An analysis of situated meaning in Direct-To-Consumer pharmaceutical advertising

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AN ANALYSIS OF SITUATED MEANING IN DIRECT-TO-CONSUMER

PHARMACEUTICAL ADVERTISING

by

Susan E. Garcia

Bachelor of Science
Troy State University, Alabama
2005

A thesis in partial fulfillment
of the requirements for the

Master of Arts Degree in English
Department of English
College of Liberal Arts

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Susan E. Garcia

Entitled
An Analysis of Situated Meaning in Direct-To-Consumer Pharmaceutical Advertising

is approved in partial fulfillment of the requirements for the degree of
Master of Arts in English

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Dean of the Graduate College
ABSTRACT

An Analysis of Situated Meaning in Direct-To-Consumer Pharmaceutical Advertising

by

Susan E. Garcia

Dr. Denise Tillery, Examination Committee Chair
Associate Professor of English
University of Nevada, Las Vegas

This thesis uses interpretive discourse analysis to critically examine the situated meaning of prescription drug Direct-To-Consumer Advertising (DTCA) as compared to the situated meaning of historical patent DTCA. Specifically, I apply James Paul Gee’s theory of analysis to show how the DTCA, past and present, builds identity, connections, and sign systems and knowledge. My analysis demonstrates that the coverage and convergence of these building tasks in both prescription and patent DTCA indicate that today’s pharmaceutical companies’ situated meaning is not significantly different from the patent medicine advertising of the past. Despite pharmaceutical companies’ claims that the prescription DTCA educates consumers, the discourse does not substantiate a situated meaning beyond that of a manufacturer selling a product. Understanding the motivation and language of pharmaceutical advertising will enable us, as consumers and patients, to make sound decisions about the medications we endorse.
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CHAPTER 1

INTRODUCTION

Consumers are bombarded on a daily basis with advertisements in television commercials and the printed pages of popular magazines. As one of the highest grossing products sold today, prescription drugs are featured in Direct-To-Consumer Advertising (DTCA) and have taken their place among ads which offer consumers a choice in what they purchase. The dilemma of DTCA for the medical profession, however, lies in the fact that the consumer cannot simply go out and buy the advertised drugs as they would any other item featured in an ad – a physician must be involved in the process. As a result, the medical profession finds itself not only prescribing proper treatments for patients, but also dissuading patients’ desires for advertised drugs which are not medically indicated.

This situation is not completely new, and the discourse of DTCA has long been a complex factor in a patient’s decision between appropriate and inappropriate healthcare choices. In fact, opposing viewpoints – typically physicians against pharmaceutical companies – about the discursive nature of DTCA complicate a patient’s decision because opponents of the practice contend it is merely a slick marketing tool which has not changed since patent medicine days while proponents of DTCA argue that the practice is more than simply a product-sales technique and has a much more valuable
intent. As consumers, then, we are left to mediate between the two sides, so we must be aware of the authorial intention behind pharmaceutical advertising in order to make sound healthcare decisions. To that end, using qualitative discourse analysis, this thesis examines a corpus of both historical and modern pharmaceutical print advertising to discover the similarities or differences in situated meaning evident in the persistent methods of medicine marketing. Since pharmaceutical advertising is such a large field for analysis, this study limits its selection of artifacts to two major patent medicines – Lydia Pinkham’s Vegetable Compound and Peruna – from the past and two hugely popular prescription medications – Nexium and Lipitor – featured in print media today.

This first chapter will establish the background for the study and provide an overview of the literature already available on DTCA of past and present, while foregrounding society’s vested interest in the tactics of medicine promotion.

Background to this DTCA Study

A short review of medication and drug advertising reform as it developed within FDA regulation is necessary because it provides a historical and sociological context for looking at the various ways in which medicines were introduced to the public. The topic of pharmaceutical advertising is closely tied to events in the development and sale of drugs and strongly influences society’s views of these medicines.

Although not officially given the term Direct-To-Consumer Advertising in the centuries before Food and Drug Administration (FDA) regulation was established, the medicines offered to the public in earlier centuries via handbills and advertising media set the precedent for today’s frequently critiqued marketing techniques. In the past,
however, drawing a definitive line between beneficial medicines and fake, or quack, nostrums was difficult because the recuperative, physician-sanctioned remedies were very rarely discussed or highlighted in the media. Instead, patent medicines were those drugs frequently advertised to the public and, by definition, were those secret recipes that originally won the blessing of the royalty in seventeenth- and eighteenth-century England. In the late eighteenth-, nineteenth- and early twentieth-century America, patent medicines were not officially “patented,” but the ingredients still remained the sole knowledge of the maker. These patent drugs could be, and often were, a composite of many ineffective or dangerous chemicals.

On the other hand, proprietary medicines were usually those drugs which physicians and pharmacists devised, but whose primary ingredients were available to those who needed to know a drug’s content. Most often, doctors would write a prescription for a medicine with the full comprehension of all ingredients. It was also not unusual for pharmacists to write and provide prescriptions for patients, too. Proprietary medicines, then, were often seen as being more ethical than the questionable patent drugs. As a result, doctors could simply recommend that patients avoid any medicines which were openly marketed to the public because the products were patent, or quack, drugs. For decades the unadvertised proprietary medications were the only doctor-recommended alternatives to patent drugs.

Whatever moral difference that could be said to exist between patent and proprietary drugs, however, disappeared when the makers of both types of medicine began to advertise to the general public. Once the layman became the target for advertising appeals of any drug manufacturer, physicians and critics denounced the promoted
medicine as being fraudulent. The Proprietary Association of America (PAA) tried to defend its members’ products from being labeled as “quackery,” but they often found themselves labeled the “patent medicine ‘combine’” (Adams 45) because critics often saw the PAA as being part of a larger entity which sold any drug to the public with little concern for consumer safety. At the same time, patent medicine makers fought for their products by claiming any restriction on advertising was a loss of freedom for the public (Carson 32). Once the distinction between valuable remedy and fake cure became dangerously blurred, the FDA stepped in with strong measures intended to protect the consumer in 1906.

Today, we face another patent/proprietary pharmaceutical industry that fosters a proliferation of DTCA, with many large companies spending several billion dollars per year in advertising costs. Most pharmaceutical companies patent at least a few key ingredients in their new prescription drugs and strive to gain brand name loyalty before the patent expires. This desire to build a strong consumer base for their medicines necessitates very competitive strategies on the part of the drug makers. With FDA regulations governing their products and advertising, these companies offer legitimate medicines and cannot usually be accused of quackery as patent medicine makers were prior to FDA laws. Still, the present debate about specific advertising appeals and situated meaning of today’s DTCA discourse hearkens back to a time when drug advertising to the public was considered highly inappropriate. Moreover, doctors today can no longer use the issue of advertising as the sole argument to convince a patient of a drug’s contraindication for a specific health condition.

DTCA prior to any FDA regulations that changed restrictions on prescription drug

4
advertising is easily placed along significant points on a timeline (see Figure 1). The period before 1905 is a time when patent medicines were advertised to the public with virtually no restriction by the government. The years between 1905 and 1962 are clearly defined as important turning points in the control of patent medicine and all pharmaceutical advertising. Finally, the span between 1962 and 1980 is a time when pharmaceutical companies marketed prescription drugs solely to physicians.

Figure 1. Timeline for Regulation of Drugs and DTCA

In 1906, the FDA acted on critical demand for federal intervention by first passing the Pure Food and Drug Act and then later transforming this regulation into the 1938 Federal Food, Drug, and Cosmetic Act. The 1906 Pure Food and Drug Act had only a limited impact on drug advertising because it centered most of its attention on food. The 1906 act did put restrictions on what could be printed on medicine labels, however, and exempted any drug in the United States Pharmacopoeia from the regulation (USC 59).
This action gave the advantage to the proprietary medicines that physicians most
prescribed and thus limited the public’s access to names and messages typically featured
as an early type of advertising on medicine bottles. Then, the 1938 Federal Food, Drug,
and Cosmetic Act, also known as the Wheeler-Lea Act, further expanded the control over
patent medicines by limiting therapeutic claims, mandating adequate use directions on
labeling, and granting prosecutorial power to the Federal Trade Commission (FTC) so it
could take action against drug makers who advertised deceptively. The 1938 act also
created a new category of potentially dangerous drugs that had to have a prescription
from a doctor (USC 75). Again, the FDA sent a message that drugs prescribed by a
physician were safer and that the advertising tactics of patent medicines were to be very
limited in scope.

In 1951 and 1962, the FDA amended the Federal Food, Drug, and Cosmetic act in
ways that wrested control of pharmaceutical advertising from the FTC. The 1951
amendment loosened some restrictions on less dangerous drugs, but maintained the
requirement for a doctor’s prescription on “habit-forming” or toxic drugs (USC 82). As a
result, the 1951 amendment also instituted strict guidelines for statements about the drugs
to include any language used on the labeling of medicine bottles or in public statements
about the cautions and/or uses of the drugs. As we have seen, FDA regulations through
1951 touched on advertising tangentially, but, in 1962 the FDA finally made a point of
specifically addressing drug advertising in an amendment that regulated the listing of all
ingredients on the label. This amendment also provided detailed requirements for
aesthetics, such as the size and placement of the font that had to appear in the
advertisements (USC 87). The FDA guidance did not specify any restrictions on the marketing appeals that can be used in the ads, however.

Review of Literature on Patent and Prescription Drug Advertising

Much of the literature on contemporary prescription drug DTCA focuses on the historical context as well. Many books and articles detail the history of prescription drug advertising, explaining that the practice did not really come into favor with the FDA until 1980. Even then, the FDA was not convinced that prescription DTCA was a good idea, but many factors influenced the FDA to acquiesce to the pharmaceutical companies' requests for broader marketing options. Alison Huang discusses, for example, the changing climate in terms of political and regulatory issues and the movement toward an emphasis on the patient’s empowerment in medical decisions as key motivating factors for prescription DTCA.

In addition to the historical information on the birth of pharmaceutical DTCA, existing literature establishes a context for the practice that demonstrates to readers why the rise of prescription drug marketing to consumers has been so rapid since 1980. One reason often mentioned is that, since DTCA has created buy-in from the general public, physicians now feel they must comply with customer demand. In fact, studies show that “three quarters of patients requesting drug prescriptions received them from their physicians” (Huang, 2240). Because the doctors are collaborating, in a sense, with the patients’ consumption of prescription medications, pharmaceutical companies have enjoyed a very profitable cost/benefit ratio in regard to DTCA. Other miscellaneous factors also influence the increase in DTCA, such as new regulations on a physician’s
authority to prescribe specific drugs and the innovative ideas of drug companies who find it less lucrative to sell their products only to doctors (Kravitz).

Rather than focus solely on the background for DTCA, other literature treats the prevalence of DTCA as an opportunity to detail the procedures that pharmaceutical companies should take to get their products into the DTCA arena. Devereux, for instance, shows drug manufacturers how to effectively implement product placement and devotes an entire chapter, “Will DTC work for your brand?” to the idea of brand name recognition for medicines. The pharmaceutical companies are encouraged to look at prescription drugs as being similar to any other commercial product, like a soft drink or a breakfast cereal. Of course, Devereux’s theory of innovative drug promotion has raised some ethical questions about DTCA.

Furthermore, most texts written about DTCA for both patent and prescription drugs tend to focus on a couple of major questions: 1) What are the ethical and legal issues of DTCA? and 2) Does DTCA change the doctor-patient relationship?

What are the ethical and legal issues of DTCA?

Discussions on the ethical problems of medicine advertising inevitably invoke the name of Samuel Hopkins Adams and his series of articles written for Collier’s: The National Weekly. Adams, an outspoken journalist, is typically credited for motivating the federal government to move against patent drugs and to enact the Federal Food and Drug Act of 1906 (Carson; Helfand; Holbrook; Young). In his series, “The Great American Fraud,” Adams heavily criticizes both the patent medicine products and the practice of proprietary medicine advertising. The articles make no distinction between patent drugs and proprietary remedies, saying there was not enough difference between
the two to separate the “sheep” from the “goats” (Adams 3). To Adams, any drug maker who advertised publicly was an unethical participant in the delusion of the public.

Adams explicitly spells out the major problems he saw with medicine advertising at the time and spares no opportunity to name specific examples of patent medicine sellers who were defrauding society. Particular targets of Adams’s critique were the numerous testimonials in the ads which greatly influenced the scientifically “ignorant and gullible” minds of the public (57) and the tactics, such as free samples and money-back guarantees, which made repeat customers of patients. As a proposed solution, Adams consistently calls for the federal government to make needed changes in the drug market: namely, to enforce the listing of all ingredients on the drug’s label and to restrict the marketing of certain drugs to a doctor for prescription because the doctor was in the best position to understand the drug’s contents.

The American Medical Association (AMA) strongly agreed with Adams on the questionable ethics of patent medicine advertising and included a special section in their report of 1908. In fact, the AMA was so concerned about the suspect nature of patent/proprietary medicines that they formed a Council on Pharmacy and Chemistry to conduct in-depth analyses of various drugs being offered to the consumer. In their findings, the AMA urged the federal government to place tighter controls on the use of paid testimonials in all periodicals. A particular target of criticism in the 1908 AMA report was the apparent abundance of religious publications that featured patent medicine advertisements. Interestingly, the AMA was not the first organization to quarrel with the religious papers who allowed pharmaceutical advertising. Twenty years earlier in 1887, a report from the Texas Medical Association published the same type of critique stating,
"Go to the religious press and you will find it teeming with [medicine] advertisements" (101). Both the 1887 report and the 1908 AMA report take religious leaders to task with the remonstration that ethical preachers did not advertise their services, so why should ethical healthcare providers advertise?

Although accounts of patent medicines advertising do not always pass such negative judgment on the character of the marketer, Stewart Holbrook makes the case that many were outright criminals. In fact, Holbrook titled his book *The Golden Age of Quackery* because he sees the period before FDA regulation as a time when unscrupulous makers of drugs ran rampant in society. Holbrook does provide insight, however, into the undeniable importance of testimonials to non-regulated pharmaceutical advertising and forecasts a future in which testimonials will always play a vital role in medicine marketing.

James Harvey Young, whose book *The Toadstool Millionaires: A Social History of Patent Medicines in America before Federal Regulation* is often cited in discussions on patent medicine (Carson; Porter; Stallings), is another author who explicitly details the successful use of testimonials in patent medicine advertising during the eighteenth and nineteenth centuries. In fact, Young’s book describes at length the great impact patent medicine had on society in the years before the FDA began to regulate the practice. Like Holbrook, Young believes that many doctors and apothecaries prepared proprietary drugs, but only the most unscrupulous of people actually advertised their drugs on the open market. Hence, these individuals were seen as frauds who needed to be controlled. Young does not analyze any drug advertisements of the early marketing period, but he does discuss in general terms the marketing tactics of quacks which “created the idea that
doctors might be deceiving the patient if they did not prescribe a medicine” (170). More importantly, Young alludes to an undesirable time in the future when even reputable medicine producers might be tempted to use the same advertising methods.

Literature that discusses the ethical and legal aspects of prescription DTCA evinces distinctly opposite viewpoints about the practice. Proponents of prescription DTCA assert that the practice empowers the public because patients gain confidence to speak up for themselves in a doctor’s office and allows for better communication between doctors and patients. In addition, pharmaceutical companies defend DTCA with the claim that they are simply educating the public. On the other side of the issue, opponents argue that prescription DTCA is not providing information to patients and is only a slick marketing tool to raise revenue for big-name drug companies.

Critics of prescription DTCA point out that the United States is one of only two countries in the world (New Zealand being the other) which allows pharmaceutical companies to advertise directly to consumers. The natural question that arises about DTCA is why the United States does not see a problem with this marketing when the rest of the world is opposed to it. In response to this question, the spotlight has focused on the conflicts that arise in the medical profession when big business (i.e. pharmaceutical companies) has an influence on patient choice. Although pharmaceutical companies, such as AstraZeneca and Pfizer, claim DTCA empowers consumers by making them more assertive in their own healthcare, David Hall argues that “the cloak of empowerment is used to hide the maintenance of control in the hands of the powerful.” Most ethical concerns about DTCA revolve around the possible conflict of interest for both the drug companies and the physicians (Henney; Gemperli; Murray).
Jane Henney specifically questions if drug marketing can “serve two masters: the promotional interest of the pharmaceutical industry and the public’s health needs” (2242) and refers to research that shows the risks in printed prescription DTCA are ignored by almost 33% of patients. The fear is that patients are convinced that they know all there is to know about a medication when, in fact, they know very little of the contraindications. Marcel Gemperli points out that doctors once were the “learned intermediaries” for patients when it came to prescription drugs, but patients today often overlook the advice of these physicians in their quest for the perfect cure. Many doctors have even admitted to caving into the demands of the patient in order to keep their business. Murray et al. discuss the ethical implications of this pressure to please the customer in their research which shows “physicians filled 69% of requests (based on DTCA) that the doctors themselves deemed clinically inappropriate” (520). The study also indicates that patients “make almost as many inappropriate requests as appropriate ones” (Murray et al 522).

From a legal standpoint, DTCA has rekindled interest in the FDA regulatory guidelines established for the practice (Leffler; Turner). Not everyone agrees on whether the current laws on prescription drug advertising are adequate, but the general consensus is that caution is indicated and changes are necessary. Keith Leffler asserts that DTCA can have some positive effects on the welfare of consumers but should not be treated as an important source of patient information. The most frequent advice given to patients on the subject of DTCA is to talk with a physician, which is ironically what the ads themselves proclaim. Leonard Weber is cautiously optimistic about the potential value for consumer education through DTCA, but advocates significant changes in the current system. Weber proposes a change from today’s method of FDA approval after an
advertisement is published to a control process wherein the FDA must approve all DTCA before it appears in front of the public. This idea has recently gained popularity for inclusion in a future FDA amendment.

