

CHAPTER 2

Pharmaceutical Witnessing: Drugs for Life in an Era of Direct-to-consumer Advertising

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People come into my office, throw down an ad and say, 'That's me.'
Psychiatrist

It's a disease that often has no symptoms.
Advert for Peripheral Artery Disease

If you answered 7 or less for question 10, you probably aren't feeling like yourself.
Website for Depression Awareness

As an anthropologist studying pharmaceuticals in the U.S., I am constantly tripped up by statements that seem to challenge my common sense, ones made by pharmaceutical marketers, advertisers, doctors and patients. A life on drugs is not alien to me, nor to most readers of this article. We often are on prescriptions and we might be on them for life. But the easy emission of these statements points to a cultural inflection that I want to investigate here using what Victor Turner called the method of processualism in anthropology, attending to processes that we are involved in and to how actors perceive, mutate and communicate their embodied worlds (Turner and Turner 1992: 172–73). All of the opening statements, I want to argue, share a relatively new grammar of illness, risk, experience and treatment – one in which the body is inherently disordered and in which health is no longer the silence of the organs, but it is illness which is silent, often with no symptoms. In this article, I want to

interrogate this grammar, examining how it involves an image of health as risk reduction, and an image of information as full of partial facts. Together, these images underpin a logic of accumulation of pharmaceuticals in the U.S. such that it becomes natural and imperative to treat one's body with more and more drugs for life. In fact, it is so commonsensical that even critics of the pharmaceutical industry and advocates of alternative medicine share in this logical growth.

This article is part of a larger, book-length study of 'mass medicine' in the U.S. Mass medicine refers to blockbuster pharmaceuticals whose yearly sales exceed one billion dollars and whose customers are measured in millions. My research included analysing hundreds of pharmaceutical TV commercials, as well as magazine ads and Internet sites; tracking patient discussion groups online; and interviewing and holding workshops with pharmaceutical marketers, doctors and patients groups. Here I examine advertisements for their grammar of facts and health. I also analyse the 'grey literature' written by pharmaceutical marketers to each other to improve their practices. I aim to show how our ways of talking articulate with theirs such that we may get what we want, but it may not be what we need. *Pharmaceutical Executive (PE)* is one journal that concentrates on marketing strategies towards doctors and the public. I trace a key shift in marketing towards what I call factual persuasion and what *PE*, in its first branding seminar in April 2002, termed 'Pharma's challenge to convert science into marketing' (Shalo and Breitstein 2002: 84).

Using tools from many disciplines, pharmaceutical marketers are building on a much longer tradition of public relations aimed at calibrating emotions for maximum effect in concert with the authoritative discourses of science and medicine that dissociate viewers from their own bodies and experiences (Tye 1998; Chomsky and Barsamian 2001; Herman and Chomsky 2002). I begin with an early pharmaceutical commercial.

Remaking the Body at Risk

The following table shows a direct-to-consumer (DTC) television commercial for a Depression Kit (manufactured by Lilly), which begins as a checklist in the form of an interrogation.

Table 2.1. Text of TV Advert for Lilly's Depression Kit

| Voiceover | Audio-Visuals |
|---|---|
| Have you stopped doing things you used to enjoy? Are you sleeping too much, are you sleeping too little? Have | Sombre music playing over black-and-white stills of unhappy people. |

you noticed a change in your appetite?
 Is it hard to concentrate? Do you feel
 sad almost every day? Do you sometimes
 feel that life may not be worth living?
 These can be signs of clinical depression,
 a real illness, with real causes.
 But there is hope, you can get
 your life back.

Text on screen:
 ‘Depression strikes
 one in eight’

Text on screen:
 ‘Get your life back’

Treatment that has worked for millions
 is available from your doctor.
 This is the number to call for a
 free confidential information kit,
 including a personal symptoms
 checklist, that can make it easier
 to talk with a doctor about how
 you’re feeling. Make the call now,
 for yourself or someone you care about.

Woman looking at
 pamphlets, phone number
 on screen, pictures of
 checklists and other
 information pieces.
 Fade to logo for Lilly.

The commercial features simple questions that are very general: are you sleeping too much or too little? But their seriousness is transmitted in the follow-up: ‘These can be signs of clinical depression.’

This conclusion converts the questions into a medical algorithm, a logical process of following a series of steps. But the grammar arrests: ‘these can be signs’ is a peculiar phrase. It is retroactively transformative: aspects of one’s life are inscribed as symptoms. What you had previously thought of – if at all – as personal variations are brought into heightened awareness. The first implication is that you are, maybe, suffering from a serious disease and do not know it. Your body, in other words, is potentially deceptive, concealing its own decline. This is not a presymptomatic form of awareness. Unlike the situation in Nelkin and Tancredi’s *Dangerous Diagnostics* (1989), where a brainscan or genetic test reveals a disease before it manifests symptoms, here you find out that you have been suffering from symptoms without feeling them.

The grammar of the phrase, ‘these can be signs of X’ or ‘you could be suffering from X’ are also not simple performatives. They do not assert that you *have* depression, they do not diagnose (Austin 1962; Kahn 1978). For legal, marketing, and health reasons, the grammar is explicitly modalized as possibility: ‘these *can* be’ ‘you *could* be’ ‘you *might* be.’ But they are giving you a *new* possibility.

Information about the *possibility* of pathology transforms modalization into mobilization (Halliday 1985). You cannot ignore the possibility morally because your status has changed (Sacks and Jefferson 1992). This can

produce a very strong duty to be healthy (now that you know you are not) and a rational ‘having to try’ (since you know there is something you can do), that is as deeply moral as the imperative to be tested identified by Nelkin and Tancredi (1989; see also Franklin 1997). You are *now* at risk, you now *know* that you have been at risk, you *have* to try to do something about it. Since treatments are available, ‘There is hope.’

From a marketer’s point of view, once you are aware of the disease in general, the question is how to get you to add depression, breast cancer, cholesterol to *your* lived anxieties, to your personal agenda, enough so that you attend to it, find out more information, and talk to your doctor about it. This is what they term ‘personalization.’ Their problem is how to get their particular facts into your head as facts that you come to depend on. This practice recalls and builds on an older generation of advertisements teaching you that you might be suffering from bad breath or be overweight and not realize it (Marchand 1986; Bordo 1993), but amplifying this personalizing effect by passing it through tests and diagnostic algorithms.

