance of articles in which physicians complained about selfish, disloyal, and

conniving patients. The AMA, it appears, was already toning down its strongly paternalist rhetoric in the 1950s.

Thus it seems from my findings that anxiety over losing the public's trust was creeping into the medical profession precisely at the pinnacle of its authority during the 1950s. Yet despite claims about escalating malpractice figures and the rise of critical coverage of the medical profession in the media, the reality was that the balance of power between patients and physicians continued to tilt overwhelmingly in favor of doctors. The media reported that patients were more willing to litigate in the 1950s than in past decades. However, the truth was that patients rarely won malpractice suits. Despite the reality that the profession was largely immune to lawsuits, the perception of increased malpractice suits concerned organized medicine for its potential to corrode trust in the doctor-patient relationship. This affected more than the physician's professional freedom to exercise his expert judgment at his discretion: in the fee-for-service system, the erosion of patient trust directly threatened the doctor's ability to name his price over the therapies and treatments he prescribed. The AMA's willingness to declare that medicine needed to clean its own house can be interpreted as minor concessions to preserve the reputation, authority and financial autonomy of the profession. By attributing the rise in medical malpractice suits to a few bad apples, the profession was prepared to do some token housecleaning without threatening an essentially laissez-faire medical structure that promoted great discretionary freedom of physicians to set fees. Organized medicine did concede that patient dissatisfaction was increasing and attributed the problem to specialization. The

AMA, however, refused to countenance the coordination of patient care through group practice, championed by consumer groups on the left since before the Depression. Instead, it promoted the family physician as the gatekeeper to specialized medical care. As it did during the New Deal era, the AMA feared group practice was the first step towards plunging the country into socialized medicine.

What happened to Consumers Union?

Second-wave consumerism as a social movement fizzled out by the 1950s. In health care matters, Consumers Union shifted away from activism for consumer protections and workers rights to focus on product-testing after the defeat of Truman's initiatives to introduce a federal health care policy. This change during the decade of McCarthyism reflected the extent Consumers Union's leaders were eager to avoid repeating its exhaustive experience with red baiters that plagued the organization in its first decade. CU maintained a neutral product-testing course for *Consumer Reports* that turned the magazine into the bible of middle-class consumers during the post-war economic boom (by 1955, the *Reports* reached a circulation figure of 725,000, according to the Ayers Directory). Thanks to well-paid union jobs, workers participated in the consumer economy in unprecedented numbers as they enjoyed for the first time a level of prosperity unseen in previous generations. According to Starr, unions in the 1950s were a driving force behind "the rise of a system of private social security" that included employer-provided health insurance: "By the end of 1954 . . . unions were now negotiating the purchase of a fourth of the health insurance in

America” (Starr 1982, 311). In this context, while its articles on health and medicine were more popular than ever,³² articles from the 1950s and early 1960s on health insurance, group health, and the quality of American health care lost the militant tone of early *Reports*’ features on health care policy. Consumers Union still came down on the side of social initiatives traditionally favored by the left, and it still regarded the AMA with a wary eye, but in my review of health insurance articles from the 1950s and 1960s, *Consumer Reports* was noticeably quiet on the movement to create national health insurance for seniors, which resulted in the Medicare Act of 1965. Only after Medicare was enacted did a few articles appear discussing the advantages and disadvantages of the new health insurance for the elderly.

In 1962 Kennedy signed the Consumers’ Bill of Rights that kicked off “third-wave” consumerism. Consumers Union was one of the few left-leaning organizations of the second-wave consumer movement that survived and the only one that actually grew in success, thanks to the popularity of *Consumer Reports*.³³ However, by the 1960s, it was no longer at the forefront of consumer activism, at least in the health care domain.³⁴ The radical activism of Consumers Union before the 1950s was carried on in the 1960s and early 1970s by a new generation of consumer protectionist groups, spearheaded by Ralph Nader and his Public Citizen organization. One of Nader’s first priorities was to set up a health care branch, the Health Research Group under the

³²According to Consumers Union in 1961, “Health and Medicine has been running in the Reports for many years and has regularly been ranked at or near the top in favor among the magazine’s features” (1961, 277).

³³Schlink’s Consumers Research continued to test and publish its magazine until the early 1970s but its influence waned long before.

³⁴Although CU contributed a significant study on the dangers of cigarette smoking in the 1950s, well before the anti-tobacco health movement got underway in the 1970s (see Silber 1983).

direction of Dr. Sidney Wolfe. Third-wave consumerism lent its language of consumer rights to the burgeoning patients' rights movement that was championed by the women's health movement, the black civil rights movement, and other groups. As we shall see in Chapter Five, consumer was a term adopted by these activist groups as a radical redefinition of the patient.

Conclusion

My research concludes that there was plenty of lay health information to be found in the mass media even during the "golden age" of medical paternalism. If, according to today's beliefs, information is supposed to empower, then why did patients at the time fail to empower themselves with the available knowledge to question their physicians, to challenge their dictates? My findings indicate that patients were not as passive about their health care needs as conventionally understood today, but, under a physician's care, they had little say in their own treatment choices. Before the late 1960s, the idea that patients had rights and could make their own decisions had yet to appear in American medicine and the culture at large. The four tenets of the 1962 Kennedy Consumer Bill of Rights—the right to choose freely, to be heard, to be informed, to be safe—eventually became the foundation of all consumer rights' bills. These rights are also to be found in the numerous patients' rights bills that states and health care organizations started to introduce in the 1970s. In the next chapter we shall see how these rights in health care played out against a backdrop of escalating medical costs and retrenchment politics in the ensuing decades.

CHAPTER FIVE

“Patient Power!” The Patient as Health Care Consumer, 1970-2006

In the 1975 patient handbook, *The Rights of Hospital Patients: The Basic ACLU Guide to a Hospital Patient's Rights*, author and distinguished bioethicist George Annas opens with the following introduction:

Each year 34 million Americans are admitted to hospitals, and each of us will be hospitalized an average of eleven times before we die. While we spend almost \$40 billion annually on hospital care, few patients are completely satisfied with the way they are treated in hospitals. Patients rightfully resent the all-too-common impersonalized and patronizing manner in which they are dealt with. Such actions on the part of health care providers both undermine the human rights of patients and perpetuate *patient-consumer* ignorance of medical treatment and health care [italics added] (Annas 1975, 1)

In the next paragraph, Annas goes on to articulate the book's goals:

This book is built on two fundamental premises: (1) the American *medical consumer* possesses certain interests, many of which may properly be described as rights, that he does not automatically forfeit by entering a hospital; (2) most hospitals fail to recognize the existence of these interests and rights, fail to provide for their protection and assertion, and frequently limit their exercise without recourse for the patient [italics added]. (Annas 1975, 1)

By 2005, Annas no longer conflates patient with consumer and explicitly argues against mistaking the rights of one for the other. In *American Bioethics: Crossing Human Rights and Health Boundaries* (2005), Annas writes, “We can call people who purchase health insurance consumers, and people who join health plans can be called

members. However, we must recognize (and protect through enforceable rights) that *sick people who seek medical care are patients* [italics added]" (Annas 2005, 101).

What happened between 1975 and 2005 that caused this leading expert on patients' rights to turn against conflating the patient with the consumer? This chapter aims to answer this question by examining sociohistorical changes since the 1970s that have contributed to the evolution of the consumer as a symbol of empowered patienthood. Recent developments in the history of American health care have complicated understandings of patient-consumerism and how consumers exercise empowerment. These include events such as the legal development of patients' rights, the growth of managed care, the ever-expanding consumer health information environment, and, since the early 2000s, the growing "post-managed care" talk about "consumer-driven" or "consumer-directed" health care coverage. This chapter also examines the impact of broader cultural ideas on the direction of American health care and policy since the 1970s. Two influences that have driven changes in the past four decades are the belief in personal responsibility and faith in information to empower the individual.

The Sixties Rights Movements and the Legitimation of Patients' Rights

Medical and public health scholars, health policy experts, and many medical professionals often consider patient consumerism a result of the intense commercialization of health care attributable to neoliberalism's impact on social policymaking since the 1980s and 1990s. Frequently cited as the causes of increased

patient consumerism are the growth of managed care and the spread of direct-to-consumer pharmaceutical advertising (Rothman 2001). Historical evidence, however, contradicts this assumption about the origins of the patient as a consumer in contemporary history. Historian Nancy Tomes (2006) notes that well-intentioned critics of “consumer rhetoric” overlook the reality that it was the sixties social activists of the patients’ rights movement, not free-market proponents, who originally adopted the consumer metaphor in their critiques of the medical system. The chronology of managed care further underscores Tomes’ point. When Annas was writing for the American Civil Liberties Union (ACLU) about the rights of patient-consumers in 1975, health maintenance organizations (HMOs) were barely a blip on the health care landscape. President Nixon had signed into law the Health Management Organization Act only two years earlier, in 1973. Even into the 1980s, HMOs and other types of managed care organizations grew at a pace disappointing to industry supporters. The patient-consumer also antecedes the deluge of physician and pharmaceutical advertising swamping current mass media. The FTC relaxed restrictions on physician advertising in 1978 shortly after the Supreme Court overturned laws that forbid lawyers to market their services (Schlesinger 2002). Another 20 years passed before the FDA, in 1997, loosened restrictions on advertising for prescription drugs that opened the floodgates to direct-to-consumer advertising. Indeed, earlier than managed care and well before direct-to-consumer advertising, the language of consumer protection and rights reentered popular discourse after Kennedy endorsed the Consumer Bill of Rights in 1961. This event triggered the return of consumerism as a

social movement, which lay dormant since the end of the war. Spearheaded by Ralph Nader, the “third-wave” consumer movement of the 1960s and 1970s established regulations and protections that impacted all facets of the American marketplace, including health care. Thus, it was no accident that, by the late 1960s, activists embraced the word consumer to redefine the patient as an active, empowered person with rights.³⁵ The consumer metaphor helped to embolden patients and their advocates to challenge medical paternalism and express their dissatisfaction with the dehumanization of patient care resulting from the expansion of medical technology and the growing bureaucratization of medicine.

