Merchants of Health: Medicine and Consumer Culture in the United States, 1900–1940

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Over the last one hundred years, Americans have lived longer, received better medical care, and pursued health more single-mindedly than ever before. American medicine has risen from a position of relative mediocrity to world dominance in research and a privileged place in modern culture. As a consequence, some scholars have argued, the “American century” might well be termed the “health century.” Yet within the last three decades, unsettling change has swept through the American health care system. Due to growing concerns about patients’ rights and health care costs, physicians and hospitals now deliver their services under fiscal and regulatory constraints unimaginable even a decade ago. Policy makers, politicians, and voters are engaged in an often rancorous debate about what has gone wrong with American health care. As the new century begins, the health care crisis looms large in the national psyche.¹

These recent developments leave historians of medicine with a great deal to explain. Much as the falling of the Berlin Wall forced diplomatic historians to rewrite the history of the Cold War, the health care crisis of the 1990s forces us to reconsider medicine’s place in twentieth-century American history. Long treated as an exemplar of the modern profession, medicine seemed exempt from external regulation by virtue of its practitioners’ technical expertise and unique relationship with patients. The startling fall of this “sovereign profession,” as the sociologist Paul Starr termed it in 1982, from a powerful lobby and an icon of progress to an object of national

The angst thus invites new historical interpretations. In providing those interpretations, historians of medicine have an unprecedented opportunity not only to address contemporary concerns but also to reflect on the changing meanings of scientific expertise, social welfare, and personal choice in twentieth-century American society.

In recent years, senior scholars, chief among them Kenneth M. Ludmerer, David J. Rothman, Paul Starr, and Rosemary Stevens, have stepped up to the challenge of offering historical insight into the current health care crisis. Through the history of the hospital, the medical school, and the medical profession, they have charted the rise and fall of medicine’s professional autonomy and cultural authority during the last century. Their work illuminates what Ludmerer calls medicine’s “first revolution,” that is, the convergence of major scientific discoveries, institutional innovations, strong leadership, and pressing social needs that brought American medicine unprecedented professional authority and cultural authority during the last century; they also explore the subsequent developments, such as internal loss of cohesion, external challenges to expert authority, and changing views of public spending, that paved the way for a second, so-called managed care revolution.

The “two revolutions” narrative, most clearly summed up in Starr’s *The Social Transformation of American Medicine*, has much to recommend it as a synthesis. But to date, it has been a narrative focused primarily on elite actors, such as the American Medical Association (AMA), medical educators, hospital administrators, corporate executives, and federal policy makers. In contrast, the categories of “patient” and “public” remain sketchy. Scholars assume that widespread popular esteem for science undergirded medicine’s growing cultural authority in the first two-thirds of the twentieth century and that the weakening of this popular confidence has been central to its loss of autonomy in the last third. Yet the process by which that popular esteem was developed, exercised, and eroded remains largely outside recent histories of modern American medicine.

Professional organizations and policy elites are undeniably the most visibly powerful and easily studied actors in the shaping of modern health care institutions. But while a defensible place to start, a top-down history focused on those elite actors is no place to stop. Historians now need to think actively and aggressively about how to write the categories of “patient” and “public” into their broad-stroke accounts of twentieth-century medicine. Much as the new social history brought insights “from

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4 These scholars are vitally concerned with the overall accessibility and effectiveness of health care institutions, yet the patient/public appears as the least fleshed-out element of their analyses. For an ambitious but overly schematic effort to provide a patients’ perspective on the evolution of modern medicine, see Edward Shorter, *Bedside Manners: The Troubled History of Doctors and Patients* (New York, 1985).
the bottom up” to medical history in the 1970s and 1980s, it is time for a new generation of social and cultural studies to deepen our understanding of the “health century.”

As a step in that direction, this essay attempts to reinterpret one key period, 1900 to 1940, from a more patient-oriented perspective. I do so by drawing on a body of scholarship that has yet had little impact on historians of medicine, namely the history of consumer culture and consumer movements. At first glance, this strategy may


seem politically suspect. Critics of managed care initiatives often point to the linguistic transformation of patients into consumers as the very essence of a new, more heartless style of health care. The language of consumerism seems to endorse a market logic that many contemporaries find disturbing when applied to doctor-patient relationships. But the very intensity of emotion provoked by the term “health care consumer” constitutes a compelling argument for looking at its historical origins more closely.7

Anxieties about treating patients as consumers reflect a cluster of ideas about medical exceptionalism in the marketplace that have been central to the shaping of twentieth-century American health care. Medicine’s first revolution helped popularize the view that the doctor-patient relationship represented a unique entity in modern consumerism and that when it comes to health and health care, the normal economic constraints on the production of goods and services in a modern market economy did not apply. Likewise, medicine’s second, or managed care, revolution has involved a deliberate attempt to reverse this exceptionalism by forcing doctors and hospitals to compete aggressively for patients, to disclose information about the price and quality of care, and to weigh costs against benefits of treatment. Without accepting these developments as desirable or inevitable, it is important to look carefully at their historical genesis.8

In health care, as in so many areas of daily life, the American century has been marked by seemingly contradictory trends, on the one hand, toward a concentration of economic power and technical expertise in small elites, on the other, toward the rise of a consumer culture in which the wishes of consumer-citizens are closely consulted. Spectacular developments in scientific and technological knowledge have vested policy-making power in a dense network of professional organizations, medical schools, hospitals, governmental agencies, and corporate bodies. Yet paradoxically, this “organizational synthesis” in health care has been accompanied by rising patient expectations and activism. The simultaneous rise of medical expertise and patient entitlement reflects the complexity of democratic politics in an age of increasingly concentrated economic and political power.9

