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Internet Health and the 21st-Century Patient
A Rhetorical View

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Internet health—here, the public use of information Web sites to facilitate decision making on matters of health and illness—is a rhetorical practice, involving text and trajectories of influence. A fulsome account of it requires attention to all parts of the rhetorical triangle—the speaker, the subject matter, and the audience—yet most scholarship on Internet health focuses on the speaker only: it typically raises concerns primarily about the dangers of unreliable sources, suggesting that, where speakers are reliable and information is accurate, Internet health simply empowers patients. This essay turns attention to the other elements of the triangle. It argues that health information is a complex entity—not only transmitted but also transformed by the Web—and, further, that Internet-health users are a complex audience—not only informed but also transformed by the Web. Rhetorically-minded researchers are well positioned to study not simply the informed patient but rather, more comprehensively, the wired one.

**Keywords:** cybermedicine; e-health; medical rhetoric; consumer health; patient empowerment; rhetoric of health; rhetoric of medicine

**Introduction: Setting the Problem and the Rhetorical Situation**

The consumer health and women’s health movements of the late 20th century went a long way to improving health promotion, maintenance, and care; they did so, in part, by making more information available to more...
people through more media. It is a good thing, for example, that, as historian Andrea Tone (2009) explains, accounts of patient experience were added to the store of public knowledge about health; personal accounts became “an integral part of the activist movements that [inter alia] made the side effects of medications part of the public domain” (p. 144). It is not clear, however, that the unfathomable amount of health information available on the Web acts primarily to produce the empowered patient celebrated in so much of the commentary on Internet health. Internet health is a complex rhetorical situation, and its effect is likewise complex.

“Internet health” (sometimes “cybermedicine” or “e-health”) refers in different contexts to different activities including, among others, accessing electronic health records, consulting physicians by e-mail, shopping online for pharmaceuticals, and blogging about illness experience. In this essay, I use the term to refer to a single online practice: visiting health-information Web sites in aid of making decisions about one’s own and one’s family’s care. My “Internet-health user” is the person engaged in this practice; I sometimes (and sometimes imprecisely) call her the “patient.” The purpose of my essay is to argue that the Internet-health user is not simply empowered by the Web but rather remade by it, and she is remade in a way that does not necessarily render her an especially good health consumer or decision maker.

One reason that being informed does not simply mean being empowered is that information is not a stable entity, retaining its shape and meaning wherever it goes. Rather, information (too often confused with knowledge, in any case) is a shape-shifting thing. It means differently in different settings; it is not a package that is delivered intact to any mind, a layperson’s or a physician’s. Moreover, as information travels through the Web, it is changed for that reason alone: information on the Web is not information just as we would have it from a physician, a friend, or a domestic health guide, only much, much more of it; it is something new. We are not, as Internet-health users, like readers of a book or interlocutors in a conversation. We are, to borrow a description from sociologist Scott Lash, a man/machine interface. Lash calls us “technological forms of life”; I simply want to note that Internet-health users are not a traditional sort of rhetorical audience.

I wish, that is, to extend the account of Internet health as a rhetorical transaction. Certainly, it is a rhetorical transaction: it involves text and trajectories of influence. Internet-health users read about, and then adjudicate on, matters of health and illness (Shall I take this medication? Shall I get myself to an emergency room? Shall I consider myself to have been poisoned?). The
syllogism underlying the common claim that Internet-health users are empowered by the Web goes like this: the more information people have, the more powerful they become; the Internet provides a lot of information; therefore, the Internet is empowering. The problem with this syllogism—aside from the perhaps too simple nature of its major premise—is that it attends to only one corner of the rhetorical triangle: the corner where the speaker resides. It suggests that if the speaker—the Internet source—is reliable,^2 and information is accurate, then all is well; the audience is called upon only to tell a good source from a bad one. I wish to turn rhetorical attention to the other two corners of the rhetorical triangle: subject matter (in this case, health information) and the audience (the Internet-health user). As Internet-health users, we understand ourselves to be sick or well, and we make judgments and follow courses of action, on the basis of information we have gathered, typically alone at our computers, sometimes late at night, often in a state of anxiety. The process is trickier than, at first, it seems—for one thing, we are not simply rational subjects at our keyboards—and the rhetoric of empowerment elides its interesting problematics. Researchers on writing and medicine have a role to play in making commentary on Internet health more complex, more realistic, more rounded, and more useful.