The connection between patient and consumer was thus forged in the same crucible of cultural change that expanded individualist rights in American society after the mid-twentieth century. It is well-established in the history of bioethics that the sixties cultural revolution shifted medical ethics away from the traditional model of paternalism to the model of patient autonomy that governs medical practice today (Faden and Beauchamp 1986; Rothman 1991; Starr 1982; Tauber 2005). Despite existing since the Nürnberg Trials at the end of World War II, the principle of patient autonomy gained traction only after the upheavals of the 1960s indelibly changed the nature of American culture and society. Bioethicist Alfred Tauber describes the cultural turmoil of the late 1960s as “a period of activism centered on championing individuality” (Tauber 2005, 82). This activism “became widespread, especially

³⁵ My interviews with representatives of three consumer health advocacy groups with histories that go back to that period support this point: Maryanne Napoli, editor, *Health Facts*, Center for Medical Consumers (September 25, 2006), David Schardt, senior nutritionist, Center for Science in the Public Interest (April 20, 2006), and Gail Shearer, director, health policy analysis, Consumers Union (October 25, 2006).

among racial and ethnic minorities, women, and homosexuals” (Tauber 2005, 82). These groups fought to secure greater personal rights and freedoms that were historically denied to them. Sixties social movements such as the black civil rights movement (Byrd and Clayton 2002), women’s health, welfare rights, and the disabled rights movement (Starr 1982) broadened to include patients’ rights because health care was central to their demands for greater social equality. The patients’ rights movement was also influenced by countercultural ideas about the individual’s right to reclaim personal responsibility for health from the control of physicians. The counterculture’s hostility towards conventional medicine and the medical establishment was grounded in the anti-authoritarian belief that individuals should be free to make their own life or lifestyle choices. Thus, the principle of patient autonomy took hold in American medical ethics only after the broader culture was reshaped by the mid-twentieth century countercultural and social movements to become less trusting of institutions and expert knowledge, including medical knowledge. Since that time, mainstream American society has largely embraced the countercultural-inspired notion that lay people are capable of making health decisions for themselves and have the right and responsibility to do so.

If the counterculture popularized the rights of individuals to personal freedom and choice, it was the Nader-led consumer movement that resurrected the tradition of consumer protections fundamental to first- and second-wave consumerism of earlier generations. By the early 1970s, numerous consumer advocacy groups emerged alongside Nader’s Public Citizen (founded in 1971) that waged legal battles with both

government and industry to fight for greater market, environmental, health, and public safety protections through regulatory reform. This type of consumer activism became known as “the public interest movement” and, according to Robert Horwitz, it sought state power to control the economic agenda of corporate America: “the logic of the public interest movement was that only a strong state could serve as an effective counterweight to big business” (Horwitz 1989, 200). But where third-wave consumerism differed from its predecessors was its interpretation of consumer protections; unlike the old “consumer citizenship” model of consumer activism, third-wave consumerism was influenced by the new ideas about individualist rights popularized by the counterculture and other social movements. The “generalization of rights” (Starr 1982) that occurred in the 1960s encompassed third-wave consumerism as much as ideas about consumer rights to greater consumer protections in the marketplace spread to other social movements. As Michael Goldstein notes, “Social movements often grow out of and influence each other. Not only can the substantive demands of a movement be shaped by others, but its strategies, self-confidence, and acceptability to the public are all responsive to the successes and failures of other movements” (Goldstein 1992, 14). Nowhere is this more noticeable than in the way the word “consumer” migrated from the consumer movement into patients’ rights discourses. This included radical discourses within the women’s health movement such as that represented in *Our Bodies, Ourselves*, a point I shall discuss later.

This cross-pollination between rights groups and the consumer movement was, to no small degree, a result of how social movements of the 1960s-70s era fought their

battles through the courts. Indeed, Paul Starr observes how the civil rights movement was the model for later rights movements except “instead of marching through the streets, they marched mainly through the courts (Starr 1982, 388). David Rothman also notes the influence of lawyers in the sixties rights movements: “The 1960s movements . . . were spearheaded by lawyers, and in many ways, their orientation, strategy, and presumptions deeply influenced the reform goals” (Rothman 2001, 256). Rothman argues, as have others in the history of bioethics, that the predominance of informed consent in modern medical ethics reflects the profound influence of the perspective and language of lawyers that underlie modern patients’ rights: “The idea [of informed consent], after all, was born in a court, owes practically nothing to traditional medical ethics, and to this day, seems to be a less than adequate formulation of the doctor-patient relationship to many physicians” (Rothman 2001, 256-257).

The pursuit of rights through the legal system and the spread of countercultural beliefs in reclaiming personal control over health inspired public interest groups to publish pamphlets and handbooks to educate lay people on their rights in the medical system. *The Rights of Patients* (1976) published by the Public Affairs Committee is an example of this drive to educate the public; it provides basic information on the legal status of patients and what steps to take to protect themselves in the health care system. It reminds readers that “with something as vital as health and medical care, we must constantly remind ourselves that in the long run we must be in charge of our own bodies” (Taubenhaus 1976, 13). The American Civil Liberties Union published a

series that laid out in plain language the rights of groups as disparate as women, teachers, mental patients, servicemen, and prisoners. Showing the influence of consumerist language, in the ACLU's 1975 handbook, *The Rights of Hospital Patients*, Annas describes the patients' rights movement as "difficult to define" and "not as well organized and identifiable as other consumer movements" (Annas 1975, 3). Three important reasons explain why hospital patients face this predicament: 1) by definition, hospital patients are sick persons and often lack the fortitude to exercise their rights, 2) patients fail to stay in hospitals long enough to organize, and 3) hospitalization, like death, is a topic most healthy Americans tend to steer clear (Annas 2005, 3-4). In 1989, the ACLU updated and republished the handbook as *The Rights of Patients*. In this version, Annas continues to describe the patients' rights movement as nebulous and difficult to define for many of the same reasons in the first edition. But, despite being "as slow as a glacier," Annas felt the movement was "ultimately healthy" and irrevocably changing the landscape of American medicine (Annas 1989, 1).

Patient dissatisfaction with modern medicine

The patient-consumer challenge to medical authority came at a time when medicine was never more successful at curing disease and saving lives. But despite higher rates of cure, the experience with modern medicine left many Americans feeling dissatisfied and disenchanting. According to Starr, critiques that appeared in the mid-1970s questioning the value of medical care further fueled the backlash against

conventional scientific medicine. Detractors like neoconservative Aaron Wildavsky and social radical Ivan Illich may have come from polar ends of the ideological spectrum, but both were highly skeptical that medicine did any good for patients. Wildavsky felt the cost of modern medical care far exceeded the benefits afforded to patients; Illich believed conventional therapies harmed more than they healed and therefore the medical system must be rejected all together (Starr, 1982, 409).

Ironically, these critiques of medicine were coming at a time when American medicine was making significant progress in lowering mortality rates: “from 1968 to 1975, death rates dropped 14 percent—or from 747 to 642 people a year in a population of 100,000” (Starr 1982, 410). Dissatisfaction with medical care was increasing even as medical research opened up new therapeutic options that were unavailable in previous generations. Moreover, the choice of physicians for Americans who had health benefits was arguably less restricted than they are today. In a pre-managed care era, medicine was less bureaucratized and giant corporate oligarchies had yet to consolidate their dominance of the health care sector. The growth of managed care snailed along throughout the 1970s after the passage of the 1973 Health Maintenance Organization Act. By July 1980, the government qualified only 112 HMOs, or a paltry participation rate of four percent of the American population (Mayes 2004, 121). With only 12 percent of physicians in the United States affiliated with any form of group practice (Rose 2004, 8:446), doctors in the 1970s were less stymied by red tape and freer from corporate control than they are now.

Disenchantment with the health care system grew notwithstanding the expansion of private and public health insurance. For the first time in US history, the majority of middle-class Americans were insured for medical care through their employers. By 1971, approximately 71 percent of Americans were insured through private health insurance programs, compared to 50 percent in 1950 (Rose 2004, 7:487). Most health care plans were essentially hospital insurance and offered limited coverage for physicians' services. But given the hospital's dominant role in modern medical practice, a position already firmly established by the 1950s, that most working Americans were covered for hospital visits by the early seventies was a leap forward from circumstances before the mid-twentieth century. Medicare's passage in 1965 improved the elderly's access to health services, as seniors typically lacked adequate health insurance once they retired. This resulted from the voluntary and privatized nature of the American health care system that was developing since the end of World War II; more than half of workers lost their employment-sustained group coverage once they retired. Individual health plans were either too expensive for most retirees or they faced actuarial discrimination because their age was considered too high-risk: "For commercial insurers, the expensive medical needs of the elderly simply made them a bad risk not worth insuring" (Oberlander 2003, 23). Medicare, however, left gaps in coverage that grew more significant as medical costs increased year by year. Nevertheless, Medicare freed seniors from having to shoulder the full costs of their medical care, which were in fact higher than the rest of the population.

