Semiotics, Stereotypes, and Women's Health: Signifying Inequality in Drug Advertising

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Les publicités de produits pharmaceutiques s'inspirent des perceptions sociales pour construire la connaissance au sujet de ces produits. Le système juridique fournit un cadre analytique au sein duquel les sociétés commerciales agissent pour créer des publicités à l'intention des médecins qui font des ordonnances. La théorie sémiotique propose une méthodologie d'analyse structurelle de ces publicités qui visent à attirer l'attention des médecins et les persuader de prescrire leurs produits. Les sociétés choisissent des images susceptibles d'éveiller des résonances chez leur clientèle-cible, en puisant dans les valeurs et les opinions que ce groupe est censé partager et qui sont donc supposées les motiver. Les publicités visant le médicament de remplacement d'hormone Premarin™, qui ont été publiées dans des revues médicales des quinze dernières années ont fait l'objet d'une analyse sémiotique. Nous concluons que les publicités utilisent, comme valeurs structurelles sous-jacentes, des visions stéréotypées des femmes, de la ménopause et de la relation médecin/patiente. Cet emploi de l'inégalité dans les annonces publicitaires sape la position des femmes comme êtres autonomes qui prennent des décisions éclairées et n'est pas sans répercussions sur la santé des femmes. Il faut comprendre la puissance de ces images symboliques et rallier les médecins, les patientes et toutes les personnes chargées d'établir les politiques générales en cette matière pour les contrebalancer.

Drug advertisements draw upon social perceptions to construct knowledge about pharmaceutical products. The legal system provides a framework within which the companies operate in creating ads directed to prescribing physicians. Semiotic theory provides the methodology for an analysis of the ways in which pharmaceutical companies structure their ads to draw in physicians and to persuade them to prescribe their product. The companies select imagery that they expect to have resonance for their audience, drawing on values and views they are expected to hold and that are expected to motivate them. Advertisements for the hormone replacement Premarin™, which have appeared in professional journals over the past fifteen years, are analyzed using this methodology. We conclude that the ads use stereotypical views of women, menopause, and the doctor-patient relationship as underlying values in their structure. The use of inequality in the ads undermines women's position as autonomous decision-makers and has implications for women's health. The power of this imagery needs to be understood and counteracted by doctors, patients, and policy-makers.

Introduction

Drug advertisements draw upon social perceptions to construct knowledge about pharmaceutical products. Prescription drug advertising is carefully created to appeal to physicians who, along with dentists, have exclusive prescribing privileges in most jurisdictions. The techniques used by advertisers are intended to persuade doctors to prescribe the product. Advertising is successful when it draws upon the norms of the target audience and connects its message to these norms. Images that engage the interest of physicians and have resonance with their values and perceptions of health, medical practice, and patients provide the link to market success. Analyses of pharmaceutical advertising have demonstrated that the messages that doctors receive, about women in particular, are stereotypical, reductionist, and oppressive.[1] Such cultural messages, however, are difficult to regulate legally, as is demonstrated by commercial expression in fields such as tobacco,[2] which require careful drafting in order to be upheld under section 1 of the *Canadian Charter of Rights and Freedoms*.[3] While legal limitations on advertising, which arise in tort law and under federal food and drug regulation, create standards that manufacturers of prescription drugs must meet in conveying to doctors information about the risks, benefits, and efficacy of their products, apart from these requirements, drug companies are relatively free to construct images and shape knowledge of their product in advertising.

In this article, we examine how drug advertising is structured to appeal to physicians and to persuade them to prescribe specific drug products. Our aim is to alert women, physicians, lawyers, and policymakers to the subtle methods that are used by pharmaceutical companies in drug advertising and to demonstrate how particular stereotypical views about women are constructed through the images presented in these ads. Our analysis focuses on a series of ads for the drug Premarin, a hormone replacement used during menopause. These ads appeared in the *Journal of the Society of Obstetricians and Gynaecologists of Canada* from

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1. Deborah Lupton, "The Construction of Patienthood in Medical Advertising" (1993) 23 International Journal of Health Sciences 805; Elizabeth Ettore and Elianne Risk, *Gendered Moods: Psychotropics and Society* (London and New York: Routledge, 1995).
2. *RJR-MacDonald* v. *Canada*, [1995] 3 S.C.R. 199.
3. *Canadian Charter of Rights and Freedoms*, Part 1 of the *Constitution Act 1982*, being Schedule B to the *Canada Act, 1982* (U.K.), 1982, c. 11.

1986 to 2000. By looking at a series of ads for one drug during this period, we are able to track the advertising strategies used by the company over time. In addition, by focusing on hormone replacement therapy (HRT) in this study, we are able to assess the portrayal of women in menopausal and perimenopausal[4] stages.

The stereotypical and destructive portrayals of women that drive the advertising of this highly successful product should give women concern. We argue that the norms used to "power" the Premarin ads over a fourteen-year period stereotype and patronize women, undermine their efficacy as autonomous decision-makers, and have a counter-productive effect on women's health. In addition, we argue that the image and its "meaning" have the potential to create biases in diagnosis and treatment, while the legal framework for pharmaceutical advertising has seemingly been irrelevant in shifting the way that women are portrayed.

Relevant aspects of federal drug regulation and tort law will be discussed to provide the context for this problem. In the first section, we examine the controls that are exercised over drug advertising under the federal system of drug regulation. An analysis of the tort action for failure to warn of product risks indicates that courts have recognized the inequality in information and power between patients and companies and have incorporated this recognition into doctrines. The methodology section provides an explanation of semiotic theory—the theory of signs. This section describes the ways in which images make use of two kinds of hierarchical relationships—those that characterize a traditional medical/political culture and those that are found in society as a whole. In the next section, semiotic theory is applied to images and text found in six advertisements for the HRT Premarin. This analysis shows that stereotypes of women's lives, bodies, and menopause are used to promote the product to physicians. These stigmatizing images exert a subtle influence and structure the perceptions of physicians. Understanding the semiotic methods used to construct the ads and the stereotypes that are used in them will enable physicians and patients to resist the imagery.

Legal Context

Pharmaceutical companies are players with immense power in the health care system in North America. In the United States, pharmaceutical retail sales in 1999 amounted to US $111.3 billion, an increase of more than two-and-a-half times over the US $42.7 billion spent in 1991.[5] Prescription drug advertising in the United States had an annual budget of US $12.3 billion during the middle of the last decade—an amount that was higher than that spent on all undergraduate and postgraduate medical education and almost as much as the budget for the National Institutes of Health.[6] Direct-to-consumer advertising in the United States

4. The perimenopausal period is the period around the menopause.
5. Andrew Sullivan, "Pro Pharma," *New York Times Magazine*, (29 October 2000), 21, citing Prescription Audit, prepared by IMS Health.
6. Martin F. Shapiro, "Regulating Pharmaceutical Advertising: What Will Work?" (1997) 156(3) Canadian Medical Association Journal 359 at 359, citing Sidney M. Wolfe, "Why Do American

amounted to $2.5 billion in 2000, and this accounted for about 15 per cent of drug promotion expenditures.[7] It has been estimated that, in Canada, 16 per cent of sales is devoted to promotion, which amounted to $950 million in 1995 on sales of $5.9 billion.[8] Ayerst Laboratories and now Wyeth-Ayerst have so successfully marketed the hormone replacement drug Premarin that for eight successive years, from 1992 to 1999, it was the leading drug in the number of prescriptions dispensed out of the top 200 drugs marketed in the United States.[9] The total number of prescriptions dispensed for Premarin was 47.8 million, out of a 1999 total of 2.8 billion prescriptions. Premarin also came eighth in the number of new prescriptions and seventeenth in dollar revenue for that year.

Product honesty in this vast market is promoted through several legal mechanisms. Federal regulation and tort actions provide bases from which to deal with deceptive, false, or misleading advertising and the failure to provide sufficient information about products. Tort doctrines promote patient autonomy by requiring that manufacturers provide adequate information about the risks, as well as the benefits, of prescribed products. The *Food and Drugs Act*[10] and the *Food and Drug Regulations*[11] require pharmaceutical companies to submit their products for safety and efficacy testing prior to marketing. Regulatory authority is exercised through the Therapeutic Products Programme (TPP), which includes the Therapeutic Products Directorate (TPD) of Health Canada. The TPP/TPD is the result of a system reorganization, which now reflects less of a consumer protection model, with scientific assessment of efficacy and safety, and more of a risk-benefit model, with an orientation towards the earlier release of drug products and a greater reliance on outside experts.[12]

Drug Companies Spend More Than $12 Billion a Year Pushing Drugs? Is It Education or Promotion?" (1996) 11 Journal of General Internal Medicine 637.

7. Meredith B. Rosenthal, Ernst R. Berndt, Julie M. Donohue, Richard G. Frank, and Arnold M. Epstein, "Promotion of Prescription Drugs to Consumers" (2002) 346 (7) New England Journal of Medicine 498.
8. Joel Lexchin, "Enforcement of Codes Governing Pharmaceutical Promotion: What Happens When Companies Breach Advertising Guidelines?" (1997) 156(3) Canadian Medical Association Journal 351.
9. Ann W. Latner, "The Top 200 Drugs of 1999: The More Things Change, the More They Stay the Same" (2000) 67 Pharmacy Times. It can be accessed at <www.pharmacytimes.com/top200.html> (last accessed: 24 May 2001).
10. *Food and Drugs Act*, R.S.C. 1985, c. F-27, as amended. See <http://laws.justice.gc.ca/en/F-27/index.html>.
11. *Food and Drug Regulations*, C.R.C., C. 870, as amended. The government provides an unofficial and dated version at <http://laws.justice.gc.ca/en/F-27/C.R.C.-c.870/index.html>. The government publication "How Drugs Are Reviewed in Canada" is available on their website at <http://www.hc-sc.gc.ca/hpb-dgps/therapeut/zfiles/english/facts-sht/fact_advert_e.pdf>. The American food and drug legislation, the *Federal Food, Drug, and Cosmetic Act of 1938*, as amended, may be found at <http://www.fda.gov/opacom/laws/fdcact/fdctoc.htm>.
12. G. Bruce Doern, "The Therapeutic Products Programme: From Traditional Science-Based Regulator to Science-Based Risk-Benefit Manager?" in G. Bruce Doern and Ted Reed, eds., *Risky Business: Canada's Science Based Policy and Regulatory Regime* (Toronto: University of Toronto Press, 2000) at 185.

An examination of the history of drug regulation indicates that the controls on advertising that were adopted initially were modest but significant, serving to limit the sales of products on a door-to-door basis, prohibiting claims of cure, and attempting to prevent false, misleading, or deceptive representations of the product's purpose and efficacy.[13] The *Proprietary or Patent Medicine Act (PPM)*,[14] enacted in 1908, did not control the advertising of those secret formula medicines that were available without prescription and that had often included such additives as narcotics, alcohol, and coal-tar derivatives. Instead the legislation prohibited offering for sale patent medicines containing prohibited ingredients and prohibited door-to-door sales and other public handouts of samples. The *PPM* was amended in 1919 to prohibit false, misleading, or exaggerated claims in ads, labels, and circulars for patent medicines.[15] Drugs in the pharmacopoeia, or prescription drugs, were covered under the *Food and Drugs Act,* which was first enacted as part of legislation in 1875 and amended in 1927 to add a prohibition on false, misleading, and deceptive advertising.[16] The current system of drug regulation reflects this history.