A couple of examples will help set the problem. A family-practice physician reports to me that a child with allergic conjunctivitis, causing red, itchy eyes, was brought to see him by her father; the case was uncomplicated, and the physician made the diagnosis. However, the child’s mother had read on the Internet that itchy eyes are sometimes associated with multiple sclerosis (MS), and she was convinced that MS was the true diagnosis; she was inconsolable (GF, physician, Vancouver, June 25, 2008, in conversation). The problem here is not the unreliability of the Internet source, and it is not the inaccuracy of the information: itchy eyes can be associated with MS. The problem is, at least in part, that the mother used the Internet in a state of anxiety and jumped to the wrong conclusion. The mother’s anxiety, moreover, left her unable to be reassured by her child’s physician: his diagnosis of conjunctivitis was unpersuasive.

The mother was trained, as many of us have been, by health-information sites and direct-to-consumer advertising, to believe that disease is a list of symptoms, a list as available to patients as it is to physicians. The democratization of health information, however, can include a faulty view of knowledge and expertise: the problem is not just that laypeople do not know what doctors know; it is that they cannot know it. To wit: In another case, an Internet-informed patient worries that blood in his stool means that he has colon cancer. His doctor knows, tacitly, that the patient’s recent—though
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diagnostically unrelated—lab work showing no abnormality in hemoglobin level is an indication that, whatever this blood is a symptom of, it probably is not a symptom of an established cancer. The patient has not thought to ask what last year’s lab work retrospectively suggests, and the physician does not think to mention what his glance over the patient’s file reveals; the physician is reassuring, but not specifically. We might then prefer to imagine a situation in which the patient is told everything the physician knows: full disclosure. Still, the patient would not know what information to request, and, if he had all possible information, would not know what, taken together, it means (or to what extent it means it). As long as biomedicine is the sort of institution it is, with well-worn institutional genres and practices—including the special education of the physician and the time-limited doctor-patient interview (not to mention systemic physician paternalism)—the Internet cannot produce the empowered patient.

We do not, in any case, usually expect information repositories to do the work of professionals trained into a regime of thinking. As professors, for example, we model routines of scholarship. In our courses, students and professors may both read, say, Plato and Derrida, but what we understand, each of us, when we read them is not the same. In the classroom, we are called upon to be not only experts on but also experts at. Yet the common view of Internet health positions information Web sites in precisely the way we would prefer our students not position Wikipedia on Plato and Derrida. I am not objecting to laypeople becoming informed on matters of health; such an objection would be ridiculous. However, the informed patient should be informed also about the natures of knowledge and expertise.

Online rhetoric in general (see, for example, Warnick, 2007) and the rhetoric of online health in particular (see Koerber & Still, 2008) are topics of growing interest in the field of written communication. My efforts here are indebted to, and, I hope, extend, the work of scholars who have begun to describe the complexity of rhetorical relationships wrought by the World Wide Web. Certainly, immediacy and flux are part of that complexity. Since I began studying Internet health, much has happened to the object of my investigations. For example, the Web site PatientsLikeMe came online in March 2006 (see Goetz, 2008) as an authoritative, experience-based site for people with serious, chronic conditions like multiple sclerosis and amyotrophic lateral sclerosis (ALS or Lou Gehrig’s disease). PatientsLikeMe formalizes the idea that, for example, the person who is coping with MS-related muscle stiffness can make better suggestions about dosing with baclofen, a muscle relaxant, than a physician can, standing back with a pharmacopeia and a prescription pad. On May 19, 2008, Google announced
the launch of Google Health (Auchard & Beck, 2008), soon to come fully online for public use. When people are able to use Google to manage their health/medical profiles by accessing health records, making medical appointments, filling prescriptions, and gathering information about diseases they may or may not have, many will do that. Internet health and Internet health platforms are shifting, and so is the rhetorical situation that I wish to describe.

While there seems to be an effort across research disciplines such as public health, health communication, and health informatics, to understand the relations of health information, consumerism, and the Internet (see, for example, Eysenbach & Jadad, 2001; Hardey, 2001; Henwood, Wyatt, Hart, & Smith, 2003; Kivits, 2004; Seale, 2003), much of the literature tends, as I have suggested, strongly in the direction of commentary on the speaker/source—in particular, its ability to empower—and there is less scholarship than one might expect on Web technology itself as it creates the 21st-century patient. In respect to technology, it has been difficult to go beyond saying, after McLuhan (2003), that the medium is the message. But we must say more. Internet health changes the world in which it appears, and the change is not adequately understood as a change in the quantity and availability of information as we knew it.