For instance, another commercial begins with a scene of many middle-aged people on exercise bikes in a gym, working out but looking tired. The only sound is a ball rolling around and superimposed above them is a spinning set of numbers. Finally the ball is heard dropping into place; the number is 265. The cholesterol roulette is over. The text on the screen: ‘Like your odds? Get checked for cholesterol. Pfizer.’

The challenge of thinking through how these commercials work dialogically lies in the fact that they aim for a retroactive status change. Rather than illness punctuating ordinary life, the everyday conceals illness. Once this is identified, once you identify with it, then your true, real life can be returned to you. The process here is a counterpart to interpellation. Althusser’s process of interpellation involved the always, already self-recognition of the subject, where the teacher or policeman hails you or asks you a question, and your response confirms the self-evidence of your being a subject: ‘I am I’ (Pecheux 1982; Althusser 1984). Here your self-evidence is directly assaulted. Your self-identity is called into question via the algorithm. You are not who you think you are. Your body is not what you think it is. Your feelings are not what you think they are. The algorithm offers in turn to identify your objective self for you. So instead of the interpellated response, ‘Yes, it’s me’, we instead say, ‘Oh! so that’s who I am.’

The challenge in studying pharmaceutical marketing is that the commercials do not usually work this easily. In fact they do not work well at all, but they do work well enough. Both the number of prescriptions and the amount of drugs per prescription are projected to continue to grow at 5–15 per cent per year for almost all classes of drugs for chronic conditions (Express Scripts 2006). For marketers, *some* people responding *some* of the time is all that they need: their processes of persuasion are designed to work

in percentages, or market share. If they can get even a small per cent more Americans to consider the possibility that they might be depressed or have high cholesterol, and a small per cent of those people actually go to a doctor and request a prescription, the profits on these tens to hundreds of thousands of additional patients are more than enough to cover advertising costs (Kaericher 2007). It does not matter whether those people ‘believe’ that they are sick, only that they *act* in accordance with that belief as delineated by the marketing campaigns. The studies that have been done on direct-to-consumer advertising suggest that these commercials are successful at generating concern and anxiety, and that they drive pharmaceutical sales just enough to justify continuing to invest in them (Aikin 2002). My ethnographic challenge is therefore to account for this aggregate growth. I am thinking of this as an ethnography of the aggregate. Thus I begin with a study of how marketers *imagine* people to be manipulable *enough*.

As businessmen, pharmaceutical marketers know exactly what their endpoint is: profit in the form of ongoing mass pharmaceutical consumption. This profit ultimately boils down to prescription maximization which can be achieved through growing the absolute number of new prescriptions, extending the time a patient stays on a prescription, or shortening the time between having a condition and getting a prescription for it (Bolling 2003).

Most pharmaceutical marketing overviews start with the product cycle. A pharmaceutical in the U.S. must go through an extensive regulatory process in order to be approved for use. This process includes testing the drug for safety, first in animals, then in humans. Its potential efficacy is then assessed, and finally its actual efficacy is tested in a clinical population for a specific illness through clinical trials. When all of these have been successfully accomplished, the pharmaceutical company applies to the FDA for approval. If granted, the company gains a number of years of exclusive right to market that drug to doctors and public for that illness. Marketers therefore divide their strategies into stages: pre-launch, launch, market exclusivity, and transition to generic competition. Embedded in their articles about direct-to-consumer marketing, however, is also a complex theory of the mass market as potential patients who do not know that they are ill, and must be led, step by step, toward a prescription.

I opened this article with a close grammatical reading of how some DTC commercials are constructed, arguing in effect that we as viewers are vulnerable to redescrptions or reclassifications of our everyday variability into symptoms, and that we can be led to identify with the possibility of disease and treatment through rhetorical persuasion. I will now continue to attend to the logics and grammars of pharmaceutical marketing as they are circulated, and analyse these in accordance with these explicit strategies outlined by marketers. Marketers have a highly developed language for articulating the steps of conversion through which non-patients come to see

themselves as undiagnosed patients, then actively visit and persuade their doctor to give them a prescription. Using their terms, but focusing on how marketers approach a person as someone who does not even know that they require a drug, I have mapped their implicit strategy onto five distinct steps. They are:

1. Awareness through Education
2. Personalizing the Risk
3. Motivation to Self-diagnose
4. Seeing and Convincing a Doctor
5. Branded Compliance

Most DTC commercials are aimed broadly at addressing people in any step, at reinforcing this step-wise progression as logical and natural, and at helping people move onto the next step. This process involves much more than just advertisements, it includes the design of clinical trials, arranging screening programmes, constructing databases, and monitoring compliance. As we, patients and potential patients, try to learn facts about our risks and illnesses and come to incorporate these into our identities and bodies, almost every aspect of the medical world we encounter is being modulated (not constructed, but adjusted) in accordance with profit motives. That is capitalism, you might say, but it is also an opportunity to understand *how*, in our capitalist culture, facts, risks and illnesses work in and on us, transforming how we experience, understand and measure health.

Awareness through Education

So companies realize that an effective way to reach commercial goals is to cultivate long-term patients through education, rather than acquiring new consumers through brand-awareness advertising. (Hone and Benson 2004: 98)

Medical sociologists have recognized how the neutrality of health information can be manipulated through selection and amplification, privileging one form of explanation over others. The idea that information empowers can be turned into a structured or controlled empowerment, what Dixon Woods has called ‘information for compliance’ in contrast to ‘information for choice’ (Dixon-Woods 2001, cited in Henwood et al. 2003: 591). One key strategy for producing a market is direct education of both doctors and the public. Even before the launch of a new drug, time is spent crafting messages about the disease that shape it towards market ends. In the U.S., advertorials are a technical term for this process: quasi-educational spots that function to teach about specific disease symptoms and mechanism.

Advertorials are ads ‘designed to deliver the experience of reading an article’ (Prounis 2004: 152). They are used increasingly in the U.S. to build disease awareness, to ‘create an urgency to treat diseases earlier and more aggressively’, and to draw attention to underserved populations.

The logical premise of education as patient cultivation is that the public, doctors and medical institutions are ignorant. The status quo is harming people in a most dangerous way because they are not even aware of the harm they are doing to themselves.