*Does DTCA change the doctor-patient relationship?*

Although physicians usually made a point of vilifying patent medicine, the general public often embraced the language and images in the advertising. For instance, an article in an 1881 issue of *Scribner’s Monthly* discusses the ongoing controversy of patent medicine advertising and the doctors’ fight to prevent patients from endorsing the drugs (Holland). The unnamed author of the article points out that many consumers saw no difference between the medicines advertised and the prescriptions they could obtain from doctors. In a non-regulated market, the consumer was willing to give anyone who could promise better quality of life a chance. In fact, the author’s general opinion was that the physicians were envious because they could not garner as much enthusiastic testimony for their remedies as the patent medicine could gather for their advertised drugs. The fact that *Scribner’s Monthly* focuses on this aspect is not surprising because the subject of testimonials comes up repeatedly in the study of patent medicine advertising.

If one issue could be said to dominate the literature on today’s prescription DTCA the debate over changes in doctor-patient relationships would be that salient feature. The array of written material is clearly divided between opponents of DTCA, usually from a physician’s perspective, and proponents of DTCA who claim the practice is beneficial to everyone involved.

Physicians, for the most part, agree that they are spending entirely too much time
“dissuading patients from taking drugs that advertising has led them to believe are unproblematic” (Huang). This additional effort on the part of the doctor results in longer office visits and increased medical costs. These increased costs are said to not only impact the patient directly but also to have an effect on the insurance premiums everyone in the general public ends up paying. A particularly worrisome aspect of prescription DTCA on doctor-patient interactions is the fear that physicians have about patients who might switch caregivers if the patients’ requests for an advertised drug were denied (Kravitz). Therefore, many physicians feel they are forced to react to the marketing versus prescribing the medication the patient really needs the most.

This concern has led to a discussion in the last few years of possible “medicalization” in the minds of today’s consumers (Hall; Arney & Rafalovich). Under this concept, DTCA is believed to have an undeniable influence on what patients perceive is a healthy lifestyle. The pharmaceutical ads are said to essentially portray a “medicalized view” of the world in which “for every ailment there is a drug to cure it” (Carroll). Patients, therefore, often resist the advice from their doctors to exercise or change their diets because the patients think a pill is available to do the work for them. In situations such as this, doctors are finding consultations with these patients to be very frustrating.

Not all of the literature on prescription DTCA’s impact on the physician-patient relationship is negative, however. Elizabeth Murray et al. conducted the first population-based survey of physicians and were the first to inquire about the doctor-patient relationship in relation to DTCA. The results of their study illustrate that DTCA can have benefits for the patient because the advertising often gives the patient the confidence to talk with their doctors. In fact, the perceived empowerment of patients is often listed
as the primary reason for allowing DTCA to continue (Keith). Arguments for DTCA’s positive influence in the doctor-patient relationship also include the potential opportunity for limiting the power physicians have regarding a patient’s choices in healthcare. Many times, patients who are aware of a newly available medication, and who continue to seek further information about the drug, end up finding their own answer to a persistent problem before their doctor does (Holmer; Kravitz). Naturally, pharmaceutical companies agree with this view and argue that they have educated patients so they can be more assertive in their healthcare.

As mentioned, most literature on patent medicine and prescription drug DTCA has primarily addressed the questions already outlined. However, very few documents actually examine the specific discourse in the ads themselves. Existing material on the medical discourse of print advertising is similar to Susan McKay’s writing in which she focuses on the language used in health risk articles in popular magazines. McKay asserts that “the media add[s] to the understanding of health and medicine in the lay public through the coverage of risk.” McKay concentrates on what the media says in magazines versus how the advertising accomplishes its objectives. Hall does not examine DTCA directly, but he does analyze a corpus of medical leaflets which he asserts are nothing more than advertisements for prescription drugs. Regarding these leaflets normally found in the average physician’s office, Hall asserts, “it might be justified to call this sort of generic misrepresentation a pragmatic fraud, since its aim is to induce one kind of reaction when ostensibly it presents itself as reassuring or disinterested (and empowering) information.”

There are a few notable exceptions to the dearth of discourse analysis of DTCA
media, however. Several articles and research studies detail the procedures for a specific content analysis of prescription DTCA. In one such study, Rebecca Welch Cline and Henry Young examined the visual cues in a number of prescription DTC ads and provided findings on the nature and consequences of the images placed in the ads. The results show that certain characteristics of the models in the ads along with the rewards which are implicit in the photographs significantly influenced the behavior of patients.

A second study concentrated on the implications of “incomplete syllogisms” included in many pharmaceutical ads (Arney & Rafalovich). This research shows that drug companies can actually create a major and minor premise for a drug in patients’ minds, thus influencing the patients’ conclusion that a drug is indicated for them. This point is illustrated with ads that give consumers a number of symptoms and then ask the consumers to check and see if they have any of the highlighted symptoms. In most cases, the consumers automatically concluded that they had the specified condition and needed the company’s advertised drug. Robert Bell, Richard Kravitz, and Michael Wilkes performed a content analysis to examine the ways DTCA might target audiences with inducements and appeals. The report concluded that drug companies are increasing demand for a product, but stated further research is necessary to find the effects on doctor-patient interaction. Cline and Young also conclude their article with a statement indicating that, while the analysis of visual cues was beneficial, a much broader analysis that includes the textual elements of prescription DTCA is necessary.

All of the aforementioned studies, however, do not attempt to find the enduring similarities or differences between the non-regulated drug advertising media of the past and a corpus of current pharmaceutical ads, nor do the studies discuss any significant
elements of situated meaning. As a notable exception, Shirley Stallings specifically
draws attention to the unchanging nature of society’s relationship with drug promotion
and details the traditions which tie today’s healthcare consumers to the patients of an
earlier era. The patent medicine makers of the past innovatively carved out a niche for
their products, and now pharmaceutical advertising has become a lucrative endeavor for
big-name drug companies. As the targeted audience for this enterprise, society “needs to
pay attention and maintain an awareness of the institutions it has sanctioned” (Stallings
214). To that end, this thesis ultimately critiques the discursive techniques used to create
situated meaning in much earlier drug advertising to determine if these factors are still
active in the building blocks of modern DTCA.

Methodology

In studying the discursive methods of present pharmaceutical DTCA in
comparison with the non-regulated advertising of patent medicines, I use James Paul
Gee’s theory of situated meaning and building tasks as a qualitative foundation for
examining a corpus of available print ads. According to Gee, situated meaning is the
concept that words depend on a particular situation to garner meaning and that “words
have different specific meanings in different contexts of use” (53). For each specific
situation, Gee suggests we examine the discourse for “who doing what” because there
will always be discursive indicators of someone establishing an identity (“who”) in order
to participate in a social activity and achieve a desired outcome (“what”) (Gee 22-23). In
that regard, Gee’s theory is very similar to Kenneth Burke’s theory of rhetorical criticism
because an agent is accomplishing a purpose through the context of the discourse.
At first glance, then, prescription DTCA would appear to have the same situated meaning as the historical patent DTCA – a medicine maker ("who") using a discourse to sell a product to consumers ("what"). In fact, physicians typically perceive this similarity of situated meaning to be at the crux of their argument against prescription DTCA and see the practice as being an undesired throwback to an earlier time. Pharmaceutical companies assert, however, that they are not simply selling a product and are instead educating the public through the discourse. If this claim is true, then the situated meaning would not be the same for patent and prescription DTCA, and the discourse of historical and current medicine DTCA should demonstrate key differences in comparison. This thesis thus examines the discourse of both patent and prescription DTCA to determine if there is in fact any real difference in situated meaning.

When doing a discourse analysis of this nature, Gee proposes asking specific questions (which will be explained in later chapters) for determining how a discourse, such as direct-to-the-public pharmaceutical advertising, might use "building tasks" (10) to build identities, establish connections, and privilege certain types of sign systems and knowledge. For the purposes of this study, patent DTCA will refer to those drugs sold by advertising to the public prior to FDA regulation, and prescription DTCA will refer to the current, FDA-governed marketing of pharmaceutical companies. The following chapters will use each of the aforementioned building tasks – identities, connections, and sign systems and knowledge – to compare and contrast patent DTCA’s situated meaning to that of today’s prescription DTCA. Although I acknowledge that innumerable over-the-counter drugs are also sold through DTCA today, the area of primary interest for my
study is the prescription drugs that require a doctor’s involvement because this area is under the most scrutiny by physicians and the FDA at the present time.

We can best decide if – as critics claim – the situated meaning of prescription DTCA is the same as patent DTCA by breaking down the discourse of the advertisements into what Gee calls “building tasks” (10). Chapter two focuses solely on the building task of “identity” (Gee 11) to uncover the ways in which authors of the advertising discourse try to position themselves with an audience. A drug maker can use an identity to establish rapport with consumers in many different ways. From identity, I move in chapter three to the building task of “connections” (Gee 13), illustrating how authors of the discourse make certain aspects relevant or irrelevant to the readers. The last individual building task this thesis employs in chapter four is “sign systems and knowledge” (Gee 13) which is vital to our understanding of the methods authors use in a discourse to privilege specific information or awareness. Finally, chapter five pulls together the building tasks discussed in the previous chapters to bring “validity” (Gee 113) to our analysis. This final step is crucial, as no building task alone should completely influence our analysis, and the interaction of individual building tasks within a discourse better enables us to make an informed decision about the true situated meaning of DTCA. If pharmaceutical companies are correct in their assertion that the discourse is designed to educate consumers about diseases and conditions, we should be able to see a significant difference between patent and prescription DTCA.
Like any other type of discourse, pharmaceutical advertising gains or loses meaning through its social interaction and context. Gee, in his theory of discourse analysis, calls this fluidity of purpose "situated meaning" (53) and explains that a discourse's meaning is conveyed through images and text that correspond to a mutually agreed-upon connotation between author and audience even though this consensus of meaning usually develops through an audience's unconscious agreement. Gee asserts that we must always look at the "who doing what" of a situation to understand how the discourse goes about creating this flexible meaning (22).

One could simply argue then that pharmaceutical advertising, like any other type of advertising, is deliberately designed to attract attention and sell a product and therefore has the same situated meaning in all cases, but that position does not fully examine the advertising discourse to determine if the situated meaning of today’s prescription DTCA is really the same as it was for the historical patent DTCA. We can only find the true nature of "who doing what" (Gee 22) by comparing patent DTCA to prescription DTCA and discussing the specific techniques the ads use to accomplish certain goals. To that end, this chapter will analyze the ways in which patent and prescription DTCA set about establishing an identity with the public, looking under the surface of the ads to uncover
the roles and positions medicine marketers assume when conversing with consumers.

In his method of examining discourse, Gee discusses several “building tasks” (10) which will typically lay the foundation for any discourse’s construction of meaning. Each of the building tasks carries with it questions we can ask to determine how a discourse aligns itself under the task’s foundational concepts. Gee calls one of these building tasks “building identities” (11) and encourages us to answer the following questions about identity when examining a discourse:

1) What identity (roles, positions), with their concomitant personal, social, and cultural knowledge and beliefs (cognition), feelings (affect), and values, seem to be relevant to, taken for granted in, or under construction in the situation?
2) How are these identities stabilized or transformed in the situation? (111)

The underlying principle behind building identities is that creators of discourse always seek to establish a certain role they feel is important to have when speaking to an audience. As a result, this role gains the discourse the right to have a voice in the situated meaning.

Identity could be compared to the rhetorical appeals to ethos, but takes on a more complex definition in the context of Gee’s theory. While the classical appeal to ethos involves the persuasive establishment of qualities intrinsic to the speaker, the building of identity in a discourse would mean not only the personal character the discourse is trying to establish for the author but also the authority or position the discourse wants the audience to recognize it as having in the immediate situation. For instance, Gee uses an example of a person leading a business meeting to illustrate the task of building identity. In the context of the business meeting, the person would behave and speak in a particular way to gain recognition as the “chair,” but would probably not act in the same manner in a peer interaction outside the meeting (99). The identity of the chair would therefore be
situated in the discourse of the meeting.

In the case of pharmaceutical advertising, we can determine the situated meaning of the discourse by looking closely at the printed ads to find the identities that DTCA from past and present construct in order to carve out a position in pharmaceutical marketing. In selecting patent DTCA for analysis, this study selected two patent medicines – Lydia Pinkham’s Vegetable Compound and Peruna – which received notoriety in the late nineteenth and twentieth centuries for the amount of money their makers spent on advertising and for the criticism their products received in the public media. Despite the often negative publicity, these patent medicines were very successful for many decades.

This study then used the same selection process for prescription DTCA, choosing two drugs – Lipitor and Nexium – that are extremely popular prescription medications which have each made billions of dollars for their makers but have received criticism as well.

We will look at the visual and textual features of all of these ads to determine if they establish identity in the same ways. Similarities would indicate – as many critics suggest – that the discourse’s sole purpose is to sell a product. Any significant differences, on the other hand, would indicate that a different situated meaning exists and would support pharmaceutical companies’ claims that the discourse is intended to educate the consumer.

The best place to begin is with a well-known patent medicine to determine how it addresses the building task of identity.

Lydia Pinkham and her family began to mass market their proprietary recipe for a Vegetable Compound to the public in 1875, and their techniques were so successful that a variation of the compound is still sold in some pharmacies today. This patent medicine was touted as being effective on the “female complaints” that all women supposedly
"suffered" (Pinkham, 1875). Typically, the ads for Lydia Pinkham's Vegetable Compound focus on the maladies that accompany menstrual and menopausal symptoms, even though the medicine is also declared in the patent DTCA to be beneficial to "either sex" when taken for "kidney complaints" (Pinkham, 1892).

In keeping with the medicine's frequently stated indications for use, the most striking visual aspect of the DTCA for Lydia Pinkham's Vegetable Compound is the overt effort the ads made to establish a strong identity with women in society. Ads appearing from 1881 to 1906, for example, consistently featured an illustration of a woman at the top of the ad where the image would be in a prominent position. The Pinkham family clearly saw the value of using a woman's image in the Vegetable Compound ads because all of their ads contained a drawing of an elderly woman said to be Mrs. Pinkham. The matronly woman in the illustration gazes out to the reader with the calm, reassuring manner one would expect of a steadfast mother.

The Pinkham family continued to use this female image even after Pinkham's death in 1883, but they were careful to transform the visual identity to match the evolution of society. For example, DTCA for Lydia Pinkham's Vegetable Compound published after 1895 removed the illustrations of the familiar elderly woman believed to be Lydia Pinkham and replaced them with younger, more attractive "working girls" (Pinkham, 1896). The persistent visual imagery of the ads demonstrates the patent medicine maker's desire to create and maintain the identity of a reputable, contemporary woman speaking to other women.

The identity created in the visual elements of the Lydia Pinkham Vegetable Compound ads meshes seamlessly with the textual content of the marketing. In fact,
DTCA for this patent medicine in the years from 1881 to 1883 featured headlines in bold text of slogans like “Woman can Sympathize with Woman. Health of Woman is the Hope of the Race” and “A Medicine for Woman. Invented by a Woman. Prepared by a Woman” (Pinkham, 1881). One ad in particular which ran for several months in 1892, pairs a drawing of an elderly woman and a younger man reading through letters (attributed in the ad to be Lydia Pinkham and her son) with 12 lines of conversation supposedly taking place between the two figures. In the text, Lydia Pinkham states, “The women of the world are my daughters, dear” (Pinkham, 1892). This heartwarming scenario perfectly marries visual and text to portray a woman who could not possibly be untrustworthy in her medicinal motives. Unfortunately, as many critics have pointed out, this specific ad was printed nine years after Lydia Pinkham’s death (Bok, Adams, Young).

Interestingly, though, the nurturing female persona of the Lydia Pinkham ads is somewhat subverted by the fact that Pinkham never addresses the reader directly in any of the ads even in the years before her death. More specifically, the lack of first-person pronouns or “I-statements” (Gee 141) shows a reluctance to fully engage with the audience. This lack of direct interaction can be compared to a speaker who will not look into her listener’s eyes during a personal conversation. The listener is naturally going to question the truthfulness of the speaker’s words and the sincerity of the speaker’s concern. In addition, the speaker will convey the impression that she has some ulterior motive for distancing herself from the conversation.

So rather than engaging the reader directly, an unnamed narrator consistently refers to Pinkham in the third person, the only exception to this rule being an autograph under the
illustration of an elderly woman assumed to be Lydia Pinkham in the ads from 1881 to 1883 that reads “Yours for Health, Lydia E. Pinkham” (see Figure 2). This autograph is also one of the rare instances when the ads use a personal pronoun to directly address the reader.

Figure 2. Top of Advertisement for Lydia Pinkham’s Vegetable Compound – 1881

Instead, the ads use first- and second-person voice to deliver positive news to the reader in the form of numerous testimonials from grateful female customers. The writers of these letters of praise direct their comments to Lydia Pinkham and reinforce her position as a woman who was concerned primarily about the health of her female clients. One ad, for example, in 1904 consists solely of the usual drawing of a young woman and two such testimonials to the value of Lydia Pinkham’s Vegetable Compound. In the ad, one letter from a Miss Merkley commends Pinkham for “the great good you have done me” while another letter from a Miss Claussen claims other women should “try Lydia E. Pinkham’s Vegetable Compound” because “they will not be disappointed with the
results” (Pinkham, 1904). The reader, therefore, is allowed to eavesdrop on the
conversation and receive sisterly advice from the testimonials. This permits the makers
of Pinkham’s Vegetable Compound to construct an intermediary with the customer.