My essay, then, is a prolegomenon to further study of the rhetoric of Internet health. Further study may proceed in many directions; the next phase of my own research focuses on the history of the health subject as consumer of medications. (We are currently an audience for online information about, and direct-to-consumer advertising for, prescription pharmaceuticals; how did we come to be the particular sort of audience that we are, so susceptible to persuasion by drug marketers? What is our collective patient/consumer biography? [Segal, 2009])

To compose the current essay, I read a range of texts—primary and secondary—through lenses of theory and history. Primary texts included health Web pages, some quite authoritative (for example, at the site of the U.S. Centers for Disease Control and Prevention) and some less so: Morethanmedication.com, which advocates for nonpharmacological solutions to health problems, is sponsored, disingenuously, by drug manufacturer, Pfizer. I studied advertising sites as well as sites that, while sponsored by pharmaceutical companies, do not appear at first glance to be advertising. For example, Depression.com is a domain name of GlaxoSmithKline; the site presents itself as a disinterested source of information, but it draws its user, with just a few clicks from any direction, to information on GSK’s prescription antidepressants. I studied patient-centered disease sites for,
among other conditions, attention deficit disorder and breast cancer. Some were what are sometimes called “Astroturf” sites (faux grassroots sites); some had a fundraising agenda. For example, a comprehensive site for breast cancer information is owned by Susan G. Komen for the Cure and is rooted in a particular, if mainstream, version of breast cancer culture.

Secondary texts included accounts of online communication, and, especially, of Internet health sites and their users (user logs are elements of the methodologies of several research projects), written across a range of disciplines, including, where possible, rhetoric and discourse studies. One of the most interesting sources I discovered was a report by specialists in medicine and computer science (White & Horvitz, 2008), produced for Microsoft on search trajectories of Internet-health users.

My filtering theory, or lens, was, for the most part, rhetorical theory, from Aristotle to Burke (see Aristotle, 1960; Burke, 1969), but it included, also centrally, media theory, beginning with McLuhan (2003) and proceeding to more recent work by sociologists Lash (2001) and Nikolas Rose (2007). My historical research took me back to the 18th and 19th centuries, with my greatest attention focussed on the period in North America and the United Kingdom, about a hundred and fifty years ago, when many homes had health almanacs and domestic health guides aimed at self-diagnosis and self-treatment, and many people were ready consumers of both patent medicines and the testimonials in their favor. (The practice of requiring physicians’ prescription for so-called “ethical” drugs did not arise until well into the 20th century.) My observations suggest a need for rhetorical, or rhetorically inflected, studies of Internet health.

A final note: As the primary locations, however virtual, of my study are North America and the United Kingdom, I have in mind a particular kind of health subject—one with, typically, some choice and, often, some power and autonomy. In other locations, and in developing countries in particular, Internet health is a different object of study.

**Internet Health: The Standard View**

Internet health is a compelling topic for rhetorical study, because the process takes place squarely in the space of public discourse. The Pew Internet and American Life Project reports that, in the United States, 80% of Internet users, or about 113 million adults, use the Web to find health information. On a typical day in 2006, about 8 million American adults went online for information about specific diseases, as well as information
about diet, drugs, exercise, smoking, and other health topics (Fox & Rainie, 2002). In Canada, among people with online access, 58% search the Internet for health information, up from 46% 5 years ago (Bendall, 2007). In 1999, Eysenbach, Sa, and Diepgen announced in the *British Medical Journal* the arrival of “cybermedicine,” citing a “revolution in health care . . . driven by a massive consumer demand for online health resources” (p. 1). The “problems” of cybermedicine, they said at the time, tellingly, were “the quality of online information, lack of standards, and lack of social equity” (p. 1).

Hundreds of scholarly articles—in disciplines from medicine to sociology of health and illness and many in between—talk about Internet health as creating a new kind of patient: an informed patient, responsible for her health and willing to make decisions about her own and her family’s care. The research literature is not monolithic, to be sure, but it does promote a dominant view, and the view is that Internet health is empowering: it provides patients with information that they can use to circumvent their physicians or else direct their physicians’ attention in accordance with their own (sometimes Web-tutored) felt experience. “Complete this symptoms check-list and bring it to your doctor” is a frequent instruction of Web pages.