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7 Contemporary critics often assume, incorrectly, that the managed care revolution inspired the linguistic transformation of patients into consumers. See, for example, Ellen Goodman, “We’ve Become Health Care Consumers—and We’re Getting Indigestion,” Boston Globe, June 17, 1999, p. A-23. The term “consumer” came into popular use in the 1970s as part of the patients’ rights movement. See Nancy Tomes, “From Patients’ Rights to Consumers’ Rights: Some Thoughts on the Evolution of a Concept,” in Making History: Shaping the Future: Contemporary Themes in Mental Health Services (Balmain, Australia, 1999), 39–48. This volume contains the proceedings of the Eighth Annual THEMHS Conference of the Mental Health Services of Australia and New Zealand.

8 On the managed care movement as an effort to undo this medical exceptionalism, see David Dranove, The Economic Evolution of American Health Care: From Marcus Welby to Managed Care (Princeton, 2000).

It is precisely that complexity that recent work on the history of consumer culture and consumerism addresses so usefully. Scholars in this field are at the forefront of efforts to understand the dilemmas of individual choice in a culture increasingly dominated by large national corporations, media outlets, and government bureaucracies. Their new, more complex view of consumers—as neither irrational, easily manipulated tools nor all-powerful sovereign shoppers—offers useful models for integrating patient perspectives into the history of twentieth-century health care. Thinking of patients as consumers suggests ways to connect the multiplicity of individual decisions that Americans have made about their health and health care—from what to eat or smoke to what kind of medical services and over-the-counter drugs to purchase—with the evolution of twentieth-century health care institutions. The history of consumerism also helps explain the growing importance placed on patient needs and wants in modern policy discussions. Last but not least, this approach invites us to think about ways in which consumers literally become patients, by adopting new forms of consumption that produce new patterns of disease, as in the case of smoking and lung cancer.¹⁰

The patient-as-consumer perspective is far from perfect. No more than any other synthetic approach can it provide a single all-encompassing narrative of the past. In recent years, historians have demonstrated just how dramatically Americans’ experiences of illness and treatment have differed according to ailment, age, class, race, ethnicity, gender, and place of residence. As a consequence, it is difficult to imagine any single framework that would link the experiences of women in childbirth with those of male workers exposed to toxic chemicals on the job or make sense of persistent racial differences in mortality rates from cancer and cardiovascular disease. Given the historical association of consumer ideologies and movements with middle-class white Americans, the patient-as-consumer approach threatens to ignore the experiences of those economically disenfranchised by virtue of poverty or race—to flatten diversity and to privilege the interests of the affluent.¹¹

Yet as the work of Lizabeth Cohen, Dana Frank, and Lawrence B. Glickman has shown, a consumer-oriented perspective need not produce histories only of white middle-class Americans’ concerns. Understanding the consumer economics of twentieth-century health care helps illuminate the deep class- and race-based inequalities that have come to be as much a part of the “health century” as its more admirable scientific and technological achievements. Nor is the consumer perspec-


tive incompatible with closer attention to the subjective experience of illness and the evolution of class, race, and gender differences in health care.12

The essay that follows explores some paths of connection between recent work on the history of medicine and the history of consumer culture. I concentrate, not on the post–World War II period when the rhetoric of consumer rights became widespread, but on the preceding decades from 1900 to 1940. In part, my choice reflects practical constraints: this temporal focus allows me to look at the economics of doctor-patient relations before the intervention of the third-party payers who now loom large in health care decision making. My choice is also grounded in the conviction that notions of medical exceptionalism formed in that era are critical to understanding modern conceptions of health consumerism.

The Origins of Medical Exceptionalism

Historians of medicine have long recognized that the decades from 1880 to 1930 constituted an economic and cultural watershed for the American medical profession. Earlier, “regular” physicians competed not only against each other but also against a variety of alternative healers in a largely unregulated medical marketplace. Commercial medical schools flourished, producing numerous graduates of dubious competence, while hospitals operated chiefly as welfare institutions for the worthy poor rather than as centers of scientific inquiry. But starting in the last decades of the 1800s, the regular profession greatly improved its competitive position vis-à-vis alternative healers by aligning itself with laboratory science, reforming medical schools, and lobbying effectively with state legislators. Historians of medicine sometimes refer to the period that followed, roughly from the 1920s through the 1960s, as the “golden age” of American medicine, due to rising physician incomes and respectability and organized medicine’s strength as a political lobby.13

12 That studies of consumer culture can be sensitive to issues of class and race has been demonstrated ably by Cohen, Making a New Deal; Frank, Purchasing Power; and Glickman, Living Wage. By “subjective experience of illness,” I refer to the individual and cultural meanings ascribed to illness, which are clearly shaped by the currents of consumer culture. On the changing dynamics of this influence, see Morris, Illness and Culture in the Postmodern Age. Although in this essay I confine my focus to medicine, the consumer perspective might profitably be extended to histories of public health and nursing.