Ilyssa Levins, chairman of GCI Healthcare Public Relations, underscored how public relations supports the ‘science and marketing connection’ by creating a receptive climate through advocacy and issue-oriented media relations. She said PR can facilitate awareness and adoption among regulators, payers, medical influencers, and patients alike by conditioning the market for acceptance of new concepts such as overactive bladder. (Shalo and Breitstein 2002)

Being ignorant of medical issues justifies an emergency public health response: explicit manipulation or ‘facilitated awareness’. There are two main approaches to awareness through education: preparing the market and health literacy. At different levels of generality, each aims at changing the status quo of common knowledge through critical presentation: redefining what health is, what treatment is, what a smart person does to be healthy, and so on. They aim, in other words, to reframe how we see the world working and what we take for granted. In this manner, fact-based marketing creates a receptive climate.

The premise of health literacy is that a large segment of the population cannot handle complicated information. They must be managed like children: ‘Limit the content. Make it easy to read. Make it look easy to read. Select visuals that clarify and motivate’ (Kelly 2003). With this kind of handholding, medical information is streamlined so that it becomes more efficient in producing more prescriptions.

The aims of health-literacy campaigns as envisioned by marketers are to cement this relationship between knowing and doing. Targeting a sixth-grade reading level allows imagining a market of 110 million people who could be addressed with health information. The health-aware individual is thus presented as one who can and will act on medical facts. While facts are typically seen as descriptive, health education is only seen as meaningful and successful if its knowledge induces action. Non-compliance with facts is thus framed as a problem of literacy. Health literacy grammatically frames the public as well-intentioned but ignorant, illiterate, uneducated and disempowered.

When health information is offered, people cannot understand or act upon it. When that happens, [often] low health literacy may be at fault. Health literacy is defined as the ability to read, understand, and act on health information, and it becomes more important as patients are asked to take a more active role in their own healthcare. (Kelly 2003)

The moral grammar of ‘health information’ is that facts will of course be acted upon. This grammar precludes resistance: if you do not act on what you know, you must be doing so for psychological reasons. You are confused, embarrassed, intimidated or ignorant. Each of these reasons offers an opportunity for strategic intervention to fix the problem of people who have encountered the information but are not acting on it.

In Europe, this challenge is acute because brand-name pharmaceutical advertising to consumers is not allowed. Sandoz (Novartis), with an antifungal agent Lamisil to promote, needed to find another way ‘to encourage patients to talk with their doctors about onychomycosis and its treatment options. So the company renamed the condition the more consumer-friendly ‘fungal infection’ and took out newspaper ads asking readers to call or write to “‘Step Wise” for a free brochure on foot care’ (Hone and Benson 2004: 96). Besides capturing future patients through the informational relationship, the phrase ‘fungal infection’ became an indirect brand, an illness fused with Lamisil as its treatment. The challenge for pharmaceutical companies is managing education that is not directly branded without giving too much away to competitors. Their goals are to ‘employ prelaunch promotion to prepare potential customers for future product use, without generating new prescriptions for the competition’ (Bolling 2003: 112). Mechanisms include quasi-branded cues that will later be branded explicitly when the drug that works on just that mechanism is launched. Even the colour schemes and typography are tied into this process of managing awareness in anticipation of a future market (Prounis 2004).

Personalizing the Risk

When its efforts to market to physicians had reached the saturation point, the manufacturer of a prescription health product for women decided to launch a DTC campaign to expand product sales. The company’s goal was to pull through new prescriptions by increasing the target audience’s awareness of the need for treatment to prevent the onset of osteoporosis. The first communication objective was to get patients to ‘personalize’ the risk so they regarded the disease state as important enough to warrant taking further action. If the company introduced the brand too early in the relationship, before the target woman considered herself to be at risk for

the disease state, she would quickly dismiss the therapy as not appropriate for her. (Bolling 2003)

Once a prospect is aware of a risk and accepts that it is possible, he or she must then be made to personalize the risk. Having been introduced to a fact, one needs to enter into a relationship with it. Personalizing involves having the risk become part of an existing internal and external dialogue. It has to become part of *my* story, how I talk about and represent myself to myself and others. Personalizing requires that the possibility of risk in general now becomes *my* possible risk. What is needed is that I worry about this possibility, that it go from being an object of my *attention* (awareness) to becoming an object of my *concern*.

Medicalization is a term used by sociologists to describe the historical process through which conditions, complaints, normal variation and socially undesirable traits are turned into medical conditions and interventions (Conrad 1992; Klawiter 2002; Lock 2002; Clarke et al. 2003). Analysed as power conflicts, medicalization can be a coercive force making people into patients in order to control and manage them. Alternately, medicalization can be a tactic by sufferers to become objects of attention and care through becoming patients (Dumit 2006). Within DTC, these problems of ‘my status’ and ‘my bodily state’ are ‘offered’ to me as explanations for what I am and should now be concerned about. It appears non-coercive, even empowering. I am offered a gift to evaluate freely. However, as Ronald Frankenberg has noted, characterizing this process of medicalization is fraught with narrative and conceptual difficulties for everyone involved (Frankenberg 1993).

How does medical identification happen? How can we ethnographically describe an encounter with an advertisement that is effective as documented in increased prescription demands, yet does not reduce the viewer to a judgemental dupe, to use a phrase from Garfinkel (1967), someone who is passively manipulated by the media. In order to investigate processes of identification, I will make a detour into the anthropology of religion and personhood, and draw on the work of Susan Harding, who studied Christian Fundamentalist followers of Jerry Falwell (Harding 2000). She analysed the techniques of evangelical witnessing, the explicit process of attempting to convert non-believers into believers through speech and dialogue. Her study offers a framework for understanding the active, participatory process of identification and persuasion that is going on in pharmaceutical advertising.

Harding approaches conversion and status change from the inside, so to speak, as one who is involved in the situation, in the dialogue, struggling to understand. Harding notices this when driving home after interviewing a minister. She almost gets into an accident. In that moment of danger, she finds herself asking, ‘What is the holy spirit trying to tell me?’ Finding herself asking this question begins a key insight. She found herself beginning ‘to

appropriate in her inner speech the evangelical language and its attendant view of the world'. Her modes of attention, cognitive and emotional, were drawn to the near accident as a gap in the ordinary, an event within the everyday where 'the seams split' (Harding 2000: 58–59).