The *Food and Drugs Act* provides for criminal prosecution for false, misleading, or deceptive advertisements. Section 9(1) states that "[n]o person shall label, package, treat, process, sell or advertise any drug in a manner that is false, misleading or deceptive or is likely to create an erroneous impression regarding its composition, merit or safety." Section 3(1) provides that "[n]o person shall advertise any food, drug, cosmetic or device to the general public as a treatment, preventative or cure for any of the diseases, disorders or abnormal physical states referred to in Schedule A." Schedule A is a list of disease conditions that require physician involvement, including such conditions as heart disease and cancer.

An "advertisement" is defined broadly in section 2 of the statute as including "any representation by any means whatever for the purpose of promoting directly or indirectly the sale or disposal of any food, drug, cosmetic or device." Labelling or packaging in contravention of the regulations is deemed to be contrary to section 9(1). Prosecutions under this section have been rare. Direct-to-consumer advertising is not permitted in Canada, and communications from drug companies incorporating representations are required to be directed only to prescribing professionals. No representation other than the drug's names, price, and quantity may be advertised directly to consumers in Canada.[17] Distinguishing between

13. L.I. Pugsley, "The Administration and Development of Federal Statutes on Foods and Drugs in Canada" (1967) Medical Services Journal 387.
14. *Proprietary or Patent Medicine Act,* S.C. 1908, c. 56.
15. Pugsley, *supra* note 13 at 401-2.
16. *Ibid.* at 408.
17. *Food and Drug Regulations*, *supra* note 11, s. C.01.044. This prohibition doesn't apply where the Schedule F drug is in Part II, requiring a prescription for human and not veterinary use, and the drug is either in a form not suitable for human use or is labelled as being for veterinary use only. See also Willem Wassenaar, "Drug Regulation in Canada" (1978) 2 Legal Medical Quarterly 209 at 214; Rhonda Shirreff, "For Them to Know and You to Find Out: Challenging Restrictions on Direct-to-Consumer Advertising of Contraceptive Drugs and Devices" (2000) 58 University of Toronto Faculty of Law Review 121; *Ciba-Geigy Ltd.* v. *Apotex Inc.* (1992), 95 D.L.R. (4th) 385 (S.C.C.).

advertising and other activities has become an important aspect of determining what is permissible.[18]

The Canadian Broadcasting Act, 1936[19] incorporated the idea of the pre-clearance of radio ads,[20] since the corporation was given regulation-making authority with respect to advertising time and control of the character of advertising. This type of administrative clearance prior to distribution continues to be used for television and radio ads by inspectors acting under the *Food and Drug Regulations* on behalf of the Canadian Radio-Television and Telecommunications Commission for advertising of any article under the *Food and Drugs Act* or the *Proprietary or Patent Medicine Act.*[21]

Advertising is also assessed by the Pharmaceutical Advertising Advisory Board (PAAB), an organization of interested groups, including manufacturers. The PAAB Code of Advertising Acceptance states that "[a]dvertising/promotion systems" (APS), which are, with a few exceptions, all media communications to health professionals containing claims, quotations, and references for a pharmaceutical product, are subject to review and clearance under the PAAB code.[22] The PAAB code requires in section 2.1 that APS be "accurate, complete and clear and designed to promote credibility and trust. Statements or illustrations must not mislead." Section 2.5 states that "[t]he Code does not accept APS that are prejudicial to any sex, race, occupation or patient group, or contravene the ethical values of the health professions." The PAAB has industry participation and operates independently of the government regulatory structure with linkage through the ex-officio advice and observation of the TPD. Since it is a code, it has less force than a regulation and depends for enforcement on the industry's voluntary adherence. The organization's role in assessing ads and its linkage to government through the pre-clearance process give some authority to this process.

The industry organization, Canada's Research-Based Pharmaceutical Companies (Rx&D),[23] developed a voluntary code of conduct for ads and other

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18. The Therapeutic Products Directorate document "Overview of Drug Advertising" explains that no one factor is determinative and that the purpose, content, and context all have an effect on this determination, along with a consideration of how and when the message was delivered, to whom, by whom, and how often. See <http://www.hc-sc.gc.ca/hpb-dgps/therapeut/zfiles/english/fact-sht/fact_advert_e.pdf>.
19. *Canadian Broadcasting Act, 1936,* S.C. 1936, c. 24.
20. Pugsley, *supra* note 13 at 413-14.
21. *Food and Drug Regulations, supra* note 11, s. A.01.025; Wassenaar, *supra* note 17 at 214.
22. Pharmaceutical Advertising Advisory Board [hereinafter PAAB], Code of Advertising Acceptance. See <www.paab.ca/index_en.html>. The PAAB is made up of eleven organizations: the manufacturers, including Canada's research-based pharmaceutical companies (Rx&D), the Canadian Drug Manufacturers Association, and the Nonprescription Drug Manufacturers Association of Canada; the professions, including the Canadian Medical Association, the Fédération des médecins spécialistes du Québec, and the Canadian Pharmacists Association; as well as the Canadian Association of Medical Publishers, the Association of Medical Advertising Agencies, the Consumers Association of Canada, Canada's Association for the Fifty-Plus, and Advertising Standards Canada. The Therapeutic Products Directorate is an *ex-officio* observer and advisor.
23. This interest group was formerly known as the Pharmaceutical Manufacturers Association of Canada (PMAC).

marketing devices such as samples, educational events, and post-marketing research. The current Rx&D Code of Marketing, which was revised in November 1999, states that all of its members agree to follow the PAAB Code of Advertising Acceptance.[24] The Rx&D Code of Marketing describes the relationship between the PAAB and the government in the following terms: "If the TPP feels that any advertising materials pose a threat to health under terms of the *Food and Drugs Act* and *Regulations*, it can ask that these materials (even if they have been approved by the PAAB) be held back and not used. The PAAB Code describes what actions will be taken if this happens."[25] The PAAB commissioner "may" withdraw clearance and suspend publication of an APS on a variety of grounds, including "cases where regulatory or independent medical advice suggest that the claims may constitute an imminent and/or significant health hazard" and, if there has been no appeal of the ruling, the advertiser is required to withdraw the APS.[26] Penalties for PAAB code violations include ad withdrawal, notices, public apologies, and remedial measures, such as letters of correction or public notices, where the information has been misleading or where it might cause inappropriate product use or create an imminent or serious health hazard.[27] Non-compliance with a ruling and a belief that advertising creates an imminent or significant health hazard requires the commissioner to inform the government. The complaints process is not accessible to consumers.[28]

The regulatory prohibition on direct advertising of prescription drugs has been under consideration by Health Canada for several years as part of its broader review of health protection legislation and its own management.[29] In August 1997, the US issued guidelines clarifying direct advertising of prescription drugs on television.[30] The broadcast of American advertising directly to Canadian consumers by the American media ensures that Canadian consumers are aware of the benefits claimed for particular prescription drug products. What constitutes advertising under the statute, and what merely constitutes information to patients, is a matter of some dispute. The PAAB offered its assistance to the industry in interpreting the Health Canada guidelines on this matter and clarified its own code at its November 2001 meeting.[31] The lack of determined enforcement of the prohibition on direct advertising, despite pressure from consumer organizations,[32] has already created a climate of acceptance for this type of approach in Canada.

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24. The Rx&D Code of Marketing can be found at <www.canadapharma.org/en/publications/code.index.html>.
25. PAAB Code of Advertising Acceptance, *supra* note 22, s. 2.2.1.
26. *Ibid.* at s. 8.7.
27. *Ibid.* at s. 9.9.
28. *Ibid.* at s. 9.1.
29. Health Canada Drugs Directorate, Background Paper, "*Direct-to-Consumer Advertising of Prescription Drugs*," Ottawa, 1996. See also other consultation documents available at <www.hc-sc.gc.ca>.
30. Andrew Somora, "Direct-to-Consumer Advertising: Are Consumers Being Informed?" (1999) 8 Kansas Journal of Law and Public Policy 205.
31. PAAB Code of Advertising Acceptance, *supra* note 22, Clarification—Implementation, April 2002.
32. Barbara Mintzes and Rosanna Baraldi, *Direct-to-Consumer Prescription Drug Advertising: When Public Health Is No Longer a Priority* (Montreal: DES Action Canada, 2001) at 3-4.

There is reason to be concerned about the consequences of direct-to-consumer advertising. In the first year and a half after the FDA clarified the guidelines permitting television advertising in the United States, the ads for seventeen of the thirty-three drugs advertised were found to have contravened the FDA regulations "most commonly by downplaying risks. Some ads also exaggerated benefits and implied that the products could be used to treat a wider range of conditions than the government approved them for."[33] Among the ads to which the FDA raised objections were Wyeth-Ayerst ads for Premarin. Their objections related to the vague health benefits claimed in the ad in the absence of sound evidence of benefits apart from the reduction of the symptoms of menopause.[34]

Therefore, while the audience to whom messages may be given has been limited, this limitation is weakening with the pressure to permit direct-to-consumer advertising for prescription drugs. Moreover, while verbal claims in drug advertising are subject to a degree of legislated control on substance, which is limited to fraudulent and deceptive representations, beyond this limitation, the ad messages targeted at doctors may be constructed in a relatively unfettered manner subject to industry and PAAB standards. Advertising regulation provides little protection against claims that are based on the subtle forms of appeal that we discuss in this article.

To begin the process of change, the federal government's role as advertising watchdog needs to be recognized as a vital part of the system whereby the pharmaceutical industry is monitored and regulated. Assessing its claims is an important means of ensuring responsible and ethical conduct by advertisers. Furthermore, Canada has ratified several resolutions calling on governments to implement the 1988 World Health Organization's (WHO) Ethical Criteria for Medicinal Drug Promotion,[35] but, in this context, it needs to do considerably more to check the stereotyping and unwarranted claims that are made by advertisers.

The WHO Ethical Criteria for Medicinal Drug Promotion state that drug promotion should be consistent with national health policies and regulations; should contain reliable claims, without misleading or unverifiable statements or omissions that could lead to unjustifiable use or health risks; should not be designed so as to disguise its real nature, for example, as educational or scientific activities; and should not promote through financial or material benefits.[36] The advertising section of the WHO criteria states that advertising to doctors and related health professionals should contain wording and illustrations that are fully consistent with the approved data sheet for the drug or other information source

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33. *Ibid.* at 6; Working Group on Women and Health Protection, *To Do No Harm* (12 April 1999) (document prepared for consultation workshop on direct-to-consumer advertising). It can be accessed at <www.hc-sc.gc.ca/hpb-dgps/therapeut/zfiles/french/consult.dtca/99-04-14_15.f.html>.

34. *Ibid.*

35. *Ibid.*; Barbara Mintzes, *Blurring the Boundaries: New Trends in Drug Promotion* (HAI-Europe, 1998), introduction, which can be accessed at <www.haiweb.org/pubs/blurring/blurring.intro.html>; World Health Organization [hereinafter WHO], *Ethical Criteria for Medicinal Drug Promotion* (Geneva: WHO, 1988), which can be accessed at <www.who.int/medicines/library/dap/ethical-criteria/ethicalen.htm> [hereinafter WHO *Ethical Criteria*].