The disconnect between better rates of cure and the pervasive public discontent with medicine and the health care system in general could be better grasped by looking at the example of breast cancer. For generations, women with breast cancer had little choice other than radical mastectomy. According to Barron Lerner (2001), for complex political reasons, radical mastectomy was the dominant method of treating breast cancer and the medical establishment refused to countenance alternative therapies until patients and their supporters pushed for change in the 1960s. Greater improvements in tumor screening, drug technologies, and surgical techniques by the early 1970s meant less invasive therapies became viable alternatives to the dreaded operation that left women physically disfigured and psychologically scarred. These other therapies eventually toppled the radical mastectomy's dominance through the combination of better science, political agitation by breast cancer patients and survivors, and the spread of information on these alternative treatments by the mass media. The women's movement, for example, influenced women's magazines to regularly carry articles on breast cancer that provided women information on treatment choices and their right to seek out viable alternatives to the radical mastectomy (e.g., Crile 1972; Champion 1972; Maynard 1970; Nolen 1971). Readers of these magazines were informed that they had options and to seek out second opinions if they did not agree with their physicians' diagnoses. But the power of the media, as they say, is double-edged: heightened media coverage of breast cancer tended to augment the perception that the therapeutic choices for this disease were abundant and successful. On the ground, however, there were no simple answers in treating individual cases

even as statistics were showing improvement in breast cancer survival rates over past figures. Breast cancer coverage was part of the endless reports of new “breakthroughs” in medical science that inundated the media environment by the 1970s. The public’s expectations for recovery from all sorts of formerly intractable diseases like breast cancer were surely inflated by this media saturation. The amplifying effect of the media presumably contributed to patient discontent by distorting the real picture, namely, that new therapies were improving survival rates in general but far from conquering many major diseases.

Perhaps the most significant reason Americans were unhappy with their health care resulted from the increase in chronic disease after World War II. By the mid-twentieth century, chronic illnesses, the so-called “diseases of affluence” such as diabetes, heart disease, and cancer, overtook acute diseases as the leading causes of morbidity and mortality in developed nations like the US. This shift in disease prevalence in the population contributed to patient dissatisfaction when conventional medicine, geared to curing and not preventing disease, was unable to address the patient care demands specific to chronic illnesses. This contributed to elevating patient dissatisfaction, to which was added the public’s growing fears about conventional medicine’s potential to harm those it was supposedly helping. The increase in chronic illnesses was a significant reason behind the growing popularity of alternative or complementary medicine that began to migrate into the mainstream from the countercultural fringe (Cant and Sharma, 1999; Goldstein, 1992). The growth of

community health clinics also offered an alternative to the alienating bureaucratic experience of modern hospitals.

Then came the tragedy of Tuskegee. The Tuskegee experiments on poor black sharecroppers were reported in the press in 1972. One of the cruelest cases in recent American medical history, Tuskegee's exposure exemplified the power of the media to spotlight egregious abuses of medical ethics and violations of patient trust. News of the scandal highlighted the urgency for better patient protections in clinical care and research. Tuskegee was a shameful event that loomed large over medical horror stories that became commonplace in the news. The media was littered with reports on the latest medical scandals, thanks to the escalation in malpractice suits in the 1970s. Finally, science itself was being questioned and feared when technology could keep people alive long after brain death or after patients were no longer sentient. In 1976, the Supreme Court of New Jersey granted Karen Quinlan's parents the right to take their daughter, who was in a persistent vegetative state, off artificial respiration. The Quinlan case is considered to have created modern bioethics by catapulting the right to die issue to the forefront of public debate (Rothman 2001). Famous cases such as Tuskegee and Karen Quinlan underscore how the media's power to publicize can fuel the public's uncertainties and, in doing so, help to keep the troubles and dilemmas of modern medicine up front in the public's awareness.

The developments discussed here thus support the contention that, by the 1970s, Americans in many ways were faced with more health care choices and decisions than in previous generations. Medicine may have made great advances in

curing disease and extending life; however, from the patient's perspective, the experience of modern medical care tended to be dehumanizing. This created greater dissatisfaction with conventional medical care despite better rates of cure.

Hospital administrators issue first statements on patients' rights

Patient dissatisfaction and fears stoked change, even if it was in the defensive. It was hospital administrators who went public with the first statements on patients' rights in the early 1970s. In 1970, the Joint Commission on Accreditation of Hospitals (JCAH) added a preamble on patients' rights to its manual listing standards that hospitals were expected to fulfill if they wanted accreditation (Annas 1975, 22-23; Rothman 1991, 145). The JCAH's preamble formed the basis of the 12-point "Patient Bill of Rights" issued in 1973 by the American Hospital Association (AHA). The AHA had legal reasons for coming out with a bill that stated the rights and responsibilities of patients as well as the level of care they can expect from hospital staff. According to Annas, hospital administrators decided they had the right to exercise some control over physicians because hospitals were found liable by the courts in several cases for the conduct of physicians practicing on their premises. These efforts resulted in the AHA's patients' rights bill as part of an overall attempt by the association to "achieve a measure of control over medical decision-making" which the medical profession exercised virtually without opposition until the mid-1960s (Annas 1975, 21).

Hospital administrators, however, were not the ones who pressed for stipulations addressing privacy, consent, and non-discriminatory treatment in the JCAH preamble and the AHA patient bill of rights. The National Welfare Rights Organization (NWRO) negotiated with JCAH to adopt some of the 26 provisions that the advocacy organization drafted on patients' rights. The NWRO designed these standards with the idea of protecting underprivileged patients who were particularly vulnerable in hospital settings: "Recognizing that the hospital system was essentially two-track, with the poor typically consigned to twelve-bed wards, treated by medical students and house staff, and, apparently, disproportionately experimented on by investigators, the NWRO attempted to impose a rights model on hospitals" (Rothman 1991, 145). The NWRO's provisions turned out to be applicable to upholding the dignity and rights of any patient regardless of income, racial-ethnic background, and social orientation. The NWRO's tenets on patients' rights received further formal recognition when the American Hospital Association (AHA) adopted the JCAH's preamble to serve as the foundation of its influential patients' rights bill. The AHA bill was initially slow to catch on; the New York Times reported in June 1974 that only a third of the 7,000 hospitals had adopted the AHA patient bill of rights (Dembart, 1974). But over time this bill inspired a proliferation of patients' rights bills adopted by hospitals, other health care institutions, and state legislatures.

Patients' rights advocates considered the JCAH statement and the AHA patient bill of rights steps in the right direction. Their major flaw, however, was that their provisions were vague regarding what patients can expect as proper medical care. The

AHA bill, for example, was criticized for focusing mostly on how hospitals workers treat patients, outlining only “rudimentary statements of courtesy and basic concepts concerning informed consent” (Annas 1975, 28). Encouraging more courteous treatment of patients was important. But, according to Annas in the 1975 ACLU patients’ rights handbook, the AHA bill’s wording was vague to the point where it would be difficult to use as the basis for patient lawsuits against unfair or substandard treatment received in hospitals: “Defining “reasonable continuity of care” is not likely to come to court unless the hospital does such a poor job that a consumer group brings a class action” (Annas 1975, 29). Despite these weaknesses, in 1975 Annas was optimistic that the JCAH statement and AMA bill on patients’ rights was capable of creating standards that would be admissible in court and possibly even applicable in cases of hospitals that did not adopt the AHA bill:

While some courts have argued that to permit the introduction into evidence of self-imposed standards would only discourage the use of such standards, the trend is certainly toward allowing their admission. The JCAH standards and hospital bylaws, for example, were admitted in one case to serve as “evidence of custom” to aid the jury in determining the standard of care to which the hospital should be held. It is possible that a court would allow the admission of a document like the AHA Bill of Rights, even if the defendant hospital had not officially adopted it, on the grounds that it would give the jury an indication of the practices of other hospitals. (Annas 1975, 29).

Annas in his 1989 revised ACLU patients’ rights handbook still regarded the JCAH and AMA bill of rights as weak protections but nevertheless have “important symbolic purposes and helped to legitimate the entire patient rights movement” (Annas 1989, 43). But the significance of these bills eventually became more than symbolic: by 1989, several states had adopted patients’ rights bills, and hospitals in these states

were legally responsible to abide by the principles established in these bills (Annas 1989, 44).

The proliferation of patients' rights bills

Countless patients' rights bills have appeared in the decades since the AHA published its bill in 1973. Hospitals, physician group practices, physicians' associations, hospices, long-term care facilities, and other health services organizations have crafted variations on the AHA bill and some combination of state laws and common laws. Other patients' rights bills are treatment specific such as the "Ibogaine Patients' Bill of Rights" (for treatment of substance addiction with the anti-addictive medication) or the "Dialysis Patients' Bill of Rights and Responsibilities" by the National Kidney Foundation.³⁶ These types of bills tend to focus on clarifying patient responsibilities to follow specific therapeutic protocols if they are to ensure their continued participation in treatment programs. These bills emphasize the contractual aspects of patients' rights upon entering care provided by health services institutions.