The raison d’être of Internet health in this view is to get information to “consumers” who need it, “when they need it, and in the amount and format in which they need it” (Eysenbach & Jadad, 2001, p. 290): “Ideally . . . , all consumers should be able to access valid and relevant information about their health status. They should be able to judge the advantages and disadvantages of all possible courses of action, according to their values, beliefs, preferences and their personal circumstances” (Eysenbach & Jadad, 2001, p. 290). Further examples characterize the dominant view in the research literature: “Contemporary thinking in the health care arena leads health professionals to view patients as consumers . . . people who are able to make their own decisions about the care they receive, express opinions about the care and evaluate the care, provided they are well enough to do so and wish to do so” (Henderson, 2002, p. 105). According to Kivits (2004), “‘Informed patients’ are negotiating agents whose health responsibility is both a matter of increasing knowledge about everyday experience as a part of a reflexive project and a matter of locating this project within a broader informational environment” (p. 510).

Not all of the cross-disciplinary literature I examined itself promotes Eysenbach and Jadad’s ideal (get the right information to consumers at the right time, in the right way), but—except for some sociological literature that critiques the consumerist model of health itself (Frank, 2002) or raises
questions about governance and the neoliberal patient/citizen (Nettleton, 1997)—most of it describes a situation in which any problem that may exist in Internet health is a problem of source reliability or the user’s ability to make appropriate selections in the face of a plethora of Web sites. The model itself of information in rapid, disorganized, motion is seldom questioned; rather, researchers describe problems that occur, primarily, when information is actually misinformation. Adams and Berg (2004) report that experts on Internet health view the current situation with “both enthusiasm and skepticism, as existing information is considered to be able either to help those searching for health care information by empowering them with knowledge, or to hurt them by subjecting them to fraud and ‘quackery’” (p. 150).

Even when researchers acknowledge that the position of the patient in the model is not problem free, this acknowledgement is seldom used to critique the model. Therefore, for example, Hardey (2001), discussing patients as both consumers and producers of information (they are producers when they go online to inform other patients), finds that patients are often untrustworthy; yet their untrustworthiness is not construed as a problem for the model itself. The gist of Hardey’s account is this: “The development of information and communications technologies . . . , and in particular the Internet, is collapsing the boundary fences around previously carefully guarded information domains that form the basis for professional monopolies such as medicine” (pp. 388-389). In other words, Internet health is democratizing and that is simply good. Nettleton, Burrows, and O’Malley (2005), offering a meta-analysis of research on Internet health, classify responses in the medical, sociological, and popular literatures as “celebratory” (positive), “concerned” (negative), or “contingent” (both positive and negative, depending on context). The authors classify their own response to patient use of health-information sites as “contingent and embedded,” making a claim about the complexity of their analysis, but they miss an opportunity for more serious engagement with their topic by not taking into account that information available to “consumers” on the Web, even when it is accurate, is more than a commodity.

Typically, in this literature, as I have said, the user is implicated in the Internet health process only as someone who may not recognize an unreliable source when she sees one. Nettleton, Burrows, and O’Malley (2005), for example, write about “rhetorics of reliability,” referring to self-reports of users on why they trust some sources and not others. The authors’ description relies on the self-construction of the user as someone who is “cautious” and “careful,” and who behaves in a way that is “legitimate, appropriate,
and sensible” (p. 984). In fact, however, users who, at the moment of searching, may be overwrought, are not always the best judges of their own reliability.

In the dominant view, then, both information and the people who get it are givens, reified. Neither is altered in the process of exchange, while the “ideal” situation is one in which all information is accurate and all consumers are careful—and the Web itself is a sort of good doctor. A rhetorical view primes us to take a closer look at computer-mediated information and at audience, and to recognize that not all users are the same, and each user is not the same all the time.

**Internet Health: A Rhetorical Account**

In addition to asking how users decide which sites to visit, know which ones to trust, evaluate information, and negotiate contradictory accounts (although these “how” questions are all important), we ought to ask some prior “what” questions. We ought to discern the rhetorical features of the Web interaction and consider the Internet-health user as a rhetorical subject, a person made in discursive interchange with Internet speakers who, typically, are both unknown and personal, utterly remote and yet, perhaps, sitting on the bed—speakers who are hyperinformed and yet almost invariably unable to supply motives for patient procedures in the particular case. When they search for information on “headache,” as we will see, many users are drawn (as if to a train wreck) more readily to “brain tumor” than to “sinusitis.” Information may be empowering when it is information-for-use, but in many situations, the Internet can do no more than provide information with little direction about how to use it.