36. Mintzes, *supra* note 35; WHO, *supra* note 35.

with similar content and that the text should be fully legible. The process needs to be accountable and broadly representative of the public interest, with limits on membership, access to the processes, and public availability of information. As Martin Shapiro has suggested, the membership criteria for the body overseeing advertising should be recast to exclude industry members and physicians who are receiving support from the pharmaceutical industry.[37]

In addition, penalties imposed on pharmaceutical manufacturers need to be more stringent so that the profits accrued through the use of the ads do not outweigh the penalties. Corrective advertising has been used as a remedy in the United States in a "significant number of false advertising cases" that were brought under intellectual property legislation.[38] This remedy has been found particularly useful to competitors victimized by false advertising.[39] It is also a remedy for egregious violations of the US *Federal Food, Drug, and Cosmetic Act*.[40] Thomas Morrison argues that corrective advertising is particularly appropriate for advertising that is directed at doctors and other health care professionals because advertising has a significant effect on their decision-making. Any lesser remedy would permit the advertiser to continue benefiting from the false advertising, leaving the medical profession with a mistaken impression.[41]

While the regulations under the *Food and Drugs Act* provide parameters that prohibit fraud, limit the target audience for drug advertising, and also prescribe certain types of scientific content, the tort system serves different purposes. The tort action for failure to warn is concerned with the kind of information disclosed by manufacturers to the physicians, who are the "learned intermediaries" between the manufacturer and the patient. Product honesty is the focus of the product liability action involving the disclosure of information. In the leading Canadian case, *Hollis* v. *Dow Corning Corp.*,[42] the Supreme Court of Canada adopted the "learned intermediary rule" from the Ontario Court of Appeal's judgment in *Buchan* v. *Ortho Pharmaceutical (Canada) Ltd.*[43] This rule established that a manufacturer has a duty to the ultimate consumer to disclose information about the risks of the product as well as the benefits and that this duty may be discharged by warning the learned intermediary—the physician—who has a duty to disclose information as part of the general duty of care. The Supreme Court of Canada also determined that a subjective test of causation would apply between the patient and the manufacturer, and it established that plaintiffs would not be required to prove hypothetical behaviour of the physician on proof by the plaintiff of the breach of the duty of disclosure.

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37. Shapiro, *supra* note 6.
38. Thomas C. Morrison, "Corrective Advertising as a Remedy for the False Advertising of Prescription Drugs and Other Professionally-Promoted Medical Products" (1994) 49 Food and Drug Law Journal 385.
39. *Ibid.*
40. *Federal Food, Drug, and Cosmetic Act*, *supra* note 11; Shirreff, *supra* note 17 at 137.
41. Morrison, *supra* note 38 at 395.
42. *Hollis* v. *Dow Corning Corp.*, [1995] 4 S.C.R. 634, 129 D.L.R. (4th) [hereinafter *Hollis*].
43. *Buchan* v. *Ortho Pharmaceutical (Canada) Ltd.* (1986), 54 O.R. (2d) 92, 35 C.C.L.T. 1 (C.A.) [hereinafter *Buchan*].

This strong protection for patient/consumers acts principally in a retrospective way, since tort law is available to provide compensation after the harm has occurred, unlike regulation whose effect is prospective.[44] In assessing the potential success of tort litigation, Lucinda Finley has argued that the pharmaceutical industry has had a particularly harmful effect on women but that tort litigation has achieved success in unearthing information about product risks, in promoting health research, and in obtaining some compensation for injured women, even though at some cost.[45] Drug manufacturers owe a duty of care to patients to disclose risks that they know or should know. This duty is owed to the patient, but it is discharged indirectly by warning the physician, who is the "learned intermediary" between the manufacturer and the patient. This "learned intermediary" rule applies to prescribed products where there is an intermediary between the manufacturer and patient. In contrast, with over-the-counter products, no such prescribing professional is interposed. The standard of care for prescribed products is high because they are ingested or implanted in the body. Manufacturers have a number of ways of communicating with doctors, including direct contact with sales representatives in doctors' offices,[46] through sponsored education events and conferences, through hand-outs of literature and videos, and through the reference book, the *Compendium of Pharmaceuticals and Specialities* (*CPS*), which is compiled annually by the industry.

In *Buchan,* Justice Robins, for the five-judge panel of the Ontario Court of Appeal, pointed out the failure of the manufacturer to use the various means available to communicate the risk of oral contraceptives. Instead, the defendant promoted the product as being safe, in contrast to the American parent company that was distributing product information warning of the risk of stroke. The Court of Appeal commented on the obligation not to undermine the warnings through the company's promotional efforts, stating that the warning "should be in terms commensurate with the gravity of the potential hazard, and it should not be neutralized or negated by collateral efforts on the part of the manufacturer."[47] The company was held to be liable since the birth control pill was found to have caused Pauline Buchan's stroke, and she would not, in the court's opinion, have taken the pill if adequate warning of the risk of stroke had been given.

In *Hollis,* which also dealt with the duty to warn, Dow Corning Corporation had received reports of the risk of rupture of its silicone gel breast implants but had not passed on this information to physicians. The Supreme Court of Canada found that the company had failed to meet the standard for disclosure, that the silicone gel implants had ruptured causing the plaintiff to have repeat surgery and

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44. Patricia Peppin, "Feminism, Law and the Pharmaceutical Industry," in Frank Pearce and Laureen Snider, eds., *Corporate Crime: Contemporary Debates* (Toronto: University of Toronto Press, 1995) at 87.

45. Lucinda M. Finley, "The Pharmaceutical Industry and Women's Reproductive Health: The Perils of Ignoring Risk and Blaming Women," in Elizabeth Szockyj and James G. Fox, eds., *Corporate Victimization of Women* (Boston: Northeastern University Press, 1996) at 59.

46. John F. Peppin, "Pharmaceutical Sales Representatives and Physicians: Ethical Considerations of a Relationship" (1996) 21 Journal of Medicine and Philosophy 83.

47. *Buchan, supra* note 43 at 101 (O.R.).

considerable discomfort, and that Ms. Hollis would not have proceeded with the implants if she had been aware of the risk of rupture. The majority adopted a subjective test of causation, while the minority (*per* Justice John Sopinka) would have used the modified objective test of causation that was adopted for the relationship between doctors and patients in *Reibl* v. *Hughes*[48] and subsequently affirmed in *Arndt* v. *Smith.*[49] Significantly, Justice Gerard La Forest, writing for the full Court on duty and learned intermediary issues, analyzed and gave full effect to the inequality between the pharmaceutical industry and the patient.

Class actions against breast implant manufacturers were certified in Québec, Ontario, and British Columbia. These actions alleged a range of harms arising from silicone gel implants, typified by the list of harms in the appendix to the certification decision in *Harrington* v. *Dow Corning Corp.*[50] Certification of the classes in the Ontario action of *Bendall* v. *McGhan Corp.*[51] took place on the basis of the duty to warn, while in British Columbia, Justice MacKenzie declined to certify on this ground. MacKenzie J. reasoned that the subjective test of causation that was adopted in *Hollis* would require separate actions for each plaintiff to determine what each particular plaintiff would have done if the risks had been adequately disclosed. The separate hearings that would have been necessary for each plaintiff in order to determine whether the subjective test of causation had been met would have been antithetical to the legislative purpose of class actions to proceed more expeditiously and fairly through determining common issues in one hearing binding on all the parties, thus avoiding a multiplicity of proceedings. Arguably, it would have been possible to determine the issues of duty, standard of care, and factual causation as common issues in one forum, while leaving the further issue of the subjective test of causation to separate hearings. While affirming the trial judgment, the Court of Appeal found that the BC legislation is flexible enough not to require that all the issues necessary for liability be determined in the hearing.[52] The issue of factual causation is the most difficult of the issues because of the uncertainty of the causal link between the implants and auto-immune disorders such as rheumatoid arthritis and lupus from which some of the plaintiffs suffered. In the *Harrington* certification decision, the subjective test of causation played an ironic role, since the test, which is usually perceived as plaintiff-positive, had the plaintiff-negative role of denying certification.

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48. *Reibl* v. *Hughes*, [1980] 2 S.C.R. 880 [hereinafter *Reibl*].
49. *Arndt* v. *Smith*, [1997] 2 S.C.R. 539.
50. *Harrington* v. *Dow Corning Corp.* (1996), 22 B.C.L.R. (3d) 97 (S.C.), affirmed (2000) 193 D.L.R. (4th) 67 (C.A.), application for leave to appeal to SCC dismissed [2001] S.C.C.A. No. 21 [hereinafter *Harrington*].
51. *Bendall* v. *McGhan Medical Corp.* (1993), 14 O.R. (3d) 374 (S.C.).
52. *Harrington* (B.C.C.A.), *supra* note 50 at para. 16. The Supreme Court of Canada denied leave to appeal. In their later decision on class actions, *Hollick* v. *Toronto (City)*, [2001] S.C.J. No. 67, an appeal based on the Ontario legislation, they defined the nature of the commonality required and stated that some aspect of liability must be common but that everyone need not share the same interest in the common issue. Whether a class action is preferable should be determined in relation to judicial economy, access to justice, and behaviour modification, taking into account the importance of common issues in relation to the claim as a whole. The *Harrington* case was settled in 1999.

On the other hand, the *Harrington* certification decision was creative in certifying the question of whether silicone gel implants are reasonably fit for their intended purpose. This question focuses on the issue of the company's creation and use of information for marketing decisions. In the British Columbia Court of Appeal, Justice Carol Mahood Huddart, for the three-judge majority, suggested that in such a negligent manufacture, design, or marketing case, it would be necessary to make several assessments. First, the court would need to assess whether the product was defective under ordinary use or, if not defective, whether it had a propensity to injure and, second, the court would need to assess the manufacturer's knowledge of dangerousness and the decision to not distribute the product or to distribute it with a warning. Consideration of the reasonableness of any warning, the issue of individual causation, and the calculation of damages would follow this determination of risk assessment. This action requires proof of a failure to attend sufficiently to the risks in the development and focuses on the very failure that would make proof of factual causation difficult in the duty to warn action. It would deal with the difficult question of factual causation in a general scientific sense—that is, whether the silicone gel implants caused the kinds of harms that were alleged. In regard to advertising, the *Harrington* case is particularly significant because it uses a different model from the duty to warn action in order to focus on the creation of knowledge about risks and marketing decisions made in that context. Any plaintiff contemplating litigation based on a pharmaceutical company's marketing decisions would need to consider *Harrington* in addition to *Hollis* and *Buchan*.

Product liability actions that relate to prescription drugs and devices have been rare in Canada, and the cases discussed earlier in this article form almost the entire case law in this area. The most contentious issues have not been the duty to disclose or the standard of disclosure, but, rather, the various aspects of causation. These aspects include the scientific causation issue indicated by the difficulty of proving that breast implants cause auto-immune disorders, the subjective test of causation to assess the plaintiff's hypothetical behaviour if adequate disclosure had been made, and the intervening causation issue. Causation dilemmas contribute to the difficulty of litigating against the industry for structuring their product information in particular ways. The intervening causation dilemma arises because the doctor's behaviour is arguably an intervening cause between the company's failure to disclose and the plaintiff's harm—the effect of which is to exonerate the manufacturer. The company might argue, as it attempted to do in *Hollis*, that the doctor would not have disclosed the risks to the patient even if the company had disclosed the risks to the doctor. If this were the case, then it could be said that the doctor snapped the chain of causation between the company and the patient.[53] In *Buchan*, the Ontario Court of Appeal commented on this problem by creating a rebuttable presumption that the doctor, if adequately warned, would

53. Patricia Peppin, "Drug/Vaccine Risks: Patient Decision-Making and Harm Reduction in the Pharmaceutical Company Duty to Warn Action" (1991) 70 Canadian Bar Review 473; Denis Boivin, "Factual Causation in the Law of Manufacturer Failure to Warn" (1998-9) 30 Ottawa Law Review 47.

have disclosed the information to the patient.[54] Further, Justice Sydney Robins noted that the manufacturer would not be shielded by a doctor's negligence if that doctor's negligence were a foreseeable consequence of the breach of duty—a position consistent with previous case law on remoteness.