Another important textual feature of the patent DTC ads for Lydia Pinkham’s
Vegetable Compound is the wording the makers use to distance themselves from the
regular physicians in the consumers’ eyes. To do so, each ad from 1879 to 1906 alluded
to the unfortunate ignorance of doctors when it came to the worth of the patent medicine.
In the 1897 ad, the narrator states, “the usual treatment adopted by physicians...is
unphilosophic, unsuccessful, productive of great suffering, and in many instances of fatal
results” (Pinkham). A testimonial in an 1898 Lydia Pinkham Vegetable Compound ad
which ran in newspapers for several years proclaimed, “The doctor gave me medicine,
but it did me no good” (Pinkham). These references to the physicians’ purported inept
handling of medications complicated consumers’ decisions in a time when little to no
regulation existed for the advertising of pharmaceuticals. Thus, the image of a warm,
motherly figure like Lydia Pinkham contrasted with the impersonal figure of the doctor
and motivated patients to opt for the patent medicine.

If Lydia Pinkham’s target was the female consumer, then Peruna could be said to
have had “everyman” as its intended audience, as it demonstrated both visually and
textually in the patent DTCA. Peruna, another patent medicine with an enormous
following, made millions of dollars from a diverse group of consumers for its founder,
Dr. S. B. Hartman. Visually, the ads for Peruna support the notion that the drug was
targeting a wide range of patients because the ads tended to use a variety of people in its
illustrations. In the years 1885 to 1901, for example, the Hartman company changed
each ad’s visual element on a frequent basis to show that people of every gender, age, and economic status were happily taking Peruna. To add further credibility, images of politicians, Catholic nuns, and celebrities populated the illustrations (see Figure 3).

![Figure 3. Top Portions of Advertisement for Peruna – 1899 (left) and 1901 (right)](image)

Rather than focus its energy on a limited audience, the Hartman company clearly preferred to establish the identity of a concerned drug maker reaching out to all members of society. Constantly changing the people represented in the ads not only allowed the Hartman company to expand its consumer base but also sent the message that the product was beneficial to everyone. In addition, this visual tactic provided the ads with new sources from which to draw praise for the medication. Even Hartman often must have gotten carried away with the testimonials, however, because many critics claimed Peruna ads featured false praise and forged letters from important members of society (Bok; Adams).

The textual elements of the Peruna ads also bear a striking resemblance to the Pinkham ads in that we again never see the drug maker reaching out directly to the public.
in order to sell the product. The Peruna ads from 1885 to 1901, for instance, never use first-person voice to address the readers and instead rely on testimonials from numerous consumers to establish the company’s image. Also similar to the Pinkham ads, are the testimonials in Peruna’s ads that are written not to the audience but to the founder of Peruna, Dr. S.B. Hartman. For example, an 1899 Peruna ad features a testimonial from a Governor Atkinson who tells Hartman, “I can recommend your preparation, Peru-n-a, as a tonic.” The reader thus has a chance to hear the praise heaped on Hartman’s product without being overtly drawn into the conversation.

Hartman, in fact, does not use the first person in any of the ads save one which is one of many attempts to disparage physicians. This 1886 advertisement (Figure 4) begins with the sentence “We do not find fault, reproach, or condemn the practice of any regular physicians…” (Peruna, 1886) and goes on to state why a good doctor should prescribe Peruna to patients.

<table>
<thead>
<tr>
<th>To Physicians.</th>
</tr>
</thead>
<tbody>
<tr>
<td>We do not find fault, reproach or condemn the practice of any regular physician—this is not our mission—but we do claim that if he were to add Peruna to his prescriptions, as directed in our book on the &quot;Life of Life,&quot; (and furnished gratuitously by all druggists), he would cure all his patients. Mr. Henry C. Reynolds, Trenton, Lawrence County, Ohio, writes: “My wife has been sorely distressed for many years. Her disease of diseases and the symptoms of them have been so varied that an attempt to describe them would be more than I feel able to undertake. I have paid over a thousand (1,000) dollars for doctors and medicines for her, without any satisfactory results. We read so much about your Peruna that I was forced to try it. She has now taken five bottles; they have done her more good than all the doctors and medicines that she has ever made use of. Peruna is certainly a God-send to humanity.”</td>
</tr>
</tbody>
</table>

Figure 4. Top Portion of Advertisement for Peruna – 1886

28
Other, more subtle attacks on physicians are carried out in the testimonials that make up the majority of the layout for every Peruna advertisement. For example, the 1886 ad also has a testimonial which asserts a patient had “consulted a number of physicians, but received no benefit whatever” (Peruna, 1886). In effect, Hartman uses the discourse to undermine physicians and better position his own product with the public.

As we have seen, the makers of both Pinkham’s Vegetable Compound and Peruna saw the need to do similar things in constructing their identity. First, both medicines use visual elements to highlight the loyal following each drug had generated. As a result, the patent DTCA relies heavily on visual representations of their existing clientele in the discourse. Next, both medicine makers use textual cues to present themselves as objective parties who are offering to share the experiences of others with the consumer. In doing so, the ads for both medicines use I-statements that are action-oriented (Gee 141), meaning that the discourse only shows what the authors did instead of providing “cognitive” or “affective” (Gee 141) I-statements which would have more personal meaning. More specifically, the statements in the testimonials do not tell the reader how the users of Pinkham’s Vegetable Compound or Peruna felt or thought but rather what they did in taking the medications. This approach to a product is what we would typically expect from advertising’s situated meaning because it asks the reader to make a decision based primarily on peer review while preserving the perceived objectivity of the manufacturer.

Finally, both patent medicine makers obviously felt it was necessary to establish a clear division between themselves and the regular physicians when building an identity with the public. The motivation for this decision is also a good fit for what we would
typically expect of advertising because no manufacturer wants the customer to go to his competitor for advice. And, the physician was definitely the competitor of patent medicines since the doctor was in the best position to dissuade the patient from buying the product. Establishing themselves as being more knowledgeable than the physician, then, would have been an extremely important role for the medicine makers to assume in order to preserve the patent drug business.

So, the ads for Pinkham’s Vegetable Compound and Peruna build identity in ways which coincide with what we would normally expect of an advertising discourse. Visual images in the patent DTCA mirror the audience the drug makers hope to attract, and the textual elements reflect Pinkham’s and Hartman’s tendency to market the patent medicines as a commodity versus a personal investment. This separation also allowed the makers to avoid a certain amount of responsibility should anyone have claimed that the drugs were not effective. In addition, the discourse shows that Pinkham and Hartman wanted to dissuade their audience from visiting their biggest competitor – the physician – which is a logical feature of business advertising.

Today, the authors of prescription DTCA claim they are doing something different in their advertising. The Pfizer pharmaceutical company, for example, stated in its 2007 report to stockholders that prescription DTCA “educates patients and is a critical conversation starter that results in life-changing diagnosis and treatment decisions” (Pfizer 84). Another pharmaceutical company, AstraZeneca, told stockholders in an annual report that DTCA “plays an increasingly important role in informing healthcare professionals and others about AstraZeneca’s medicines and the diseases they treat” (AstraZeneca 16). If this is true, then the ways in which they build identity in the
discourse of prescription DTCA should be somewhat different than it was for the patent medicines already discussed. To see if a difference genuinely exists in situated meaning, then, we must look at prescription DTCA for the same elements of visual imagery, I-statements and voice, and physician interaction. In selecting the prescription drugs for analysis, this study chose Nexium, an acid-reflux drug made by the AstraZeneca company, and Lipitor, a cholesterol-inhibiting drug made by the Pfizer company, because both drugs have received significant publicity for the amount of money AstraZeneca and Pfizer have spent on advertising – $16 million in one month alone for Nexium and $11 billion in 2006 for Lipitor (Bazell, Mar 2007).

Visually, Nexium and Lipitor establish identity with the audience in ways that might appear incongruous at first glance, but they contain discursive features shared by all prescription DTCA. Nexium’s ads from 2006 and 2007, for instance, always feature color photographs of people from a wide range of backgrounds, genders, etc., but the people in the images are not customers who are currently taking Nexium. Instead, the photos are of potential patients who are said to be in desperate need of the product, and an omniscient voice narrates each image warning of the danger of an undiagnosed condition, such as acid reflux. Since the images are supposedly of people who should be taking Nexium, the ads do not have a true testimonial element as patent DTCA once did, rather they reflect the ominously directive tone of the accompanying text.

This narration lets the readers feel as though they too are peering through a window with an increased knowledge of what may come for the poor unassuming person in the image. One ad for Nexium, for example, shows an elderly man in a cardigan sweater who placidly looks at the reader while the text beside the photo asserts: “Knows that his
car isn’t the only thing that needs a regular check-up”...”Knows an apple a day won’t always keep the doctor away”...”Doesn’t know acid reflux may be damaging his esophagus.” (Nexium, Jun 2007). AstraZeneca takes a position of all-knowing expert in the Nexium ads and uses discourse which allows the readers to hear the implied warning and feel as though they now have an awareness of medical issues that they previously had not possessed. Using this same concept in all of the Nexium ads (see Figure 5), AstraZeneca appears to share a professional secret with the reader about the unsuspecting people in the photos.

![Figure 5. Top Portion of Advertisement for Nexium – 2006](image)

Lipitor, on the other hand, uses the imagery in their ads in a way which is somewhat different from the Nexium ads. The Lipitor advertisements use a color photograph of a patient, Dr. Robert Jarvik, who states he is currently using the product, so the visual is a type of testimonial, but the appeal is made directly to the reader versus the appeals of
patent DTCA which, as we said earlier in this chapter, were made to the drug maker. For example, Dr. Jarvik gazes calmly at the readers from one ad (see Figure 6) and reassures them that “Lipitor lowers bad cholesterol 39-60%. It lowered mine” (Lipitor, Dec 2007).

The presence of Dr. Jarvik in the prescription DTCA for Lipitor is beneficial to Lipitor’s building of identity for two reasons: 1) Dr. Jarvik is a patient who highly recommends the product to other consumers and 2) Dr. Jarvik is a physician and “Inventor of the Jarvik Artificial Heart” (Lipitor, Jun 2007) which increases the perceived credibility of the spokesperson and the product. Dr. Jarvik’s reported expertise in cardiac medicine helps Pfizer immensely because he makes a trustworthy and professional representative for their cholesterol drug. Criticism of Pfizer’s use of Dr. Jarvik as a spokesperson has included claims that Dr. Jarvik is not a practicing physician and that his experience with the artificial heart was significantly overrated (Bazell, Mar 2007), but this negative publicity about the marketing campaign has not affected Pfizer’s revenue since “Lipitor hit $3.3 billion” (Bazell, Mar 2007) in sales immediately after enlisting Dr. Jarvik’s assistance in 2005. In fact, consumers have responded so well that Dr. Jarvik is
currently the only person featured in any of the Lipitor ads.

In the language of the ads, AstraZeneca and Pfizer do seem to want a closer relationship with the consumer than patent medicines once had. In fact, the pharmaceutical companies build an identity through the advertising which shows this to be true. Lipitor and Nexium ads, for example, use an authoritative tone in both the visual and textual elements of the prescription DTCA to bolster their position in the discourse. Although AstraZeneca begins with third-person voice for the visual aspect of the Nexium ads, it switches to second-person pronouns in the body of every ad’s text. While no I-statements are used, the ads speak directly to the readers giving them an idea of what could happen if Nexium is needed but not used. For example, one ad states, “Unlike your stomach, the esophagus offers little protection against acid. This means the heartburn pain you feel is actually from stomach acid rising up into the esophagus…” (Nexium, Sep 2006). Another ad asserts, “If you suffer from acid reflux disease…you could have serious damage to your esophagus and not know it” (Nexium, Jul 2006) Statements such as these are meant to demonstrate to the reader that AstraZeneca can be trusted in its knowledge of medicine and in the indications for Nexium.

Pfizer begins its Lipitor ads with the images of Dr. Jarvik speaking to the audience and carries this first-person voice into the body of every ad’s text. The I-statements in the Lipitor ads come directly from Dr. Jarvik and are not only action-oriented – telling the consumers what they should do – but are also what Gee calls “cognitive” (141) because Dr. Jarvik gives indications of what he thinks of heart attacks, strokes, etc., from a doctor’s perspective. In addition, the tone, as in the Nexium ads, is authoritative because it speaks to the reader in prescriptive language. For example, one Lipitor ad tells
the reader, “if you take LIPITOR, tell your doctor if you feel any new muscle pain or weakness” (Lipitor, Dec 2007). Another ad directs the reader to find more information about the medicine through Pfizer’s website.

Another aspect of building identity that appears to be different in the text of prescription DTCA is the interaction with physicians that the pharmaceutical companies demonstrate they want to have. Whereas the patent DTCA from the past attempted to build a separate identity from the doctors, the prescription DTCA makes several attempts in each ad to exhibit professional goodwill toward physicians. Nexium ads, for instance, repeatedly use lines such as “Ask your doctor if NEXIUM is right for you” and “…discuss it with your doctor” (Nexium, Sep 2006) throughout the text. Of course, maintaining an image of collaborative effort with physicians is important if the company hopes to have its medication sell. After all, physicians must prescribe Nexium and Lipitor if a patent is to take them, and AstraZeneca and Pfizer are careful not to bite the hand that feeds them.

To that end, Lipitor ads use similar language, but are interesting in the way they continue to have an authoritative voice even while referring a patient to a doctor. For example, after directing the consumer to see a doctor, one Lipitor ad states, “Your doctor should do blood tests to check your liver function before and during treatment…” (Lipitor, Dec 2007). The pejorative use of the word “should” in this line in relation to what a proper doctor would know to do indicates that Pfizer still feels it has the upper hand in the discussion of Lipitor and wants to convey this position to the public.

An element of today’s prescription DTCA which is impossible to compare to the patent DTCA is the full page, or often several pages, of text on the reverse side of the
printed ads that describes the side effects and risks of the prescription medications. Historically, the patent DTCA never had this feature because the patent drugs were not regulated in any way. The FDA, however, now requires that all “product-claim” ads — those prescription ads that feature both a medicine’s name and indications — include a lengthy textual component that provides consumers with important information about a drug. In this component of the prescription DTCA, however, we usually see the drug company’s desired image — a concerned corporation speaking directly to a potential patient — diluted by the accompanying legal requirements of the text. Nexium ads, for example, commonly begin the reverse side of their ads with the warning to “ask your doctor about NEXIUM” (Nexium, Sep 2006). From that point on, the ads revert to a detached third-person narrative filled with technical language and legal terms. Likewise, the Lipitor ads begin the text for side effects and risks with a conversational tone but quickly evolve into a very authoritative voice with statements that begin with prescriptive words such as “Do not...” and “Take....” Pharmaceutical companies therefore have an interesting convolution of identities happening in a single discourse due to the FDA rules.

As one can imagine, building an identity in the prescription drug market today is vital to a pharmaceutical company’s success, and ironically FDA rules sometimes make establishing this identity easier for a drug maker in the discourse of the ads. For example, one common way for a pharmaceutical company to establish its identity is in the strategic placement of ads that don’t even address a particular medical condition. Instead, these ads, categorized as “reminder” (Weber 160) by the FDA, are allowed to mention only a brand-name drug but not a specific disease, condition, or guidelines for use. By FDA regulation, these reminder ads can refer a consumer to a physician, but they cannot
address any particular indications for the prescription drug in the ad. Therefore, while the content of the reminder ad is not designed to overtly sell medicine, it nevertheless invites the public to associate a company’s brand name with a positive image.

AstraZeneca, like many other pharmaceutical companies, has found an innovative way to build its own identity with DTC reminder ads. Although AstraZeneca follows the FDA rules in these ads by including the Nexium name, it also takes the opportunity to pitch the company’s ethical appeal. With this unique combination of reminder and corporate-identity advertising, AstraZeneca tries to build its positive ethos by showing what the company is doing to be socially responsible. For example, in one such reminder ad, AstraZeneca tells readers “NEXIUM users don’t have to go far for free support” and encourages the reader to “Be part of Purple Plus – a free program for NEXIUM users” (Nexium, Sep 2006). The ad then goes on to tell the reader how AstraZeneca can help them save money when purchasing the drug. Although this particular Nexium ad does mention getting advice from doctors, these hybrid ads often omit any reference to a physician and could be compared to public service announcements from agencies who profess an altruistic dedication to overcoming a social dilemma.

AstraZeneca and Pfizer are very diligent about carrying over the positive image created in their reminder ads to the text of their more traditional ads. All product-claim DTCA for Nexium, for instance, contains a three-line entry at the bottom of the ad that reminds the reader about Nexium’s “Purple Plus Program” encouraging the reader to call for more information. The small print under this reminder informs the reader that AstraZeneca might be able to help users of Nexium with their prescription costs. Pfizer uses the same concept in its product-claim DTCA for Lipitor, ensuring the reader knows
about its "helpful answers" (Lipitor, 2006) program that can help uninsured patients with funds for their Lipitor prescriptions. So, pharmaceutical companies like AstraZeneca and Pfizer now use FDA rules to create a unique marketing situation wherein the image of monetary assistance from a benevolent company is clearly highlighted for a needy customer.