There are also patients' rights bills adopted by numerous advocacy organizations for disease- or disorder-specific patient populations. These types of bills are designed to assert the authenticity of a particular disease. In such cases, a bill of rights symbolically establishes the legitimacy of a disease in order to secure rights to

³⁶ Dora Weiner Foundation, "Ibogaine Patients' Bill of Rights," Dora Weiner Foundation, http://www.doraweiner.org/bill_of_rights.html; National Kidney Foundation, "Dialysis Patients' Bill of Rights and Responsibilities," National Kidney Foundation, <http://www.kidney.org/atoz/atozcopy.cfm?pdfink=DialysisBillRights.pdf>.

respectful care and to procure specific treatments, insurance coverage, and other community resources. Google “patients rights” or “patient bill of rights,” for instance, and among the pages of links to patients’ rights bills that appear are such examples as the Fibromyalgia “Pain Care Bill of Rights,” the “Pituitary Patient Bill of Rights,” the “Cancer Patients’ Bill of Rights,” and the “Worldwide Charter for Action on Eating Disorders.”³⁷

The Fibromyalgia pain care rights bill, adapted from the American Pain Foundation’s patients’ bill of rights, opens with a statement that affirms the right of fibromyalgia patients to have their disease recognized and their treatment concerns respected: “As a Person with Pain, you have the right to have your report of pain taken seriously, and to be treated with dignity and respect by doctors, nurses, pharmacists and other health care professionals.” The Pituitary Patient Bill of Rights includes measures found in standard rights bills’ on protecting patient autonomy, privacy, and so forth. But the bill mostly concentrates on declaring the right of patients with pituitary-related illnesses to be recognized as deserving the resources they need to treat their conditions. For example, the Pituitary Patients rights bill declares that “Pituitary diseases, tumors and the resultant hormonal imbalances shall be recognized as a serious, major public health problem afflicting a large segment of the world’s population.” This is followed by a statement affirming the pituitary patient’s right to

³⁷ FACES Inc., “Pain Care Bill of Rights,” Fibromyalgia Association Created for Education and Self Help, <http://www.fibrocop.org/paincarebillofrights.htm>; Pituitary Network Association, “Pituitary Patient Bill of Rights,” Pituitary Network Association, http://www.pituitary.org/about/patient_bill_of_rights.aspx; CANHELP, Inc., “Cancer Patients’ Bill of Rights,” CANHELP, Inc. <http://www.canhelp.com/billofrights.htm>; Academy for Eating Disorders, “Worldwide Charter for Action on eating Disorders,” <http://www.aedweb.org/documents/WWCharter3.pdf>.

financial and medical resources as any person with a recognizable illness is entitled to: “The financial and intellectual resources of my government and our public and private health services shall be as fairly allocated to me and my disorder as they are to any other life-threatening and life-altering disease.” CANHELP, a group advocating alternative cancer therapies since 1982, has its own patients’ rights bill that lays out the cancer patient’s right to alternative treatments and to be listed on a tumor registry, among other points.³⁸

The Academy for Eating Disorders (AED), an international organization of health professionals involved in the research and treatment of eating disorders, launched in November 2006 its global Charter that comprises six rights regarding communication with health professionals, assessment and treatment planning, access to fully funded, high-quality care, rights to respectful, informed care, and rights to resources and respectful treatment for caregivers. These rights define what patients with eating disorders and their families should expect and insist on when they seek care from health professionals. According to an AED press release, this international patient Charter “seeks an end to discrimination against people with eating disorders by insurance and treatment providers” by calling “for insurance companies and health care systems around the world to provide coverage for the treatment of people with

³⁸ The American Cancer Society has a patient bill of rights that is based on the standard AHA patient bill model and makes no reference to cancer patients having rights to participate in alternative cancer therapies. See American Cancer Society, “The Patient’s Bill of Rights,” American Cancer Society, http://www.cancer.org/docroot/MIT/content/MIT_3_2_Patients_Bill_Of_Rights.asp.

eating disorders that is equal to the treatment available to those with any major medical illness.”³⁹

The above examples illustrate the symbolic function of patients’ rights bills. These bills have no legal weight, but they articulate standards and expectations of care that can be understood in the context of human rights versus legal rights. Human rights articulate values, as Annas explains in the ACLU handbook on patients’ rights: “[human rights] are statements of what the law ought to be, based on a political or philosophical conception of the nature and needs of man” (Annas 1975, 6). Health was affirmed a basic human right by the United Nations in the Declaration of Human Rights. It is a generally accepted value in most societies that people have a human right to medical care when they are sick. But human rights are not automatically legal rights. Legal rights in the US encompass statutory rights of citizenship provided through the Constitution, state laws, and court decisions and *probable* rights that have a high probability to be recognized as legal rights in a court of law (Annas 1975, 5).

Legislating patients’ rights, consumer rights, and the rise of HMOs

Since the early 1970s, the patients’ rights movement has influenced most state legislatures in the US to adopt patient bills of rights that have translated human rights regarding patient autonomy into legal rights. However, the problem of access to care—the patient’s right *to* health care—still remains for the most part in the domain of human rather than legal rights for most Americans. The states have led the way in

³⁹ Academy of Eating Disorders, media release, November 10, 2006, “Eating Disorders Organization Calls On Insurers to Cover Treatment,” <http://www.aedweb.org/media/insurance.cfm>.

extending health insurance to low-income children; as of this writing, a few states, led by Massachusetts, are taking or considering steps towards reducing their uninsured population and implementing plans to mandate universal health insurance. By the end of 2006 California became the latest state to propose making affordable health insurance available to all residents. At the federal level there are no constitutionally guaranteed legal rights to health care beyond emergency care and health insurance extended to veterans, the elderly through Medicare, the disabled and low-income citizens through Medicaid. An overview of the struggles to nationalize health insurance since the 1960s will show that the failure to establish a federal patients' bill of rights is directly connected to the failure to establish a comprehensive health insurance program at the national level.

The early 1970s saw the last vestiges of the Great Society's liberal influence on social policy. After the success of Medicare and Medicaid, the push for national health insurance was revived in 1971 when Senator Edward Kennedy introduced his single-payer universal health care plan. Consensus on nationalizing health insurance seemed imminent; the AMA was in the mood for compromise, Nixon's "National Health Insurance Partnership" was a compromise between what AMA and labor wanted, and public support for universal coverage was high (Mayes 2004, 90). But Kennedy's bill did not pass. Another attempt in 1974, the Kennedy-Mills bill, was stymied by several factors, including the ironic fact that it was labor that refused to accept any compromises represented by this second bill. By 1974, after the first oil crisis, "stagflation," and Medicare's escalating costs dominating the media, the public

was no longer in the mood to support any plans for increased government expenditures in health care. All hopes for universal health coverage ended after the mid-1970s when conservatives took power and fixated on cost containment, with the intent to shrink government financing of health care.

With Nixon's support, Congress passed the Health Maintenance Organization Act in 1973. According to Starr, this represented an ironic turn of events because managed care was actually a conservative adaptation of traditionally liberal ideas about group care that originated during the Depression. The crucial difference between earlier group care plans and Nixon's plan was the introduction of for-profit insurers and group practices:

A remarkable change had taken place. Prepaid group practice was originally associated with the cooperative movement and dismissed as a utopian, slightly subversive idea. The conservative, cost-minded critics of medical care had now adopted it as a more efficient form of management. They had substituted a rhetoric of rationalization and competition for the older rhetoric of cooperation and mutual protection. The socialized medicine of one era had become the corporate reform of the next. (Starr 1982, 396)

This created the initial opening into the health care market that permitted greater privatization and commercial dominance by insurance corporations and other for-profit corporate entities, with the blessing of successive neoliberalist administrations in the 1980s. Initially, however, HMOs grew at a very slow pace: "Managed care's growth started slowly with President Nixon prodding Congress to pass the 1973 HMO Act. By July 1980, the government had qualified just 112 HMOs and only 4 percent of all U.S. citizens were members" (Mayes 2004, 121). HMOs did not really hit their stride until the 1990s when "employee enrollments in managed care plans increased

from 5% in 1984 to 50% in 1993” (Rizzo and Yang 2006, 46). Employers saw managed care as a way of cutting costs as the price tag for employee health insurance steadily inflated. But the “managed care backlash” was already happening even as managed care enrollment grew exponentially in the 1990s. The problem with managed care was the way cost-savings was structured from the “supply” side. Physicians were given incentives to see more patients and keep costs down by denying care unless medically necessary. This left a perception among patient-consumers that their health care was being compromised through the rationing of health services. However, the backlash against managed care never resulted in the implementation of national health insurance: The infamous defeat of the Clinton health insurance proposal in 1992 represented the fourth failed attempt in twentieth-century American history to institute universal coverage through federally mandated health insurance.⁴⁰ With the subsequent Republican domination of Congress and George W. Bush’s two-term takeover of the White House, national health insurance seemed a lost cause—that is, until the 2006 midterm election returned the Democratic party to power in Congress and resurrected the health insurance issue with an urgency not seen since Clinton’s ambitious effort 14 years earlier.