Justice La Forest referred to the *Buchan* presumption, which he characterized as "a somewhat similar approach," and decided that the plaintiff was not responsible for proving a hypothetical situation and that the company could not raise the learned intermediary rule to defend itself if it had failed in its duty to warn. Only if there were "extraneous conduct" by the doctor that would have made the warning irrelevant would it be possible for the intervening causation argument to work for the defence. It could also be an apportionment issue. The *Hollis* decision has made the plaintiff's job easier by preventing the manufacturer from insulating itself from liability on the basis of the plaintiff's inability to prove a hypothetical situation. The Supreme Court of Canada's adoption of this approach signals its further awareness of the inequality in knowledge as well as the need to protect plaintiffs from purely speculative arguments about the non-negligent doctor. The judgment firmly supports the obligation on the manufacturer to disclose risks they knew or should have known and effectively prevents the manufacturer from avoiding liability for a failure to disclose by making speculative intervening causation arguments.

This doctrine has important implications for drug advertising since advertising is one means that is used to fulfil the obligation to disclose. The Supreme Court of Canada's strong support for patient autonomy and its recognition of the importance of the power imbalance for the doctrines that govern the relationship among manufacturer, doctor, and patient are important affirmations that could help patients and doctors in making demands—whether in court or elsewhere—for a higher quality of information in drug advertising.

Since this tort action provides direction to manufacturers about their disclosure responsibilities, it also provides direction for the information page of any ad and sets an outer limit on the kind of claims that can be made in it. As was noted earlier in this article, Robins J.A. found a duty not to undermine—negate or neutralize—warnings through promotional efforts.[55] The imagery used in the ad to represent the doctor, patient, or drug can have a significant impact on the perception of the drug's suitability for particular patients, as we will demonstrate later.

Prescription drug advertising appears in two segments in professional journals. One portion uses colourful imagery and bold claims that are typical of consumer advertising and that appear throughout the journal. It is followed at the end of the journal by the second segment, which involves a separate small-type listing of information about the drug's biochemistry, indicated uses, contra-indications, and adverse effects. The more obvious role of drug advertising is to promote the product. Companies achieve these purposes by inserting the ads in print media that will reach the targeted professional audience, primarily through

54. *Hollis*, supra note 42 at 63, citing US authorities.
55. *Buchan*, *supra* note 43.

professional journals. The image and text that accompany the image, which we will examine, contain representations about the drug, including claims about its purpose, safety, efficacy, and relative merits. Since the same information channel is used to inform the physician about the drug and to promote the drug, the company must walk a tightrope between duty and desire. Clearly, the marketing efforts of the company can undermine disclosure. Where this is the case, and harm has resulted, litigation based on the earlier precedents would be possible.

Joel Lexchin reports that studies over a quarter of a century "have consistently shown that the more physicians rely on promotion for their source of information about drugs, the less appropriately they prescribe."[56] Other authors have found that even doctors who deny the influence of drug advertising on their drug practices, either because they are unaware of it or because they are reluctant to admit to it, are in fact influenced.[57] Studies suggest that significant numbers of physicians observe and read drug ads and that some, particularly those who have been in practice for less than two years, those who work in group practices, and those living in urban areas, are more inclined to write prescriptions based on their reading of ads.[58] Drug advertisements are more visually arresting and conceptually accessible than scientific papers, and physicians appear to respond to these cues.[59] A. Mant and D.B. Darroch go further by suggesting that even a negative reaction helps the advertiser, since intense reactions ensure that the product name is retained and prescribing may follow.[60] It meets the first criterion in advertising's AIDA formula—capture Attention, maintain Interest, create Desire, and get Action.[61]

Although this study is directed at the impact of the imagery and textual representations used in drug ads, it is important to note that research on the scientific claims in these ads has also demonstrated significant deficiencies in their accuracy and conformity to regulations. A. Herxheimer, C.S. Lundborg, and B. Westerholm studied 6,710 ads in medical journals in eighteen countries and found that important warnings and precautions were missing from half the ads, while side effects and contra-indications were missing in approximately 40 per cent.[62] D. Stryer and L.A. Bero's study of 486 items distributed by drug companies indicated that over 40 per cent contravened at least one of the three FDA regulations that they were examining, including seventeen cases that discussed unapproved uses for the drugs.[63] M.S. Wilkes, B.H. Doblin, and M.F.

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56. Lexchin, *supra* note 8.
57. J. Avorn, M. Chen, and R. Hartley, "Scientific Versus Commercial Sources of Influence of the Prescribing Behavior of Physicians" (1982) 73 American Journal of Medicine 4; A. Mant and D.B. Darroch, "Media Images and Medical Images" (1975) 9 Social Science and Medicine 613.
58. S.M. Petrochius, P.A. Titus, and K.J. Hatch, "Physician Attitudes toward Pharmaceutical Drug Advertising" (1995) 35 Journal of Advertising Research 41.
59. Avorn, *supra* note 57.
60. Mant and Darroch, *supra* note 57.
61. W. Nöth, *Handbook of Semiotics* (Bloomington: Indiana University Press, 1990).
62. A. Herxheimer, C.S. Lundborg, and B. Westerholm, "Advertisements for Medicines in Leading Medical Journals in Eighteen Countries: A Twelve-Month Study of Information Content and Standards" (1993) 23 International Journal of Health Services 161.
63. D. Stryer and L.A. Bero, "Characteristics of Materials Distributed by Drug Companies" (1996) 11 Journal of General Internal Medicine 575.

Shapiro carried out a study to assess the accuracy of scientific data in ads and their compliance with FDA regulations by asking experts to assess the validity of claims made in 109 advertisements in ten leading medical journals.[64] The reviewers found deficiencies in the ads where FDA standards existed.[65] They also found in 44 per cent of cases that experts thought the ad would lead to improper prescribing if the physician had no other information.[66]

Even when the scientific claims made by manufacturers are accurate, the images used by the pharmaceutical industry have the potential to send other messages that override or excessively enhance the claims made in the ad. In the following section, we examine the way in which advertising is constructed, using the analyses developed by semiotic theorists.

Methodology

Semiotic theory provides an analysis of how advertising operates.[67] It defines the sign as a thing plus meaning. A sign is essentially something—a material object, a person, or a character—that has a value to a person or group of people. The process of attributing meaning to an object is called signification. The viewer provides the meaning for the material object—its connotation—based on what the viewer already knows. This attribution of value, based on the viewer's desire for meaning and self-actualization, is what "powers" the ad process.[68] Once the meaning of the object is provided, it is transferred from the sign to the product to be consumed. The process by which the attribution of qualities is created and transferred is an unconscious one, until the viewer becomes aware of the way in which ads operate.

The referent system is the term attributed by semiotic analysts to the source of the meaning ascribed by the viewer to the object.[69] The referent system provides the ideological source for the process of signifying, thereby supplying the essential value to be attributed to the object and transferred to the product. For example, nature and science appear as two major sources of meaning in advertising.[70] In the transfer of meaning from the sign to the product, the sign signifies for the product and denotes what it is. Roland Barthes calls the signifiers of connotative signs connotators and

64. M.S. Wilkes, B.H. Doblin, and M.F. Shapiro, "Pharmaceutical Advertisements in Leading Medical Journals: Experts' Assessments" (1992) 1166(11) Annals of Internal Medicine 912.
65. *Ibid.* at 917.
66. *Ibid.*
67. Roland Barthes, *Mythologies,* translated by Annette Lavers (New York: Hill and Wang, 1972); Roland Barthes, *The Semiotic Challenge* (New York: Hill and Wang, 1988); Ferdinand de Saussure, *Course in General Linguistics,* translated by R. Harris (London: Duckworth, 1983); Nöth, *supra* note 61; T. Sebeok, *Signs: An Introduction to Semiotics* (Toronto: University of Toronto Press, 1994); H. Silverman, ed., *Cultural Semiosis* (New York: Routledge, 1998).
68. Robert Goldman, *Reading Ads Socially* (New York: Routledge, 1992), at 60.
69. Judith Williamson, *Decoding Advertisements: Ideology and Meaning in Advertising* (London: Marion Boyars, 1978); Goldman, *ibid.*
70. Williamson, *supra* note 69 at 43.

describes how they mixed into systems of connotations. The rhetoric of advertising, its ideological core, is located here.[71]

At the outset of this research, we considered that the referent system for drug advertising consisted of two kinds of hierarchical relationships. The first involves the paternalistic, interventionist, and heroic values that are thought to be inherent in the medical political culture and the second kind includes the relationships of disadvantage existing among various groups in society, including the inequality of women. These two types of relationships will be examined in the following sections.

Paternalism and Power in the Doctor-Patient Relationship

One meaning drawn by advertisers from the medical political culture is the set of perceived assumptions that doctors make about their patients, their professional self-image, their desirable doctor-patient relationships, and the nature and expression of disease. Canadian, American, and British medical practice, through much of the twentieth century, fit the traditional model of paternalistic and hierarchical practice. This model, which developed out of the establishment of the power of the medical profession through the nineteenth century, was based on doctors' exclusive control over specialized knowledge[72] and the seemingly problematic nature of women's bodies.[73] Medical practice became increasingly reductionist, focused on disease rather than on patients. The doctor was to be in control, providing benefit to patients, and avoiding harm, while the patient was to reciprocate by trusting and relying on the doctor. As Jay Katz explained in his ground-breaking analysis *The Silent World of Doctor and Patient,* silence was an essential component of the doctor's behaviour since it was perceived as being necessary to maintain the patient's hope.[74] Speaking with patients could lead only to a loss of unilateral trust and the unquestioning belief in the healing power of the doctor, and curing would be undermined as a result. For a doctor to reveal uncertainty to a patient would be to admit fallibility and therefore to step out of this authoritative role. The structural inequality between doctor and patient was based on disparate expertise and skill, but it was also heightened by a widespread scepticism about patients' abilities to understand their own bodies and engage in responsible medical decision-making.[75] The practice of medicine was individualized as the doctor had relatively unfettered power to make medical diagnoses and treatment decisions. These decisions could be made without the participation of patients, family members, and colleagues as well as without the

71. Barthes, *Mythologies, supra* note 67; and Barthes, *The Semiotic Challenge, supra* note 67.

72. Suzanne E. Hatty and James Hatty, *The Disordered Body: Epidemic Disease and Cultural Transformation* (Albany: State University of New York Press, 1999) at 15; Barbara Ehrenreich and Deirdre English, *For Her Own Good: 150 Years of the Experts' Advice to Women* (Garden City: Anchor Books, 1979).

73. Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada* (Toronto: University of Toronto Press, 1991) at 48-76.

74. Jay Katz, *The Silent World of Doctor and Patient* (New York: Free Press, 1984).

75. Susan Sherwin, *No Longer Patient: Feminist Ethics and Health Care* (Philadelphia: Temple University Press, 1992) at 140-4.

intervention of those even further outside—those "strangers at the bedside"—bioethicists, judges, or journalists.[76] In the decade between 1966 and 1976, there was a transformation in this method of practice, which David Rothman has identified, whereby the collective decision-making in human subject research took hold, the formalities of written documentation were established, and outsiders began to define the normative structure of the doctor-patient relationship.[77]

Legal challenges to paternalistic practice focused on the need for patient participation in a process of informed decision-making. Courts and legislators took steps to require greater disclosure of medical information to patients. In many jurisdictions, including Canada, the duty to disclose material risks and other information replaced a standard of professional disclosure—that is, disclosing only that which other doctors would disclose. The *Hopp* v. *Lepp*[78] and *Reibl* v. *Hughes*[79] decisions established the criteria for a duty to disclose and also served to define the further elements of causation that were necessary for a negligence action. The movement into positions of power by baby boomers, the patient-centred activities of feminist organizations and individuals, and legal protections for patient autonomy converged with higher education levels and the eventual access to alternative sources of information through the Internet, so that patients have taken on increasingly participatory and autonomous roles in the context of medical decision-making.