The reorganization of American medicine in this period has been portrayed as a successful effort to “escape from the corporation,” in the words of Paul Starr, that is, to resist modern market forces of competition and external regulation. Sociologists and economists have attributed this autonomy to medicine’s unique position within the world of modern goods and services. Neither patients nor doctors behaved as “normal” consumers and suppliers did. From the patient side, illnesses were usually unexpected and potentially life-threatening, diminishing the chance to shop for care; patients also lacked the information and expertise to compare doctors or balance treatment against price (what economists refer to as the “shopping problem” and the “information problem”). Instead, they had to rely on the profession’s credentialing process and the individual physician’s commitment to healing. As professionals, doctors adhered to a code of medical ethics that explicitly put the patient’s welfare before their own profits. As the economist Kenneth Arrow put it in a famous 1963 article on the uniqueness of the medical marketplace, “It is clear from everyday observation that the behavior expected of sellers of medical care is different from that of business men in general” because they are “governed by a concern for the customer’s welfare which would not be expected of a salesman.”

This view of medicine as a special market case reflects the unique position that the doctor-patient relationship came to occupy (and still occupies) in the world of twentieth-century goods and services. In an economy increasingly organized to promote consumption, choosing a doctor remained distinctly different from buying a tube of toothpaste or a refrigerator. At the same time, I believe scholars have overstated medicine’s exemption from the currents of modern consumerism. The habits of mind cultivated in a consumer culture organized to sell toothpaste and refrigerators did indeed spill over, if only indirectly, into views of health-related products and services. The conception of medical goods and services as “special” depended on comparing them with other categories of goods and services. These distinctions did not magically appear, but had to be laboriously defined and defended.

In the interwar period, American medicine experienced what might be termed the doctors’ dilemma: The challenge of achieving prosperity in a maturing capitalist economy without appearing to be driven by a concern for profit. Physicians faced a modern, secular version of what Edward Sears Morgan dubbed the seventeenth-century Puritan dilemma: to flourish in the marketplace without becoming enslaved...
by its values. In what follows, I examine four themes that illustrate the difficulties American medicine encountered in separating and purifying itself from the growing influence of the new consumerism: the changing conception of physicians and hospitals as “merchants of service”; the representation of medical care as a luxury good in interwar health policy debates; the persistence and commercialization of self-help health traditions; and the problem of the disenfranchised health care consumer.

**Merchants of Service**

For all their enhanced professional position, early-twentieth-century physicians, like their nineteenth-century predecessors, remained “merchants of service,” as the novelist Morton Thompson phrased it in 1954, that is, a professional group deeply dependent on clients’ willingness to pay for their care. Conceptions of medicine as a professional service and beliefs about its appropriate cost were transformed in this period not only by scientific and technological changes but also by the dynamics of the larger economy. As their economic position improved, doctors faced new challenges in balancing their image as disinterested professionals with the visible signs of medicine’s growing economic prowess.

By the early 1930s the provision of health care was “one of the largest industries of the country,” as the physician and educator Ray Lyman Wilbur observed in 1933. Even during the depths of the Great Depression, Americans spent more than $3.5 billion a year on medical services and commodities, or roughly 4 to 5 percent of the gross domestic product. In the size of its work force and the value of its services and products, the health care sector ranked sixth among American industries, above the automobile, iron and steel, oil, and coal manufacturers. In family expenditures, medical care also ranked sixth, well below spending on food, housing, and clothing but still a sizable expense. But unlike other industries transformed by technological innovation and institutional reorganization in the early twentieth century, American medicine did not follow the Fordist model of more goods at lower prices. Indeed, as Wilbur noted, the impact of science had had the opposite effect: as the new medicine became more efficacious, it also became more expensive. “We may anticipate that the costs of personal services will increase while the costs of machine-made things will decline,” but as a result, he wrote, “increasingly for many people the choice is to live with disease or to suffer with debts.” Early cost-of-living surveys found that the prices of doctors’ services and drugs roughly doubled between 1914 and 1927. By the late 1920s, the

cost of treating a serious illness might amount to between 10 and 25 percent of a family's annual income. The burden of paying such bills occurred at a time when almost 80 percent of health care spending came directly from patients. (In 1960, the comparable figure for direct patient contributions was 55 percent; in 1997, less than 20 percent.) In other words, the social transformation of American medicine was bankrolled chiefly by paying patients. Thus it becomes important to understand who those patients were, how they were “sold” on the new medicine, and how their needs and expectations shaped the evolution of health care institutions.\(^\text{18}\)

In trying to gauge how doctor-patient relations changed in this period, historians have focused primarily on the new scientific knowledge and professional confidence that the former had to offer the latter. Judith Walzer Leavitt, Charles Rosenberg, and Rosemary Stevens have demonstrated that the leading edge of medicine's economic transformation was the new-style hospital; it was patients' willingness to come to those “white palaces” for surgical procedures and for childbirth that fueled the interwar expansion of health care industries. Rima Apple and other historians have documented how physicians successfully convinced a generation of women imbued with an ideology of “scientific motherhood” to accept medical direction on issues such as infant feeding and childhood disease prevention.\(^\text{19}\)

Yet an effort to situate medicine within the broader history of consumer culture suggests a more complex set of possibilities. Early-twentieth-century physicians and hospitals were reshaping their identities as service providers in an era when a widening range of American institutions, from department stores to large corporations, were wooing consumers with promises of personal attention. As part of a growing competition for brand name and institutional loyalty, businesses large and small...