What we typically think of as getting health information is, in any case, not wholly a unidirectional process, in which the Web informs the patient, well or badly, and the patient takes the next step—sees her doctor or purchases a drug, or has her fears allayed and withdraws to Google another day. Rather Internet health is a bidirectional process: the Web makes the user and the user makes the Web too. The Web makes the user in part by immersing her in information that is simultaneously remote and immediate, pertinent and impertinent; it keeps its distance and casts an unimaginably wide net, and, at the same time, it may interrogate the user directly with diagnostic checklists, and hail her (that very person) as a patient. Meanwhile, the user makes the Web in a number of ways. The user may not act back on the Web purposefully, although she may do so, for example, by posting
something to a discussion board that then becomes part of what the next user finds. The user, in any case, makes the Web passively. We know, for example, that, in most search engines, the most accessible Web sites are the ones most frequently accessed; they appear highest up in the chain. Software companies can track users of health Web sites and generate records of searches that may then become maps for other users.

With these trajectories of influence in mind, we may seek warrants in media theory for claims about what the Internet does to information other than just deliver it to us. One approach is to consult sociologists Nikolas Rose and Scott Lash to tease out a view of the Web/user interface more generally, and bring their observations to bear on the case of Internet health.4

Citing research by Carlos Novas (2003) on Huntington’s Disease Web sites, Rose (2007) says, “the practices of posting, reading, and replying to messages in . . . webforums and chat rooms can be seen as techniques of the self, entailing the disclosure of one’s experiences and thoughts according to particular norms, values, and forms of authority” (p. 126). The Internet, in other words, constitutes a new realm in which to be ill, and this realm has special codes of conduct. Using the codes, Rose suggests, changes us and changes our relation to the world. According to Rose, experiential authority “can be ‘folded’ into the self . . . . In the process, relations with older forms of authority, such as medical and genetic expertise, mutate” (p. 126). Rose’s discussion of the altered patient supports the notion that Internet health does not simply increase information, and access to it, within an existing relation of information source, audience, and subject matter. All elements of the rhetorical triangle need to be reexamined and reevaluated, because the triangle is new: it is a triangle within a new technology. 

Lash does not himself address matters of health and medicine, but he explains that the Internet transforms both information and the people who use it. He can be taken to give an account of what it means, in 2009, for the medium to be the message (per McLuhan, 2003); he offers the notion, “technological forms of life.” “We make sense of the world,” Lash (2001) says, “through technological systems” (p. 107). As sense-makers, we operate as “interfaces of humans and machines,” “conjunctions of organic and technological systems” (p. 107). The rhetorical study of Internet health subsumes some understanding of that interface. What is in play, as I have said, is not information as if it were coming from our family doctor or a friend or a book, only more of it, at our fingertips. In other words, the online patient is not new by virtue of being terribly well informed; she is new by virtue of being, arguably, a technological form of life—at least, a nontraditional rhetorical audience, engaged with a nontraditional message.
Lash (2001) goes on to say that new technologies are nonlinear, and “the break with linearity involves speed-up” (p. 110). For the same reason, he says, narratives, metanarratives, and reflection itself, as we know them, belong only to nontechnological forms of life: “Technological forms of life are too fast for reflection . . . . They not only compress linearity; they outpace it” (p. 110). Furthermore, technological forms of life are “disembedded”; “they are somehow ‘lifted out’” (p. 113). Lash’s description supports what I have in mind when I say that both information and its users are changed by a technology which is understood only inadequately as a technology of communication. Indeed, “communication,” with its invocation of sources, targets, channels, and arrows—and its (John) Lockean view of ideas as transferable in language from one mind to another—oversimplifies what is going on when people turn to the Internet with health concerns.

**Considering the Whole Internet-Health User**

People who access health information online can be divided, in a first cut, into two kinds, although the same person can be both kinds at different times. There are users who seek health information primarily for health promotion and maintenance or for already diagnosed chronic conditions (for example, migraine, diabetes, or arthritis) on which they may have already become expert. Other users approach the Web with a different motive, in a different mood, and, often, with a pressing question: “My arm is numb; am I having a stroke?” “My chest feels tight; is this a heart attack?” Proxy users are sometimes in this state, searching for information about their children, for example, and their hands are shaking as they key into a realm that I would submit, frankly, they cannot always navigate well: “My 3-month old has a high fever; should I take her to an emergency room?” “My 2-year old has red, itchy eyes; what does this mean?” Both indiscriminate and hopelessly personal at the same time, sped up and lifted out, Internet health has some of the structure of panic itself.