As we observe these powerful changes affecting medical interaction, we must also be cautious about concluding that legal changes have resulted in the participation of autonomous patients in medical decision-making. Differential access to outside information and expertise as well as unequal social situations that affect the interaction are indications that the ideal doctor-patient relationship is not necessarily the norm. The kind of transaction that the Supreme Court of Canada envisaged is difficult to achieve. For example, anthropologist Susan Greenhalgh has written about her own diagnosis and treatment for fibromyalgia and has shown how medical power influenced her active participation and moulded her behaviour to the traditional norms of the compliant patient. Greenhalgh also discusses how socially constructed gender expectations were used as part of this process.[80] Acquisition of the right to make choices is only the initial step in transforming a relationship that is so embedded in the power of science, expertise, and money in North American medicine. Susan Sherwin has pointed out that physicians have acquired an increasing degree of control over women's bodies, as is demonstrated by recent excessive surgical interventions in childbirth, the expansion of reproductive services through new reproductive and genetic technologies, unwarranted hysterectomies and mastectomies, the high rates of psychiatric

76. David J. Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (New York: HarperCollins Publishers, 1991) at 2.
77. *Ibid.* at 3-4.
78. *Hopp* v. *Lepp*, [1980] 2 S.C.R. 192.
79. *Reibl*, *supra* note 48.
80. Susan Greenhalgh, *Under the Medical Gaze: Facts and Fictions of Chronic Pain* (Berkeley and Los Angeles: University of California Press, 2001).

diagnoses and prescriptions for psychotropic drugs.[81] Since beneficence is seen as the basis for these interventions, physicians can be "insensitive to their own participation in patterns of thinking that, overall, are harmful to women."[82] Race and class have complex interactions with medical power. The power imbalance existing between doctors and patients has been identified and given doctrinal force by the Supreme Court of Canada in its decision on a sex-for-drugs deal offered by a physician to a patient, an Aboriginal woman who was addicted to a barbiturate.[83] Five of the six judges analyzed the power imbalance existing between doctor and patient, based both on the disability of the woman and on the relationship of dependency and power between doctor and patient. The traditional model of paternalistic care has fewer proponents and more critics than it did in the past, but it has remained as a powerful motivator for various sectors of the medical profession through the latter part of the twentieth century and has consequently provided a source of meaning for pharmaceutical companies.

Heroic and Interventionist Medicine

Other aspects of meaning that pharmaceutical companies consider part of the medical political culture are the heroic model and the interventionist model.[84] Heroic medicine calls upon the doctor to save the patient at all costs, waging battle against the enemy disease on the quiescent patient's body and exercising control on the clinical battlefield.[85] This mediaeval archetype includes the notions of hierarchy and beneficence provided through war and also calls up an aggressive, doctor-centred, and reductionist notion of care. Heroic doctors continue to act as individuals, sometimes in opposition to the host of "outsiders"—the bioethicists, lawyers, and judges—who would intrude on the medical event. Since the warrior image is masculine, it calls on gender assumptions about roles, including the passive and acquiescent role of the person in need of rescue, and also plays into the Victorian-era idea that woman have fragile bodies.[86] Women's diseases, such as menopause, are indications of this weakness.

Heroic medicine focuses on intervention by the doctor to save the patient. Interventionist medicine is a related concept since it focuses positively on intervention into the patient's illness—something must be done and the physician is the one to do it. The high value given to activity in this model of health care

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81. Sherwin, *supra* note 75 at 153.
82. *Ibid.*
83. *Norberg* v. *Wynrib*, [1992] 2 S.C.R. 226.
84. Celia Lury and Alan Warde, "Investments in the Imaginary Consumer: Conjectures Regarding Power, Knowledge and Advertising," in Mica Nava, Andrew Blake, Iain MacRury, and Barry Richards, eds., *Buy This Book: Studies in Advertising and Consumption* (London and New York: Routledge, 1997) at 87. Lury and Warde show how commercial and academic knowledge operate dialectically. They give the example of the market research consulting agency called Semiotic Solutions, which specialized in the application of "myth technology" to the marketplace.
85. Deborah Lupton, *Medicine as Culture: Illness, Disease and the Body in Western Societies* (London: Sage Publications, 1994) at 61-4.
86. Hatty and Hatty, *supra* note 72 at 16; Mitchinson, *supra* note 73.

would be contrasted with a health care model that adopted a "wait and see" approach. North American medicine of the late twentieth century is highly interventionist, and, as a result, the description seems self-evident. The less intrusive forms of treatment found in alternative medicine or the kinds of health care provided by other non-traditional health practitioners, such as midwives, provide examples of non-interventionist medicine. Intervention into the patient's illness is obviously desirable from the pharmaceutical industry's point of view. Identifying the need to intervene and intervening through prescribing are steps in the chain between manufacturer, advertising, doctor, and ultimate profit. Ads are designed to create the perception that intervention is needed. Clearly, the interventionist model of medicine is a particularly appealing model on which to draw in creating ad images.

Social Inequality and Stereotyping

Semiotic theory identifies the referent system as the ideological basis for the ad that provides it with its source of meaning. Advertisers create ads that will, they think, call upon the norms and values of the particular group to whom the ad is targeted. In this article, we are identifying the stereotypes associated with social groups as one normative basis for advertising that operates through the referent system in order to give meaning to the ad. The referent system includes the structure of power and entitlements in society, with its "indicia of discrimination"—stereotypes, historical disadvantage, or vulnerability to political and social prejudice—in *Charter* jurisprudence.[87]

The construction of drug ads, as we will show, relies on a vision of an idealized type, an essentialist representation of woman. She possesses other particularized qualities that are stereotypes of advantage along the dimensions of race, class, and disability and that fail to represent the diversity that exists among women. Ads use stereotypes along one dimension, such as gender, while drawing on aspects of advantage through the portrayal of women as being only white, seemingly able-bodied, and middle class. Making use of stereotypes and under-representing particular groups are two ways that advertisers call upon social inequality to power the ads. Semiotic theory identifies the referent system as the source of meaning for the ad. Imagery that is created to reflect underlying prejudices and discrimination in society uses social inequality as the ideological meaning for the ad that operates through the referent system.

For example, the idea of activity plays a significant and complex role in drug advertising. In American and Canadian culture, social preference attaches to physical activity, youth, and individual assertion. Men are stereotypically active, while women are passive. Historically, women's activities were confined to the house and family and then to education and nursing, which are seen as inactive

87. *R.* v. *Turpin*, [1989] 1 S.C.R. 1296 at para. 47; *Law* v. *Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497 at para. 44. See also *Andrews* v. *Law Society of Upper Canada*, [1989] 1 S.C.R. 143.

arenas in contrast to the active public arenas in which men acted. Varda Burstyn describes the gendered construction of the sports that dominate the media and argues that its creation and promotion "in the associations, economies, and culture of the modern sport nexus" reflects and promotes other forms of social inequality, producing "*hypermasculinity,* that is, an exaggerated ideal of manhood linked mythically and practically to the role of the warrior."[88] This image of activity is used repeatedly in drug advertising, in which activity is connected to health and activity's antithesis is the forced inactivity of disease. Infirmity, weakness, and disease are connected. These images have often been attached to women in drug advertising.[89]

Referent systems change over time with cultural shifts in the meaning of those referent systems. As the cultural codes used for particular groups become socially unacceptable, we would expect to see them disappear from advertising. Assumptions about gender, race, and social class have found their way into imagery that is salient to a largely upper middle-class, white, male-dominated profession. The profession's composition, social policies, and individual attitudes have all changed to some degree in the recent past, and powerful social forces have changed medical practice.[90] The continuing resonance of these creators of meaning needs to be explored.

Despite feminist theorizing about women's health, menopause is still treated as an illness in mainstream medicine. Pharmaceutical companies perpetuate this medicalization of menopause through their advertisements for HRT. The following examination of advertisements for Premarin illustrates the use of negative stereotypes of women and menopause to create a continuing market for this particular HRT.

Application to Premarin Advertisements

Menopause itself has meaning, and the meanings attached to menopause are culturally specific. The bio-sociocultural view of menopause in Western society is that it is a hormone deficiency disease and a period of loss and decay, which needs to be treated and that, if untreated, may lead to heart disease and osteoporosis.[91] The WHO has defined it as an estrogen-deficiency disease requiring adjustment on the woman's part.[92] Emily Martin has demonstrated how menopause has been portrayed in medical textbooks as a failed process of production, in which the goal of production—pregnancy—can no longer be achieved.[93] In these educational texts, which construct meaning for the next generation, menopause has not been

88. Varda Burstyn, *The Rites of Men: Manhood, Politics, and the Culture of Sport* (Toronto, Buffalo, and London: University of Toronto Press, 1999) at 4. Burstyn also defines hypermasculinity as "the belief that ideal manhood lies in the exercise of force to dominate others" (at 192).

89. Lupton, *supra* note 1.

90. Londa Schiebinger, *Has Feminism Changed Science?* (Cambridge: Harvard University Press, 1999) at 121-5.

91. D. Defey, E. Storch, S. Cardozo, and G. Fernandez, "The Menopause: Women's Psychology and Health Care" (1996) 42 Social Science and Medicine 1447.

92. Sherwin, *supra* note 75 at 186.

93. Emily Martin, *The Woman in the Body* (Boston: Beacon Press, 1987) at 42.

described as a normal process of a woman's life but, rather, one in which the organs atrophy and decline. Anthropologist Margaret Lock has contrasted this perspective with the experience of Japanese women, who rarely have hot flushes. In her work, she has noted that gynaecologists in Japan wonder why Western women are so disturbed by hot flushes. HRT is used very little in Japan, partly because it is not needed for symptom relief but also because of the low incidence of osteoporosis and heart disease relative to North American women.[94] Londa Schiebinger notes that

> [m]edical anthropologists caution against universalizing Western patterns of ovulation and menopause in theoretical models and clinical practices concerning hormone replacement therapy. The North American and European pattern of constant ovarian cycling may not be a norm of female physiology. Sperling and Beyene suggest that awareness of the differences in women's hormonal regimes around the world may lead to new ways of treating postmenopausal osteoporosis and cardiovascular risk.[95]

One of the forces influential in this construction of menopause is the pharmaceutical industry. Premarin continues to be the top drug in terms of prescriptions dispensed in Canada.[96] The market for this product is immense, consisting of 50 million or more women in North America in the menopause age group, who may take the product for the remainder of their lifetimes.[97] However, until properly structured, long-term randomized controlled trials provide evidence, debate will continue over the desirability of universal HRT. Our analysis of the Premarin ads will demonstrate how the pharmaceutical industry constructs their ads to sidestep this debate and promote the product. In this part of the article we analyze a series of ads for Premarin, a conjugated estrogen prescribed for women in the menopausal and perimenopausal years. There were eight ads for the drug Premarin presented in the Journal of the Society of Obstetricians and Gynecologists of Canada from 1986 to 2000. These ads, and additional ones, appeared in American medical journals during the same period. The ads we analyze appeared first in 1986, 1989, 1991, 1996, 1998, and 2000.[98] The 2000 ad is the final ad for Premarin itself; since that time, the manufacturer has inserted in journals only ads

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94. Margaret Lock, "Anomalous Women and Political Strategies for Aging Societies," in Susan Sherwin, ed., *The Politics of Women's Health* (Philadelphia: Temple University Press, 1998) at 200. See also Margaret Lock, *Encounters with Aging: Mythologies of Menopause in Japan and North America* (Berkeley: University of California Press, 1993).
95. Schiebinger, *supra* note 90 at 121, referring to Susan Sperling and Yewoubdar Beyene, "A Pound of Biology and a Pinch of Culture or a Pinch of Biology and a Pound of Culture? The Necessity of Integrating Biology and Culture in Reproductive Studies," in Lori Hagar, ed., *Women in Human Evolution* (New York: Routledge, 1997).
96. *National Post* (3 April 1999) A3.
97. Natalie Angier, *Woman: An Intimate Geography* (New York and Toronto: Anchor Books, 2000) at 229. This figure "amounts to 1.5 billion women years of drug consumption."
98. Variations on the ads appeared during this time. For example, the stylized "P" used as a sign for Premarin in the jogging ad appeared as an ad on its own after the jogging ad was published.

for PremPlus, a new progesterone-added product. The six ads reflect widely divergent strategies for the drug's promotion, but they also consistently reflect inequality in their approaches to women and women's place in society.