\(^{18}\)Wilbur, “Foreword,” vi. On the rising price of medical services and drugs, see the National Industrial Conference Board, *The Cost of Living in the United States, 1914–1927* (New York, 1928), 126. For the 10–25% figure, see Falk, Rorem, and Ring, *Costs of Medical Care*, 583. On the percentage of patient contributions in 1933, see *ibid.*, 10. On patient contributions in 1960 and 1997, see National Center for Disease Statistics, *Health, United States, 1999* (Hyattsville, 1999), 215. In stressing the centrality of patient contributions, I do not deny the symbolic and practical importance of research funding from private foundations and voluntary health associations such as the National Tuberculosis Association during this period.

The uneven quality of information on household budgets and medical spending over time makes it hard to quantify the rise in medical costs. The early budget studies all focused on working-class families and so provide no sense of more affluent households' spending patterns. Data on workers' budgets collected by Carroll Wright in 1889–1890 suggest that about 4% of the total family income was spent on sickness and burial costs. See Daniel Scott Smith, "A Higher Quality of Life for Whom? Mounds to Feed and Clothes to Wear in the Families of Late Nineteenth-Century American Workers," *Journal of Family History*, 19 (Jan. 1994), 1–33, esp. 9. Data from 1917–1919 cost-of-living surveys done by the Bureau of Labor Statistics suggest that household expenditures on physicians, medicines, and hospital bills amounted to about 6.4% of the total budget in white households, 5.6% of the total in black households. See Joel D. Howell and Catherine G. McLaughlin, “Race, Income, and the Purchase of Medical Care by Selected 1917 Working-Class Urban Families,” *Journal of the History of Medicine, 47* (Oct. 1992), 439–61, esp. 448–49.

began to emphasize higher standards of service. Department stores, movie theaters, hotels, and chain stores—all sought to increase their profits by delivering better goods more efficiently.20

Obviously, visiting a doctor’s office or checking into a hospital involved quite different concerns than did shopping at Macy’s or taking in the latest film at the Savoy. Yet it seems likely that rising standards of consumer service and comfort heightened patient expectations of care, especially among affluent families living in urban areas where the service ideal was most developed. From this perspective, historians’ accounts of the early-twentieth-century hospital take on new significance: in striving to provide comfortable private rooms and precision nursing care, hospital administrators were appealing to a clientele used to hotel comforts and department store service. Likewise, the increasing volume of patient complaints that the new-style hospitals were cold, impersonal, and uncaring places may reflect not only changes in their architecture and management but also rising expectations of personal comfort and service.21

We know far less about how changing standards of personal service may have played out in the doctor’s office. In the nineteenth century patients, especially middle-class women, often shopped around for physicians who suited their personal tastes, and there is little reason to think that their twentieth-century counterparts were any less inclined to do so. Indeed, by the interwar period, patients weighed the need to pay the doctor a visit against a widening range of more appealing spending options. Physicians’ services now competed with many other expenses, such as food and entertainment, that consumers found much more “enjoyable,” as the interwar health economist Michael M. Davis observed. “Medical care stands out in the average consumer’s budget as the one undesired necessity,” as he put it. Advice manuals for physicians and reminiscences of physicians suggest that for all their superior technical training, doctors still had to work hard to attract a well-paying clientele by taking care in decorating their offices, cultivating an appealing manner with patients, and making house calls.22

When tracking changing expectations of medicine as a professional service, historians need to pay special attention to issues of class and gender difference. Until recently, scholars have tended to examine consumer issues and influence primarily in relation to a middle-class female constituency. Certainly, recent work confirms that a variety of twentieth-century health care developments, from painless child-

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20 On new notions of service, see Leach, Land of Desire, 112–50; and Shelley Stamp, Movie-Struck Girls: Women and Motion Picture Culture after the Nickelodeon (Princeton, 2000), 10–40.


birth and birth control to cosmetic surgery, register women consumers' demands for particular kinds of goods and services. Yet new scholarship has begun to challenge the exclusive focus on middle-class women consumers. In pursuing research on patient expectations of health care, historians of medicine need to broaden their attention to gender and class differences, particularly how services and specialties may have evolved to suit the health concerns of American men.23

**Medical Care as Luxury Good**

In the interwar period the courting of new patients, whether male or female, was limited to a comparatively narrow consumer base. For many Americans, the new medicine and surgery represented a luxury good; that is, it was a set of services affordable only by families in the top third of income levels. Put simply, medicine's first revolution priced many potential consumers right out of the medical marketplace. Realizing that the new medicine constituted a professional service that two-thirds of all Americans could hardly afford throws a very different light on medicine's interwar "golden age."