In a recent study for Microsoft, investigators Ryen White and Eric Horvitz (2008), found that people who use the Internet to acquire health information are susceptible to cyberchondria, which the authors define as “the unfounded escalation of concerns about common symptomatology, based on the review of search results and literature on the Web” (p. 1, italics in original). White and Horvitz’s large-scale, longitudinal, log-based study of how people search for medical information online found that Internet users tended to proceed to rare and catastrophic explanations for their
complaints, even when common and benign explanations were available. For example, a search on “headache” would lead many users more readily to “brain tumor” or “ALS” than to muscle tension or sinusitis. The authors suggest changes in “document ranking, user modeling, machine learning, and user interface design” to stem the panic of Internet-health users (White & Horvitz, 2008, p. 36). White and Horvitz provide strong evidence that Internet navigation creates opportunities for increase of anxiety. I have been suggesting that sitting alone at the computer, possibly in the middle of the night, often already in a state of anxiety, sponsors such escalation as well.

White and Horvitz’s (2008) study adds to only a small corpus of research on the frightened or anxious Internet-health user. Eysenbach and Diepgen (1999), for example, write about the “motivation, expectations, and misconceptions” of certain patients seeking medical information and “teleadvice” on the Web. The authors looked especially at unsolicited e-mails sent to physicians in search of advice; the e-mails spoke of “frustration and/or desperate information seeking from multiple sources” (p. 154). In an essay titled “Worried and Wired,” Eastin and Guinsler (2006) suggest that “an individual’s level of health anxiety moderates the relationship between online health-information seeking and health care utilization decisions” (p. 494). Anxiety, however, is seen here as a pathological condition of the user. Eastin and Guinsler found that “individuals with even moderate levels of anxiety seek higher amounts of online health information. Frequent online seekers also tend to make more medical appointments based on information found online” (p. 497).

Eastin and Guinsler (2006) do not comment on the nonpathological frightened user. Balka (quoted in Bendall, 2007) gets closer: “[W]e tend to go online after health crises,” she says. “While it would be nice to think that we’re mostly sussing out the benefits of Pilates or the best sources of vitamin D, that isn’t happening . . . . [M]ost of us are checking symptoms and looking up treatments” (p. 1). Since the term cyberchondria was coined in 2000, articles have appeared from time to time, in both print and online news services, on its vagaries. For the most part, the topic has been treated lightly—which is not surprising: hypochondria itself is often a topic of, however uncomfortable, humor. Ever since the figure of the hypochondriac appeared in public (see, for example, Molière’s La Malade Imaginaire), that figure has been ridiculed and his—the original hypochondriac was gendered male—suffering was made laughable (see Segal, 2005). Microsoft takes cyberchondria seriously.

In fact, most of what is written about Internet health takes my first kind of health-information user as the default kind: this user is, typically,
interested, inquiring, and rational. The very idea of information-based decision making and health consumerism is rooted in what rhetorical theorists recognize as *logos*: it is judgment driven by the arguments themselves. We know, however, that quite a different process of persuasion is taking place when *pathos* surpasses *logos* for judgment—when, for whatever reason, the audience is tilted for emotion. That is the condition my second kind of user is in categorically.

I am picking up this piece of rhetorical theory—Aristotle’s tripartite division of appeals (*logos* is the rational argument; *pathos*, the argument from emotion; and *ethos*, the argument from the character of the speaker)—to make the point that emotion, and fear as the most salient of these, is significantly a key element in the selection and navigation of Internet health sites. My first concern is not fear as it plays at any particular Web site, although fear is part of the catalogue of appeals in Internet health and is standard fare in direct-to-consumer advertising of prescription pharmaceuticals. In the case of the anxious Web user, the emotion most rhetorically powerful is not the emotion that, for example, a pharmaceutical company brings to the rhetorical situation; it is the emotion already in the user when she begins to click.

In general, the fear neglected in research on Internet health is that fear that resides in the user. People seeking health information on the Web are, at least some of the time, not best characterized in the cool figure of the home researcher. Any information seeker may, however transiently, have something in common with the aforementioned *cyberchondriac*, trying on diagnoses and waiting for confirmation from her body. In other words, again, the Internet-health user is not the new empowered patient that Eysenbach and Jadad (2001) and others describe: not only is information ambiguously useful and the user, sometimes, irrational, but also the informed, decision-making, patient is anything but new.