1986 Advertisement

In this ad, we find the head of an attractive blond woman wearing pearls. The number "25" is wrapped around her head. It is placed in the foreground and consequently stands out as a key sign in the ad. Black type in a rounded font states "Naturally restoring what nature has lost," while the drug name "Premarin" appears in red type in capital letters. The words "nature" and "naturally" in the primary slogan suggest good, safe, and everything in its place. These words promote the drug as natural and imply that it is unnatural to be without it. Nature's use in drug advertising is ironic. Even when composed of natural substances, such as pregnant mares' urine, which makes up Premarin, any drug is inherently non-natural. Any drug intervention is implicitly opposed to the natural processes of the body, which include disease. The attempt to construct drug therapy as being equivalent to nature is achieved through semiotic methods in which the transfer of meaning is meant to occur unnoticed.

The photograph, number, and phraseology, when considered together, signify that by taking Premarin, the woman will naturally restore her estrogen level and will therefore be the same as a twenty-five year-old woman again. By reading the fine print, it is possible to determine that the twenty-five refers to the twenty-five day cyclic course of Premarin therapy. The symptoms listed are hot flushes, insomnia, and irritability. It is worth noting that the ad campaign in the 1980s through the mid-1990s focused primarily on the symptomatology of menopause. In the late nineties, however, the focus changed, in concert with the trend towards health promotion in the wider health care arena, to the prevention of serious diseases such as heart disease, osteoporosis, and Alzheimer's. Now we find a recantation of earlier claims, particularly with respect to heart disease. Ann Walling, Raja Al-Dashti, and Cara Tannenbaum in their review article on HRT in the primary and secondary prevention of coronary artery disease conclude that "hormone replacement therapy for primary prevention must be individualized until results of randomized trials are available ... and that it is not recommended to slow the progression of coronary disease." These authors, like many others, suggest that healthy lifestyle habits, including diet, exercise, and no smoking, and perhaps not HRT as previously claimed, are critical to the prevention and treatment of heart disease.[99]

99. Ann Walling, Raja Al-Dashti, and Cara Tannenbaum, "Hormone Replacement Therapy in Primary and Secondary Prevention of Coronary Artery Disease: Cardiologist and Geriatric Specialist Perspectives (2001) 23 Journal of the Society of Obstetricians and Gynaecologists of Canada 409-16.

1989 Advertisement

This ad is an extension of the 1986 ad. It covers two pages of the journal and is more complex in both photography and text. The 1989 ad presents an image of a woman's head and a man's arm clothed in a white lab coat, signifying scientific authority.[100] The man's arm is resting on the table and in his hand there is a small picture of a woman's head with a figure "25" wrapped around it. It is the same woman who was in the 1986 ad. The elements of the ad denote quite clearly a patient's visit to a doctor. The setting of the appointment includes dark wooden furniture, a traditional lamp with gold features, and a gold doctor's watch, all of which create an impression of solidity and of being in a setting where one can trust the physician. Although we can see only the back of the woman, we can tell by her gold earrings, suit, and well-cut hair, that she is a white, middle-aged woman of some means, hence, an ideal patient.

Philipa Rothfield writes of the unitary character of the "good patient" in Western medicine, one that does not by and large acknowledge that patients "have a part to play in the determination of their own bodily and human being."[101] In this ad, we see a woman who, it would appear, requires knowledge about her condition and the drug that is meant to cure it. Why these pictures of attractive, middle-aged women? Our conclusion is that the drug company knows that the photograph of the essentialized and feminized middle-aged woman will be comfortable for the physician and that its emotional appeal will attract the doctor's attention. She is pivotal to the message; she cannot be omitted. A large landscape painting on the doctor's wall signifies nature, one of the most powerful and authoritative referent systems, along with science.[102] The signification of safety and goodness through nature occurs in the painting in this ad, while the 1986 ad represented nature in the text.

The picture in the doctor's hand needs to be deciphered. The picture is from a Prem-Pack, which is a cyclical calendar pack of Premarin. Recognition of this picture requires knowledge of the packaging of the product, either from previous use or from a previous ad that featured this image. While the picture in the doctor's hand simply denotes a suggestion of the product to the patient, the meaning connoted is quite different. The placement of the picture in the doctor's hand and in relation to the patient (she faces it) makes it look like a small mirror. This image suggests that the woman in the "mirror" is a reflection of the patient. However, the women look very different—the woman on the Prem-Pack picture has blonde hair, while the patient has dark hair. While the number "25" that is wrapped around the Prem-Pack woman's neck might denote the twenty-five day cyclical calendar, its implied meaning is the promise of youth, of looking and feeling like a twenty-five year old.

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100. Nora H. Krantzler, "Media Images of Physicians and Nurses in the United States" (1986) 22 Social Science and Medicine 933.
101. Philipa Rothfield, "Bodies and Subjects: Medical Ethics and Feminism," in Paul A. Komesaroff, ed., *Troubled Bodies: Critical Perspectives on Postmodernism, Medical Ethics, and the Body* (London: Durham Press, 1995) at 168.
102. Williamson, *supra* note 69.

Colour is used to distinguish words that concern the effects of the drug from the words of the doctor. This use of colour and the alliteration of the "p" words to emphasize the name Premarin (provides, prevents, protects, and promotes) heighten the effect of the messages being conveyed. As well, the reference to competitors in a way that emphasizes the safety, security, and stability of Premarin and the comment about the patient's compliance underscore the marketing purpose and the desirability of compliant patients.

The implication of the 1989 ad is that all women want to be young and beautiful, in the particular way that is constructed in the ad, and that the drug intervention recommended by the doctor will enable them to achieve this goal as long as they rely on his judgment. The ad is devoid of conflict. The patient appears to be listening to the doctor's advice, accepting his proposal of treatment, while engaging in a positive interchange. This image is consonant with that of the good patient. A good patient, as Susan Greenhalgh describes, is "a patient who remained in treatment (that is, who *was* a patient), followed the doctor's orders (was 'compliant'), and trusted her doctor's judgment, abilities, and promises to make her better ('had a good attitude')."[103] The "good patient," Greenhalgh argues, is moulded by the doctor from her sceptical and subversive self, through rhetorical appeals to biomedicine that take on an increasingly threatening nature. Gendered expectations operate within relationships so that a woman is expected to be pleasant and personable, to prevent conflict, and to avoid subverting the authority of the man.[104] When combined with the power in the medical relationship, this code of gendered conduct has the potential to be immensely harmful.

1991 Advertisement

An image of a woman, the text "SHE IS WOMAN" and the name "Premarin" are what one sees at first glance in the 1991 ad. "She Is Woman," a twist on the title of the song "I Am Woman,"[105] sung by Helen Reddy, sets the ad in the feminist language of the day. The woman in the ad is not the woman that many would have pictured based on the words of Reddy's famous song. This woman is presented in shades of black and white, mostly grey and she is blurred. The words "She Is Woman" are in thick red capital letters as is the word "Premarin" whenever it appears in the ad. The thickness of the letters indicate solidity and reliability of the product[106] and connecting the two words through colour implies that Premarin makes her a woman or, rather, that without Premarin she is not a woman. The blurring can be interpreted in several ways: it allows her to be generalized, signifying that she is one of millions, that she is without definition

103. Greenhalgh, *supra* note 80 at 113.

104. *Ibid.* at 144.

105. I am woman, hear me roar / in numbers too big to ignore, / and I know too much to go back to pretend / 'cause I've heard it all before / and I've been down there on the floor, / no one's ever gonna keep me down again (Helen Reddy and R. Burton, "I Am Woman," Capital Records).

106. G. Meyers, *Words in Ads* (London: Edward Arnold, 1994).

until she takes Premarin, that womanhood is defined in terms of the reproductive process, and that she is ageless.

The text under "She Is Woman" begins by describing the activities of the woman of the 1990s in bursts of incomplete sentences:

> Today's woman. Woman of the nineties. More aware, living longer and living better.

By using unexpected parallelisms at the beginning of a paragraph, the reader is drawn further into the ad.[107] At this point, the message shifts, and this shift is obvious not only from the meaning of the words but also from the structure of the sentences. From phrases with positive connotations, the text moves to complete sentences that suggest that today's woman is incapable of obtaining and acting on reliable information and that it is the responsibility of the physician to gain control of the situation and set her on the right path to a more liveable life through Premarin.

> In today's need-to-know society, more and more women are seeking information about matters which concern their health and well-being ... Many women devour articles from the lay press, which more often than not, reflect simple reportage and lay opinion. And some are still hung up on myths and yesterday's attitudes.
>
> Ayerst believes that you, the medical practitioner, are the best equipped to dispel these myths about the menopause, to provide the *proper* [emphasis added] perspective through patient counselling and education. You are the best equipped to determine the need for therapy and choice of therapy...
>
> A public awareness program has been initiated urging women in their menopausal years to get the *real* [emphasis added] story on the menopause, its cause and effect. And to get the facts from a professional source. You. The physician.
>
> ... you can help make life more liveable for patients in their menopausal years. And after.

We see conflicting messages in both the image and the text of this ad—feminist language in bold type is used to draw the reader into the ad and then into the text, thereby sending anti-feminist messages. The image suggests fuzziness in contrast to the boldness of the foreground text. One sign in this ad is the text, which is calling upon the doctor's views about the doctor-patient relationship and the doctor's role as a professional expert. It conveys the regressive message that patients must comply in order to be well-informed—and well. W. Nöth states that there are many variations of the text-image relationship, yet the one commonly

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107. *Ibid.*

used is a relationship of mutual determination in which the verbal text directs the interpretation of the picture but the picture is equally necessary to understanding the words.[108] The full meaning of this ad becomes apparent only when the early messages of the text and picture are read in relation to the subsequent text.

The highly political notion of compliance is connected to the paternalistic and hierarchical view of the doctor-patient relationship. The doctor provides beneficent care while the patient relies on the doctor and receives the care provided. This model of care has little to do with the informed and efficacious patient envisaged by the Supreme Court of Canada in the leading case of *Reibl* v. *Hughes*.[109] In the ad though, the woman who seeks information outside the relationship is a traitor, someone who has stepped outside her role as a "good" patient, breaking the social contract of dependence. This patient is deserving of the ultimate put-down—she is non-compliant.[110] She is woman, but she is not really a woman because she is menopausal. She is woman, but she is a misdirected woman since she depends on unreliable sources. She is woman and so she needs the physician to guide her to the correct decision.[111]

Robert Goldman points out that many ads of the late 1980s attempted to exploit feminism and the personal and economic gains made by individual women: "When advertisers appropriate feminism, they cook it to distil out a residue—an object: a look, a style ... Sign-objects are thus made to stand for and are made equivalent to, feminist goals of independence and professional success."[112] Advertisements achieve this exploitation by combining the liberating choices of feminism with the possibility of being personally attractive through consumer choice, in this way joining feminism with femininity.[113]

> Redressing the power imbalance in gender relations was invariably cast in terms of commodity consumption and personal appearance: change occurs not through politics, or strikes, or challenges to the legal system, but through individuated commodity consumption ... These commodified definitions of liberated women are ahistorical and fictional: magically reconciling and unifying the culturally contradictory relations of independence and ultrafeminine romance.[114]

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108. Nöth, *supra* note 61 at 454.