After the national health program debacle, the Clinton administration turned its attention to address the public’s dissatisfaction with managed care. A Presidential

⁴⁰ For an account of the political struggles surrounding the Clinton health proposal, see Theda Skocpol’s *Boomerang: Health care reform and the turn against government* (New York: W.W. Norton & Co., 1997). For an account of the earliest attempts to institute compulsory health insurance during the Progressive era, see Beatrix Hoffman’s history of the New York health insurance campaign, *Wages of Sickness: The politics of health insurance in progressive America* (Chapel Hill, NC: University of North Carolina Press, 2001).

Advisory Commission on Consumer Protection and Quality in the Health Care Industry drafted a “Consumers’ Bill of Rights and Responsibilities” in 1998 that included “four fundamental post-1970 patient rights (informed choice, confidentiality, emergency care, and respect) and three contract-based consumer rights (contract information, choice of physician within a plan, and access to an independent appeals mechanism)” (Annas 2005, 100). These standards were represented to varying degrees in a series of House and Senate patients’ rights bills introduced in the late 1990s-early 2000s. Congress, however, deadlocked in 2001 over the consumer’s right to sue HMOs. This did not stop consumers from pursuing the right to sue their managed care agencies through the courts; from the mid-1990s to early 2000s, patients and doctors seeking to curb the power of managed care organizations initiated numerous lawsuits to allow consumers to sue their HMOs.

Since efforts to pass a patients’ rights bill was at a stalemate in Congress, in the mid-1990s state governments began to pursue their own initiatives to legislate patients’ rights in health care. Texas led the way in 1997 with a law (that the then Governor George W. Bush refused to sign) that permitted consumers to sue their HMOs for damages resulting from denial of care. California followed in 1999 with a tough HMO consumers’ bill that instituted a Department of Managed Care for independent review of denied services and permitted the right to sue HMOs for punitive damages. In 2002, the Supreme Court upheld the Illinois state law—similar to laws of 41 other states—that the state had the right to protect HMO consumers in “employee-sponsored benefits plans that contracts with an outside medical provider”

by guaranteeing independent arbitration over the medical necessity of treatments prescribed by primary care physicians (Greenhouse 2002).⁴¹ However, the Supreme Court in 2004 ruled against state laws such as Texas's and California's wherein consumers under employer-sponsored plans had the right to sue their HMOs for damages from denial of care. Because employer-sponsored health plans fell under the 1974 ERISA law (Employee Retirement Income Security Act), the Supreme Court ruled that consumers could sue for *reimbursement* of denied medical services, but they were forbidden to sue their HMOs for *damages* resulting from the denial of services. This meant that California, Texas, and eight other states that adopted tougher health care consumers' rights legislation found their laws nullified. A federal patients' bill of rights would have addressed these issues, had one passed.

As of this writing, the US has no federal patients' bill of rights. The last attempt was in 2001, when House Representative Charles Norwood introduced a compromise patients' rights bill that limited patient lawsuits against HMOs. President Bush accepted the Norwood bill, but the White House and the Senate reached an impasse over the Senate bill sponsored by McCain-Edwards-Kennedy, also introduced in 2001, that did allow patients to sue. Both bills died in-house because of the disagreement over the patients' right to take their HMOs to court and because the events of 9/11 eclipsed the urgency of patients' rights as a federal issue. The push for a federal patient bill of rights waned also because the managed care industry itself made policy changes in reaction to the public backlash (e.g., dropping prior review and

⁴¹ This did not apply to 56 million Americans who did not have this protection because they are employed by large employers who operated self-insured plans.

approval of physician-recommended medical services). Patients' rights became a lost issue in the capital as the Bush administration turned to reforming Medicare in 2003. The 1996 Health Insurance Portability and Accountability Act (HIPAA) is currently the only federal legislation governing patients rights in health care in the area of patient information and the protection of privacy. It has been criticized as providing only the minimum standards of information privacy protection and its health insurance portability safeguards are considered by some critics as rather toothless because of the complexities between state-regulated and federally regulated commercial health insurance (Stroupe 2000).

To reiterate, the conflation of the patient with consumer resulted from conditions particular to the 1960s and 1970s that promoted the patient as a rights-bearing entity entitled to certain protections as an autonomous individual against the paternalism of a powerful medical profession. The conditions that produced the figure of the empowered patient-consumer emerged from the confluence of the various rights movements involved in patient rights, including the consumer movement, and factors such as the expansion of choice in viable medical care and, conversely, the deepening of patient dissatisfaction and distrust against medicine when it failed to live up to patients' expectations. Just as important to this history was the failure to establish universal health care. These events further entrenched the market-based, commercial nature of the US health care system, especially after the 1980s when successive neoliberal administrations established free-market policies that encouraged corporate profit interests to drive the managed care industry.

The battle between the federal government and the states over patients' rights in the 1990s highlights the problems inherent at the juncture of what constitutes patients' versus consumers' rights. These are often tough to differentiate since self-determination and autonomy in decisionmaking form the basis of both patient *and* consumer rights in a market-based system. But the chief difference agreed upon by bioethicists would be the right of patients to medical care because they are a vulnerable population. The right to health care still remains a human versus a legal right for the majority of Americans because of the privatized nature of health insurance in the US. With national health insurance a lost cause after the first Clinton administration's failed proposal, the drive to establish a federal patients bill of rights pivoted on the consumer right to sue their HMOs over denial of care. This issue faded after 2001 because of the events of 9/11 and changes in the managed care industry itself. After the 2006 midterm Congressional elections, for the first time since 1992 health insurance has reemerged as an issue garnering political attention at the federal and state levels. Although no longer in the public spotlight, the troubles concerning patients' rights *in* health care have not gone away, and calls for implementing federal legislation persist: "Federal law is . . . the only way to protect all patients (in or out of health plans) and the only way to level the playing field for all health plans in the United States" (Annas 2005).

Taking Back Personal Responsibility, the Return of Self-Care, and the Politicization of Choice

The same factors at play in the emergence of the patients' rights movement and the proliferation of patients' rights bills since the 1970s contributed to the return of self-care as part of what Michael Goldstein (1992) has labeled the "health movement." According to Goldstein, the nebulous contemporary health movement largely sprung from disillusionment with biomedicine's inability to stem the rising tide of chronic disease. Finding no relief through conventional medicine, chronic disease sufferers contributed to driving up the popularity of countercultural "holistic" health practices that emphasized preventive, self-help measures such as diet, exercise, and the inclusion of alternative or non-Western medicine. To reduce dependency on conventional biomedicine, the sixties counterculture rediscovered self-care through these holistic health care practices that shifted control over health directly into the hands of health care consumers and patients.

The counterculture introduced holistic health care to the larger population in the 1960s and 70s, but the idea that individuals can attain "high-level wellness" through personal responsibility did not originate with the counterculture. Neither was the call to take back personal responsibility a message unique to the progressive or radical elements of the sixties social movements. The modern health movement comprised different groups—including the women's health movement, the patients' rights movement, and the consumer movement, among others—that shared the

determination to democratize medicine but were not necessarily motivated by a common ideological perspective nor political orientation: “Feminism, gay liberation, and movements for the rights of senior citizens and the disabled as well as the consumer movement, self-help movement, and fundamentalist religious movements have all had interactive and mutually reinforcing effects upon the health movement” (Goldstein 1992, 14). The message of personal responsibility resonated with these disparate movements because on a general level they shared the aim “to demystify and deprofessionalize health care” by returning more control over medical decisions to individuals (Goldstein 1992, 141).

That individuals can affect change, be it personal, political or spiritual, is a belief that has deep roots in American culture and resonates across the different political-ideological divides that striate contemporary American society. In the realm of health, the idea that people are responsible for their own wellness has existed in some form or another throughout American cultural history since the colonial era. As discussed in chapter four, self-care handbooks were very popular before scientific medicine grew to dominate healing practices beginning in the late nineteenth-early twentieth centuries. Taking responsibility for one’s own health care needs was a pragmatic response to medical care that was largely unreliable before the advent of modern biomedicine in the late nineteenth century. During the nineteenth century, numerous popular health movements subscribed to some variation on the belief that individuals can transcend poor health and illness without the aid of physicians through personal effort, discipline, and vigilance. Against this history, the antiauthoritarianism

inherent in the modern self-care revival in this respect was not unique. But what was different from past social movements in health was the politicization of choice and the legal pursuit of rights to ensure individuals can make their decisions freely. With the women's health movement, for example, encouraging women to take up self-care was in keeping with the feminist call to make the personal political; women helping themselves and each other with their health needs was seen as a political, consciousness-changing act that empowered women to reject conventional medical care as a paternalistic product of a patriarchal, capitalist society (Ruzek 1978). In the broader patients' rights movement, the politicization of choice was defined by the drive to establish through the courts the legal rights of individuals to decide medical matters independent of their physicians' determinations and other outside elements, including the wishes of their families. The consumer movement sought to create more and safer choices for health care consumers by securing greater regulatory controls against fraud and personal injury in the health marketplace, including protecting patients as consumers of institutional services such as hospitals and nursing homes. These different groups on the political left shared a similar regard for information as the key to empowering ordinary people in health care.