Harding argues that one moves from being an unbeliever to believer through a 'process of acquiring a specifically religious language ... If you are seriously willing to listen, and struggle to understand, you are susceptible to conversion' (2000: 57) It is the unwitting, basic desire to understand that aids this process. It is specifically not a ritual in that there is no social sanctioning that bridges the two worlds. Rather, the listener gets 'caught up in certain kinds of stories' in which the personal referents, the pronouns, 'Christ died for *you*', slip up, and slip into one's own language. Her description is deeply processual: the listener struggles to make sense of stories with uncertain references, stories that force attention onto events, past, present and future, which disrupt the normal flow of life, leaving those disruptions open and vulnerable, and making sense of them only through a religious grammar.

Harding shows that the worlds of the believers and the unbelievers regarding fundamentalism are each clear and logical, but that evangelicals want to convert or save others. While it appears that from either position there is no middle ground, that you either believe or you do not, Harding insists that there is a substantial in-between position, which evangelicals describe as 'being under conviction'. Harding describes 'coming under conviction' as a kind of individualized dialogic approach to status change.

Similarly, the suggestion: 'These may be signs of a serious illness' and the question, 'Is this a symptom?' can be thought of as part of coming under a biomedical conviction. This 'inner rite of passage', Harding suggests, works 'subliminally' in that she and others who are witnessed to often have no idea what is happening. They are not changing status with a culture, however that is to be defined, but are instead switching cultures or worldviews.¹ Finding oneself asking the question, 'Is my cholesterol too high?' is already such a switch. One has begun acquiring a specifically pharmaceutical language and worldview.

In pharmaceutical marketing, this switch often turns on some sort of bodily hook. This is a facilitated recognition in which I come to understand that what I had previously taken for granted or overlooked in my body is in fact an object of concern. In this manner, my attention to a risk possibility and my self-concern become linked, and the temporal fact that I had overlooked this before adds an emotional surprise and worry to the mix. The archetypal form of this identification is the 'ouch test' as described by virtual contributing editor Vern Realto in *Pharmaceutical Executive*:²

Of course, in the world of DTC, it helps to have a product indication in which patients can point to a spot on their bodies and say, 'Ouch!' Prilosec [for acid indigestion] has such luck. And its DTC creative makes full use

of the fact. Patient self-selection is the point. For a heartburn sufferer, looking at the campaign's ever-present cartoon figures is like looking in the mirror. Does it hurt? Yes. Would you like 24-hour relief with a single pill? Yes! (Realto 1998: 14)

The grammar of this concise description conceals the interpellation at work. 'Patient self-selection' is the retroactive effect of the campaign when it is successful. A person who does not consider herself a patient or even necessarily a sufferer comes to recognize a complaint as suffering and as treatable and therefore recognizes herself as a patient. Althusser called this process of coming to see oneself as having already been a patient a 'subject effect'. I call this process, when it happens through a scientific fact, 'objective self-fashioning' because one's new identity appears to have been verified as one's real and objectively true identity (Dumit 2004).

This retroactive effect can also happen at a bodily level, within a subject's body, when an ache or complaint is reframed as a symptom. In the following description, by patient compliance expert Dorothy L. Smith, the headache is always already a symptom that the unaware consumer has mistakenly ignored.

DTC ads can make consumers aware that symptoms they have tried to ignore, believing that nothing could be done, are actually the result of a treatable condition. For instance, a person who suffers from frequent headaches may learn from a DTC ad that those may be the symptoms of a migraine and that there is treatment available. Those ads can give us hope. They can help us identify positive steps to take. They can motivate us to talk with the doctor about subjects we find embarrassing. (Smith 1998)

Furthermore, one recognizes that a third-party expert enabled this objective redescription of one's 'symptom' as the truth of one's experience. In addition to a subject-effect here, there is also a truth-effect. At this point in the DTC process, the target is common sense. First, in the awareness step, I recognize that heartburn is a *treatable* medical condition and also that I should have known this. As a fact, it should have been part of my taken-for-granted background against which I examine the world. 'If we think there is no treatment available for our symptoms, we may decide it's not worth spending the money on an office visit' (Smith 1998). Now, with personalization, I see that *I* may be suffering from this treatable medical condition. I may be a patient. What I now *know* is that I am a *possible* patient.

Realto's account of Prilosec (above) notes that it is 'lucky' to have this built-in auto-identification 'ouch' test. Then, the problem is only one of medicalizing a portion of experience. The bigger challenge for marketers is producing identification with an asymptomatic condition, 'making patients

recognizing themselves' despite feeling healthy. Medical sociologists and anthropologists have long used a distinction between *illness* as lived experience framed by lay notions of suffering and *disease* as biomedical knowledge (cf. Kroll-Smith et al. 2000). The aim of risk and symptom personalization is precisely to fuse these understandings of illness and disease together so that one talks in terms of medical facts, risk factors and biomarkers, so that one literally experiences risk factors as symptoms.

Will the same approach work for a cholesterol-lowering medicine? No. But if a way exists to make patients recognize themselves through any DTC communication, therein lies the first lesson in consumer health care marketing. You can take it to the bank. (Realto 1998)

The lived body must be reframed as no longer giving forth symptoms, but instead as naturally concealing them. One's body itself, as marked or measured, then takes the place of a bodily symptom. Even a basic demographic attribute like sex, race or age can become the basis for risk personalization and marketing. In a commercial for the osteoporosis-prevention drug Fosamax, women are urged to recognize themselves first *positively* as healthy, active, successful and empowered, and *therefore* as at risk. It presents a number of such vibrant women saying, 'I'm not taking any chances. I'm not putting it off any longer. A quick and painless bone density test can tell if your bones are thinning. If they are, this is the age of Fosamax.' The commercial concludes with multiple female voices:

Bone density test?

Bone density test.

Sounds like a good idea to me.

Ask your doctor about a bone density test and if Fosamax is right for you.

For a viewer, identifying as a positive, healthy woman becomes identifying with the risk, which must be tested since it cannot be experienced. A successful advertising encounter is one which accepts and internalizes this uncertainty under a biomedical conviction: that one *might* need Fosamax, and only the bone density test can tell.

Targeting a slightly older demographic, a series of commercials for Zocor feature grandmothers and grandfathers, including the famous football coach Dan Reeves, discussing how much they enjoy their time but how much they want to see the future, their grandchildren's graduations, etc. They narrate having had a heart attack and how diet and exercise were not enough to lower their cholesterol:

I could dance all night back there. So I was thrilled when my grandson wanted to follow in my footsteps. But before our first lesson, I had a heart

attack. I needed to lower my cholesterol. How will you take care of your high cholesterol and heart disease?