**A Historical Piece for the Rounded Account: The *Old* Empowered Patient**

Laypersons have long had access to health information, independent of their physicians. In the 18th century, for example, no literate household was without a comprehensive domestic health guide, complete with recipes for treatments that could be prepared at home.

Eighteenth-century medicine was characterized by the populist notion of “every man his own physician,” which was, in fact, the short title of a widely
circulating book by John Theobald, called, *Every Man his own Physician. Being a Complete Collection of Efficacious and Approved Remedies. For every Disease Incident to the Human Body. With Plain Instructions for their Common Use. Necessary to be Had in all Families, Particularly Those Residing in the Country.* The book was published in 1764, and, with other domestic health guides, it circulated in a world in which, as historian Charles Rosenberg (1992) has said, “knowledge and competence were not segregated in credentialed heads and hands” (p. 57). By the end of the 19th century, however, following a series of events that included the rise of technologies that removed the patient from the process of her own care,6 medical competence was in the hands of licensed practitioners, in a proprietary frame of mind, and, self-help books notwithstanding, physicians sought explicitly to deprive their patients of the sense that they could look after themselves.

An 1890 book for practising physicians offers this advice:

> Especially avoid giving self-sufficient people therapeutic points that they can thereafter resort to. . . . It is not your duty to cheat yourself or other physicians out of legitimate practice by supplying this person and that one with a word-of-mouth pharmacopoeia for general use. If compelled to give a person remedies under a simple form, study to do so in such a way as not to increase his self-conceit and make him feel that he knows enough to practice self-medication and dispense with your services. (Quoted in Starr, 1982, p. 87)

The concerns of such physicians resonate with the well-documented concerns of some 21st-century physicians about Internet health. Eysenbach and Jadad (2001) report, for example, that a “survey from the US shows . . . only 39% of all professionals see the Internet as a valuable health information source for consumers” (p. 291).

Far from being simply an innovation, Internet health is a new iteration of a direct exchange between patients and information, absent the physician. I have said that health without professional mediation was, well into the 19th century, the way people conducted quite a lot of health business. If we look at Internet health this way—as a new technology for disintermediating the physician7 rather than a means of inventing a empowered patient—then we may return imaginatively to a choice point, late in the 19th century, to help us focus questions about information, knowledge, trust, expertise, autonomy, and decision making in health.

The late-20th-century patient had far to come in establishing herself as an informed decision maker. We might wonder what might have happened
if she had not become disempowered and uninformed in the first place, if there had not been energetic boundary work performed in the 20th century, especially, to lock in proprietary medicine and lock out patient authority, health democracy, domestic contexts of care, and practical health almanacs? What if there had been instead continuous efforts to recruit the patient and her body of knowledge to the project of her own care? If we consider how far the patient had to fall as a rhetorical subject in order to rise again with her computer, we might more fully understand the complications, not least for the biomedical model itself, of going back to the future in health and health care.

Conclusion

In a recent article in the New York Times Magazine, author Emily Gould (2008), a contemporary sort of person, reveals herself as someone who has blogged into a whole new way of being human—that is, being human shamelessly and in public. Gould has blogged autobiographically, artfully, and promiscuously, and she reports that people have responded to her, in both the virtual world and the “real” one, in ways that she does not always like. Gould tells her New York Times readers that she has changed in recent years by interacting with her own Web self.

Internet health does not figure at all in Gould’s metaconfession; yet her essay seems to me relevant to mine, since it is centrally about relationships between, on the one hand, online activity and, on the other, identity and subjectivity. These relationships are pertinent to the phenomenology of Internet health and deserve the attention of researchers.

Much of the scholarship so far on Internet health isolates the use of health-information Web sites from the contexts of that use—from, for example, personal contexts (using Internet health is only one thing that Internet-savvy people do), contexts of health and medicine (Internet health is only one of many practices in the conduct of health and medicine), and cultural contexts (widespread use of Internet health is, for example, in part a function of medicalization, “a process by which nonmedical problems become defined and treated as medical problems . . .” [Conrad, 2007, p. 4]). Rhetorical study resitutes Internet health in its contexts. It invites us to consider more carefully the full-bodied, sometimes emotional, subjects that are the audience for Internet health, and it acknowledges that Internet health is not only a puzzle itself but also a piece of other puzzles. It may turn out that inserting Web-informed patients into existing biomedicine,
while leaving intact established role descriptions, hierarchies, codes of conduct, and encryptions is, in fact, untenable.