Educating citizens about their health care rights and choices was the goal shared by patient groups and consumer health advocacy organizations that appeared in the early 1970s. Through newsletters, magazines, books, and other publications, these groups provided the lay public with information on pharmaceuticals, therapeutics, self-care, patients' rights, and so on, with the goal of fortifying lay people with the

necessary knowledge to assert their needs in a paternalistic and increasingly corporatized medical system. Consumer groups such as the Health Research Group division of Nader's Public Citizen carried on the muckraking tradition of earlier consumer protections movements into the self-help genre through bestsellers such as *Worst Pills, Best Pills*, first published in 1980. Other consumer groups established in the 1970s that continue today include the Washington, DC-based Center for Science in the Public's Interest (CSPI) (established in 1971) and the Center for Medical Consumers (CMC) (founded in 1976). CSPI claims the widest circulating health newsletter in North America and has a membership of 900,000. In 1976, the CMC opened in New York City's Greenwich Village a medical library free to the public and began to publish its newsletter, *Health Facts*, which continues to enjoy widespread circulation both in print and on the Internet. By the early 1980s, other consumer groups appeared that lobbied on behalf of consumers' interests in medical care and the health marketplace, such as The People's Medical Society. Founded in 1983, this organization claims to be the "largest medical consumer advocacy organization in the United States."⁴² According to its website, the People's Medical Society has "published an impressive assortment of health classics, including *Medicine on Trial* and *Take This Book to the Hospital With You*." Families USA is another prominent consumer organization that was founded in the early 1980s and sees itself as the "voice of health care consumers."⁴³ Consumers Union returned to the health policy arena in the early 1970s by establishing a lobbying office in Washington DC and has

⁴² People's Medical Society, "About the Society," People's Medical Society, <http://peoplesmed.org/abutmenu.html>.

⁴³ Families USA, "About Us," Families USA, <http://www.familiesusa.org/about/>.

been active in supporting measures for universal health coverage. In 1992, it published *The Health Care Crisis: Affordable Protection for All Americans*, a book that detailed CU's ongoing support of a single-payer universal health care system as a solution to the managed care crisis.

Information equals empowerment: The impact of *Our Bodies, Ourselves* as a self-care bible

All these developments have contributed to the perennial popularity of the self-help genre in the lucrative field of consumer health information. No self-help manual made more of an impact on changing public attitudes about health and medicine than *Our Bodies, Ourselves* (OBOS), first published in 1973 and collectively written by a group of white, middle-class women self-taught in health and medical knowledge calling themselves the Boston Women's Health Collective.⁴⁴ Since its debut, OBOS has been accepted by millions of women in the US and eventually worldwide; OBOS has been translated into 18 languages including Braille, has sold 4 million copies worldwide, and has never gone out of print (O'Grady 2005). It was updated in 1984, again in 1992, and most recently in 2005.⁴⁵

OBOS's phenomenal success in raising public awareness and changing the medical profession's attitudes about women's health issues has been amply documented in the popular media and in academic literature. OBOS was considered

⁴⁴ The Boston Women's Health Collective now goes by Our Bodies Ourselves or the Boston Women's Health Book Collective (<http://www.ourbodiesourselves.org>).

⁴⁵ Our Bodies Ourselves, "History of Our Bodies Ourselves and the Boston Women's Health Book Collective," Boston Women's Health Book Collective, <http://www.ourbodiesourselves.org/about/history.asp>.

revolutionary for its coverage of taboo subjects about women's health and sexuality; it was frequently described in the mainstream press as an enduring classic and a "manifesto" for a generation of women. Judy Norsigian, one of the Boston Women's Health Collective's original 13 members, was quoted in a 1985 *New York Times* article describing how the feminist health movement was called "the crazy women's health movement" back in the day when they began their work to advocate for greater women's health rights. However, as the article noted, "some of its 'crazy' ideas—such as advocating that information about risks be supplied with birth control pills, or that women have an alternative to the traditional hospital setting for childbirth—have become widely accepted in the 1980's" (Lawson 1985, 1). The book did not please all women; Elenore Lester reviewing the book in the *New York Times* felt it was helpful for the information it gathered, but in her mind it was not revolutionary as she considered OBOS too biologically deterministic (Lester 1973, 390). And Wendy Kline's research has shown that some readers were dissatisfied with OBOS from the moment it was published, chiefly because OBOS did not include their perspectives and experiences. Disaffected readers complained through letters to the OBOS authors that the experiences captured in the book were generalized towards a particular feminist point of view that mostly reflected the experiences of middle-class, white women (Kline 2005). Nevertheless, as Kathleen O'Grady, a research associate at the Simone de Beauvoir Institute, Concordia University in Montreal, and director of the Canadian Women's Health Network, commented in the *Globe and Mail* in 2005 :

OBOS also highlighted that women's health was more than just boobs and babies. The collective made sure to include a wide range of

women's health experiences understood in cultural and emotional terms. They also drew on social determinants of health, such as the ways in which violence, poverty, gender, ethnicity and other social, occupational and environmental factors combine to influence health status." (O'Grady 2005)

In general, OBOS was critically acclaimed from virtually the moment it hit the bookstands: it was heralded in the *New York Times* as one of "several important health books by women" that appeared at that time (Seaman 1972, 35). OBOS was not the first women's health self-care handbook that appeared in the late 1960s and early 1970s. But, as reported in the 1972 *New York Times* article, one reason OBOS stood out from the pack was because of its collective authorship by a group of laywomen who educated themselves on gynecological practices whereas books like *The Nature and Evolution of Female Sexuality*, *Why Natural Childbirth*, and *Women and Madness* were written by women physicians (Seaman, 1972).

In addition to helping shift public opinion towards acceptance of the then radical idea that women's needs are legitimate and are different than men's, *Our Bodies Ourselves* also contributed to the growing popularity of understanding the patient as an active, informed consumer with rights. OBOS promoted women as health consumers who have the right to question and even refuse to obey their doctors' orders if they deemed the latter not in their best interests. By portraying women as consumers and not patients, the Boston Women's Health Collective's hope was to change their readers' own attitudes about themselves as women and patients to assert the validity of their health needs. This move was also to get away from connotations of dependency associated with the traditional figure of the patient. OBOS openly instructed its female

readers to challenge the male-dominated medical establishment by asserting their rights as consumers in the doctor-patient relationship: “The myth still persists that we meet one another as parent and child, and that you as patient must both obey and pay money for the privilege. How long it will take and how possible it will be to fully convey to both parties the sense of consumer-employee, which is the reality of the relationship, is hard to imagine.” (Boston Women’s Health Collective 1973, 253). OBOS taught women that if physicians will not accept the legitimacy of their health concerns, then women as consumers can take their business elsewhere. OBOS sought to encourage women to think of themselves as consumers entitled to information about their health: “We hope that women will come to feel entitled to more information about their medical care, will demand better care for themselves, and will work for better care for all women.” (Boston Women’s Health Collective 1973, 236) Calling patients consumers was also a way to draw attention to the unfairness of a health care system that costs consumers a great deal of money yet they are not even entitled to their own health information, which would be unacceptable in other markets: “There is no other area of American life in which so little consumer information is available in proportion to the amount spent for services. Discrimination according to social class is also more widespread than in other areas of consumer spending” (Boston Women’s Health Collective 1973, 243). As Rothman points out: “the new feminism challenged social practices in the physician’s office. They redefined doctor-patient relationships that had once seemed natural and appropriate (the good patient as compliant) as part of a larger male design to keep women powerless, and at the same time, as part of a

professional design to keep all laypeople powerless.” (Rothman 1991, 142). In these ways OBOS’s outstanding success helped to change public attitudes about medicine and contributed to popularizing the informed patient-consumer as the modern paragon of patienthood. The Boston Women’s Health Collective’s ultimate goal was to change the capitalist nature of the American health care system, “to rethink the idea that health is a commodity to be bought like any other item in the marketplace,” and work towards public policy that would uphold the principle of health care as a basic human right guaranteed in US law:

We feel it is time to assert that the health of all the people in the broadest sense is a basic right and a highest social priority and that we should work to eliminate the profit motive from the health-care system and develop a planned, decentralized system that is responsible to the community and funded by public money (Boston Women’s Health Collective 1973, 242).

But until that day, “for women who need medical care and doctor care today, who can’t wait for the revolution to get here” (Boston Women’s Health Collective 1973, 242), *Our Bodies, Ourselves* aimed to arm women with as much pragmatic information as possible to navigate the American health care system as “savvy” consumers prepared to look out for their own health care needs. This is in keeping with the traditional ideas of self-care that hinge on principles of personal responsibility and faith in the power of individuals to transcend their current health circumstances.

How to get the best care as health care consumers

Our Bodies, Ourselves’s popularity helped spread its anti-paternalist message beyond the women’s health movement and contributed to the transformation of

mainstream American cultural attitudes towards the medical profession. OBOS was revolutionary as a milestone not only in women's health manuals but in the way it influenced the entire genre of self-help books in health and medicine:

[OBOS] changed the tenor and tone of many health books to come—because it dispensed with the weighty technical jargon and cold diagrams popular with health textbooks and puberty primers of that time. The “need to know” facts were there, but the voices and experiences of women were validated in what was at the time a new pedagogical model of teaching health through personal narratives. (O’Grady 2005)

OBOS also dispensed practical advice and tips on how to assess the qualities of a good doctor, how patients can be more assertive with their physicians, what questions to ask and how to ask them, what to expect in hospitals, specific advice on “managing the obstetrician-gynecologist,” and the importance of patients knowing their rights. With this information, and in its narrative style, OBOS pioneered a new style of self-help health handbook that aimed to make the medical system's inner workings more transparent to patient-consumers. The goal was to help consumers better prepare themselves to take greater control over their health care experiences.