Their doctor's information about Zocor gives them a salvatory solution: 'Be good to yourself. It's your future. BE THERE.' This mode of storytelling provides an image of a responsible rational actor who upon hearing a new fact incorporates it through concern and then action. The very act of reciting this tale repeats this process, passing on the informational possibility of risk to the listener, and the personalized possibility of taking it up responsibly.

Rhetorically repeating a tale about a fact is a mode of passing on the grammar through witnessing. The tale is told in the exact words that the viewer can in turn state for themselves, to others, and to their doctor. 'Because I want to be there.' At the same time, the risk information is translated from an 'odds' sense of possibility to a powerfully imperative one of probability. If you too are a woman or middle aged, how can you not 'be ready', 'get checked' and so on. Putting these tactics together requires a precise effort at timing the market – coordinating public relations campaigns including mass media articles and doctor awareness so that biomedical identification and pharmaceutical conviction successfully take place.

Motivation to Informing Self-diagnosis

The goal during this pre-launch stage is not to motivate patients to see their doctors but to motivate them to respond for more information. (Bolling 2003)

Once identification has taken place and the person accepts a possible risk as their own, marketers see the next step as converting the possible into actual risk, or in the case of symptoms, getting the patient to self-diagnose. The next step of motivation then confirms this personal possibility as a probability through some kind of objective self-assessment: a self-diagnosis through a checklist or another external tool. Self-help is promoted as a 'free' activity, it does not cost anything to 'see' if you fit the criteria. You do not risk anything, you just take this simple quiz. Ambiguities of language in ads and teaser articles aim to induce curiosity and concern about one's apparently neutral and healthy status.

Checklists and risk-factor charts are provided in DTC commercials, ads, news articles, on websites and in direct-mail pieces. The personalized patient is still a patient-in-potential, and these self-help techniques aim to create empowered self-identified patients whose next task will be visiting and convincing their doctors of their condition and need for treatment.

Checklists empower and disempower at the same time. The paradox of checklists is that while they appear to be a form of *self*help they take the question of diagnosis, ‘Am I sick?’, out of the subject’s hands. Even if feelings and experience are used to fill out the checklist, the algorithm then decides whether or not these *count* as objective symptoms. The score one receives thus takes the place of a lived experience of illness, the score can even become its own experience. In this manner, one comes to verify that indeed the possible risk or symptom is a true risk or symptom. One has gained not just a fact about oneself but also a vocabulary, rationale and moral judgement about the unfinished process.

Checklists thus function as a kind of rite of passage. Anthropologist Victor Turner described rites of passage as liminal processes in which a person is socially unmade and then remade into a different person – a boy into a man. Within DTC campaigns, nominally healthy persons (prospects) become secretly sick persons – patients in waiting (Sunder Rajan 2007) – who are oriented towards becoming healthy again. In the DTC rite of passage, one gives up one’s sense of self and health – the body becomes a silent traitor that has concealed its condition. One then submits to the ritual of questions in order to discover that the body really is disordered. If one is sick, the promise is that one will then be treated and reunited with one’s true self and true community. This process is enacted explicitly in many DTC commercials. Figure 2.1 shows the visual images that accompany the commercial for Zoloft reproduced in Table 2.2.

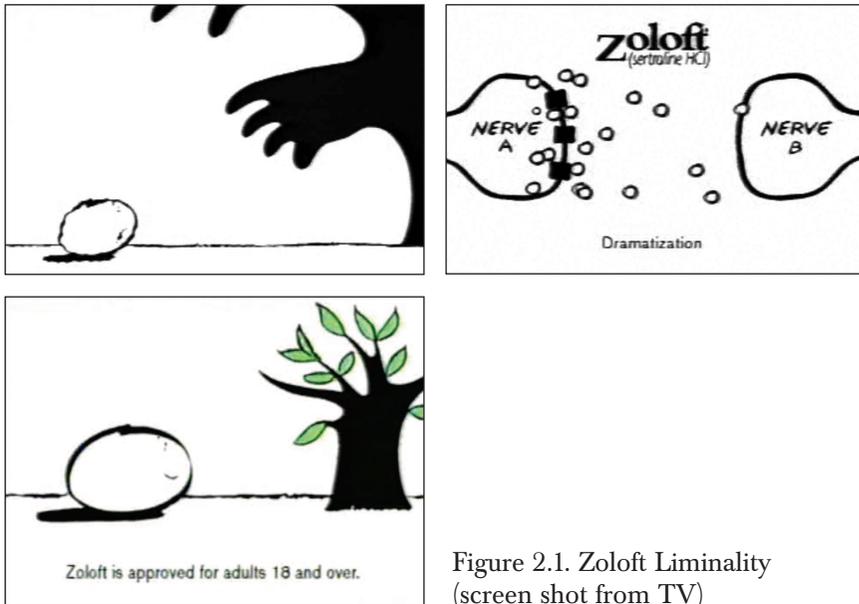


Figure 2.1. Zoloft Liminality (screen shot from TV)

Table 2.2. Zoloft TV Commercial

| Voiceover | Audio-visuals |
|--|---|
| You know when you're not feeling like yourself. You're tired all the time. | Drawing of fuzzy egg (or neuron?) with sad face. |
| You may feel sad, hopeless, and lose interest in things you once loved. | Egg cries. A ladybug approaches egg and egg loses interest, sighing. |
| You may feel anxious, can't even sleep. Your daily activities and relationships suffer. You KNOW when you just don't feel right. | Nighttime, a crescent moon comes out and egg starts walking |
| Now here's something you may not know: These are some symptoms of depression. A serious medical condition affecting over twenty-million Americans. | Text at bottom of screen: 'Symptoms persist every day for at least two weeks' Egg looks surprised, then then sad again. |
| While the cause is unknown, depression may be related to an imbalance of naturally occurring chemicals between nerve cells in the brain. | Shifts to picture labelled 'Chemical Imbalance', with 'nerve A' and 'nerve B' with little balls going from A to B. Text at bottom: 'Dramatization'. |
| Zoloft, a prescription medicine, works to correct this imbalance. | Zoloft symbol appears as 'chemical imbalance' words fade, and black boxes appear on 'nerve A' |
| When you know more about what's wrong, you can help make it right. | Birds chirping, shift back to egg, who is happy and has grass growing near it. |
| Only your doctor can diagnose depression. | Butterfly comes and egg smiles at it, then chases it. Text at bottom: 'Depression is a serious medical condition'. |

Voiceover

Zoloft is not for everyone. People taking medicines called MAOIs shouldn't take Zoloft. Side-effects may include dry mouth, insomnia, sexual side-effects, diarrhoea, nausea and sleepiness. Zoloft is not habit-forming. Talk to your doctor about Zoloft – the number one prescribed brand of its kind.