Indeed, growing concern about the new medicine's status as a luxury good prompted policy makers' first explicit recognition of consumers as a distinctive group important to the shaping of health care policy. Of course, physicians and hospital administrators had long been concerned with the difficulties many patients had in paying for their services. Nineteenth-century doctors were accustomed to writing off unpaid accounts, accepting barter for payment, and treating deserving cases for free. Nor was there anything new in the awareness that poverty and disease were often linked, or that wealthy people could afford more and better medical care than the poor. But as Rosemary Stevens suggests, the economic disparities took on new forms and implications in the early decades of the twentieth century. The proliferation of effective but expensive hospital treatments—the tonsillectomies, appendectomies, and painless childbirths—accentuated the dire consequences of an unequal distribution of medical resources. The more attractive and efficacious the new professional services appeared, the more disturbing became the growing inability of many Americans to afford them. In a supposed "democracy of goods," as Roland Marchand has termed it, the problem of unaffordable medical care took on seemingly life-and-death significance.24

The discipline of medical economics emerged in the interwar period as scholars and policy makers sought to understand and correct these troubling disparities in

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access to the new medicine. Concerns about medical care’s luxury status fueled the first systematic and wide-scale surveys of consumer spending on health care, which in turn focused policy debates on the key question: Was health care a social entitlement, that is, a special kind of good that all citizens both desired and deserved? In this respect, historians have long recognized the importance of the Committee on the Costs of Medical Care (ccmc) set up by Herbert Hoover in 1928, which conducted the first major surveys of American spending on health care. The ccmc’s surveys showed that the 10 percent of most affluent families (those with incomes over five thousand dollars per annum) accounted for 30 percent of the spending on physician fees, hospital services, and drugs. Meanwhile, families in the low- to middle-income ranges found it hard to afford the rising costs of the new medicine, especially when faced with a major illness. The ccmc also documented that medical services were concentrated in cities, while many rural areas, especially in the South and West, had no hospitals and few physicians.25

At the time leaders of organized medicine roundly disputed the ccmc’s findings, insisting that medical care was much more affordable and available than the committee suggested. But historians agree that the depression exacerbated what was already a noticeable stratification in Americans’ access to the benefits of modern medicine. Much of the nostalgia for the old country doctor and the beloved family physician expressed in the depression era appears to reflect the absence of regular medical care that many families were experiencing. From the standpoint of most patients, as well as that of the general practitioners dependent on their patronage, the interwar era looks more gilded than golden.26

The rising costs and unequal distribution of medical care led to a remarkable period of ill will and political discontent around health care issues. Historians have examined these New Deal battles largely as evidence of the growing political power and conservatism of the ama. Yet interwar reformers’ efforts to convert the new medicine from a luxury good to a basic necessity of modern life can also profitably be viewed as incubators for a new kind of consumer-oriented health activism. Although unsuccessful, social welfare advocates’ determined campaigns, first to include health benefits in the Social Security Act of 1935 and then to pass a national health bill, helped popularize the idea that all Americans deserved affordable medical and hospital care as a matter of right. Their efforts clearly put organized medicine on the defensive, as was evident in the Department of Justice’s 1938 antitrust suit against the ama and several of its local affiliates for harassing physicians affiliated

25 The Committee on the Costs of Medical Care (ccmc) published twenty-eight reports, culminating in the summary: Committee on the Costs of Medical Care, Medical Care for the American People (Chicago, 1932). On the importance of the ccmc, see Starr, Social Transformation of American Medicine, esp. 261–66. On medical economics more generally, see Daniel M. Fox, “From Reform to Relativism: A History of Economists and Health Care,” Milbank Memorial Fund Quarterly/Health and Society, 57 (Summer 1979), 297–336.

26 On the disparities in availability of care, see Michael R. Grey, New Deal Medicine: The Rural Health Programs of the Farm Security Administration (Baltimore, 1999). For a summary of depression-era surveys on patients’ choice of doctors, see Davis, America Organizes Medicine, 22–35. Citing a 1938 survey of moderate- and low-income families living in New York City, he noted, “Although many families clung to the idea of a ‘Family Doctor,’ less than one-third of them thought they had such a doctor.” Ibid., 27.
with forerunners of health maintenance organizations. (The AMA lost the suit on appeal in 1943, but it won the battle by convincing many state legislatures to pass laws preventing the formation of such cooperatives.) While limited in their immediate successes, New Deal critics of American health care helped legitimate consumer interests as an important policy issue. Many of their concerns about access and equity would reappear in post-1960 arguments about the need to expand health insurance coverage.27

**Health in a Bottle and a Book**

While extremely important, the debates over access constituted only one arena in which new concerns about consumerism began to influence health care policy. Along with spending more on doctors and hospitals, Americans also spent growing sums on health-related products and activities outside the control of organized medicine. The obsession with good health and bodily disciplines characteristic of nineteenth-century reformers took on more popular, commercialized forms in the early decades of the twentieth century. In an increasingly robust consumer culture, Americans of all classes were exposed to a rising tide of commercial messages designed to create a perpetual state of dissatisfaction with their current health status and a longing for a new and improved self. In response to those longings, they purchased a widening array of health care products and services. Making sense of this spending draws much-needed attention to the context of twentieth-century health-seeking behavior, especially the commercial influences on its expression.

During the decades from 1880 to 1920 when American medicine assumed its modern form, a distinctive twentieth-century consumer culture also began to take shape. That consumer culture influenced not only conceptions of doctors as “merchants of service” but also patterns of health-related consumption and popular definitions of good health. The growing efficiency and productivity of American industry spurred the rise of national advertising and marketing schemes, which enticed consumers with a dazzling array of new goods and services. Many of the most heavily promoted goods, including food, cigarettes, and over-the-counter drugs, had widely acknowledged connections, both negative and positive, to health and disease. Americans sought not only “health in a bottle,” through expenditures on over-the-counter drugs, but also “health in a book,” through the avid consumption of health advice. Print media and later radio began to cover health issues more widely; they also became increasingly dependent on revenue from health-related advertising, which constituted its own powerful form of commercialized advice.28

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28 In addition to the works on advertising cited in note 6, see Stephen Fox, _The Mirror Makers: A History of American Advertising and Its Creators_ (New York, 1984); and Daniel Pope, _The Making of Modern Advertising_ (New York, 1983). Many histories of health and hygiene provide insightful discussions of advertising. On adver-
Six centuries ago, the Black Death reached Europe in its march around the world. It killed one-quarter of the population. Into the same wide grave went saint and sinner, rich and poor, alike.