As consumers, however, we must remember what Samuel Hopkins Adams said in *The Great American Fraud*—"It is safe to assume that every advertising altruist who pretends to give out free prescriptions is really a quack medical firm in disguise" (62)—because the discourse of prescription DTCA should not always be accepted at face value. After all, the FDA continues to enact laws which strongly regulate the marketing practices of prescription DTCA. So, while AstraZeneca and Pfizer do appear as though they are acting out of concern and compassion in their advertising discourse, they also include specific textual elements simply because the FDA tells them they must do so if they want their ads published. For instance, the rejoinders in the prescription DTCA to "see your doctor" or "discuss this medication with your doctor" are not altruistic decisions made solely by the pharmaceutical companies. Rather, the FDA mandates that these types of statements be included in every product-claim ad that is published in the mass media.

In terms of situated meaning, however, prescription DTCA does reflect key differences compared to patent DTCA in the way both discourses build identity. The ads for Pinkham's Vegetable Compound and Peruna, for instance, exhibited language which made them sound more like second-hand news from a disinterested reporter. We also saw how the patent DTCA used imagery and language to highlight the patients who were
already taking the medication, hoping that the testimonials would have a bandwagon
effect on other consumers. Apparently, the patent drug makers did not feel that they
needed to engage directly with potential consumers or include them in a discussion in
order to sell the medication. In effect, the patent DTCA does not give the impression that
the makers genuinely cared about the readers.

The visual and textual components of the prescription DTCA, on the other hand, do
indicate the drug makers’ desire to include the reader in the marketing and typically
focuses on people who are not taking the medication. This shows that the pharmaceutical
companies feel the need to insert themselves in a dialogue with potential patients in a
way that makes the consumers feel as though they are involved in a medical decision
versus simply engaged in a commercial product selection. This interaction with
consumers would support the pharmaceutical companies’ position that they are using the
advertising discourse to educate the public.

Therefore, the prescription DTCA does seem to be undertaking a discourse within a
situated meaning that is somewhat different from the context of the patent DTCA;
however, we must be careful about agreeing to this difference after only looking at the
building task of identity. Establishing identity is only one of many behaviors occurring
within a discourse, so we must look at other building tasks to fully validate an analysis.
Therefore, for pharmaceutical advertising, we can also look at the ways in which the
DTCA builds connections, and the next chapter will discuss this aspect of the discourse.
CHAPTER 3

BUILDING CONNECTIONS

As previously explained, a discourse clarifies its situated meaning – the “who” doing “what” – through its construction of certain “building tasks” (Gee 10). This thesis has already shown how a discourse like pharmaceutical advertising establishes its identity and what the authors’ position can tell us about the context and desired effect, but we also need to look at other building tasks to truly determine a particular situated meaning. The building tasks function independently, but they also work in combination to signify a context. To that end, this chapter focuses on the building task of “connections” (Gee 12-13) to analyze pharmaceutical advertising and determine if the situated meaning of prescription DTCA is any different – as the pharmaceutical companies often claim – from the situated meaning of the advertising discourse used for historical patent medicine.

Just as he did in his explanation on the building task of identity, Gee provides us with several questions about connections that any good analysis of a discourse will ask. In regard to building connections, Gee suggests we examine a discourse with the following thoughts in mind:

1) What sorts of connections – looking backward and/or forward – are made within and across utterances and large stretches of the interaction?
2) What sorts of connections are made to previous or future interactions, to other people, ideas, texts, things, institutions, and Discourses outside the current situation?
3) How do connections...help (together with situated meanings and Discourse models) to constitute ‘coherence’... (112)

Asking these questions will help us determine how a discourse makes its content pertinent (or not) to a current or future situation. To further explain the concept of building connections, Gee returns to his example of the person leading a business meaning (discussed in this thesis in chapter 2). In the context of the business meeting, the person leading the meeting behaves and speaks in a particular way to gain recognition as the chair; thus the identity of the chair is situated in the discourse of the meeting. At the same time, the person leading the meeting would use specific language to make what he/she says during the course of the meeting relevant (or not) to a time outside of the meeting (Gee 100-101). For example, if we wanted people attending a meeting to, at a future date, make an operational decision about hiring practices based on the company’s vision, we would need to ensure we use language in the meeting that could help the attendees draw that connection later. In a way, building connections is similar to planting a seed in a discourse and then implying to an audience why they should help that seed grow. In doing so, discourses often use emotional appeals to *pathos* to bolster the connections they create.

A discourse can build (or break, for that matter) certain connections in many different ways. Gee states that he prefers to start looking for connections by first finding the “motifs” (153-155) that seem to act as running themes in a discourse because the motifs indicate ideas the author wants to reinforce with an audience and tie different parts of the discourse together. As this is a good place to start, this chapter will look for the motifs in pharmaceutical advertising, again using the patent DTCA for Lydia Pinkham’s Vegetable Compound and Peruna along with the prescription DTCA for Nexium and Lipitor as
specific artifacts for study. Using these same ads throughout this thesis is important because we must remain consistent in the analysis examples we use if we want to reach a valid conclusion. In the process of finding language that establishes motifs, this chapter will also explore how the construction of the discourse’s language helps make it easier or more difficult for an audience to find relevance in the advertising. We will pay particular attention to the use of syllogisms and phrasing in both patent and prescription DTCA because these textual elements often are the most effective at facilitating an audience’s acceptance of a drug (Arney & Rafalovich). Marketers often rely on syllogistic premises in the text to help a reader reach a conclusion that seems logical.

Returning to the patent medicine of the past, we find that common motifs existed in the advertising for both Lydia Pinkham’s Vegetable Compound and Peruna. The first of these predominate motifs was that certain health issues were universal to all readers. For the Pinkham company, this appears to have meant that simply being of the female gender was a health issue because the advertisements usually stated the patent drug was good for all manners of “female complaints” (Pinkham, 1879) or “female weaknesses” (Pinkham, 1883). In making such female problems more specific for the reader, the DTCA for Pinkham’s Vegetable Compound typically described a wide variety of health issues that were open to interpretation. For example, the ads from 1879 to 1906 contain references to everything from fibroid tumors to women’s “organic derangement” which a 1906 ad said was particularly terrible (see Figure 7). This ad was amazingly comprehensive in its indications when it stated the patent drug was good for:

Irregular suppressed or painful periods, weakness, displacements or ulceration, that bearing-down feeling, inflammation of the female organs, backache, bloating (or flatulence), general debility, indigestion and nervous prostration, or...such symptoms as dizziness, faintness, lassitude, excitability, irritability, nervousness,
sleeplessness, melancholy, “all gone” and “want-to-be-left-alone” feelings, blues, and hopelessness. (Pinkham, 1906)

With such a disparate list of symptoms, the ad effectively made it possible for any woman to see that she should include herself in the vast majority of female consumers who have what Pinkham’s medicine terms significant health problems.

Figure 7. Advertisement for Lydia Pinkham’s Vegetable Compound – 1906

For its patent DTCA for Peruna, the Hartman company took the same approach on this theme that conditions were universal and that everyone suffered at least one of the drug’s stated indications. In fact, pinning down a specific illness that Peruna was designed to treat is difficult because the ads from 1885 to 1901 ranged from discussions of “catarrh” (Peruna, 1885), which is essentially a form of sinus congestion, to “kidney complaint and dizziness” (Peruna, 1886) and “fever and ague” (Peruna, 1901). The
patent DTCA for Peruna even gave a nod to the same premise the Pinkham ads established for female problems by linking Peruna to “female catarrh” (Peruna, 1899) – asserting women have sinus congestion that differs vastly from that of a man – and the “weaknesses peculiar to” the female sex (Peruna, 1899).

Overall, however, the Peruna ads consistently showed audiences of all ages and genders that certain health issues were common to society as a whole. In keeping with its “everyman” identity (as discussed in chapter 2) when building connections, Peruna used wide-ranging conditions that were sure to have at least one link to each person. Thus the wording of the patent DTCA across multiple examples conveys the coherent thought that consumers should see their own health as connected to that of others with the same symptoms. Establishing this bandwagon connection was important in the situated meaning of patent DTCA because the audience was able to see themselves in the discourse and relate their own everyday experiences with the effects mentioned in the ads.

The next motif – that everyday health issues, although common, were not conducive to a happy life and needed to be “cured” – ran throughout the patent DTCA discourse to connect the illness to the medicine. In the ads for Lydia Pinkham’s Vegetable Compound, for example, the word “cure” was used repeatedly in each ad to show what the medicine supposedly had the power to do. In fact, one ad began with the large-font heading “Female Complaints and successful METHOD OF CURE” (Pinkham, 1879) and employed a version of the word “cured” a total of eight times in a single 2x8-inch space. By telling readers that Lydia Pinkham’s Vegetable Compound could cure “the blues” (Pinkham, 1906) and other vague symptoms, the patent drug makers effectively sent the
message to consumers that what they might be feeling was not acceptable and therefore had to be fixed. Of course, the only way to correct the problem, according to the drug maker, was to use the advertised patent drug.

To someone who is closely reading the patent DTCA, the two motifs of common conditions and necessary cures might appear incongruous at first. The natural question would be: How could readers accept that health issues shared by all could also be abnormal? The answer resides in the syllogism which results from the patent DTCA’s construction. The first motif, for instance, establishes the major premise that all people share a certain set of physiological or emotional conditions. Readers can easily situate themselves within this premise because they correspond to the targeted group. The second motif then establishes the minor premise that the stated condition means unnecessary suffering that can be “cured” with the advertised drug.

The major and minor premise, working together, lead readers to make the concluding premise that they have the condition and need a remedy. In the Pinkham ads, for example, after telling a female consumer that 1) All women have particular health issues (major premise) and that 2) These issues do not need to be endured and can be cured with the Vegetable Compound (minor premise), the discourse silently encourages the female reader to reach the conclusion of “I am a woman. I have this problem, so I need this medicine – and lots of it – in order to live well.” A Peruna testimonial made this type of syllogistic construction evident in the simple statement, “If others who have been sick are now well and happy, why shouldn’t you be?” (Peruna, 1889). Using language to “medicalize” a perfectly normal health condition, the patent drug makers benefited from society’s ability to make assumptions. James Young points out that patent DTCA
"recognized that nearly every man is vulnerable to the power of suggestion and sought to make him sick so they could make him well" (184). As we will see later in this chapter, drug makers are still using syllogistic construction to accomplish the same goal.

In the ads for Peruna, the Hartman company again mirrors the efforts of the Pinkham ads in the motif that common conditions degraded a consumer's quality of life and had to be eliminated. The Peruna ads also employed repetitive language, such as the word "cure," to connect various health problems to the recuperative effects of the drug. One such ad begins with the heading "A FAMOUS MUSICIAN Cured of Catarrh and La Grippe by Peruna" (Peruna, 1901) and continues in a testimonial to say how glad the person is that the wonder drug has at last cured him of his problems. Another Peruna ad goes even further in linking illness to a cure in a testimonial which asserts, "It has robbed the grave of one victim, for I was in a critical condition..." (Peruna, 1899).

The unique aspect of the Peruna patent DTCA, however, is that the discourse of the ads not only ties the drug to possible problems the readers might have had, but also draws a strong correlation to the amount of the so-called cure which might be necessary. In very specific language, the Peruna ads tell the audience that using multiple bottles of the patent medicine would be the best way to eradicate a health concern. For example, an 1885 ad mentions that a woman "has now taken two bottles, and is so much better that she will never quit its use until she is entirely well" (Peruna, 1885). Another ad a year later features a testimonial about a woman who "has now taken five bottles..." (Peruna, 1886). This language continues throughout the Peruna ads often mentioning the use of several bottles of the drug (see Figure 8) and in 1899 culminates in a testimonial wherein a woman claims she has "taken ten bottles of your Pe-ru-na and will continue taking it..."
(Peruna, 1899). None of the ads ever address, however, why multiple bottles or continued use might be necessary if the drug was, in fact, a genuine cure. Of course, critics often pointed out that Peruna was approximately 28 percent alcohol (Adams; Young; Bok) and Lydia Pinkham’s Vegetable Compound was around 20 percent alcohol (Bok), so patients were often willing to take more and more of the products with very little encouragement beyond the first bottle.

![Advertisement for Peruna](image)

Figure 8. Advertisement for Peruna (aka Pe-ru-na) – January 1899

While the patent DTCA for Peruna might have been somewhat humorous in its methods to sell increased amounts of its product, the advertising discourse has a more serious effect in building connections. Gee points out that a discourse has the power to influence what he calls “prototypical simulations” (95-96). A prototypical simulation is
the image or story that a person carries in his/her mind about what a typical situation would look like. The person then uses this simulation to determine whether something is "normal" or not. For instance, each of us has a prototypical simulation of what is typical or normal for a wedding or for parenting, etc (Gee 95-96). If we were to then attend a wedding that did not match up with our prototypical simulation, we would either be confused by the juxtaposition or we would have to adapt to the change.

In the same way, patent DTCA established connections which may have influenced consumers' prototypical simulations about healthcare. More specifically, the advertising for both Peruna and Lydia Pinkham's Vegetable Compound demonstrated an effort to change what readers comprehended as being normal for everyday health. For instance, what women may have originally seen as just being a bad mood became – through patent DTCA – normalized as a problematic and worrisome female issue. After the consumers made the shift in their thinking to what should be normal or typical, it was a short jump for them to assume it was then normal to need large doses of an advertised medication.

At this point, we might expect an audience to seek a doctor's advice before blindly accepting the need for a medicine, but the patent DTCA used a final motif which served to break or mitigate any connection readers might have had with a physician. In fact, the discourse made the need to see a doctor irrelevant with statements that showed the "medical arts" (Pinkham, 1879) had been ineffective and thus were not necessary. Lydia Pinkham's Vegetable Compound ads typically broke the connection between patient and doctor by stating frequently that the "female complaints" had "baffle[d] the skill of the best medical men" (Pinkham, 1885) and that doctors gave medicine which had no effect on the illness (Pinkham, 1898). Interestingly, a Pinkham ad in 1883 departed from this
approach by claiming "PHYSICIANS USE IT AND PRESCRIBE IT FREELY," but the Pinkham family, under heavy scrutiny, quickly dropped this line from the advertising the following year.

The Peruna ads followed suit in the effort to disrupt the patient/physician relationship and often discussed the futility of seeing a doctor. A testimonial in 1885 informed the reader that the patient "had consulted every physician far and near" (Peruna, 1885). Obviously, since the patient was now speaking on behalf of Peruna, the doctor visits had been unsuccessful. Another testimonial in 1886 proclaimed, "I have paid over a thousand (1,000) dollars for doctors and medicines...without any satisfactory results" (Peruna, 1886). Thus the reader is encouraged to save money on doctor bills and buy multiple bottles of Peruna instead. Later Peruna ads were even more overt in their attempt to dissuade consumers from visiting doctors. Statements such as "I did not call the doctor, but used your medicine" (Peruna, 1899) littered the text of patent DTCA to further the drug makers' efforts to make traditional medical care irrelevant.

As we have seen, in terms of situated meaning, the patent DTCA built connections in ways that correspond to the basic advertising context of a manufacturer marketing a product to the public. In this case, the drug makers primarily wanted to increase sales by showing audiences they absolutely needed their medicine. The first step in doing that was to help the consumers see that they were part of the population who had a certain condition. Next, the advertising had to guide the consumer into the realization that the product would help overcome the health problem they possessed. To accomplish this, Lydia Pinkham’s Vegetable Compound and Peruna worked to make the consumer feel included through syllogistic reasoning. Finally, the advertising sought ways to prevent
any interaction potential buyers might have in the future with the competition – who in
this case was the physician. Doing so effectively locked the buyers into repeated
transactions with the manufacturer.

Like patent DTCA, advertisements for today’s prescription medications also build
connections in the discourse, so we can turn to the ads for Nexium and Lipitor to
determine how the current pharmaceutical companies make certain elements relevant (or
not) to the public. Just as we did with the DTCA for Pinkham’s Vegetable Compound
and Peruna, we will look for the motifs featured in the ads along with the construction of
the textual elements.

In the first noticeable motif, we can certainly hear echoes of the historical patent
DTCA because the most salient feature of prescription DTCA is the theme that readers
are not aware of the health dangers that are common to our society. AstraZeneca, for
example, uses language that implies no matter how well a person thinks he/she is
managing acid reflux, serious problems are still imminent. The Nexium ads, as we
discussed in chapter 2, typically begin with the visual image of a normal-looking person
who is blissfully unaware of how much he/she might be in jeopardy. We said this image
helps AstraZeneca draw the audience in as a silent observer to this person’s woes.

To help build a connection, however, the drug maker switches in the text of the ad to
statements such as, “Even if you’re treating your heartburn, you may still have damage”
(Nexium, Sep 2006) and “If you suffer from acid reflux disease...you could have damage
to your esophagus and not even know it” (Nexium, Jan 2007). The ads now enable the
consumer to make the leap from bystander to active participant by appealing to the fear
readers might have of their own undiagnosed problems. One ad for Nexium especially
plays on this fear by stating, “IT’S DIFFERENT FOR PEOPLE WITH ACID REFLUX DISEASE. Because beneath the heartburn, something more could be brewing” (Nexium, Jul 2006). Suddenly, readers make the connection that their occasional episode of heartburn – which, in fact, might result from a bad meal – is nothing less than the chronic condition exhibited in the prescription DTCA. They begin to see themselves as the unfortunate person in the ad’s graphic. If readers were to look more closely at the text of the Nexium ads, however, they could see that AstraZeneca also selects its wording very carefully.