Zoloft. When you know more about what's wrong, you can help make it right.

Audio-visuals

Egg bounces past large Zoloft logo, chasing butterfly. Text at bottom: 'Zoloft is approved for adults 18 and older' then 'See our ad in People magazine' then 'www.ZOLOFT.com'

Text says same thing with egg bouncing along. Then text at bottom: '1-800-6-ZOLOFT'

The story in the Zoloft commercial mimics a Van Gennepian rite of passage as delineated by Turner. The subject, 'you', begins separated, alienated by a series of descriptions that are aligned into accusations. The biomedical facts are then introduced in a reflexive, subjunctive voice, the voice of liminality. These may not be your fault, they may be symptoms of a biology. 'You' at this point in the story is in the liminal state of being both this and that, both mental and physical, accused and sick. You "know" you don't feel right, but you need the commercial to tell you that the feeling is a real symptom. And the grammatical voice, as Turner observed, can then shift from the subjunctive to the optative, from hypothesis and possibility into emotion, wish and desire (Turner 1982). 'There is hope' a narrator explains, 'treatments are available'. The conclusion of the story is of course re-aggregation, a return to society with a new status, a new, true 'you'.

These stories are sanctioning themselves through the model of the rite of passage. They have appropriated the frame of the rite and packaged it for consumption. From the point of view of Harding's conversion, the viewer is first called on to attend to interpersonal tensions as patterned problems requiring solutions, and then offered a narrative grammar that makes sense of them. Within the story, the shifts in status function as what rhetorician Kenneth Burke (1984: 126) called a 'conversion downward' – in which the complex social situation of the distressed, struggling 'you' is given a much simpler rationality of motivation.

Using a process vocabulary that overlaps in important ways with Turner's description of liminality, Harding attempts to characterize the way in which one who is confronted by an evangelical who witnesses can 'gradually come to respond, interpret, act, as if believing [in Jesus], with or without turmoil and anxiety'. This process is not a social ritual, but rather, it is 'a kind of inner rite of passage' that involves acquiring a new form of 'inner speech', a

process in which one is gradually alienated from one's old voices because they no longer satisfy the gaps one experiences. One is cast into limbo, 'somehow in a liminal state', she says, 'a state of confusion and speechlessness, and begin to hear a new voice' (Harding 1987:170). A number of commercials explicitly elaborate this concept, where a voiceover offers a diagnosis and treatment and the patient says, 'I feel like *me* again', or a loved one states, 'I remember you!'

These commercials and hundreds like them engage in a form of biomedical informing we might call pharmaceutical witnessing. Through passing on facts embedded in stories where the subject of the story is potentially you, the viewer is put in a position of having to make sense of the story or ignore the risk it portrays altogether.

Steve Kroll-Smith uses the self-test as an example in which the voice of experience and the voice of medicine are 'beginning to converse outside of the once solid container of institutionalized medicine' (Kroll-Smith 2003: 639). Kroll-Smith has studied the development, deployment and use of 'excessive daytime sleepiness' (EDS) as definite illness defined publicly through a Likert measure of excessive sleepiness, a self-test. He suggests that 'a person who self-diagnoses with EDS after taking [self-test] ... is exercising, if only momentarily, an alternative authority [to that of modern medicine]' (Kroll-Smith 2003: 640). Calling for a both-and approach to illness and disease, he suggests that popular media plays a crucial role in fashioning medicine and bodily knowledge.

Stigma and social approbation are intimately associated with how persons come to think of themselves. Whereas Kroll-Smith uses contested diseases as examples, marketers see the same media empowerment as useful for emphasizing 'outsider' conditions and amplifying the power of the checklist over the consumer, and the consumer over the doctor. Marketers do not like stigma because they fear it will inhibit self-recognition of patient status and therefore reduce prescription demand. They call these stigmatized diseases, 'diseases of denial', implying that individual psychology is at the heart of the marketing problem.

Diseases of denial can be broadly categorized as medical conditions that make patients feel excluded, rejected, devalued, inadequate, or guilty ... That's one reason pharma marketers should facilitate undiagnosed or untreated patients' self-identification and encourage them to communicate with healthcare providers about treatment options. (Edlen-Nezin 2003)

Marketers are here aligned with other sufferers who struggle to understand, accept and communicate their suffering as illnesses. Sufferers often form their own communities online in discussion groups, and offline in mutual-help groups. In these sites, they actively invent ways of living with

their conditions (Dumit 2006; Martin 2007). Of course there are often many different groups with different approaches to the same condition. Marketers with treatments to sell actively court these groups whose interests align with their needs. They accelerate the circulation of these social innovations in ways that also help sell products. The result is often a public service ‘educational advertising’ campaign that draws attention to an illness by reifying it as treatable, and by destigmatizing it.

The marketers I have talked with regularly monitor online discussions of pharmaceuticals, they hold focus groups with patients, and some of them have hired anthropologists to conduct ethnographies of diseases. They consider one of their greatest strengths to be finding a patient who eloquently expresses a private insight about an illness that accords with their mission to increase prescriptions. Their job is then to amplify that insight so that others may come to identify with it. Cutting and pasting is thus a fitting description of the general circulation and mediation of pharmaceutical experiences and practices. Communicational media, mass media, everyday discussions and research techniques feed back on one another (Strathern 1992; Melucci 1996).

Turning worry into incipient action and navigating between hope and stigma thus requires precise attention to the live language of consumers as potential patients who are struggling with a concern. Perhaps more than at any other step, grammar matters when the personalized risk must become incorporated into the consumers’ identity as a patient. Individual differences among persons thus require careful scripting in order to produce a mass market. One marketer explained that the level of attention is increasingly precise:

HealthMedia uses a combination of Healthcare technology and behavioral science to design ‘action plans’ that give patients tips, advice, and strategies to obtain a healthcare ‘goal.’ In essence, the action plans are the front end of a highly sophisticated customer relationship management program that can segment at the individual level so that each fragment of every sentence in the plan is customized and corresponds to how patients answer a constellation of questions. (Breitstein 2004)

Michel Pêcheux, in his study of language, ideology and discourse, found that motivation and identification were mediated by specific word choices (Pêcheux 1982). In the above passage, marketers manage these processes through empirically verified texts. Questionnaires are ‘meticulously’ designed through ‘extensive market research’. Each question on surveys and checklists is a psychological tool. At the conclusion of this step, concerned consumers have become worried, self-diagnosed potential patients who know what they have and want treatment for it. From a marketing point of view, they are empowered patients ready and motivated to see their doctor.