Today, the Black Death slumbers. Its legions are as terrible as ever, but they march no more through lands where medical science stands on guard.

Man’s ancient enemy, disease, is everywhere. But now his ranks are thinning, before the light of medical science—the light that shines for all. For saint or sinner, rich or poor—this bright white light burns on. Brighter and brighter it grows, piercing the farther darkness, lighting the way to health and happiness.

In its radiance, workers in chemical and biological laboratories have learned to make products for the preservation of health and the relief of suffering, products of uniform effectiveness and safety; and found the way to bring these products, through modern medical service, within the reach of all.

The House of Squibb is dedicated to the service of scientific medicine. We shall go on working with the medical profession, guardians of the public health.

E. R. SQUIBB & SONS
MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1848

THE PRICELESS INGREDIENT OF EVERY PRODUCT IS THE HONOR AND INTEGRITY OF ITS MAKER

Goodwill advertisements, such as this 1936 one from E. R. Squibb and Sons, promoted positive views of medical science and the medical profession. Courtesy Bristol-Myers Squibb Company. Courtesy J. Walter Thompson Company Archives, Hartman Center for Sales, Advertising & Marketing History, Rare Book, Manuscript, and Special Collections Library, Duke University, Durham, North Carolina.
Thus interwar doctors’ and patients’ expectations of each other were formed by a widening stream of media, from newspaper columns and magazine articles to advertisements and manufacturers’ informational booklets. As I have shown in my own work, advertising was particularly important in the growing fluidity of information circulation. Advertising and marketing efforts sought aggressively to portray many kinds of products as essential aids in the American consumer’s quest for good health. Manufacturers invoked the new medicine’s prestige in a myriad of ways, from making claims about doctors’ smoking preferences in cigarette ads to promoting faith in medical science. Makers of goods with dubious hygienic properties, such as candy or cigarettes, had to work doubly hard to counter prevalent perceptions that they were unhealthful.29

The positioning of products vis-à-vis popular health concerns became all the more important, I have argued, because of changing mortality patterns. The deluge of health-related advertising in the 1920s and 1930s coincided with the growing awareness that as mortality from infectious diseases declined, ailments associated with greater longevity and prosperity were becoming the leading causes of death. By 1921, heart disease had become the “new number one” among causes of death for Americans, a position it has retained to this day. By the late 1920s, cancer had also assumed its modern preeminence as a leading cause of death. Ironically, as medicine gained prestige from its seeming conquest of infectious diseases, doctors and hospitals were increasingly being asked to treat very different ailments for which they had few effective therapies.30


30 Nancy Tomes, “We Die Differently Now: Popular Perceptions of the Mortality Transition in the Interwar United States,” in Health in America: The Last One Hundred Years, ed. Judith Seidler and Daniel M. Fox (New York, forthcoming). Cancer alternated as the second or third leading cause of death with pneumonia and influenza, the only infectious diseases to remain high on the interwar mortality list. The role of such groups as the National Tuberculosis Association, the American Cancer Society, and the American Heart Association deserves much more attention from historians. The best account remains Selskar M. Gunn and Philip S. Platt, Voluntary Health Agencies: An Interpretive Study (New York, 1945).
Thus at the very time when New Deal reformers were worrying about health problems associated with underconsumption—that is, the inability of some Americans to afford adequate food or basic medical care—other commentators drew attention to the health dangers posed by overconsumption. Drawing on a long tradition that equated luxury with disease, they pointed to the negative consequences of overeating, underexercising, and excessive use of alcohol and tobacco. While recognizing that heredity and other factors played a role in their genesis, commentators frequently blamed the rising rates of cardiovascular disease and cancer on modern standards of living, particularly the temptations of unhealthy consumption. These concerns not only informed interwar self-help regimens but also shaped advertising appeals for products that claimed to counteract the health risks of modernity.31

Of course, Americans’ use of over-the-counter drugs and diet aids long predated growing concerns about cardiovascular disease and cancer. The point here is that medicine’s expanding cultural authority by no means spelled an end to the nineteenth-century tradition of “every man his own doctor.” Indeed, new forms of media and marketing only multiplied the commercial opportunities for self-medication. Whereas late-nineteenth-century entrepreneurs relied on trade cards and patent medicine shows to hawk their wares, twentieth-century “medical messiahs” could use mass media to promote themselves.32

The remarkable vitality of interwar commercial health culture complicated interwar medical authority in ways that historians need to explore more fully. Not the least of the complications was consumers’ spending on nonphysician services. Many American families spent what little they had available on health products and services other than those provided by physicians. For example, the CCMC’s surveys found that 18 percent of the health care dollar was being spent on drugs, including 10 percent on patent medicines, compared to 28 percent for physician services. Those surveyed spent another 3.5 percent on so-called cultists, that is, osteopaths and chiropractors. This evidence suggests that many families allocated scarce resources to patent medicines and alternative healers rather than to more orthodox medical advice. Even consumers more favorably disposed to the new medicine may well have regarded buying over-the-counter medicine as a useful strategy to avoid a more expensive trip to the doctor.33