In fact, today’s pharmaceutical companies are much more cautious than the patent drug makers were in the wording of the discourse. The patent DTCA was unregulated, so just about any claim could appear in the ads with impunity. Prescription DTCA, however, must conform to FDA laws or it can and will be held liable for false or misleading statements. This is not to say that the ads do not manipulate shades of meaning, however. The language in the prescription DTCA, for instance, consistently takes advantage of numerous modal words like “could,” “may,” and “might” throughout the advertising space to not only avoid any absolutes which might violate FDA regulation but also deflect any blame for misdiagnosis. A good example of this concept is a line which appears in every Nexium ad – “This condition may affect 1 in 3 people with acid reflux disease, and if left untreated, could get worse” (Nexium, Jun 2007). This wording choice maintains the ads’ relevance for possible users of Nexium while not specifically telling the consumers that they have a problem. The phrasing of sentences in Nexium ads also evinces a tendency to place a warning about imminent danger above the more comforting words of the discourse. For example, the common heading in Nexium ads –
“Even if you’re treating your heartburn, you may still have damage” (Nexium, Jun 2007) – phrases the information in such a way that emphasis is placed mainly on the potential damage and discounts the fact that the patient might be trying to treat the condition already.

Pfizer, in its Lipitor DTCA, is slightly more encouraging on this motif of cautioning the ignorant consumer but, like the Nexium ads, still seems to offer more warning than enlightenment. The Lipitor ads typically list a number of items they identify as risks for heart disease and tell the readers that they could be in danger if they have “multiple risk factors” (Lipitor, Jul 2006). These factors range from something as arbitrary as “age” to more specific issues such as “high blood pressure” (Lipitor, Dec 2007). The confusing aspect with this approach, however, is that some Lipitor ads state the patient would need to show “multiple risk factors” – no quantifiable number is given – to need Lipitor, while other Lipitor ads state the patients would only need “type 2 diabetes and at least one other risk factor” (Lipitor, Nov 2007) to be a candidate for the drug. This discrepancy leads the consumers to resolve the difference by erring on the side of caution and accepting the need for the drug on the smallest provocation. In fairness, this study found that the Lipitor ads do let readers know that Lipitor may not be indicated in some cases, but only lists “those with liver problems” and “women who are nursing, pregnant, or may become pregnant” (Lipitor, Dec 2007) as the exemptions. This, of course, leaves a large population who could be potential buyers of the drug, and the wording throughout the Lipitor ads helps make that choice more obvious.

Once patients acknowledge that they probably have to be concerned with one of more of the health issues identified in the prescription DTCA, they will notice the next motif
which appears in the advertising discourse and is very similar to the non-regulated patent DTCA — the realization that only the advertised prescription drug will help them. To that end, Pfizer goes to great lengths in the discourse to make sure the public sees Nexium as being very relevant to an acid-reflux condition. The image of an actual Nexium capsule appears at prominent positions within the textual component of each ad to reinforce the medicine’s shape and color for the readers (see Figure 9).

![Image of advertisement for Nexium](image)

**Figure 9. Bottom Portion of Advertisement for Nexium – 2007**

In addition, the words, “The Little Purple Pill,” run through every ad and even show up in the name of the customer-service website — www.purplepill.com — for the medication. These words and graphics work together to solidify the connection in the consumers’ minds between their condition and the medication that they should request. AstraZeneca also includes references frequently throughout the ads to the recuperative power of Nexium with statements such as “NEXIUM is the healing purple pill” (Nexium,
Jul 2006) and “it [Nexium] can also heal the most severe erosions in the esophagus…” (Nexium, Jun 2007). The ads do not mention whether any other options are available for treatment.

Pfizer structures its ads for Lipitor to accomplish the same objective of brand recognition. Lipitor is strongly portrayed as being the answer to the consumers’ concerns about heart disease and cholesterol. To support these claims, all of the DTCA for Lipitor pictures Dr. Robert Jarvik – again personifying the Pfizer corporation as part of the company’s identity – offering numerical data such as “Lipitor lowers bad cholesterol 39-60%” (Lipitor, Dec 2007) and “Lipitor reduces risk of stroke by 48%” (Lipitor, Dec 2007) which serve as a convincing “scientific” tool to equate efficacy with the drug. Each Lipitor ad also includes the line “Lipitor is one of the most researched medicines with over 400 ongoing or completed clinical studies” (Lipitor, Nov 2007).

Of course the Lipitor ads do not make relevant the fact that there have been so many studies of the drug partly because it has been under heavy scrutiny by the FDA. In fact, several lawsuits in the past have taken Pfizer to task for the claims in the Lipitor ads, including one suit which recently even tried to subpoena Dr. Jarvik. This suit, filed in April 2007 by several labor unions, accuses Pfizer of knowingly using language in the Lipitor ads which resulted in a large number of patients requesting (and often receiving) the drug when it was not indicated. The litigation primarily centers on wording that shows Pfizer marketed the drug to consumers with an “LDL cholesterol level of 130 ml/dL” when medical professionals suggest cholesterol levels only indicate intervention at “160 ml/dL” (Edwards 14). The labor unions insist that Pfizer’s ads have resulted in approximately 40 million people taking Lipitor when not medically necessary (Edwards).
The statistics have been in dispute for a while now, but the numbers are unquestionably persuasive to readers who make conclusions on what they believe is scientific information. In addition, Pfizer's "helpful answers" campaign – mentioned in our discussion of identity because the reference is included in every Lipitor ad – acts here as a bridge since the customer now not only remembers the company as having a positive image but also connects that positive ethos to convincing numerical data in their attempts to make a logical healthcare choice.

In helping readers make selections, the construction of the sentences in prescription DTCA shares much in common with the patent DTCA. Earlier in this chapter, we said patent DTCA helped normalize common feelings, such as a bad mood, into what people came to see as a condition that needed to be treated. This same concept works in today's prescription DTCA as consumers change their prototypical simulations of illness based on the advertising they read. Like the patent advertisements, prescription DTCA often uses syllogistic language to accomplish this change in normality. To explain this idea, Jennifer Arney and Adam Rafalovich conducted a study of prescription DTCA that showed the overwhelming use of "incomplete syllogisms" (49) in the wording of the advertising made a significant difference in the "medicalization" (50) of health conditions. According to Arney and Rafalovich, prescription DTCA almost always offers a major premise which invites readers to identify with stated conditions. Then, a minor premise helps frame the condition as being symptomatic of a condition needing a medicinal remedy. The concluding premise is unstated, but the major and minor premises work together to convey "a narrative that paints the concluding premise as almost inevitable" (Arney and Rafalovich 57). The ads for Nexium and Lipitor exhibit
this type of construction mainly in the form of hypothetical syllogisms – premises that use an “if” statement – that range from “If you suffer from acid reflux...” and “if left untreated...” (Nexium, Jan 2007) to “if you have multiple risk factors...” (Lipitor 2006). Pfizer, for one, asserts that its DTCA helps “de-stigmatize disease” (Magee 4), but leading consumers to a conclusion also changes their expectations.

In terms of breaking or mitigating connections, prescription DTCA does not follow patent DTCA in its efforts to disrupt the relationship with physicians, but the current ads do make certain information irrelevant in the discourse. Of course, we must first remember that the FDA mandates the inclusion of statements like “talk to a doctor,” so the historical ads had more freedom to discount doctor intervention. Prescription DTCA instead typically downplays options, other than the advertised drug, which exist to manage a condition. One clear example of this approach is to mitigate the importance of diet and generic drugs. AstraZeneca’s ads for Nexium always begin with the message that acid reflux “despite treatment and diet change” (Nexium, Jan 2007) could be damaging the reader’s esophagus while Pfizer’s ads for Lipitor ensure patients know that “diet and exercise” (Lipitor, Dec 2007) may not be enough to avoid the need for medicine.

Nowhere in the advertising discourse for either company is any information to educate consumers on the proper diet they should consider or the availability of other medications. In fact, Kravitz notes that “patients may become angry when their physician insists on a low-fat diet...” and “I study found that as many as half of patients would register disappointment, and 15% would consider switching physicians, if their physician refused a request for an advertised prescription medication” (Kravitz 2244). In
regard to forms of treatment other than the advertised drug, Dr. Robert Jarvik is featured in one Lipitor ad telling the audience that “I take Lipitor instead of a generic: There is no generic form of Lipitor. If you switch, it will be to a generic of a different medication” (qtd in Huckman 1). Language such as this strongly devalues less expensive options than Lipitor in the consumers’ minds and enables Pfizer to continue posting Lipitor sales of over $13 billion per year (Bazell, Mar 2007).

Interestingly, prescription DTCA also mitigates the very elements which would support pharmaceutical companies’ claims that they might be educating the public in the discourse. For instance, the reverse side of the product-claim ads (see Figure 10) that must contain the listing of side effects and risks has the potential to convey extremely important information to consumers.

Figure 10. Reverse Side of Advertisement for Nexium – Sep 2006
In the Nexium ads, however, this text is so crowded and linguistically dense that many patients — up to one-third according to Henney — do not even attempt to read the information, thus making the print practically irrelevant to the situation. Instead, patients simply remember the drug’s brand name and go to doctors asking for the medication with only a surface understanding of the details.

In the case of Lipitor advertising, the design of the reverse side of the product-claim DTCA has the potential to make the most serious side effects of the drug irrelevant to both patients and physicians. In 1979, the FDA began to mandate that pharmaceutical companies place “black box warnings” (FDA 9) on labeling to indicate the most severe side effects of a particular drug. As part of that requirement, drug makers must include a black border around the text that informs readers of the most dangerous aspects of a medication. According to FDA guidelines, the black box warnings are supposed to indicate that:

- There is an adverse reaction so serious in proportion to the potential benefit from the drug (e.g., a fatal, life-threatening or permanently disabling adverse reaction) that it is essential that it be considered in assessing the risks and benefits of using a drug

  **OR**

- There is a serious adverse reaction that can be prevented or reduced in frequency or severity by appropriate use of the drug (e.g., patient selection, careful monitoring, avoiding certain concomitant therapy, addition of another drug or managing patients in a specific manner, avoiding use in a specific clinical situation)

  **OR**

- FDA approved the drug with restrictions to assure safe use because FDA concluded that the drug can be safely used only if distribution or use is restricted (e.g., under 21 CFR part 314, subpart H, § 314.520 “Approval with restrictions to assure safe use”).

A boxed warning can also be used in other situations to highlight warning information that is especially important to the prescriber. Information included in the WARNINGS AND PRECAUTIONS and CONTRAINDICATIONS sections should therefore be evaluated to determine whether it should also be placed in a boxed warning. (FDA 9)
Although the FDA has not made the labeling requirements for black box warnings a mandatory part of DTCA yet, many prescription ads use the black borders in their layout. The design of the Lipitor ads, however, features all of the text on the back of the product-claim ads in black boxes (see Figure 11). With this format, all of the side effects and risks are treated equally and highlighted without discretion in the discourse. Therefore, nothing truly stands out or is made relevant to patients and doctors because they become accustomed to seeing everything in black borders. Not only does this lack of connection to serious warnings prove more time consuming for busy physicians who must search through the text for meaningful data, but it also could prove dangerous to the health of confused patients.

![Figure 11. Reverse Side of Advertisement for Lipitor – Dec 2007](image-url)
Coming back to the purpose of our analysis of prescription DTCA's situated meaning as compared to the situated meaning of historical patent DTCA, we can see that there are a few differences between the two discourses. Unfortunately, these differences do not support the pharmaceutical companies' claims that they are using DTCA to educate consumers about conditions or diseases. Instead, any significant changes in the ads - as compared to the historical ads - typically result from factors which are essentially beyond the companies' control and reflect how businesses react to potential legal issues that impact drug advertising. For instance, prescription DTCA's frequent use of modal verbs to soften their claims about medications and advisory statements to consult physicians are elements we did not see in patent DTCA. However, the drug companies use these new elements as a way to avoid sanctions by the FDA versus as a tool for educating readers. We also saw how the FDA laws have made the addition of side effect and risk listings a part of prescription DTCA, but the pharmaceutical companies only comply with the necessary information that focuses on the advertised drug. The companies rarely offer any additional information that does not directly relate to the medication. As a result, the reverse side of product-claim ads hardly encourages close reading, and consumers often find it difficult to glean any substantial information about a disease or condition from the DTCA.

Therefore, in terms of situated meaning, we cannot ignore the strong similarities which exist between the two discourses. Both patent and prescription DTCA tend to use language in a motif that builds connections between potential common health conditions and the consumers. The main difference is that in the patent DTCA, like Lydia Pinkham's Vegetable Compound and Peruna, just about any symptom could be included
in the ads. Although, today the FDA keeps strict controls on the pharmaceutical companies which forces drug companies to be more specific in the listed indications, the prescription DTCA still evinces a desire to use fear as a way to make the ads relevant to readers.

In addition, both patent DTCA and prescription DTCA consistently structure the text of ads towards a theme that implies a condition is degrading the quality of consumers' lives and only the advertised drugs can help. In that regard, very little has changed between the directives in Lydia Pinkham’s Vegetable Compound ads that “No other medicine has such a track record of cures...” and “Refuse to buy any substitute” (Pinkham 1906) and Dr. Jarvik’s assertion in the Lipitor ads that any generic drug would not be acceptable. Both discourses also tend to use syllogisms to help normalize or medicalize the prototypical simulations the public uses to make decisions.

Finally, the text of both discourses contains elements which make other options irrelevant even if they could be effective to a given condition. In the past, the connection between patient and physician was broken because patent DTCA had the freedom to eliminate the interaction. With FDA requirements as to wording, prescription DTCA does not have this same freedom, but chooses instead to break the connection to future decisions about generic drugs and lifestyle changes.

Overall, in terms of situated meaning, prescription DTCA appears to approach the building task of connections in a way that does not clearly indicate a genuine desire to enact any other situated meaning than that of advertising. To ensure we are giving the discourse a fair examination, however, we will look at the ads through one final building task – that of sign systems and knowledge – in the next chapter.
CHAPTER 4

SIGN SYSTEMS AND KNOWLEDGE

Thus far, we have seen how the building blocks of a discourse like pharmaceutical advertising shape meaning through identity and connections. However, these elements are far from being the only means of creating a context for a situation. In fact, authors must work continuously to reinforce the "reality" (Gee 11) which is their ultimate goal for a particular discourse. A corpus will exhibit these other means of accomplishing a desired effect, or the "who" doing "what," through many building tasks. Besides the tasks of identity and connections that we discussed in earlier chapters, a discourse will also tend to use visual images and text which make specific sign systems and knowledge important to a situation in an effort to foreground particular elements (Gee 13).

This chapter explores our corpus of advertising for this building task of sign systems and knowledge, again applying Gee's criteria for the task to the patent advertisements for Lydia Pinkham's Vegetable Compound and Peruna and the prescription DTCA for Nexium and Lipitor. An analysis of both discourses in this manner will give us another lens through which to view the similarities or differences between the two advertising formats. Ultimately, this study will determine if enough difference exists in situated meaning to support pharmaceutical company assertions that they not only sell medicines but also educate readers to shape them into well-informed patients.
Once more, Gee offers us assistance in doing a discourse analysis through his research questions for each building task. For the purpose of sign systems and knowledge, our prompts for exploration include:

1) What sign systems are relevant (or irrelevant) in the situation (e.g. speech, writing, images, and gestures)? How are they made relevant (and irrelevant), and in what ways?
2) What systems of knowledge and ways of knowing are relevant (or irrelevant) in the situation? How are they made relevant (and irrelevant), and in what ways?
3) What social languages are relevant (or irrelevant) in the situation? How are they made relevant (and irrelevant), and in what ways? (112-113)

The term “sign systems” may seem abstract at first, but this concept simply represents the various communicative tools we have at our disposal with which to convey an idea to others. Gee, in fact, strongly emphasizes that language is only one of many sign systems and that we tend to pull graphs, images, equations, and other non-language elements from our discursive toolbox in a way that helps us create situated meaning in a social interaction. More importantly, the way we structure and position these sign systems, and how we use them to make knowledge or belief claims, undeniably privileges – or values – one system over another (Gee 101).

More importantly, sign systems are the essential building blocks for the construction of various types of knowledge. Therefore, we can use certain sign systems, either alone or in combination, to privilege a specific form of knowledge in a discourse. Gee points out, for instance, that Native Americans, or “real Indians,” transmit their “cultural knowledge” through sign systems that are difficult for “non-Indians” to imitate (25). The gestures and speech patterns of “Indians” make a claim to cultural knowledge that closes a discourse to outsiders. Other forms of knowledge tend to have their own sign systems and are often privileged in pharmaceutical advertising.
Social knowledge is the term this thesis will use for the common or ordinary knowledge that is transmitted on an affective level through interaction with others in a group. This social knowledge usually takes the form of "everyday language" (Gee 101) and is mediated through the experiences of those around us. Social knowledge is difficult to quantify because it often privileges human emotions over factual data and relies on the recipient’s receiving and responding to stimuli. For this reason, Bertrand Russell referred to this type of knowledge as "knowledge by acquaintance" or "experient knowledge" because it is conveyed through direct awareness…of the thoughts, feelings and desires" (qtd in Hayner 423) of others. As this chapter will show, the testimonials in pharmaceutical advertising are particularly effective in constructing social knowledge because for the recipient "social knowledge amounts to some capacity for cheater-detection, and some information about the reliability of different types of people" (Kusch 11). Therefore, social knowledge can be privileged if readers of an ad believe a spokesperson or image to be genuine.