Soon after OBOS's national success, self-help books claiming to help patient-consumers get the best health care possible proliferated throughout the 1970s, with titles such as *The Consumer's Guide to Health Care: How to Get the Highest Quality Medical Care from Your Doctor and Hospital* (1976), *The People's Hospital Book: How to Increase Your Comfort and Safety, Deal with Nurses and Doctors, Obtain the Best Total Care* (1978), and *The Life You Save: A Guide to Getting the Best Possible*

Care from Doctors, Hospitals, and Nursing Homes (1979).⁴⁶ In content, these manuals were distinct from home remedy encyclopedias or books warning against everyday dangers in foods and medicines in the *100,000,000 Guinea Pigs* tradition, although some did include information on prescription drugs and alternative medicine. This new breed of self-help manuals' main focus was to deconstruct the health care system itself in order to educate patients on how to be better consumers of health care services. This format grew to include handbooks that in their content reflect developments in health care since the 1970s, such as the dominance of managed care beginning in the 1990s and, starting in the late 1990s, the Internet's takeover of the consumer health information environment. Titles such as *The HMO Health Care Companion: A Consumer's Guide to Managed Care Networks* (1994), *Managed Care and You: The Consumer Guide to Managing Your Health Care* (1995), *Making Informed Medical Decisions: Where to Look and How to Use What You Find* (2000), and *After Any Diagnosis: How to Take Action Against Your Illness Using the Best and Most Current Medical Information Available* (2001) are typical of the hundreds of self-help titles found under the consumer health category in recent decades. In language and substance, these self-help patient handbooks teach their readers how to be active patient-consumers by dispensing advice on how to profitably assess the quality of their physicians' professional skills, hospital care, health care services, health insurance, and managed care networks. Readers can learn tips that include how to spot the markers of a good doctor, what questions to ask about their treatments, how

⁴⁶ Findings on "post-OBOS" self-help health literature are from my review of 20 self-help books between 1970 and 2006.

to keep their own health records, and where and how to complain if something goes wrong or do not meet their expectations. In all these books, information is heralded as the key to empowering patients; generally speaking, this consumer health genre works from the assumption that patient-consumers are best protected when they are able to act for themselves with access to reliable information. These self-help handbooks invariably paint a picture of the health care system that, at best, is excellent but flawed, and, at worst, an inhumane industry that exposed unwary patients to harm, fraud, and possibly death. And all warn that in the modern American health care system the patient can ill-afford to indulge in passivity and total dependency on their physicians. For example, the author of *Medical Mayhem: How to Avoid It and Get the Best Possible Care from Your Doctor and Hospital* cautions readers that, as a seasoned physician, he has seen an “increasing deterioration in modern medicine.” As a result, he has “become convinced that what is needed are more knowledgeable medical consumers” (Nash 1985, xv). He aims to puncture the public’s naïve expectations of “unsullied altruism” from their health practitioners and warns

Despite fantasies to the contrary on the parts of practitioners and consumers alike, it is long past time for us to realize that medicine is big business, that it is influenced in part by the same economic considerations and unethical practices that affect every business. . . . Until major reforms are instituted—a development I hope this book will accelerate—there is little possibility that the system will right itself or that doctors can effectively police their own. In the meantime, patients are paying the price. . . . The only practical and reasonable solution to the growing crises these conditions produce is for patients to protect themselves by taking an active role in their own health care. (Nash 1985, xiv)

This author's "it's a jungle out there" opinion of the American health care system is a persistent theme in self-help patient manuals and continues to echo in more recent examples such as the bestselling *You: The Smart Patient* (2006). In this book, the authors advise readers (in more cheerful language) to become a "Smart Patient" because it would be foolish and downright dangerous to rely on a far from infallible medical system: "the odds that you'll need to use the tips in this book to save your life or for critical well-being are shockingly good. . . . All tallied, medical mistakes in U.S. hospitals alone cause an estimated 44,000 to 98,000 fatalities a year" (Roizen and Oz, 2006, 9).

In short, these popular books' message of personal responsibility reminds their readers that no one is looking out for them, that they must acquire the skills to assert their needs in a cold, impersonal, profit-driven health care system. But unlike *Our Bodies, Ourselves*, very few of these self-help books address the larger structural and socioeconomic reasons at the root of the health system's troubles. Instead, all stress that individuals must protect themselves and their families by becoming the smartest, sharpest, best informed health care consumers around. If nothing else, according to these books, being informed can at least assuage some of the fears and insecurities that patients face, helping them to feel more in control and able to deal with their circumstances (Oster, Thomas and Joseff, 2000). Self-help patient handbooks thus paint a picture of patients as Davids against a formidable Goliath that can be bested if they know their rights and what they are up against in the American health care system. As part of the expanding health media universe, the continued popularity of

self-help patient handbooks has contributed to perpetuating the societal acceptance of the message of personal responsibility for health.

The Expanding Consumer Health Information Market

The importance of information to taking personal responsibility for health is reflected in the enormous market expansion for consumer information on health since the 1970s. More health information and news saturate print media and the airwaves today than at anytime in previous decades. In broadcasting, health news flood the airwaves on radio and all the major television networks while entire cable channels exist today that are devoted to fictional and reality-based shows about health and “wellness” topics (Freidman 2004). In print media, it has been estimated that new consumer magazines devoted to health and fitness appear at a rate of 50 per month (Rothman 2001, 259). Newspapers routinely carry articles on health and medicine in the “lifestyles” and science sections while medical news frequently appear as headline stories on the front pages of major newspapers, including the *New York Times*. In 2005 for the first time the category of “health and fitness” newsletters reached the top five types of newsletters listed in the Oxbridge Directory of Newsletters, bumping out education to be included with law (917), medicine (696), and computers and automation (590).⁴⁷ By my count, out of the 392 health newsletters in print in 2005 listed in the Oxbridge Directory, 370 were specifically oriented towards consumer versus professional or trade audiences. Rising circulation figures attest to the

⁴⁷ *Oxbridge Directory of Newsletters*, 2006, New York: Oxbridge Communications.

popularity of health and fitness magazines. According to MediaWeek.com (Moses, 2006, unpaginated electronic source), among top magazines in this category, total circulation in the first-half of 2006 for *Fitness* grew 1.8 percent to 1.5 million, *Shape* gained 3.1 percent to 1.7 million, and *Self* shot up 6.4 percent to 1.5 million. Then there are the countless books published on health, beauty, nutrition, diets, and fitness that line the shelves of bookstores nationwide. And, albeit controversial, the amount of health and medical advertising in the mass media is another source of consumer information that keeps the topic of health prominently in the public consciousness.⁴⁸

Of course no discussion of health information nowadays can leave out the Internet. Since the late-1990s, the Internet has rocketed to importance as a health communication tool and the pre-eminent source of consumer health information in an already crowded media environment. The Internet's innumerable websites devoted to health has turned the medium into a metonym for consumer health activism. Quantitative studies relying on large population surveys have yield figures of Internet usage for health information by all American adults with access to the Internet at somewhere between 30 to more than 50 percent (Baker et al. 2003; Brodie 2000; Fox and Rainee 2000; Miller 2001). The Internet's accessibility to hundreds, if not thousands, of health websites amplifies the longstanding problem for consumers of how to find trustworthy information. Concerns about the way the media reports on science have been around for some time (Nelkin 1987) and today users, health care practitioners, and researchers harbor similar concerns about the credibility of health

⁴⁸ According to Clarke and Evans, "between one-quarter to one-third of advertising in the most popular magazines features a health-related message, usually involving a patient using an over-the-counter medication or a diet-related product" (Clarke and Evans 1998, 6).

information on the Internet. Many self-help patient handbooks published since 2000 directly address this issue, with some entirely dedicated to directing readers to credible sources on the web and in print.⁴⁹ The problem of credible health information has become a source of aggravation for physicians and other health care practitioners as patients increasingly turn to the Internet as an information resource. This issue has been framed in some scholarly discussions as a renewed effort by the medical profession to regain their former gatekeeper status over health information and medical decisionmaking, that is, a renewed paternalism that pits the expert's ability to interpret the Internet's sea of health information against the lay person's narrower comprehension of scientific data (Lewis 2006). However, a 2000 Pew survey found that consumers who use the Internet as a health resource are often seeking information for a second opinion, not necessarily for self-diagnosis, and that they, too, worry about the credibility of health information found on the Net (Fox and Rainie 2000). The credibility issue is also a chief concern of consumer advocacy organizations that are dedicated to educating consumers on their health and health care choices through salient and trustworthy information.⁵⁰ The credibility of health information on the Internet is a serious concern when soaring rates of chronic illnesses have catapulted preventive medicine and the importance of patient education to the forefront of public health concerns.

The concerns regarding the credibility of health information in the media and now the Internet highlight how contemporary ideas about the nature of "patient

⁴⁹ For an example, see *After Any Diagnosis: How to take action against your illness using the best and most current medical information possible* (Svec 2001).