109. *Reibl*, *supra* note 48.

110. Norman Fineman, "The Social Construction of Noncompliance: A Study of Health Care and Social Service Providers in Everyday Practice"(1991) 13(3) Sociology of Health Care and Illness 354.

111. The "big business" of hormone replacement therapy is, as Angier states, like "a vociferous, clanking tank ... that has so much work to do, so many millions of women to persuade." Angier, *supra* note 97.

112. Goldman, *supra* note 68 at 131.

113. *Ibid.* at 107-8 and 132.

114. *Ibid.* at 107 and 108. An early example is found in the use of notions of modern womanhood and empowerment by the industry to create the stereotype that women are solely responsible for birth control. Andrea Tone shows how the pharmaceutical industry in the 1930s marketed birth control that they knew to be completely ineffective and even dangerous in certain cases. They marketed

A woman's body is given value by the male viewer, and, in this way, patriarchal dominance is reasserted.[115] In this ad, she may be woman, but through opting out of the good patient relationship she has abandoned the doctor's gaze. This ad powerfully devalues her as an individual and as a patient.

In the 1991 ad, feminism is portrayed as a dangerous phenomenon. This image fits with the notion described by cultural anthropologist Emily Martin in her analysis of images connected to the process of conception. She explains that when women are active, women are dangerous—spiders luring men into their webs.[116] The autonomous woman of the 1991 ad is presented as a direct threat to the doctor's control over treatment. The uppity women are daring to obtain information outside the context of the doctor-patient relationship. And when they acquire the information, they stop taking the drug. The drug company tries to portray this process in negative terms to the doctor, drawing on the paternalistic hierarchical model of medical practice and using anti-feminist messages to achieve this result. The advertiser makes the overt suggestion of an independent woman with a subversive message about the threat—to the woman—of taking independent action. It is, as Goldman has suggested about consumer ads, an appropriation of feminism. The ad turns feminism against the woman by pointing out the danger of independence and by providing and advocating a return to patient compliance with the doctor's (industry-structured) views. This ad is also constructed to appeal to doctors who see themselves as having the answers and who resist consumer education outside the doctor-patient relationship.

1996 Advertisement

In contrast to the 1991 ad, the 1996 version presents a very clear, definite image of a woman. She is a white middle-aged woman. Her face is reddish, she has sweat on her furrowed brow, her eyes are open very wide, her mouth is half-open, and she has wrinkles. Her facial expression shows emotion, in contrast to the neutral expression on the faces of women in the previous ads. The text on top of this image reinforces the connotation that one derives from the image—in thick, black, straight capital letters the text reads "SHE NEEDS YOUR HELP!" This is a woman who is menopausal, having a hot flush. When the image and text are considered together, we see a woman who is vulnerable, helpless, out of control, pathetic, and who is appealing for help. The text uses the pronoun *your* (help) as a device to direct the appeal directly to the doctor. The exclamation point suggests that action—prescribing Premarin—is needed.

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these products as feminine hygiene products in order to get around the prohibition on contraception. This convenient marketing device prevented the regulation of its false claims, while the ostensible purpose was well-recognized. Andrea Tone, "Contraceptive Consumers: Gender and the Political Economy of Birth Control in the 1930s" (1996) Journal of Social History 485.

115. Goldman, *supra* note 68 at 113.

116. Emily Martin, "The Egg and the Sperm: How Science Has Constructed a Romance Based on Stereotypical Male-Female Roles" (1991) 16 Signs 485.

The next significant aspect of the text is found in the three short statements that advise the doctor, who is not visible in the ad, to "Help treat the hot flushes now. Help prevent osteoporosis now. And stop to think about how to help your patient stay on therapy." The main advertising message has been expanded to reflect research that has demonstrated that women do not remain on therapy.[117] The remainder of the text deals with the issue of compliance. It is paradoxical that the pharmaceutical company suggests that the reason women cease taking Premarin is its effectiveness in decreasing their symptoms. Other significant reasons, such as discomfort with side effects or long-term risks, are not considered. In order to increase compliance and "Keep her on Premarin," which is the advice presented in bold letters at the bottom of the ad, the physician is encouraged to look into the Premarin Compliance Program. This program consisted of a video and magazine called *Seasons,* which is to be given to the woman. The image of the woman on the cover of *Seasons* is in strong contrast to the image of the woman in this ad. The *Seasons* woman (post-HRT) is blonde, beautiful, and smiling.

The 1996 ad is designed to appeal to a traditional paternalistic medical culture; the doctor is in charge, being urged to provide a benefit to the dependent patient. It is a classic heroic medicine ad. With all the exhortations to help, the knight—the doctor—must rescue the woman. The drug plays a critical role as a rescuer, but the ad copy downplays this role and emphasizes the doctor's role in creating compliance. This ad is probably reassuring to those doctors who felt threatened by the feminist woman. This woman clearly needs to be rescued and is pathetically appealing for that help.

1997 Advertisement

A more recent Premarin ad shows a thin woman jogger on a beach, silhouetted against a sunrise or sunset. The colours infusing the ad are soft yellow and rosy hues. This woman is a baby boomer, whose concern for her own health is evident by the fact that she is exercising, whose socio-economic status is demonstrated by her jogging outfit and access to a beach, and whose carefree but controlled nature is suggested by the ponytail flying out behind. The message of the ad is: "She's got better things to think about than osteoporosis and heart disease." What should she be thinking about?

This ad is a departure from the ads of the previous ten years. It focuses in a more explicit way on the prevention of osteoporosis and, for the first time, of heart disease rather than dealing with prevention in a way tangential to the treatment of menopause: "Start with Premarin for the relief of menopausal symptoms. Stay with Premarin for long-term benefits." The healthy lifestyle that is engaged in by this woman determines the operation of the ad. The lifestyle illustrated by jogging is characterized by freedom, possibilities, and continuing youth. Life is being

117. L.E. Nachtigall, "Enhancing Patient Compliance with Hormone Replacement Therapy in Menopause" (1990) 75(4)(Supplement) Obstetrics and Gynecology 775.

lived in the way that women, and their doctors, want it to be—and it is also free from heart disease and osteoporosis.

The sign, in which the woman exerciser is outlined against the soft background of the referent system nature, has elements of a more accepting image of womanhood, although we have concerns about the development of a new stereotype. She is not the uppity woman seeking information outside the doctor-patient relationship, although this woman is clearly an independent and health-conscious person. She is not the pathetic woman needing to be rescued by the doctor and the drug. She is not the ideal woman patient in pearls in the doctor's office, reflecting his social status and her need. This woman is not ill—although there *is* such a thing as being too thin—and is not thinking about diseases. However, the text says that she has more on her mind than osteoporosis and heart disease, even though her activity suggests that this is exactly what she has on her mind. The message is that it is the job of doctors to keep the diseases and their treatments in mind. The jogger is like the woman in pearls in having the necessary income and social position to allow her to take up jogging on a beach. In that sense, she is an updated version of the ideal patient, with some added independence.

Her relative youth places her in the baby-boom generation, which is the target audience for the advertisers' connections between feminism-produced independence and consumption. As in Goldman's ad analysis, the woman's independence and consumption are linked—she can be independent as long as she consumes.[118] Bryan Turner has commented that the self becomes a commodity to present in a package. If so, then the body itself is a sign. "Capitalism has commodified hedonism ... Hedonistic fascination with the body exists to enhance competitive performance. We jog, swim and sleep not for their intrinsic enjoyment, but to improve our chances at sex, work and longevity."[119] The company is appropriating the favourable sign that she has created of herself in order to sell its product back to her so that she can maintain that sign. There is a good reason why she *shouldn't* be thinking about osteoporosis and heart disease. The jogging sign recognizes consumer culture, the purpose of which is to produce desire.[120] "Within a consumer culture the body is proclaimed as a vehicle of pleasure: it is desirable and desiring and the closer the actual body approximates to the idealized images of youth, health, fitness, and beauty, the higher its exchange-value. Consumer culture permits the unashamed display of the human body."[121] It is "the exterior territories, or surfaces, of the body that symbolize the self at a time when unprecedented value is placed on the youthful, trim and sensual body."[122] In this ad, the woman is only a surface, a silhouette, although ironically it's her heart and bones that matter.

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118. Goldman, *supra* note 68.
119. Bryan S. Turner, *The Body and Society* (Oxford: Basil Blackwell Publishers, 1984) at 112.
120. *Ibid.* at 172.
121. M. Featherstone, "The Body in Consumer Culture" (1982) 1 Theory, Culture and Society 18 at 21-2, cited in Turner, *supra* note 119.
122. Chris Shilling, *The Body and Social Theory* (Sage: London, 1983) at 3.

Rosalyn Diprose has said that the body is a sign inviting the interpretation of others. It is "this text of our being-in-the-world which is the object of biomedical practice" and because it is the self being expressed in the body, the ethical dimension of medicine arises.[123] Suzanne Hatty and James Hatty have noted that the modern body has become the focus of individual attention to an extraordinary degree, and the view that the body can be controlled through scientific intervention[124] paradoxically creates uncertainty about how much remodelling one wants to do.[125] In addition, Jean Baudrillard points out that having a body is no longer enough but instead one has to be "into" it—a hedonism indicated by the innumerable fitness studios and gyms across the continent[126] and presumably by jogging on the beach. The woman in the ad doesn't need to think about heart disease and osteoporosis and is free to think about her body image. As Hatty and Hatty argue, the body is engaged in the consumer culture, and it is women in particular "who are inexorably ensnared in this world of false body images," with images designed to create conformity to the stereotypes of femininity. "Therein lies the triumph of the thin woman over the fat woman."[127] In the jogging ad, we see this concept played out as the thin perimenopausal woman triumphs—through Premarin—over her future fat self.

By starting early, she will have a head start on the ideal patient of the second ad, the woman who was looking at the "25" and desiring the beautiful body image that Premarin promised. One signifier is the jogging woman's relative youth, as she is in the perimenopausal stage rather than the menopausal stage depicted in the other ads. The ad asserts that if she takes hormones on a long-term basis, then she can receive the protective benefits against heart disease and osteoporosis. If this group is successfully targeted by the industry, it will mean a massive increase in its potential market.

The woman is portrayed silhouetted against nature, traversing it rather than being part of it. She is a conqueror of nature. In this ad, nature is depicted as a calm and benign force to be experienced by the actor and subsumed to her own purposes. The woman appears as a backlit figure in the scene, which shows that she is also a part of nature. The ad is suggesting that she can keep this healthy and benign position in relation to nature if she takes the drug. The drug will enable her to continue to defy nature. Nature contains within itself the potential for deterioration and disability and so has an implicitly threatening role in this ad. Drugs in general are intrusive rescuers from the ill effects of nature, having the potential to produce or maintain the benign face of nature.