In addition to social knowledge, pharmaceutical advertising often uses sign systems that privilege or make claims to scientific and judicial knowledge. These types of knowledge tend to be – or at least appear to be – more fact-based and positivist, although both usually take advantage of rhetorical appeals to persuade an audience. Claims to scientific knowledge would depend on the presence of observable data while judicial knowledge would be privileged with the use of rules and standards for right and wrong. As we will see in this chapter, however, scientific and judicial knowledge, when used in advertising with outsiders (e.g. average consumers), effectively closes the discourse just as "non-Indians" are excluded from "Indian" discourse.
In order to further clarify the building task of sign systems and knowledge, Gee returns once more to the example of a business meeting that this thesis included in chapters 2 and 3. In the situated meaning of the business meeting, we said the person leading the meeting behaves and speaks in a particular way to gain recognition as the chair, thus the identity of the chair is situated in the discourse of the meeting. At the same time, the person leading the meeting would use specific language to make connections between what is said in the meeting to a time outside of the meeting. Furthermore, the meeting chairperson would also ensure that he/she uses a social language and gestures (sign systems) which privilege the business environment – or corporate knowledge – versus using sign systems which would be more appropriate for “everyday” conversation (Gee 101). For example, we would typically speak to peers and subordinates in a much more professional manner, so we would not use the same language, body movements, etc., in a business meeting that we would use when speaking to close friends. We can also think of sign systems as being the outcome of how well we understand the nuances of our rhetorical purpose.

In our study of pharmaceutical advertising, we can find many types of sign systems which imply a type of knowledge, but this chapter will pay particular attention to the various non-language sign systems, such as images and ad design, in the discourse. In addition, the social languages used throughout the unregulated patent DTCA and today’s FDA-monitored prescription DTCA will equally inform our determination of drug marketing’s situated meaning. Ultimately, this chapter will show how these sign systems work together to make certain types of knowledge – specifically social, scientific, and judicial – relevant (or irrelevant) in the discourse. It is important to mention at this point
that some of the elements which will be discussed in this chapter as communicative signs were also mentioned in the previous chapters as part of building identity or connections. This versatility is to be expected and occurs because, as Gee often notes, the components of a discourse usually function as multiple tasks within a single situation. So, a particular element of an ad, such as a photograph, can easily assist an author in building identity, connection, and, as we will see in this chapter, knowledge.

Images played a large role as a sign system in the patent advertising published prior to FDA regulation. As we saw in chapter 2, the images helped establish identity for the drug maker, but, in terms of communicative systems, they also served as instant-recognition symbols for anyone who saw the ads. From only a quick glance, a reader knew instantly which sectors of the population the drug maker was targeting. Lydia Pinkham’s Vegetable Compound ads, for example, usually featured the familiar face of the maker or a female who could be a sister of sorts to the reader. These images typically took up a large portion – in some cases over half the advertising space – of the ads, so it is evident that the Pinkham company saw these non-language sign systems as being equal in importance to the text in making a knowledge claim to potential customers. Since the drug was touted as being a wonder drug for “female weakness” (Pinkham, 1883), the images would certainly have captured the attention of women readers. Moreover, the visual aspect added weight and reinforcement to the many testimonials in the language of the ads.

Not surprisingly, Dr. S. B. Hartman’s company also positioned images in prominent areas of its Peruna ads to quickly convey the type of people who took the drug and to support the claims made in the textual component. More importantly, though, the Peruna
ads used graphics which demonstrated the company’s belief that a diverse portion of
society should be taking the medication. Like the Pinkham ads, the Peruna ads
consistently divided the allotted space equally between text and drawings, although the
Peruna ads included images of men, women, and entire families rather than focusing on
just one demographic. One ad, in particular, used a smaller drawing of a nun inset on a
much larger image of the orphanage to which she was assigned. The overall drawing
easily took up over half of the ad and effectively made the claim that major institutions,
such as “St. Vincent’s Orphan Asylum” (Peruna, 1899) were buying and using Peruna.
The layout (e.g. font type/size, borders, etc.) of the ads is itself a sign system because it
telegraphs the social knowledge that the authors want the audience to have after reading
the discourse. According to James Harvey Young, this aspect of the patent DTCA was
always a premeditated factor because “Distinctive type induced a feeling of
familiarity...[just as] pictorial symbols served the same function” (167). In the case of
Lydia Pinkham’s Vegetable Compound, the ads used repetitive lines printed in various
fonts that appeared in random places within an ad and continued into other ads for the
drug. For instance, one ad in 1879 (see Figure 12) used significantly different font from
that of the surrounding text to share the overall message of the ad in a few scattered lines.
This larger, bolder font loudly tells the reader that “MRS. LYDIA E. PINKHAM” is the
maker and that the drug is for “Female Complaints” and is a “METHOD OF CURE”
(Pinkham, 1879). Other Pinkham ads used bolding, underlining, or frilly borders to
capture these same thoughts in a few key areas of the text, such as in Lydia Pinkham’s
name or the allusion to female illnesses.
The Peruna ads mirrored the layout used in other patent DTCA, like Pinkham’s, because the Hartman company used different font sizes and types to help distinguish the drug and the people taking it. Most often, the Peruna ads employed a bolded headline like “PERUNA PROTECTS THE FAMILY. Coughs and Colds. Grip and Catarrh” (see Figure 13) at the top of the advertising space to encapsulate the most important information. This formatting was a way for the Hartman company to impart social knowledge because, if the consumers were to read only the aforementioned text, they would still walk away with a coherent message about the patent medicine.
PERUNA PROTECTS THE FAMILY.
Coughs and Colds. Grip and Catarrh.

The Roberts Family, of Pella City, Neb., Are Healthy and Happy—A Rare Sight in These Days. They Say,
"We Think Peruna Is The Greatest Medicine On Earth."

Mr. Carl T. Robbins, of Lincoln, Nebraska, is active and strong and all of his
children—four—are healthy and happy. Mr. Robbins is not subject to repeated attacks of old
chronic colds. He is a practical man and believes in Peruna for his family, but a practitioner, in a
private letter to him, recommends something else which has been greatly resisted by
his family. Peruna, he wrote, is the best medicine for the prevention of colds in the family.

"Our boys, James, had them both bronchitis and pleurisy, and after he recovered he was
object to another attack of flu and fever. Our boys, Walter, was also object
to chronic catarrh and pleurisy. Our third boy, John, was subject to attacks of
chronic bronchitis. Your remedy, Peruna, cured my boys, and now I have none of
these troubles, and I am happy to report that Peruna has been given to
my family. Peruna is a household medicine, A complete work on chronic catarrh
sent for any address by The Peruna Medicine Co., Columbus, Ohio.

Figure 13. Advertisement for Peruna – 1901

The patent drug makers used the imagery and layout of the ads to appeal to the
effects of consumers and to thus privilege social knowledge about medicine and
illness. Of course, to fully develop a message, the non-language aspects of the patent
DTCA worked in combination with the social languages in the discourse. According to
Gee, multiple social languages or voices in a discourse are common and have the
potential to make a corpus "heteroglossic...[or] 'double-voiced'" (37). We can see this
mix of social languages in patent DTCA because it tended to be composed of two
different voices. The first voice was the authoritative, pseudo-scientific language we
might expect to hear from a patent drug company trying to work its way into the
discourse of the medical profession. The words of the third-person narrators in the Lydia
Pinkham Vegetable Compound and Peruna ads, for example, were authoritative because
they set the tone that both companies knew what was best for not only sick consumers but also for physicians. Thus, the ads placed emphasis on scientific knowledge in lines such as “For all Weaknesses of the generative organs of either sex, it is second to no remedy that has ever been before the public” (Pinkham, 1883) and “…a certain, absolute cure for catarrh is a public good” (Peruna, 1899).

The words in the ads also typified the medical terminology which was probably intrinsic to insiders of the medical profession but often unfamiliar, yet persuasive, to the public. The ads for Lydia Pinkham’s Vegetable Compound, for example, often stated the drug was good for “Falling of the Uterus, Leucorrhoea, Bearing Down Feeling…” (Pinkham, 1879) without specifically explaining the terms or the stated indications. The ads for Peruna from 1885 to 1901 overwhelmingly favored the term “catarrh” (Peruna, 1899) and used it for just about any condition imaginable. In fact, in Dr. Hartman’s opinion catarrh could mean anything from appendicitis to mumps to female complaints to “whatever ails you” (Adams 13). The abundant use of strange, medical-sounding terms with no clear definition – but with the appearance of scientific knowledge – was therefore one of the most criticized features of patent medicine advertising. Samuel Hopkins Adams scathingly reprimanded the patent medicines or “subtle poisons” (32) for persistently using terms not readily known to the scientifically ignorant, yet hopeful, consumer.

The second voice we hear in patent DTCA is that of the average person engaged in everyday social conversation. The drug makers relied heavily on testimonials to help them sell the patent medicines because the words of people who could be perceived as a reader’s family or friend were extremely convincing. Therefore, the language the ads
used to create this familiarity had to be simple and homespun. One ad for Lydia
Pinkham's Vegetable Compound, for instance, featured the testimonial of a young
woman who stated, "It was highly recommended to me by a friend. Now I feel like a
different girl; no more aches and pains. I am praising it to every one" (Pinkham, 1896).
Employing this same type of social language, a testimonial in an ad for Peruna declares,
"I feel like a different person already. A number of my friends have used it, and they
think it is a wonderful remedy" (Peruna, 1886).

The construction of this social language, with its direct sentence structures and easy
vocabulary, shows that the drug makers wanted the discourse to be conversational. As
mentioned earlier, this type of language is a good way to transmit social knowledge
because the participants feel as though they share experiences within a relationship. Of
course, many authors (Adams; Young; Bok) have questioned whether the testimonials
were really written by consumers or were fabrications of the patent drug companies, but
consumers seemed to react favorably in either case. In terms of privileging a particular
social language, patent DTCA divided the advertising space equally between the two
different sign systems, so we can see that they did not necessarily privilege one above the
other. Instead, the patent drug makers preferred to keep the two languages working in
tandem to make an assertion to the reader.

An important point to note, however, is that the patent DTCA did not privilege
scientific knowledge or value any language or information in the ads that was not directly
related to the advertised drug. For example, no patent advertising ever mentioned the
causes for a condition or the alternative choices available for alleviating an illness.
Instead, the patent DTCA included text in every ad that directed readers to write to the
drug maker for more information about healthcare issues rather than waste advertising space to any educational material. The Pinkham company, for instance, had its “Guide to Health” available for requestors while the Hartman company offered a booklet entitled “Ills of Life.” These information pamphlets, however, often turned out be nothing more than additional advertising for the patent medications (Adams; Young).

As we saw earlier in this thesis, patent DTCA provides us with a good example of a discourse whose primary situated meaning was the advertisement of a product to the public. In the building task of sign systems and knowledge, the patent DTCA once again supported this “who doing what” of advertising in a number of ways. The non-language sign systems – the images and format – facilitated the social knowledge about the drug that the patent medicine companies hoped to convey. The social languages, also key sign systems, in the text of the ads allowed the audience to hear both the voice of a knowledgeable “medical” professional and the familiar voice inherent in everyday interaction with friends. These sign systems were intensely focused on the product and combined to make knowledge claims about the patent medicines which would help increase overall sales of the drug.

With our awareness of patent DTCA’s situated meaning, we can now analyze in comparison today’s prescription DTCA, also examining its use of sign systems and knowledge as a building task. As in previous chapters, our focus will include similarities, but will ultimately search for any key differences the prescription DTCA have from the patent DTCA. Significant differences we find in the use of sign systems and knowledge would help support pharmaceutical company assertions that they are doing much more than advertising a drug.
As a communicative tool, images have certainly retained their value to the discourse of drug makers. In fact, the modern ads have access to techniques, like color photography and digitally generated graphics, that patent medicine manufacturers could only have imagined. Therefore, the visual aspects of prescription DTCA today are eye-catching with their true-to-life representations of people and products. If we were to look solely at the images in the ads for Nexium, for example, we would always see the pill – in its lifelike purple and gold form – that the AstraZeneca company is featuring. The image of the pill silently makes the claim that only this particular drug is going to help heal acid reflux, so the consumers need to know exactly what the pill looks like when they request it from their doctor.

The Nexium ads also use photographs of everyday people who look healthy and happy, but, as we soon discover, are unaware of their problems. The people featured in the color photographs are fathers, teachers, grandfathers, etc., and all look toward the camera with smiles and robust demeanors. In one Nexium ad, for instance, a father is laughing with his children as they all play in a tree house together. At first glance, the reader gets the impression that this is a normal family doing everyday activities. But, the captions inset on the photos actually disprivilege the happy scenario in the photo with warnings about the impending illness that is ready to strike down the father. Even though the photographs take up over half of the advertising space, the captions take precedence with statements such as “Knows they have homework. Knows they have chores. Knows their favorite hiding place. Doesn’t Know acid reflux may be damaging his esophagus” (Nexium, Sep 2006). Suddenly, what the readers initially thought they knew turns out to be incorrect.
The ads for Lipitor use color photographs in ways that not only build social knowledge but also make vague claims to scientific knowledge in order to add prestige to the captions. At the top of every ad, the ubiquitous representative of Lipitor – Dr. Robert Jarvik – gazes calmly at the reader with a reassuring smile. He wears a white lab coat and a blue-plaid shirt whose colors exactly match the colors in Pfizer’s blue logo that appears at the bottom of the ads. If we look closely at the image, we also see other people wearing white coats in the background. In fact, Dr. Jarvik and these other people appear to be standing in a laboratory of some kind (see Figure 14).

Figure 14. Advertisement for Lipitor – Dec 2007

Without even reading the text, the reader can quickly look at the photograph and conclude that this is a group of medical professionals engaged in scientific endeavors.
This assumption can lead readers to believe the group will share reliable, scientific knowledge with them. The captions inset onto the photograph then use another type of non-language sign system – numerical percentages – to further support and privilege this idea. For example, Dr. Jarvik himself assures the reader that “Lipitor lowers bad cholesterol 39-60%...” (Lipitor, Dec 2007). Statistics such as these, although not fully explained in the ads, can be very persuasive to an audience which is uneducated about the medical studies.

Other non-language sign systems in the prescription DTCA are equally reminiscent of the patent DTCA because the ads depend on formatting to privilege a message and make a knowledge claim about the drugs. AstraZeneca is especially creative at doing this in its layout for the Nexium ads. All we have to do is look at the colors used in the design of the ads to see that they foreground a correlation to the “little purple pill” (Nexium, Jun 2007). Every ad for Nexium uses a purple background to the textual fields of the ads. In addition, most of these ads separate the textual element from the visual component with a small gold line. Each of the captions for the image at the top of the ads is also underlined in gold. In combination, these colors – purple and gold – call to mind the exact drug Pfizer is marketing in the situation. In effect, looking at the ad’s visual cues in their entirety is the same as looking at one of the Nexium pills.

Moreover, the Nexium ads echo a technique we saw in the patent DTCA for Lydia Pinkham’s Vegetable Compound by strategically placing bolded lines of text – again in AstraZeneca’s trademark purple – in random positions throughout the advertising space. These lines are in a larger font size than the surrounding text, so they quickly stand out to the reader. One Nexium ad (see Figure 15), in particular, demonstrates how scattering
key lines of text and using various non-language sign systems can effectively come
together to build social knowledge in prescription DTCA. First, this ad’s entire
background is a single, color photograph of a woman wearing a red scarf. The red scarf
is carefully positioned in the image to represent the woman’s irritated esophagus. We
soon learn this is true because a font – in a different type from that of the rest of the ad –
is superimposed on the length of the scarf claiming, “Behind this scarf acid could be
burning the lining of her esophagus” (Nexium, Jul 2006). To reinforce our knowledge as
to how dangerous acid reflux can be, the scarf is knotted around the woman’s neck. As is
the typical color scheme for Nexium ads, the woman is wearing a light purple shirt and is
standing against a dark purple backdrop. The graphic of the purple and gold Nexium
capsule is positioned close to the woman’s heart.

Figure 15. Advertisement for Nexium – Jul 2006
This Nexium ad then employs the technique of formatting certain lines in a different font type/size in a way that communicates a coherent message even if readers were to only read those lines. As shown in Figure 15, the resulting message from the scattered lines in this particular ad is:

IT'S DIFFERENT FOR PEOPLE WITH ACID REFLUX DISEASE. Because beneath the heartburn, something more could be brewing. Acid reflux disease can damage your esophagus. NEXIUM heals the damage. Talk with your doctor about Nexium. FOR A FREE TRIAL OFFER, Visit PURPLEPILL.COM....

(Nexium, Jul 2006).

The ad does mention a medical condition, but the focus of these carefully placed lines is directly on the prescription drug that AstraZeneca is advertising.

An example of a Lipitor ad which effectively ties together several non-language sign systems to build social and scientific knowledge is shown in Figure 16. The photograph and graphics of this ad dominate over half of the advertising space. The photograph shows Dr. Jarvik in casual street clothes this time versus his usual white lab coat. The caption under the image privileges this apparel as it states Dr. Jarvik is “Inventor of the Jarvik Artificial Heart and Lipitor User” (Lipitor, Nov 2007). Thus, the readers now know that Dr. Jarvik is not only a medical professional but also one of the audience members – an insider who shares their social knowledge.

In the photograph, Dr. Jarvik stands in front of a dark background in which we now see a much-larger, realistic scan of a human skull and brain. Subtly, the image makes the claim that Dr. Jarvik also possesses scientific knowledge because he can discuss aspects of the brain. To the side of the brain scan and Dr. Jarvik, the ad also privileges a numerical statistic stating, “...Lipitor reduces risk of stroke by 48%” (Lipitor 2007). Directly under the photograph, this Lipitor ad shows a blue field which coincides with the
colors Pfizer uses for their logo. The familiar blue font is then carried over into the remaining textual component of the ad for continuity. As with the Nexium ads, the Lipitor ads use these non-language sign systems to privilege the medication, and any stated symptoms of a health condition are usually re-routed back to the drug.