Convincing the Doctor, the Critical Moment

Marketers can generate significant product sales by motivating physicians and patients to take action and by influencing their interaction. On the consumer side, that means

- * providing enough information to patients so they can convince a busy, uninformed, or disinterested physician to prescribe the brand
- * getting more patients to fill their initial prescriptions
- * motivating patients to comply with their medication regimen. (Bolling 2003)

With self-diagnosis accomplished, the goal of pharmaceutical promotion is still only half-way done. The potential patient must now get to the doctor, convince the doctor to diagnose and prescribe treatment, and the patient must then take the drug and continue taking it. Marketing must now aim at 'pass-through persuasion', giving the patient the tools to convince their doctors. Doctors in turn, are seen as obligatory obstacles to be overcome without authority actually to make a diagnosis. Any resistance on the doctor's part is seen as a lack of knowledge, of interest or of time. This reading may seem harsh, but it is constantly reinforced in DTC campaigns in spite of their required acknowledgement that 'only your doctor can make the diagnosis'. Some campaigns make doctor incompetence a direct theme, where the patient has to diagnose herself through seeing a commercial and filling out an online checklist in order to convince the doctor of her true condition.

The problem is that doctors also depend on these checklists which are essentially the only measure of an illness and treatment effectiveness that otherwise is not perceptible to anyone, doctor or patient. In many cases, checklists developed in order to conduct clinical research have become both marketing and self-diagnostic tools (Healy 2002). This blindness and disempowerment is all too visible in both the descriptions of emplotment of doctors by patients online – in which they discuss how to get what they want from their doctor by saying the right things – and in commercials which directly encourage such behaviour. The virtual world for the clinician is precisely the self-identified world of the advertisement grammar. As members of what Ulrich Beck calls risk society, we are prepared for the fact that many dangers are imperceptible to us, below our conscious perception, that we cannot trust our senses, but must trust instruments and other technologies of identification (Beck 1992).

Medical anthropologists Cheryl Mattingly, Mary-Jo Delvecchio Good and others have shown convincingly that even as they appear to be offering patients a choice, many doctors ask questions and phrase responses that elicit the response that the doctor thinks is right. They have identified this

process as ‘therapeutic emplotment’ (Del Vecchio Good et al. 1994; Mattingly 1994). Similarly, when Martínez-Hernández describes doctors’ conversion of patient stories into ‘a language of facts’, he was launching a critique of ‘the conversion of symptoms into physical signs; the suppression of authorship; avoidance of the message; and the meaningful intention of the complaint. In short, the intention of the reader comes to dominate, limiting the symptom to his own interpretation’ (Martínez-Hernández 2000:248).

These critiques are quite perspicacious. The reification of symptoms often results in the evacuation of the meaning of suffering and delegitimizes the speaker’s authority. But as patient social movements and DTC marketing show, there is a counter-politics to this semiotics: patients often discuss in support groups and online the possibilities to take this increasingly mechanical form of diagnosis and use it to emplot their doctors, telling them exactly what needs to be said to get what they want (Dumit 2000, 2006). Martínez-Hernández’s notion of the ‘reader’s domination’ here becomes the domination of both reader and speaker, patient and doctor, by the code or algorithm, or symbolic domination (Melucci 1996).

Much DTC marketing, therefore, offers a consumer the precise language with which to accomplish this counter-employment. Through the focus groups, interviews and fieldwork, marketers attempt to fuse personal stories with the rules of diagnosis. Calibrated for maximum effectiveness, the scripts thus simultaneously dumb down and reify the patient’s experience into generic branded stories of suffering, and in so doing, empower them to translate these stories into effective action in their doctors’ offices – in order to get what they ‘now’ know they want. The doctors are in the end even more dumbed down and reified. For if a patient should arrive in the doctor’s office saying these words, the doctor will have little choice but to observe that the patient has stated all the right things in the right way (Kravitz et al. 2005). In a section called ‘Critical Moment’, Realto’s article describes how important this scripting is:

All of the DTC communications for Prilosec aim at this crucial intersection of physician and patient. The campaign primes potential gastric reflux patients to report symptoms accurately and ask about treatment with Prilosec. (Realto 1998: 14)

This situation of doctor-employment through witnessing was also illustrated by the Effexor XR antidepressant website (in its 2002 format). It was designed so that the first thing the viewer saw was a list of statements and was told to ‘Click on the link that sounds like you’. Choices were: ‘Maybe I’m just down’, ‘I think I should see a doctor’, or ‘I want to share my story with others’. Clicking one of these brought up a page that did nothing other than offer the words that best fit these feelings. There were no further instructions.

Maybe I'm Just Down Does this sound like your situation?

Please note: The following story is fictitious and describes a general situation.

'After a few weeks, I knew something was wrong. Nothing really bad happened, but I was having more and more negative thoughts. At first, I figured it was normal to feel sad and empty (even hopeless) for a few days, maybe even a week. After all, I wondered, don't most people feel down every once in a while? But I couldn't snap out of it. I started to get concerned that something was seriously wrong. Why was this happening to me? I decided to look for some answers.

'I learned that I was experiencing the symptoms of a medical condition –depression – and that my doctor could help me feel like 'me' again. I also learned that I should not feel ashamed or embarrassed because it was beyond my control. That's when I called my doctor.

'It didn't happen overnight, but I really have come a long way. Recognizing that I was experiencing the symptoms of a medical condition and understanding that help was available was the best thing I could have done for myself.'

Do you feel sad and empty? Do you no longer feel like 'you' anymore? Perhaps you are suffering from symptoms of depression. You may find some helpful information in *What Is Depression?* or *What Is Generalized Anxiety Disorder?* and *Symptoms of Depression* or *Symptoms of Generalized Anxiety Disorder*. You might also want to use the *Success Scale* or see *Evaluation and Treatments for Depression*.³

These pages are written in a non-reflexive manner. They are posed as fictional stories that tell your story better than you could tell it yourself. The situations are described in the past tense as personal testimony but they are grammatically precise such that in repeating them you would obtain from one's doctor exactly what you think you want. The isomorphism of marketing is here aligned with that of patient groups against a healthcare system, that for good or ill is attempting to resist the *costs* of increasing pharmaceutical interventions and maintenance. The net result is the aggregate increase in patients asking for and receiving prescriptions for daily medicines. The final stage of marketing is then to have patients complete the purchase and to continue to refill these prescriptions as long as possible.