⁵⁰ Interviews with Maryanne Napoli, September 25, 2006, and David Schardt, April 20, 2006.

power” are built on the assumption that one of the keys to consumer empowerment is access to reliable information. While historical evidence shows that the symbolic power of patients as consumers has in the past three to four decades contributed to expanding the rights of patients, it is also well-documented that factors in the contemporary health care market can thwart the empowerment of health care consumers who want to exercise personal responsibility over their health. Despite the booming mass media market for health information, it is still difficult for the public to find information on physicians and hospitals, and consumers mostly do not know where to turn for dependable knowledge. National and state medical organizations provide information on physicians for free, such as the Administrators In Medicine’s (AIM) “Docfinder” webpage, and new commercial websites such as HealthGrades are beginning to appear that allow consumers to search out information on doctors, hospitals, nursing homes, and even specific surgical procedures for a fee.⁵¹ However, these resources can only disclose complaints, disciplinary actions, and malpractice information within the legal parameters that regulate this information, which vary from state to state. Reporting of medical errors in hospitals is still largely voluntary in most parts of the country as various interest groups (i.e., health providers, government, lawyers, consumer groups, business, and public health organizations) have bogged down over the design of mandatory reporting systems and fears of increased litigation

⁵¹ *Docfinder*, Administrators in Medicine, <http://www.docboard.org/docfinder.html>; HealthGrades website at <http://www.healthgrades.com/>.

(Graham 2002).⁵² Then there are the human contingencies involving language skills, literacy, cultural attitudes, personal interest, generational differences, and so forth, that factor in the extent of patient autonomy under the consumer model. For example, one study cited by Mary Graham (2002) in her work on disclosure in the medical system found that many factors complicated consumers' usage of hospitals report cards that disclosed mortality rates: "consumers cited lack of access to the data, lack of understanding, lack of interest, lack of trust in the data, and lack of meaningful choice. Only about 50 percent of employees of large companies had a choice among plans" (Graham 2002, 133). As a result, the study found that most consumers continued to rely on information from family and friends to assess their health care and insurance choices.

Responsibility and Choice Under Managed Care

Epidemiological, political, and economic developments that came to the fore four decades ago have intensified the message of reclaiming personal responsibility over health initiated by countercultural, patient and consumer movements in the late sixties and early seventies. Rates of chronic disease and health care costs have since escalated while several decades of neoliberalism have shifted the focus of health policy towards cost-containment. Where the various rights movements fighting for greater patients' rights saw the reclamation of personal responsibility as a means to

⁵² The seriousness of deaths resulting from medical errors is expressed in figures comparing death rates: "Between 44,000 and 98,000 patients died in the United States annually as a result of medical errors in hospitals. That was more than the 43,458 people who died in 1998 in motor vehicle accidents, the 42,297 who died from breast cancer, and the 16,516 who died from AIDS" (Graham 2002, 105).

subvert medical paternalism, personal responsibility under managed care came to represent ideas about prevention as a method of lowering risk for high-cost diseases, ultimately to reduce HMO subscribers' utilization of services. In 1982, Starr predicted that the public backlash against "big government" that began after the economic crisis of the early 1970s would accelerate the trend towards greater privatization of health care, allowing a "new system of corporate medical enterprise" that would have a negative impact on health care choices for patients and erode physicians' professional autonomy (Starr 1982, 419). Managed care became associated with this corporate expansion after Nixon allowed business investment into the managed care field. Managed care was a means of reforming a health system that was already facing runaway costs in the 1970s; however, the problem was not managed care per se, but, as Starr puts it, "the "conservative appropriation of liberal reform" (Starr 1982, 428).⁵³ The greater acceptance of preventive care by the public and in contemporary medicine as a means to curb the epidemic of chronic diseases thus coincided with the ascent of neoliberal policy that led to managed care corporations consolidating their hold over the US health care system by the 1990s. By that time virtually all managed care organizations promoted prevention as an important means of lowering the risk of disease, but the extent of preventive care offered by different HMOs ranged from the basic level of providing patients with information to offering various higher-cost

⁵³ Elements of managed care formed the basis of a comprehensive plan to extend health insurance coverage to uninsured Americans first proposed by Alain Enthoven and Richard Kronick in 1989. The plan would achieve health equity by reducing waste and promoting efficiency through a strategy of "managed competition" that involved the development of "public sponsor" organizations. These collective agencies would "manage a process of informed, cost-conscious consumer choice that would offer the reward of more subscribers to health plans whose providers delivered high-quality care economically" (Enthoven and Kronick 1989a, 35).

intervention services such as cholesterol screening, Pap smears, and mammograms (Cafferky 1995, 74). The pressure to operate as profitable business enterprises influences the extent HMOs are willing to invest in preventive health services: “Several research studies have shown that it takes up to five years or more to reap the results of intense primary prevention services. Because health plan members change health plans every two or three years, the incentive for a health plan to manage health promotion is lost if another health plan reaps the results” (Cafferky 1995, 74)

By 2002, employee enrollments in managed care plans hit 95 percent (Rizzo and Yang, 2006, 46). Although the majority of Americans with health insurance are in some form of managed care, today many experts talk of the US health system entering a “post-managed care era.” This term refers to how managed care itself has changed as it has reduced or eliminated the cost-control mechanisms that spurred the 1990s backlash against HMOs. Lawsuits initiated by patients and physicians against managed care corporations focused on the denial of services to patients that were deemed medically necessary by their primary care physicians: “Many of the administrative rules and procedures that made managed care so successful in temporarily containing costs were despised by both patients and medical providers. Hence, over time most were either legislated or litigated out of existence” (Mayes 2004, 151). HMOs instead have retailored their traditional emphasis on the “supply side” to recruit consumers on the “demand side” in their efforts to control costs. “Consumer-driven” or “consumer-directed” are the latest buzzwords that reflect this conceptual shift in health financing and risk management.

Consumer-driven health care, generally speaking, refers to health plans that allowed consumers to access information on quality and cost via the Internet to determine their choices for suitable coverage. Consumer-directed health care took on another dimension after health savings accounts (HSAs) were established under the Medicare Modernization Act in 2003. HSAs were introduced as one of the building blocks of the Bush administration's neoliberal vision of an "ownership society" that would see individual Americans invest their money directly in their health care through these savings vehicles that function similarly to retirement savings accounts. HSAs bestow favorable tax incentives on people enrolled in high-deductible health plans; consumer-directed health plans (CDHPs) refer to HSAs that are linked to a high-deductible insurance policy and are a rapidly growing segment of the health insurance market (Robinson 2005a, 1200). By most expert accounts, these plans allow consumers more options of providers and benefits and a certain degree of control over the selection process. Supporters of CDHPs, like long-time advocate Regina Herzlinger of the Harvard Business Administration School, believe it to be the answer to America's health care quandary by allowing consumers more power to dictate the market: "Consumer-driven health care is fundamentally about empowering health care consumers—all of us—with control, choice, and information. Consumer control will reward innovative insurers and providers for creating the higher-quality, lower-cost services we want and deserve" (Herzlinger 2004, xvii).

Other experts, however, are concerned that the promised increase in flexibility and control would be counteracted by consumers having to assume greater financial

risk (Gabel et al. 2002; Iglehart 2002; Robinson 2005a; 2005b; Scheffler and Felton 2006). Consumer-driven health coverage presents larger moral-philosophical questions regarding the impact on collective responsibility over health care: “the health savings account . . . reflects a philosophical shift in emphasis from collective to individual responsibility for the management and financing of care” (Robinson 2005a, 1199). Recent studies suggest that the spread of consumer-driven health plans could lead to a situation where healthier and wealthier consumers opt for CDHPs while those remaining in the non-CDHP market will experience higher premiums because they tend to be sicker and poorer (Scheffler and Felton 2006, 47). With the issue of universal health insurance returning to the political spotlight in late 2006, it remains to be seen how consumer-driven health plans factor in the larger dilemma of sorting out personal versus collective responsibility for health care in contemporary US society.

EPILOGUE

In the post-managed care era, bioethicist George Annas warns against confusing patient rights with consumer rights, which represents a stark about-face from his position in the 1970s. It would seem that his change of heart reflects how the meaning of “consumer” and “consumerism” has undergone changes and variations in the past 40 years that mirror the directions health policy and the health care market has taken since Annas wrote about patients’ rights in the 1970s. The difference, Annas is saying, between patients’ rights and consumer rights is that in an era dominated by a highly corporatized health industry, consumer rights keeps the focus only on the contractual rights of health insurance purchasers whereas patients’ rights involves far more and especially access to health care as a fundamental human right irrespective of a consumer’s purchasing power. The concern seems to be that the over-representation of the patient as a consumer would confuse the public into believing that a choice in health plans or more freedom to tap into information via the Internet amounts to the same thing as genuine patients’ rights when many of the endemic problems of the American health care system derives from the for-profit nature of its corporate organization. Rather than representing the expansion of health care rights as it did in the 1970s, critics today are inclined to see patient consumerism as an outcrop of the hyper-commercialized nature of the American health care system.

In light of the history I have laid out in this dissertation, the above conclusion risks oversimplification. True, the forces of neoliberalism have co-opted and exploited the language of empowered patient-consumerism. And as a democratizing force in American health care, progressive consumerism's influence on health and medicine has proven only partial. The legacy of the patient as consumer, as I have shown, is complex, not easily reducible to uncomplicated assumptions, and will continue to exert its influence on health and medicine in the United States.

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