![Figure 16. Advertisement for Lipitor – Nov 2007](image)

Short quizzes, another innovative method for communication, also appear in prescription DTCA to help build a perception of scientific knowledge about a drug. Nexium ads, for example, sometimes use a three-question, true/false quiz for readers to answer. The questions include such statements as “If I have heartburn, I shouldn’t worry about it” (Nexium, Sep 2006) and are portrayed as attempts to dispel myths about acid reflux. Of course, the answer to the question previously mentioned is “False” (Nexium,
Sep 2006), so the non-language sign systems again bring the reader’s attention right back to the advertised drug. The quizzes in prescription DTCA are unique elements that invite consumers to read themselves into the ads as they answer the questions.

The language sign systems in prescription DTCA also have a great deal in common with the patent DTCA because we again hear multiple voices in the discourse just as we did in the historical ads. Whereas the patent DTCA showed two distinct social languages working together, however, the prescription DTCA shows a tendency to use three languages which ironically do not work as well in combination. First, prescription DTCA mirrors patent DTCA in that it often speaks to the readers in the social language of everyday conversation. The ads for Nexium, for example, often use humor in the short, declarative sentences which form the captions for the visual elements. One ad demonstrates this when it alludes to an old, familiar joke as it states, “Knows no dog has ever eaten any homework” (Nexium, Jun 2007). Other prescription DTCA continues to use testimonials in the form of well-known spokespersons, like Lipitor’s Dr. Jarvik, who talk to the audience in simple-to-understand language and appear to take the readers into their confidence. These conversations with the readers are not very different from the interactions we usually have with friends or family.

Next, prescription DTCA uses the authoritative voice usually reserved for the scientific language of medical professionals in a way that is similar to the language in patent DTCA, although the tone in today’s advertising appears to be more tentative in its approach at times. Just as a physician would first diagnose a problem and then prescribe treatment for it, the prescription DTCA tells the readers what their health problem probably is and what the treatment – the advertised drug – should be. The Nexium ads,
for instance, begin with bolded headlines such as “Even if you’re treating your heartburn, you may still have damage” (Nexium, Jun 2007) and “This condition may affect 1 in 3 people with acid reflux disease, and if left untreated, could get worse” (Nexium, Jan 2007). In participating in the language of medical experts, prescription DTCA does provide an explanation, of sorts, for the indicated health condition, but the clarification normally comes in the form of parenthetical definitions which do not fully expound on the causes or symptoms.

Instead, the ads tend to make social knowledge more relevant than scientific knowledge because they give one or two distinguishing features of the stated health concern and then return quickly to the brand name of the drug. Nexium ads, for instance, prefer to state, “If you suffer from acid reflux disease – persistent heartburn 2 or more days a week, despite treatment and diet change – you could have serious damage to your esophagus and not know it” (Nexium, Jan 2007). In this statement, acid reflux is defined in a parenthetical manner as stubborn heartburn even though many other symptoms are typically present if a person genuinely has acid reflux. Pfizer’s ads for Lipitor use the same method of definition in the discourse, but their primary emphasis is on defining the drug rather than the health issue. For example, Lipitor ads usually begin with the line “LIPITOR is a prescription drug” (Lipitor, Nov 2007) and proceed to list what Lipitor’s distinguishing features are. The ads tell readers that “It [Lipitor] is used in patients with type 2 diabetes, and at least one other risk factor for heart disease…” (Lipitor, Dec 2007), but do not explain what the term “heart disease” can encompass.

In addition, the ads continue the vague scientific discussion with a remedy for the health problem. Naturally, pharmaceutical companies want to sell their products, so the
prescription DTCA offers a cure in the form of the advertised drugs. Nexium ads make a claim to scientific knowledge when they state the drug “not only provides 24-hour relief from heartburn” but also “can heal even the most severe erosions in the esophagus caused by acid reflux” (Nexium, Jan 2007). At the same time, this knowledge is made less relevant when the language in the ads significantly modulates the phrasing with qualifying words, such as “if,” “may,” and “could” that conflict with the confident timbre we would expect of a licensed medical professional. The ads also include the reminder that “only a doctor can determine if you have this condition” (Nexium, Sep 2006), but this statement is a requirement of the FDA and establishes the third voice – that of legal professionals – in prescription DTCA.

Pharmaceutical companies predominately use language to build judicial knowledge in their DTCA in a way that was unheard of in historical, patent medicine advertising. Ironically, this third voice of prescription DTCA has evolved through FDA laws pertaining to “product-claim” ads. These ads allow the drug manufacturer to focus on specific prescription medications and the situations which would indicate the need for the drugs, but in presenting a drug to the public, the drug company must follow a set of rules the FDA outlines. For example, a product-claim ad “must present a ‘fair balance’ of benefit and risk information” and “if they are in print, contain a ‘brief summary’ of a drug’s side effects, indications and effectiveness” (NIHCM 14). Interestingly, these FDA rules inadvertently set up a unique, and often conflicting, combination of marketing and legal genres for the prescription DTCA.

In fact, the juxtaposition of social languages in product-claim DTCA establishes a context in which the consumers receive information in a discordant mixture.
Furthermore, when the building task of “sign systems and knowledge” is used to analyze the ads, an indication of how “various ways of knowing” (Gee 112) can affect meaning and value becomes evident. For example, consumers reading the front page of a Nexium or Lipitor ad will hear the voice which tells them that the advertised drug is safe and indicated for the stated condition. However, since these product-claim ads are allowed to mention both a medicine and a medical condition, AstraZeneca and Pfizer must detail all of the FDA-mandated information, such as safety considerations and side effects, on the reverse or opposite page. This cautionary information develops from legal precedents in most cases, so the language sounds legislative in nature, is often difficult for the layperson to decipher, and ultimately seeks to avoid future lawsuits. The language of lawyers comes through in the densely packed text on the reverse side of Nexium ads, for instance, in a sea of terms that would understandably be impossible for average consumers to decipher:

Symptomatic response to therapy with NEXIUM does not preclude the presence of gastric malignancy. Atrophic gastritis has been noted occasionally in gastric corpus biopsies from patients treated long-term with omeprazole, of which NEXIUM is an enantiomer...Esomeprazole is extensively metabolized in the liver by CYP2C19 and CYP3A4. *In vitro* and *in vivo* studies have shown that esomeprazole is not likely to inhibit CYPs, 1A2, 2A6, 2C9, 2D6, 2E1, AND 3A4.... (Nexium, Sep 2006)

Thus, the reverse side of the ad issues a complex warning of serious effects of the drug while the front side of the ad promotes the drug as having “a low occurrence of side effects, which may include headache, diarrhea, and abdominal pain” (Nexium, Sep 2006).

Admittedly, the Lipitor ads do a slightly better job than the Nexium ads of interpreting the legal language for consumers and speaking in a more natural voice, but the overall result is identical. For example, the front side of Lipitor ads tries to allay the
fears of potential users with the statement “If you take LIPITOR, tell your doctor if you feel any new muscle pain or weakness. This could be a sign of rare but serious muscle side effects” (Lipitor, Dec 2007). This claim that negative effects hardly ever happen is encouraging to readers, but the reverse side of the ad complicates the knowledge by stating the “muscle problems...can lead to kidney problems, including kidney failure...Your chance for muscle problems is higher if you take certain other medicines with LIPITOR” (Lipitor, Dec 2007). Suddenly, the muscle problems take on a greater significance for consumers, and the ad never explains what other medications might cause these life-threatening issues in combination with the advertised drug.

The two different intentions in the languages – encouraging versus warning – have separate and distinct situated meanings of their own and thus affect the knowledge the consumer derives from the ads. Gee points this out in his own analysis of two social languages he observed on the label of an aspirin bottle:

The first speaks with a lawyerly voice (who) responding to specific potential legal problems and court cases (what); the second speaks with the official voice of a caring, but authoritatively knowledgeable company (who) trying to protect and advise people, especially women and children, while still stressing that aspirin is not particularly special or dangerous compared with drugs in general (what). Of course, the second who-doing-what sits in some tension with the first. (37)

This conflict between the languages – and the forms of knowledge – contributes to the reason why very few consumers actually take the time to fully read the text on the reverse side of the prescription DTCA. When faced with a choice between the social knowledge that a drug offers hope for a better quality of life and the judicial knowledge enacted through confusing language that acts as a disclaimer and strives to ward off legal problems, readers naturally gravitate to the former mode of communication. Studies have indicated that the complex wording of the legal jargon deters consumers from reading the
information in most cases (Murray et al, 513). The prescription DTCA appears to anticipate this action and relies on repeated imperatives to see a doctor for more information or training.

Therefore, prescription DTCA constantly repeats that consumers should see their doctors for an explanation of the language in the ads or – as patent DTCA once did – asks consumers to send away for a free pamphlet from the pharmaceutical company. This method of building knowledge works against the idea that the companies might use the ads to provide education about a disease or condition. In fact, both the non-language and language sign systems in prescription DTCA indicate that only the advertised drug is truly privileged in the discourse, and even most exhortations to talk to a doctor are in the context of asking for the drug. In their defense, pharmaceutical companies assert they refer readers to a physician for advice in order to better educate the public, but as David R. Hall found when he analyzed medical leaflets, “frequent exhortations to ‘see your doctor’ actually militates against the effectiveness and usefulness of these consumer product” documents (273).

Overall, in comparing prescription DTCA’s situated meaning to that of patent DTCA for the building task of sign systems and knowledge, the communicative signs of prescription DTCA do not exhibit strong differences which would validate the pharmaceutical companies’ assertions that the product-claim ads are educational material for the public. In both patent and prescription DTCA, the images, statistics, and social languages on the front side of the ads work together to build prestige for and social knowledge of the advertised drug. At the same time, the language on the reverse side of today’s ads – albeit a mandate from the FDA – privileges a voice that works in opposition
to the other sign systems. In fact, one has to wonder if the pharmaceutical company would even include this information if it were not directed in FDA guidelines because the density of the material detracts from the desired goal of marketing a product.

Moreover, when readers want to gain actual scientific knowledge about a disease or condition, the tiny print at the bottom of the ad does not offer much assistance. Instead, physicians are expected to know everything about all prescription drugs because they serve under the learned intermediary doctrine (LID) which "places the responsibility solely on healthcare professionals to ensure that patient-consumers are adequately warned, and thereby shields manufacturers from failure-to-warn suits" (Ronald, 288). Thus, the effect the sign systems have on the relationship between doctors and patients and their ways of knowing about a drug is exactly what has created considerable controversy today.

As this thesis has explained in previous chapters, however, we must pull together the various building tasks that function within a discourse in a comprehensive manner in order to validate an analysis of situated meaning. The next chapter will accomplish that goal by revisiting the building tasks of identity, connection, and sign systems and knowledge as well as reach a conclusion about the nature of "who doing what" in pharmaceutical DTCA.
CHAPTER 5

MAKING A VALID CONCLUSION

Over time, people interacting within a community or particular activity will establish a way of speaking and writing which has special meaning within the context of the group. Any new members to the group will either have to adopt these same ways of communicating or risk being ostracized from the others. This common way of speaking or writing within the group helps members form attachments and gain acceptance as insiders with the others. Therefore, the discourse used within the group will demonstrate a specific situated meaning or what Gee calls the "who doing what" (22-23) to convey ideas and messages. Gee further explains that:

The key to Discourses is "recognition." If you put language, action, interaction, values, beliefs, symbols, objects, tools, and places together in such a way that others recognize you as a particular type of who (identity) engaged in a particular type of what (activity), here-and-now, then you have pulled off a Discourse (and thereby continued it through history, if only for a while longer). (27)

It follows, then, that when the insiders of a community want to make changes to their situated meaning, the discourse again should evince significant markers that show this desire for change to be true. Furthermore, the only way to genuinely know if a situated meaning has changed is to carefully analyze past examples of the discourse in comparison with new artifacts, examining both for the ways in which they build meaning. This comparison is necessary because "sometimes what we build is quite similar to what we have built before; sometimes it is not" (Gee 10).
The specific activity of advertising medications to the public is, and has been for a long while now, a subject of much debate in our society. As we saw in chapter 1, the fight to regulate what drug makers can say to the public started in 1905 with Samuel Hopkins Adams's *Great American Fraud* articles and continues today. Critics, past and present, of DTCA argue that the discourse is merely the language of marketers whose only concern is selling a product. The pharmaceutical companies today, however, assert that the new prescription DTCA has elements which not only talk about a brand-name drug they wish to sell but also are intrinsically educational about diseases and conditions.

Like it or not, consumers and their physicians have always been the targets of medicine advertising and therefore have the ultimate responsibility in deciding which advertised drugs are warranted. As early as 1800, Young points out that an editor stated about patent DTCA, "The vendors of patent medicines...in the U.S. are fattening on the weaknesses and folly of a deluded public" (32). The advertising continues to this day, so the constant barrage of multi-media print and television advertising forces consumers to make judgments about the content and claims. The consumer, unfortunately, is thus under considerable pressure to distinguish between selling technique and factual information. Therefore, the audience for drug marketing would benefit greatly from a close reading of the ads to better understand the intentions exhibited in the discourse.

The challenge for this thesis was to determine if the pharmaceutical companies' claims - that the situated meaning in their advertising was different from that of earlier drug advertising - is accurate. To accomplish this goal, the study had to include examples of drug advertising from the past because older artifacts of a corpus are essential in comparing the discourse across time. Since the non-regulated patent DTCA
theoretically falls within the same discourse community as the prescription DTCA, this study went all the way back to the advertising that Adams was so contemptuous of in his 1905 critiques. This study thus selected two samples – Lydia Pinkham’s Vegetable Compound and Peruna – from the many artifacts of patent DTCA available for use in this analysis because both patent drugs sold extremely well and were mentioned by name in Adams’s articles. These patent ads were then placed alongside two of today’s ads for prescription medications – Nexium and Lipitor – using Gee’s theory for examining situated meaning as the methodology for the comparison. The next concern of this thesis was to ensure that the method of analysis was valid. Once again, Gee’s theory of discourse analysis provides criteria which assists us in determining validity.

In fact, Gee discusses two criteria – coverage and convergence – which, if shown to exist in an analysis, can ensure the determination of whether a discourse’s situated meaning is valid. Gee explains that “the validity of the analysis will reside in how the ideas we can generate [from one set of artifacts] help to illuminate other data (coverage), data that we hope will lead us to similar constructions (convergence)” (Gee 154). In other words, unless we have these standards by which to judge a final determination, we cannot expect any analysis to be convincing. Therefore, this chapter will explain how this study of patent and prescription DTCA met both the criteria of coverage and convergence in its effort to do a sound analysis. In addition, this chapter will make a final assertion about the nature of prescription DTCA’s situated meaning and offer recommendations to pharmaceutical companies in regard to their advertising.

Coverage, as Gee defines it, is the premise that “the analysis is more valid the more it can be applied to related sorts of data. This includes being able to make sense of what
has come before and after the situation being analyzed..." (114). With that idea in mind, this study began its analysis of pharmaceutical advertising with a search for artifacts that were representative of a corpus of patent and prescription DTCA. The amount of material available for historical and current drug advertising is overwhelming to say the least. With the set of artifacts in hand, this thesis then examined the patent DTCA that predated today’s prescription drug advertising for indications of the construction tools or building tasks that Gee provides in his theory of discourse analysis. It quickly became apparent that any of Gee’s building tasks would have been appropriate for looking at the pharmaceutical advertising, but this study focused on identity, connections, and sign systems and knowledge because these methods for creating reality within the situated meaning were most evident.

The study then employed the same analysis for the building tasks of identity, connections, and sign systems and knowledge to make a fair and consistent analysis of the prescription DTCA. Although other building tasks were clearly present in prescription DTCA, the study did not deviate from those elements used to evaluate patent DTCA. In this way, the thesis achieved the validity marker, as Gee defines it, of coverage and could progress to the issue of convergence.

The premise that a corpus will tend to have the same situated meaning – who doing what – the more the building tasks meld within and between artifacts was an extremely important factor for this study’s overall purpose. According to Gee, “a discourse analysis is more, rather than less, valid (i.e., ‘trustworthy’), the more the answers to the [questions outlined in his building tasks] converge in the way they support the analysis or, put the matter the other way round, the more the analysis offers compatible and convincing
answers to many or all of them” (113). Therefore, this thesis predicted that if the analysis did not result in significant convergence of the building tasks in patent and prescription DTCA, the likelihood that their situated meaning was the same would be very small. This outcome would then have supported pharmaceutical companies in their argument that prescription DTCA has an educational role about diseases and conditions and is not simply a marketing tool for the drugs. On the other hand, if there were considerable, or possibly absolute, convergence between patent and prescription DTCA on the building tasks, the prescription DTCA’s situated meaning would be identical to historical examples of medicine advertising and would not lend credence to the idea that prescription DTCA is different from earlier drug advertising.

Considering the criteria of convergence, we can see that the building tasks of identity, connections, and sign systems and knowledge in patent DTCA came together in a number of ways in the visual and textual components of the ads to highlight a company selling a product. First, the visual component functioned to build both identity and sign systems and knowledge. In previous chapters, we discussed how the Pinkham and Hartman companies carefully crafted the identity they wanted to be perceived as having in the discussion of healthcare through the illustrations of people who were safely and happily taking Lydia Pinkham’s Vegetable Compound and Peruna on a daily basis. The Pinkham company centered its imagery on women, especially on Lydia Pinkham herself, because the medication was supposed to be good for “female weaknesses” (Pinkham, 1883). The illustrations of the caring, motherly figure of Lydia Pinkham helped solidify her authority to speak to other women on the subject of their medical needs. As times changed for women, the Pinkham company also became adept at creating new images of women, or
"working girls" (Pinkham, 1896), in the workplace to maintain the drug maker's role of advisor to women. As for the imagery in the Peruna ads, the Hartman company went after practically everyone in the general public, as the DTCA clearly demonstrated with ever-changing drawings of men, women, nuns, congressmen, and entire families. The Hartman company clearly wanted the position of medical expert and authority for all consumers. Both patent drug makers, therefore, visually conveyed the image they wanted to have with society.