33 Committee on the Costs of Medical Care, Medical Care for the American People, 14–15. On the persistent appeal of alternative practitioners, which also heightened competition for patients, see Norman Gevitz, The D.O.'s: Osteopathic Medicine in America (Baltimore, 1982); Norman Gevitz, ed., Other Healers: Unorthodox Medicine in America (Baltimore, 1988); and J. Stuart Moore, Chiropractic in America: The History of a Medical Alternative (Baltimore, 1993).
Both the AMA’s leaders and their New Deal critics were well aware of this “dark figure” in medical expenditure and sought to redirect consumer spending into what they deemed more productive channels. As even consumer advocates were prone to do, physicians and welfare advocates tended to consider Americans’ unruly buying habits evidence of their irrationality and ignorance. Buying a patent medicine or seeing a chiropractor rather than saving up to visit a qualified doctor gave evidence of the “masses’” inability to choose wisely and their need for expert direction. As policy makers were well aware, such defects of judgment could be found among all classes. Interwar commentators often repeated stories of wealthy patients, usually women, who foolishly refused to invest their money in quality medical care.34

The leaders of organized medicine believed that if American consumers could be taught to appreciate the real value of modern medicine and to rein in their foolish spending, almost everyone could afford quality medical care without recourse to dangerous schemes such as group practice or national health insurance. As Elizabeth A. Toon has argued, the AMA and other medical societies invested significant time and money in popular campaigns to direct consumer dollars away from health quacks and cultists and toward their own constituents. Yet substantial numbers of Americans continued to vote with their pocketbooks against the rising cost of medical treatment and in favor of more autonomous forms of self-care.35

It is hard to determine what exactly consumers sought to buy with the money they spent on laxatives, Listerine, and diet manuals. But my own research on interwar health-related advertisements suggests that many products were successfully promoted as “magic bullets” against the perils of overconsumption. In a typical claim, a 1932 advertisement for Phillips’ Milk of Magnesia explained, “Modern science now throws a new light on the problem of overindulgence—eating too much, smoking too much, drinking too much coffee and other stimulants,” and it offered an easy corrective, namely a few teaspoons of the advertiser’s product swallowed every night. In other words, thanks to modern science, consumers could now have their cake and eat it too.36

Although advertising for a few patent remedies openly scorned the regular medical profession, the vast majority of consumer goods were marketed with

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34 On interwar experts’ ambivalence about consumer rationality, see McGovern, “Sold American.” For representative medical critiques of uninformed consumer behavior, see Louis F. Bishop, “Preventing Heart Attack,” Hygeia. 13 (Jan. 1935), 12; and Wilbur, “Foreword,” vi.


36 Phillips’ Milk of Magnesia advertisement, “He Ate a Whale of a Dinner,” Saturday Evening Post, Nov. 19, 1932, p. 48. These generalizations are based on my research in the Competitive Advertisements, J. Walter Thompson Company Archives (Special Collections Library, Duke University, Durham, N.C.). On advertising and the modern body, see also Lears, Fables of Abundance, esp. chap. 6; and Marchand, Advertising the American Dream, esp. chap. 1.
Addressed to health-conscious consumers, this 1942 advertisement combined the image of a glamorous woman with references to the “unpleasant symptoms” of heavy smoking to promote Julep cigarettes. Courtesy J. Walter Thompson Company Archives, Hartman Center for Sales, Advertising & Marketing History, Rare Book, Manuscript, and Special Collections Library, Duke University, Durham, North Carolina.
HE ATE A WHALE of a DINNER
Then Smoked Incessantly Almost All Night

Yet—this Morning Finds Him Clear-Headed, Clear-Eyed
No Upset Stomach—No "Heady" Feeling

Modern science now throws a new light on the problem of overindulgence—eating too much, smoking too much, drinking too much coffee and other stimulants. A way that millions are learning. And millions doing.

"What you do in this:
"Take—1 tablespoon of Phillips' Milk of Magnesia in a glass of water before bed."
"Take—1 tablespoon of Phillips' Milk of Magnesia in a glass of water before bed."
"Take—1 tablespoon of Phillips' Milk of Magnesia in a glass of water before bed."

Or take its Phillips' Milk of Magnesia thankful the same way, which gets at efficient amount of its valuable ingredient, Magnesium carbonate, the basis of the Phillips' Milk of Magnesia.

"Tomorrow you'll feel great. Science says it is the quickest, simplest and safest way to overcome the effects of overindulgence due to eating, smoking, or the use of stimulants.

How It Works
Results are quick and safe because this small dosage of Phillips' Milk of Magnesia acts to alkalize the system. An alkalized system is largely impervious to the bad after-effects of too much smoking or other overindulgence.

"Take Every Night
Every person who smokes excessively should know this. And never go to bed without taking this minute quantity of Phillips' Milk of Magnesia before. And everyone who lives too well overindulges—should never forget it.

"Try it—now. Feel how clear your head feels the next day—how fine you are from head-dullness and depression. You will be amazed.

PHILLIPS' Milk of Magnesia
NEUTRALIZES FOOD AND TOBACCO ACIDS A FEW MINUTES AFTER TAKING.

PHILLIPS' Milk of Magnesia Tablets are now on sale at drug stores everywhere. Each tablet is the equivalent of the teaspoonful of genuine Phillips' Milk of Magnesia.