Rhetorical research adds to research on Internet health that has focused primarily on source reliability and the figure of the empowered patient. It is a corrective to the dominant view that the problems posed by new technology are (only), as Eysenbach, Sa, and Diepgen described them in 1999, “the quality of online information, lack of standards, and lack of social equity” (p. 1). Accounts that may seem at first to have little to do with Internet health—accounts, for example, of Web/user interfaces, subjectivity and virtuality, biomedical institutional culture, and medicalization—actually have a lot to do with it. The Internet-health user is not simply a rational health consumer, abstracted from culture and from history, and Internet health is part of a discursive field with interlocking roles and genres, agents and actions.

Notes

1. Patient is the term used most widely in the literature, and seems the least likely of the available terms to draw attention to itself as a term. For simplicity, I use the feminine pronoun to designate that patient; women are more frequent users than men of health-information Web sites.

2. Some sites name authors who might count as human speakers, but there is a difference between real speakers and an assemblage of speaker-markers (perhaps, a name, a photograph, and a putative set of attributes). Warnick (2007) writes about what she calls the “authorless message” of the Internet, explaining that users lack traditional means to judge the credibility of message content. According to Warnick, factors in authorlessness include “the absence of authorship information, the emphasis on corporate authorship, and an increasing reliance on coproduction to generate site content” (p. 36).

3. The dominant view includes a negative characterization of health professionals who do not embrace Internet health. Eysenbach and Jadad (2001), for example, sympathize with “consumers” who “still find themselves interacting with providers who favour the ‘classical’, authoritarian, paternalistic, asymmetrical model of consumer-provider interaction” (pp. 290-291).

4. Seale (2003) notes that the “two fields of study—media studies and the sociology of health and illness—appear to stand at a distance from one another” (p. 514). Briggs and Hallin (2007) are anthropologists interested in the constitution of a new health subject: “a neoliberal subject, the patient-consumer who actively and responsibly seeks health information and produces health by regulating his or her choices accordingly” (p. 3). Briggs and Hallin’s construct, biocommunicability, refers to the “relationship between discursive ideologies/practices [in health and medicine] and social relations” (p. 4).

5. We are familiar with this line of advertising for prescription drugs: “You thought you had indigestion; maybe it’s Acid Reflux”; “You thought you were just bloated; maybe it’s Irritable Bowel Syndrome.” Pharmaceutical marketers themselves explain, “[Condition brands] tend to be favorable when a condition is perceived as having serious consequences, for which individuals are not blamed or stigmatized, and which is caused by factors for which
individuals are not responsible and over which they have no control” (Angelmar & Kane, 2007, p. 342). Interestingly, nonprescription drug advertising has tended to go in the opposite direction, selling drugs by *allaying* fear. From a mid-20th-century newspaper advertisement for *Phillips's Milk of Magnesia*: “He Spent His Days Worrying About a ‘Disease’ He Didn’t Have. *Thousands of People Who Think They Have ‘A Serious Disorder’ Have only ‘Acid Stomach’ Now Easily Relieved*” (Medicine and Madison Avenue, 2008).

6. A number of authoritative sources on the social history of medicine, including, most saliently, Starr (1982) and Foucault (1973), detail the shift away from patient authority. An excellent source on the “reign of technology” in medicine is Reiser (1978). On the relations of 19th-century patent medicine advertising and contemporary direct-to-consumer advertising for prescription pharmaceuticals, see Conrad and Leiter (2008).

7. *Disintermediation* is a term for the removal of the middle person from transactions. The term was coined in the 1960s in reference to banking: when you invest your money directly, rather than depositing it into a savings account for your bank to invest for you, that is disintermediation. Internet health sites are a means of disintermediation in health—and not every physician thinks well of them. On disintermediation as remaking authority, see Grant McCracken (2004). Note that McCracken writes on a blog, performing the disintermediation of the peer reviewer (http://www.cultureby.com/trilogy/2004/07/disintermediati.html).

8. From a novel by Elinor Lipman (1992), “That was one of the tedious but often useful things about being friends with a professor: every damn thing reminds them of a piece they read in the *Times*” (p. 256).

9. One presumption of Internet health is that the problems that send us in search of health information are, in fact, problems of health and illness. Medicalization acts, then, as both cause and effect of the widespread use of health Web sites: medicalization causes people to use these sites in search of solutions for a wide range of problems; the proliferation of the sites themselves entrenches medicalization.

References


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