But, as previously mentioned, identity for the companies was only one part of the value of visual components because they worked equally well for the building task of sign systems and knowledge. The illustrations of the female customers in the ads for Lydia Pinkham's Vegetable Compound, as non-language sign systems, communicated to women who might not be using the drug that they too could trust the medication to be effective. Considerable advertising space – up to half the page in most cases – was devoted to the drawings of average women said to be taking the drug, so the Pinkham company obviously realized a way to fully engross a female reader who might otherwise bypass the ads. In keeping with its identity, the Hartman company's imagery in the Peruna ads made the claim to consumers that a wide variety of people believed in the efficacy of the medication. After all, one ad even subtly indicated that an entire orphanage was using a steady supply (Peruna, 1899).

The layout of the ads was another non-language sign system that greatly affected awareness of the patent drugs (identity) and easily merged with the task of building connections. In particular, randomly scattered lines of text – in a distinctively different font type/size than that of surrounding lines – ran throughout the layout of the ads for
Lydia Pinkham’s Vegetable Compound and formed a coherent message to readers when the lines were joined together. This sign system not only made the knowledge claim that the drug was a “METHOD OF CURE” (Pinkham, 1879) but also helped women change their ideas of what should be considered normal or abnormal, one of the common motifs in patent DTCA. As we saw in chapter 3, the treatment of common symptoms as a problematic condition influenced consumers’ “prototypical simulations” (Gee 95-96) for illness. In this case, simply being female somehow connoted a weak character that must be treated with a chemical remedy. The Hartman company’s imagery capitalized on this theme too, but they exhibited a layout that privileged a larger audience for its product in an effort to also help a diverse population make the connection that certain illnesses, like the ubiquitous “catarrh” (Peruna, 1899), were universal to all members of society – another motif of patent DTCA – and must be cured with multiple bottles of Peruna.

The textual component of the patent DTCA complemented the messages of the visual element and demonstrated convergence in its overwhelming compatibility in all three building tasks of identity, connections, and sign systems and knowledge. In terms of identity, we saw how the Pinkham company avoided direct “I” messages that might divert attention away from the manufacturer’s authority in discussions of the drug. Only the testimonials, for example, for Lydia Pinkham’s Vegetable Compound and Peruna directly addressed the readers; otherwise the ads were narrated in a third-person, authoritative voice. This detached tone allowed the patent drug makers to escape some accountability and preserve the perception that the patent drug makers were every bit as professional about medicine as the regular physicians.

The text of patent DTCA then continued the separation from medical doctors as it
tried to break connections and assume multiple social languages to effect knowledge. For example, we discovered that Peruna ads were very straightforward in their attempts to make physicians irrelevant with persistent assertions that nothing but the drug was effective. This was a common theme in patent DTCA as “throughout history [promoters] have used a monistic theory with a one-shot therapy, and the panacea is the medicine advertised” (Young 170). Testimonials such as, “I did not call the doctor, but used your medicine” (Peruna, 1899), showed readers they could save themselves the trouble of visiting a physician. The duality of the language sign systems reinforced this premise as the authoritative, “scientific” voice in the ads talked about symptoms in vague terms – like the “bearing down feeling” (Pinkham, 1879) that all women were reportedly suffering from – and collaborated with the everyday conversational voice of eager users of the drugs.

Without question, the building tasks of identity, connections, and sign systems and knowledge that we observed in patent DTCA converged within the discourse to depict a patent drug maker (who) focusing all of its energy and advertising space to concentrate on a product it was selling to the public (what). In fact, the patent drug makers did not typically claim to be doing otherwise, and this study found no evidence that the patent DTCA ever included much material of a truly educational nature. Thus, the entire situated meaning of the marketing was to sell a medication and keep consumers from going to the patent drug makers’ biggest competitor – regular doctors who would most likely dissuade patients from taking the advertised drugs.

Once this study had clarified the situated meaning of “what came before” (Gee 114) the current prescription DTCA, we could now apply the same criteria, or coverage, to
today’s drug advertising to identify where, if at all, convergence might take place. In the same building tasks of identity, connections, and sign systems and knowledge, our analysis found that almost every point already mentioned for patent DTCA is to some extent evident in and compatible with the current prescription drug advertising.

Prescription DTCA’s visual component, for example, is used in much the same way as it was in patent DTCA to build identity and make claims through non-language sign systems, but this study shows it has more potential to capture attention due to advances in print media and a change in approach to the public. As we saw in previous examples, the images still take up at least half of the advertising space but are now published in glossy, color photographs that feature people who appear to be healthy. The accompanying captions, however, simultaneously garner authority for the pharmaceutical company in the discourse and make a statement about who should be taking the drug. Unlike patent DTCA, prescription DTCA tends to spotlight people who are not yet taking the drug and address readers directly – making frequent use of “I” statements – to draw the public into making a connection between their own health and that of the person in the photograph. Thus, the current advertising has a more personal effect on its audience than the patent DTCA once did.

In doing so, the pharmaceutical companies assert their authoritative position by telling readers that the people in the photographs don’t know how sick they really are. Ads for Lipitor have emphasized this expert role even further by insisting on including Dr. Robert Jarvik in every ad as its official, credible spokesperson and superimposing his image against a laboratory-like setting in the background to make a statement about the trustworthiness of the drug. This use of a personal spokesperson goes back to patent
DTCA and works because “the perfect testimonial . . . must have the appearance of truth and must be acceptable to those who, from lack of special knowledge, are unable to recognize any fallacy that may be present” (Holbrook 231).

The versatility of prescription DTCA’s non-language sign systems when moving between the building tasks shows convergence in its efforts to keep the readers’ focus on the advertised drug. This premise is especially evident in the formatting of the ads. The ads for Nexium, for example, usually display a prominent graphic of the “little purple pill” (Nexium, Jul 2006) near the top of the ad to clearly identify the drug consumers should request from their doctor. In addition, every ad uses the purple and gold background that acts as a visual reminder of the pill itself. These non-language sign systems not only privilege the medication but also help build relevance (connections) in the readers’ minds for the drug and its brand name. Like the historical patent ads for Lydia Pinkham’s Vegetable Compound, the current Nexium ads have a proclivity for randomly scattering lines of text in a distinctive font to quickly convey a message about the drug when the lines are combined. Furthermore, the ads for Lipitor employ formatting – special blue font that corresponds to the Pfizer logo – that connects the drug to the company in the discourse and serves as a visual brand-name reminder to consumers.

In fact, prescription DTCA probably has a greater ability to build identity with consumers than did the patent DTCA since pharmaceutical companies now have a special avenue through reminder ads. As we discussed in chapter 2, the FDA’s alignment of ads into three separate categories – reminder, help-seeking, and product-claim – has had the side effect of allowing pharmaceutical companies to get their brand names out into the
public to assume a role and make connections without having to worry about discussing the health effects or risks of any particular drug. The reminder ads are especially adept in building identity for a company and making connections since the ads, by law, cannot mention the conditions for which a drug is advertised. This requirement allows the pharmaceutical companies to focus entirely on building a positive image as a manufacturer.

The visual elements definitely achieve several goals in the situated meaning of advertising, but the textual component – in the same way it did for patent DTCA – ultimately brings together all of the building tasks of identity, connections, and sign systems and knowledge to direct our interest to a drug. In addition to the “I” statements already mentioned in the discussion of imagery, the prescription DTCA uses language to simultaneously show affinity with physicians yet retain authority over the medicine discussion. The dilemma for today’s pharmaceutical companies is that – unlike patent drug makers who could separate themselves from regular physicians to avoid competition – they must send consumers to doctors in order to sell the product. Since physicians must be involved in the process to prescribe the advertised drug, the pharmaceutical companies must maintain rapport with the medical field. However, the language of the prescription DTCA is often authoritative even when referring to doctors. The ads for Lipitor, for example, consistently tell readers what doctors “should” be doing to effectively provide healthcare to patients. As one Lipitor ad remarks, “Your doctor should do blood tests to check your liver function before and during treatment…” (Lipitor, Dec 2007).

The textual elements also work in much the same way as patent DTCA once did to both make and break connections in the discourse. For instance, the syllogistic
construction of the discourse assists in the “medicalization” (Arney & Rafałovich 50) of common symptoms, thus enabling consumers to see a condition as being abnormal and needing a remedy – motifs we first saw in patent DTCA. Today, for example, we even see ads for Botox that establish the idea for consumers that wrinkles around a woman’s mouth or eyes signify an undesirable health condition that needs to be fixed.

Furthermore, prescription DTCA also relies on the frequent use of modal words, like “could” or “may,” in the discourse to force a connection to certain conditions while deflecting blame for any misdiagnosis that might occur.

Finally, the text in prescription DTCA often makes irrelevant other forms of care, such as diet and exercise or generic, less expensive drugs that would be just as effective. Interestingly, a recent class-action lawsuit was formed against the makers of the prescription drugs Zetia and Vytorin for this method of breaking connections. The ads for Zetia and Vytorin have claimed for the last several years that their drugs were more effective than generic brands, but studies have shown this claim to be false. Ironically for Lipitor, one of the ads analyzed in this thesis, the ads for Vytorin are notorious for their comparisons of Vytorin to Lipitor in their assertions that Vytorin “lower[s] bad cholesterol more than Lipitor alone” (Vytorin, Dec 2007). At one time, this comparison might have demonstrated how well Pfizer, the maker of Lipitor, was accomplishing its manufacturing goal since a competitor was using Pfizer’s drug as a benchmark, but now the legal action against the makers of Vytorin, and its advertising comparison, begs the question about Lipitor’s effectiveness. As a result, the scrutiny of Lipitor as “one of the most researched medicines” (Lipitor, Dec 2007) is sure to continue. In fact, Congress
recently expressed interest in questioning Lipitor’s spokesperson, Dr. Robert Jarvik, about misleading statements and practices in the DTCA (Saul).

The connections which are broken or established in prescription DTCA are further reinforced by and compatible with the sign systems of multiple social languages. Prescription DTCA, for example, mirrors the patent DTCA in its use of both authoritative and conversational social languages. Most of the ads we examined for Nexium and Lipitor exhibited the tendency to first diagnose a condition from stated symptoms and then prescribe a remedy – the advertised drug. In doing so, the ads included language that spoke to consumers as a friend or peer would. These two sign systems work well together, just as they did in patent DTCA, to build trust and highlight the advertised drug. FDA regulations, however, have influenced a third language in prescription DTCA that creates a fundamental problem for advertisers.

The text on the reverse side of product-claim ads in many ways negates the efforts of the social languages on the traditional marketing side of the ads. From a continuity standpoint, the risks and contraindications listed on the back of the ads do not converge well with the building tasks previously discussed. On the surface, this lack of convergence with what came before in the discourse might appear to indicate that the pharmaceutical companies are correct in their assertions that they are interacting in a different situated meaning, but in fact, the pharmaceutical companies have this third language thrust upon them. Read closely, the FDA-mandated text actually works against the pharmaceutical companies’ claims that they are educating consumers about diseases or conditions.
The tone on the front side of the ads, for instance, helps build the companies’ identity with its direct, conversational address to readers, but the reverse side of the ads abruptly breaks the connection with prescriptive language in a third-person, judicial voice. The material does little to educate a consumer about illnesses because this part of the advertising is only required to contain usage information about the advertised drug, and pharmaceutical companies do not usually add any other information that is not mandated. Interestingly, Harvard Business School also found that the listing of negative side effects of a drug, especially in the DTCA for Lipitor, actually decreased patients’ compliance with a prescription drug regimen (Wosinska). Furthermore, consumers often do not take the time to read through the complex wording. Instead, patients remember a few key phrases they might gather from the front side of the ads and depend on physicians to know all the benefits and risks of every prescription drug on the market.

As a result, product-claim DTCA has essentially de-privileged the interaction that doctors used to have only with drug companies, and consumers are now invited into a three-way conversation they may not be adequately prepared to have. Before the FDA allowed DTCA, pharmaceutical companies could only advertise to physicians, so doctors were better able to monitor claims about medications. Now, however, consumers are seeing many advertisements before their physicians do, and regardless of the multiple forms of sign systems in any drug ad, the patient ultimately seeks wording that promises relief from an adverse condition. Doctors claim patients now come to them, motivated by the DTCA, with only a surface knowledge of a drug. This situation has caused many critics of DTCA to lobby for changes in the learned intermediary doctrine – the legal framework that releases pharmaceutical companies from liability because courts ruled
the 1960’s) that doctors were in the best position to warn patients of all medication
dangers. The opponents of DTCA state the learned intermediary doctrine should be
changed to place more responsibility on the shoulders of the pharmaceutical companies
since the advertising bypasses the physician’s control (Ronald).

As it stands now, the superficial awareness of a drug and the connections established
to symptoms of a medical condition in DTCA’s situated meaning make some patients
feel they can enter into the medical discourse on equal terms with the other participants.
Pharmaceutical companies may create their ads with the ideal audience in mind,
intending to reach only people who understand they must rely on a physician’s training
for medical advice, but doctors are seeing patients who feel they now have the requisite
knowledge to debate the necessity of a medicine. Unfortunately, mass marketing
prescription medications is not the same as marketing other commercial products. The
ideal audience on a general population level does not exist because every medical
condition varies slightly from another. Thus, the risk of a patient’s misinterpretation of
an ad or a medical illness is a very real factor.

Of course, pharmaceutical companies claim they subvert this danger by including the
advice to see a doctor; however, the drug manufacturers cannot accurately claim that the
ads’ persistent encouragement to “see your doctor” is altruistic on their part. Once again,
these statements are FDA-mandated text that actually help the drug makers allay some
responsibility – under the learned intermediary doctrine – for genuinely educating
consumers. Even if the FDA did not require the wording, this tactic might not be as
effective as pharmaceutical companies might hope. First, relying on doctors to dissuade
the patient from taking a non-indicated medicine means that physicians must use valuable
time getting familiar with every new drug on the market and talking patients out of certain choices. Fearful of losing patients who might feel a doctor visit was not satisfactory (i.e. the doctor did not prescribe the requested drug), many physicians admit they sometimes prescribe a medication simply because the patient wanted it, as long as the drug would not harm the patient (Murray et al, 515). Second, most patients again do not have the training necessary to understand the complex interplay of symptoms and often are not able to distinguish their health issues from those indicated in the ads.

Therefore, upon careful analysis that included Gee’s validity criteria of both coverage and convergence, this thesis has determined that, for all of its advances in technology and FDA control, prescription DTCA has not moved very far – at least not significantly – from the situated meaning of patent DTCA. The pharmaceutical companies’ claims that they are using the DTCA to educate the consumers might be true to the extent that they are informing the readers about a drug on the market. But, the claim that they are providing education about diseases and conditions is not well supported in the analysis of their discourse. In fact, many of the elements of the ads make it difficult to find significant information about the causes of or preventative measures for health conditions and diseases. Rather the entire focus of prescription DTCA, as it was for patent DTCA, is promotion of the advertised drug and mitigation of competition.

In today’s society, there is nothing wrong with advertising medications as a marketing tool; however, if pharmaceutical companies want to show they are sincere in their efforts to educate consumers about diseases or conditions, they must demonstrate this desire in the DTCA. A recommendation this study would make to them would be to structure the discourse in a way that equally privileges information about medical
illnesses and treatments versus spending so much time on a particular drug. As we saw, pharmaceutical companies today already have a very effective way to capture readers’ attention as they build identity through reminder and help-seeking ads, so they could easily use that momentum to make information about lifestyle choices and alternative care more relevant in the images and text. In addition, the reverse side of product claim ads, while it must contain side effects and risks of a drug, could easily be transformed through a better balance of discussion for both drug and illness while using a social language which is more easily accessible to the audience.

While pharmaceutical companies might aspire to educate in DTCA, they are ultimately in business to make a profit. Therefore, consumers must look critically at prescription DTCA to determine the best course of action to take for their health concerns. As Dr. Marcia Angell, editor of the New England Journal of Medicine asserted, “...that’s not their [pharmaceutical companies] business, education. Drug companies are not in the education business. Medical schools and teaching hospitals are. It’s like expecting beer companies to educate people about alcoholism. It is not what they do.” So, even with FDA controls in place and further studies in progress, pharmaceutical advertising has the potential to be misleading, or at the very least confusing, for readers. Furthermore, through the comparison in this study, we can see that today’s prescription DTCA has not significantly distanced its imagery and text – and consequently its situated meaning – from the who doing what of patent DTCA (see Figure 17).

As consumers, we should remember that as early as the Renaissance, Galen said there were three factors which could do much to build a patient’s confidence in physic: “a
strong personality in whom the individual has faith;" "an environment rich in symbols;" and "suggestion" in a course of treatment (qtd in Harley 431), so we must be cautious when reading ourselves into the discourse of pharmaceutical advertising. As demonstrated in this thesis, Gee’s building tasks of identity, connections, and sign systems and knowledge can help illustrate the methods drug companies use to establish an image with the public, make certain information relevant or not, and manipulate the sign systems of medical discourse to influence patients’ decisions to request a drug from their doctors. Patient education through advertising, as espoused by pharmaceutical companies, could be beneficial for patient and doctor alike, but true knowledge should be an end result.

Figure 17. Advertisement for Lydia Pinkham’s Vegetable Compound – 1896 (left) and advertisement for Nexium – Jul 2006 (right)
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