Since this woman shows strength and is in control, in a way that the pathetic woman in the previous ad clearly was not, she does not exhibit the more obvious stereotypes that were displayed in the earlier portrayals of women. She is active

123. Rosalyn Diprose, "The Body Biomedical Ethics Forgets," in Komesaroff, *supra* note 101 at 210.
124. Hatty and Hatty, *supra* note 72 at 22.
125. *Ibid.*, citing Shilling, supra note 122.
126. Jean Baudrillard, *America*, translated by Chris Turner (London: Verso, 1988) at 35, cited in Hatty and Hatty, *supra* note 72 at 22-3.
127. Hatty and Hatty, *supra* note 72 at 23.

and has therefore moved away from the stereotype of men being the active participants and women being the passive supportive nurturers or the vulnerable. It is important to observe that although she is active, she is under threat. The drug's role is to support her in living life in this way. Since she represents the body in consumer culture, she has the pseudo-freedom to express herself through consuming and creating her body.[128]

The diagnostic image for doctors is the baby boomer rather than the older woman. Gerry Stimson argued that diagnostic images are constructed by associating age and lifestyles with a condition and its cure, thereby creating a shortcut to the drug for the practitioner in the diagnostic setting.[129] Since many doctors who are currently in practice are themselves baby boomers, this image has resonance for doctors. The doctor's role, according to the pharmaceutical company, is to identify women who can benefit from the drug at an earlier stage and to educate women who are unaware about the potential benefits—benefits that are under debate among scientists. The signifiers of health and youth, attributes that she already possesses, are transferred over to the drug and then circle back to her future self, leaving her metaphorically where she is now.

Dale Spender makes this point with respect to language, saying that language shapes ideas and that once the classification system for the universe is established in a language, then people using the language "*can see only certain arbitrary things.*"[130] Language is a sign that operates to include and exclude meaning in ads. In the same way, the image that has been selected to present the prescribing profile shapes ideas so that doctors "can see only certain arbitrary things."[131] It is critically important to the health of patients that these perceptions be accurate.

2000 Advertisement

The final ad in the series appeared in 2000. It shows an x-ray of a woman with a fractured hip. The direct message of the ad is that Premarin can prevent the osteoporosis that results from hip fractures. The text, which reads "Premarin could have cushioned her fall," could make readers smile if they pictured a Premarin pill in the woman's hip pocket acting like a cushion, particularly if they imagined the sponge and metal supports found in hip protector pants that are available to the elderly. The message of cushioning continues in other parts of the text: "So, when your patients ask about osteoporosis and menopause, tell them you have some

128. Judith Williamson, "Woman Is an Island: Femininity and Colonization," in Tania Modleski, ed., *Studies in Entertainment: Critical Approaches to Mass Culture* (Bloomington: Indiana University Press, 1986) 99 at 106.

129. Gerry V. Stimson, "The Message of Psychotropic Drug Ads" (1975) 25 Journal of Communication 153. We have explored the implications of this argument in Patricia Peppin and Elaine Carty, "Innovation, Myths and Equality: Constructing Knowledge in Drug Research and Advertising" (2001) 23 Sydney Law Review 543.

130. Dale Spender, "Language and Reality: Who Made the World?" in Lucy Burke, Tony Crowley, and Alan Girvin, eds., *The Routledge Language and Cultural Theory Reader* (Routledge: London and New York, 2000), 145-53 at 145 [emphasis in original].

131. Nöth, *supra* note 61 at 232.

very comforting news." As in the previous ads, the message is paternalistic and plays on a particular theme. All ads are meant to draw the reader in, and, in this ad, the primary text of the ad is placed in a soft, slightly rounded font, which contrasts to the stark x-ray image of the pelvis.

The sign of the fractured hip bone represents the whole woman who has fractured her hip. It is a reductionist image, with the part representing the whole and the injury representing the disease. The fractured hip itself signifies the menopausal experience. Although the use of body parts in which women are reduced to their most sexual parts has been criticized in advertising literature,[132] its use in this context lacks this type of offensiveness. The sign of the hips is a perfect illustration of Michel Foucault's idea that the profession's gaze is directed not at the person but rather at the disease, a transition that left behind the act of caring for patients.[133] The use of the fractured hip creates a focus on this sole problem to the exclusion of other aspects of menopausal experience.[134] This focus replicates the latest medical information indicating that the protective effects of Premarin extend to bones. The text says that when taken long term, Premarin has been shown to reduce osteoporotic fractures by 50 per cent. There is an asterisk at the end of this statement that directs the reader to the fine print, which states: "in addition to other therapeutic measures such as diet and exercise." This addition reflects the current debate on the relative merits of lifestyle versus pharmacological approaches.

In her analysis of medical advertisements in Australia in 1993, Deborah Lupton reports that several dominant archetypes are used: the dismembered patient, the mechanical patient, the gendered patient, and the active patient. Generally speaking, the ads she studied depicted patients as medical conditions or body parts rather than as whole individuals and, in this way, diminished the importance of human conduct in the medical encounter. Lupton notes that the patriarchal doctor-patient relationship dominated.[135]

The hip might have come from any woman. In this sense, the hip represents all women. It is not specific to any racial group, unlike the previous ads in the series, which portrayed the majority white population. This hip then signifies the essentialized woman,[136] devoid of any racial characteristics. This ad provides a response to the criticism of an over-representation of one group to the exclusion of others, at least to the extent that it does not choose to represent only one group.[137]

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132. Robert Goldman and Stephen Papson, *Sign Wars: The Cluttered Landscape of Advertising* (New York: Guilford Press, 1996).

133. Michel Foucault, *The Birth of the Clinic*, cited in Greenhalgh, *supra* note 80 at 19.

134. See Elizabeth A. Grosz, *Volatile Bodies: Toward a Corporeal Feminism* (Bloomington: Indiana University Press, 1994), for a discussion of the relationship between signified and subjective experiences of bodies.

135. Lupton, *supra* note 1.

136. Elizabeth Spelman, *Inessential Woman: Problems of Exclusion in Feminist Thought* (Boston: Beacon Press, 1988).

137. Finy Josephine Hansen and Dawn Osborne, "Portrayal of Women and Elderly Patients in Psychotropic Drug Advertisements" (1995) 16 Women's Therapy 129. Hansen and Osborne

It does not exclude any particular group, but rather leaves it to the viewer to decide which groups to include. At the time that this ad appeared, we found that ads were beginning to show signs of inclusion of multiple racial groups, various social classes, multiple ages, and both genders. A few ads accomplished this by including a group of patients in the ad itself or around the border of the ad, while others have used an ad series showing different patients with different concerns.

The ideal patient that is represented in the first ads in this series—the socially acceptable woman who is dependent on the white-frocked doctor for assistance with the symptoms of menopause—has changed in this last ad into a fractured hip, which is a sign for menopause. The patient's dependence on the doctor is no longer evident. The doctor and the drug share the heroic role of rescuer in the first three ads, and they do rescue—most explicitly in the third ad ("she needs your help")—but in the x-ray ad, it's too late. In this last ad, the woman is a failure. She has failed to take the hormone and has suffered a bone fracture. All the other women can be rescued by the drug, since this is the essential message in all advertising. Even the uppity woman who has obtained information elsewhere can be set straight by the doctor, particularly by the doctor who obtains the Premarin Compliance Package. The baby boomer jogger can be rescued too, or has already been rescued, by the doctor who has symbolically traversed the distance in order to reach her running against the sunset. None of these ads depicts patient participation in a positive light. The anti-feminist ad is the most clearly anti-participatory of the ads and the most insidious portrayal of women that we have encountered. Only for the bones is it too late.

Conclusion

The ads in this series depict the menopausal woman desiring an earlier body image, a menopausal ideal patient, the feminist non-compliant woman who needs to be brought back into line (but who, strangely enough, seems to have the fewest symptoms of menopause), the pathetic menopausal woman who needs to be rescued, the perimenopausal jogger who is achieving the thin body image and who does not need to worry, and the essentialized woman who is reduced to the sign of menopause itself—a fractured hip.

All the ads presented in this discussion use stereotypical views of women. Women are reduced to the simple constructs that drug companies think will resonate for doctors at a particular time—the ideal patient woman, the uppity feminist woman, the symptomatic needy woman, the bony baby boomer jogger, and the entirely bony essentialized woman. Each ad calls upon different responses from a doctor—trust me and rely on me, listen up and comply, I hear you and I will help, and keep up the good work. No ad represents the situations of the multiple diversities of women's social situations and experiences. The only women who are portrayed are Caucasian, middle or upper middle class, and

found that there were too few ads portraying groups other than white for them to conduct an analysis of race.

seemingly able-bodied, apart from the final ad in the series in which a hip fracture represents "woman." No ad acknowledges the variety of ways women experience menopause. There is no guarantee that the particular woman will receive an appropriate treatment for her own situation. It is also significant that the target audience changes throughout this period of time, from the clearly menopausal woman to the perimenopausal woman. At the same time, the health "problem" that is being targeted also changes, from the hot flushes of menopause to cardiovascular protection and the prevention of osteoporosis. Over this fifteen-year period from 1986 to 2000, the scientific literature has been replete with debates over the relative contribution of lifestyle factors as well as hormones to prevent and/or counteract these conditions of aging.

Semiotic analysis has shown how drug advertising leaves nothing to chance. The ad as a whole, and also every detail within it, is created to draw upon particular values that are transferred to the product and that will lead to the prescription of the drug. Consciousness of the semiotic process and the particular constructions of women and disease used to power the ads will ultimately help revise the images and understandings of health and illness experienced by all women. As prescribing privileges are extended to more health practitioners, including midwives and nurse practitioners, and as direct advertising increases in scope and direct ordering of prescription drugs through the Internet expands, an opportunity is presented to reshape advertising images and the construction of women. Since the process of construction is subtle, it defies simple regulation through the blunt instruments of legislation and regulation. An awareness of the methods used by advertisers, the ways in which they present patients, and the images created in the minds of doctors would be beneficial for advertising reviewers. The WHO's Ethical Criteria for Medicinal Drug Promotion contain the requirements that promotion should contain reliable claims that do not contain misleading or unverifiable statements and that they should contain no omissions that could lead to health risks. Ads that predispose physicians to prescribing in over- and under-inclusive ways for particular groups have led to health risks.

Stereotypical presentations undermine effective relationships between doctors and patients and lead to further health risks. The messages of drug ads imply certain things about women that are not in women's best interests or in the interests of the doctor-patient relationship. Discriminatory practices can ultimately harm health.[138] Perceptions that are structured using stereotypes are particularly invidious because they both perpetuate and extend discriminatory images. As a result of the way these drug images portray some individuals and exclude others, ads exert a subtle influence with high costs in the discriminatory impact of such imagery.

The literature on the medicalization of the body focuses on the knowledge and power of the medical profession in creating medicalized bodies. Our research indicates that the pharmaceutical industry uses these medical perceptions, along with social stereotypes, to sell more products and that a by-product of this ad

138. N. Kreiger, "Embodying Inequality: A Review of Concepts, Measures, and Methods for Studying Health Consequences of Discrimination" (1999) 29 International Journal of Health Services 295.

process is the continuation of these oppressive perceptions and practices. The role of the drug industry in creating the non-inclusive medicalization of the body needs to be recognized, and the unconscious link between the pharmaceutical industry and medical practitioners needs to be broken. Doctors and other health professionals need to be educated in the construction of drug advertising. An awareness of the semiotic methods used to construct ads and a consciousness of the types of stereotypes and myths operating within the ads will alert doctors to the kinds of categorizations invited by the advertisers. Undergraduate medical school curricula can include analyses of drug advertising, and continuing medical education sessions can perform this function for practitioners. At the same time, consumers need to develop a heightened awareness of advertising techniques. Through the education of professionals and patients, through the use of the legal process in strong cases, through efforts to strengthen the ad evaluation process, and through activism in this arena, we may be able to come closer to achieving the health goals of safety and efficacy and to achieving for all women a greater degree of equality in our health care.