Branded Compliance

Companies are increasingly using physician-supplied patient starter packs containing user leaflets, tips, FAQ advice, and patient diaries at the initial prescribing consultation to help ensure the right patient/brand compliance from the start. Those packs create the basis of initial patient expectations with resulting patient treatment outcomes fostering repeat brand loyalty in terms of prescribing decision making and user preference. (Hone and Benson 2004:104)

The final stage is the payoff – one prescription purchased and hopefully many more in the future. Compliance refers to patients staying on the prescriptions they are given and refilling them. For marketers, compliance also refers to the general gap between those who should be on life-long meds and those not.

The aim at this point is to cement a relationship between self-assessment, diagnosis and branded treatment – to integrate the pharmaceutical into the everyday and reinforce a notion of dependent normality. The notion of a ‘healthstyle’, requires support from many different directions. The initial one is through community with other patients. Second, brands are proposed as anchoring a patient’s healing to future purchases. With brand loyalty comes ‘product advocacy’.

Addressing those needs by providing valuable, customized information will not only foster product loyalty among patients, it will generate product advocacy. And there’s nothing more powerful than patient-to-patient endorsements. Although a physician’s recommendation may be highly credible, it doesn’t carry the power of empathy and understanding that a fellow sufferer typically conveys. Great brands not only become part of patients’ health and perception of well-being, they become part of their lives. (Bolling 2003)

Achieving this integration starts with knowing as much about patients as possible, and making sure that they understand ‘the need to take medication daily’, ‘how to convert education to action’, and to ‘associate their medication with being sick or well’. Above all, researchers need to determine: ‘Do patients accept that they have a chronic disease or condition and need to continue to take medication for it, or are they in denial that they need to do that?’ (Bolling 2003). Contrary to writing on chronic illnesses that stem from pain or fatigue or suffering, none of these issues are taken for granted with these lifelong pharmaceuticals aimed at asymptomatic conditions.

This explicit manipulation of unfounded fears offers insight into the

single-mindedness of marketing. The war here is between companies, branded versus generic multinationals, in which patients are the means, their minds the instruments used in waging the battle. Bolling goes to recommend: 'Overall, the key is to increase consumers' comfort level so they're resistant to change if faced with the option to switch' (2003:117).

Conclusion

In liminal situations, Turner argues, we develop our grammar, 'ways of talking about indicative ways of communicating ... We take ourselves for our subject matter' (Turner and Turner 1992: 137). Perhaps even in subliminal marketing experiences, we develop and refine our modes of expressivity, changing our minds in order to change our bodies. In addition to his careful attention to the grammar and creativity of process, Turner constantly attended to the role of the anthropological writer who must always make choices in where to locate agency in process: in the individual, the social structure, or to strive for some sort of balance. Here I have portrayed the pharmaceutical marketing encounters with an emphasis on how they can convict some people some of the time. In other work, I have stepped back, behind the focus groups to see how activists and everyday acts of creativity and resistance have shaped the terrain of the doctor-patient encounter and invented most of the forms of informing that marketing has in turn taken up and amplified (Dumit 2006).

Health activist groups today are often in a dilemma as to whether or not to accept funding from commercial, especially pharmaceutical sources. Roddy Reid has described how even anti-smoking activists have been caught off-guard when they are offered money by Novartis who considers them to be helping to grow the market for nicotine patches and smoking prevention pills.

Many drugs work, much of the time, for most of the people they are intended for. The issue at stake in DTC for marketers is how to continue to grow the market big enough and fast enough to keep up with investors' expectations, often stretching the evidence from clinical trials. Many of the currently used pills do work to modulate our bodies in ways that we may not be able to describe completely, but which we nonetheless desire for curative, preventative, experiential or experimental reasons. However, we have far too little data and are not in fact collecting data as to the long-term effects and side-effects of most drugs, as to the interactions between chronic drugs, nor of the positive dimensional effects like enhanced school performance, mood brightening, and so on. Especially consider the increasing tendency to add drugs in treatment algorithms for the side-effects of a previous drug.

The expressivity of the commercials, websites and marketing efforts

remains my key concern. To the extent that they do posit objective self-identification of feelings and possible risks as symptoms, I wonder where, when and how self-talk adopts and deploys this new grammar within and alongside other modes. The topic of my ongoing work is the invention of ways of living within this pharmaceutical world. As much as marketing provides potential patients with the exact words with which to emplot their doctors into providing them with their pills of ‘choice’, people also share and disseminate counter-strategies to avoid certain drugs, to calibrate their own doses through splitting pills, and to explore alternative treatments, alternative diagnoses and alternative explanations.

For the moment, though, the average patient, by which I mean the marketer’s average, comes to experience his or her body under pharmaceutical conviction. This body is silently disordered, counter-experiential, waiting to be evaluated and measured in order to speak. This body is always under construction. For more and more Americans, health is a sign of concern, health is something they must see a doctor for in order to ward off the invisible risk they have been taught to worry about. Treatment is neither an imposition or a choice, it is increasingly ordinary.

Notes

1. Consonant with Turner’s distinction between liminal (pertaining to more traditional societies where rituals involve the whole social group) and liminoid (pertaining to industrial societies where individualization both flattens rituals into ceremonies and invents the social categories of leisure and the arts). The process that Harding describes is individualized and, more importantly, antagonistic. It borders on manipulation, and is not unsurprisingly called ‘brainwashing’ by those who are outside of evangelical culture and see only the external effects of conversion. Conversion as a practice, and coming under conviction as an experience, require an extension of liminality in the direction of the sub-group or competing groups within a culture – pointed to by the felicitous term, ‘subliminal’, a term that connotes a form of liminality at a sub-conscious, sub-social, or social unconscious level.
2. According to his by-line, ‘Vern Realto is a virtual contributing editor to DTC Times, a composite of regular staffers and other advisors’. As a composite, Realto thus speaks the collective wisdom of the pharmaceutical marketing industry, precisely the level of enunciation I am interested in analysing.
3. <http://www.effexorx.com/p/p10.jhtml>, accessed 4 May 2002.

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