Many over-the-counter remedies were promoted as antidotes to excessive consumption of food and drink, as in this 1932 Phillips' Milk of Magnesia advertisement. Courtesy Bayer Corporation, Consumer Care Division. Courtesy J. Walter Thompson Company Archives, Hartman Center for Sales, Advertising & Marketing History, Rare Book, Manuscript, and Special Collections Library, Duke University, Durham, North Carolina.
excessive displays of deference to medicine’s scientific authority. In part, this deference reflected the regulatory constraints set by the Federal Trade Commission, which began to prosecute deceptive health advertising more vigorously in this period; it also reflected the advertising profession’s fear of the AMA. But the vigor of the health sell revealed a more positive strategy as well: to appropriate the scientific legitimacy of the new medicine while delivering its benefits in more affordable form. Advertisements for many products routinely appealed to medical approval by including the now-familiar phrase, “More doctors recommend this brand than any other,” and by citing laboratory tests and medical literature to support their claims. Likewise, advertisers fostered images of the old country doctor and the beloved family physician at a time when many Americans had no such medical counselor in their lives. So while upholding the wonders of modern medicine, advertisements for over-the-counter drugs subtly promised autonomy from real physicians; their “doctor in a bottle” could be safely substituted for an expensive trip to the doctor’s office.

Interwar commercial health appeals also sought to play off the luxury status of the new medical care. Many over-the-counter drugs were presented as knockoff versions of high-end health services that only the affluent could easily afford. A good example is the marketing of dental hygiene products. In the interwar period, affordable dentistry was as hard to find as regular medical care, and many Americans had discolored, missing, or decayed teeth. Not coincidentally, during this same period, dental hygiene became a prominent area for aggressive marketing. White teeth and pleasant breath not only became requisites for popularity and sexual attractiveness; advertisements also invoked research that tied infected teeth and gums to heart disease and other life-threatening ailments. Against this backdrop, manufacturers promoted the regular use of toothbrushes, toothpowders, and mouthwashes as routes to good health and personal happiness that did not require potentially painful, expensive trips to the dentist.

Health Issues and the Modern Consumer Movement

Concerns about the new medicine’s status as a luxury good, debates about the new consumerism’s relationship to diseases of affluence, and the commercialization of self-help traditions—all contributed to the emergence of another kind of interwar health activism within the organized consumer movement. From their earliest years, groups such as Consumers’ Research (founded in 1930) and its


38 There has been remarkably little work on the history of dentistry or popular dental hygiene. The most comprehensive work remains Bernhard Wolf Weinberger, An Introduction to the History of Dentistry (2 vols., St. Louis, 1948). On focal infection, see Andrew Scull, “Desperate Remedies: A Gothic Tale of Madness and Modern Medicine,” Psychological Medicine, 17 (Aug. 1987), 561–77. For a contemporary view of the sorry state of American teeth, see Falk, Rorem, and Ring, Costs of Medical Care, 47–53.
Manufacturers of toothpaste, toothbrushes, and mouthwash promoted their goods as invaluable aids to health, as in this 1933 advertisement for Squibb's Dental Cream. Courtesy Bristol-Myers Squibb Company. Courtesy J. Walter Thompson Company Archives, Hartman Center for Sales, Advertising & Marketing History, Rare Book, Manuscript, and Special Collections Library, Duke University, Durham, North Carolina.

rival Consumers Union (founded in 1936) expressed concern about the changing nature of doctor/patient relationships and the health dangers of an aggressive commercial culture. To date, historians have paid little attention to this tradition of health care activism, which has been overshadowed by the New Deal battles over health insurance. This distinctive strand of health consumerism deserves
more attention, for it foreshadows an orientation that would become increasingly important after World War II.39

Interwar consumer activists shared social welfare advocates’ worries about the rising costs of medical care and their hostile view of the “Chicago Trust,” as the AMA was unaffectionately known in reformers’ circles. But in addition, they reflected a rising desire among middle-class consumers to get their “money’s worth,” as the economist Stuart Chase and the engineer Frederick J. Schlink titled their 1927 best seller. Imbued with early-twentieth-century notions of efficiency and economy, interwar consumer activists expressed doubts that the new medicine was “delivering the goods” to middle-class urbanites such as themselves. Their writings focused on the challenges patients faced in a more costly and competitive medical marketplace, such as finding doctors who treated them with respect, choosing from a host of confusing specialities, sorting out misleading advertising claims, and resisting the deadly allures of consumer culture.40

The writings of early consumer activists such as Chase, Schlink, and their colleague Arthur Kallet suggest that interwar medicine’s professional sovereignty hardly went uncontested. Believing that physicians often acted to protect their own economic interests, they encouraged American consumers to approach encounters with doctors with the same skepticism they brought to the purchase of appliances or automobiles. Consumer activists expressed a middle-class sense of entitlement that at the prices physicians were charging, they owed their patients better service. As Schlink put it in a 1936 letter, “we have had physicians ourselves, and there is hardly anyone who has not done a good deal of inward raging at the cavalier treatment physicians do commonly afford their patients.”41

The consumer-critics had a keen sense of the weak links in the expanding health care industry of the period. Schlink and Kallet’s 1933 best seller, 100,000,000 Guinea Pigs, which denounced the safety of over the counter drugs and the food supply, inspired a succession of other “guinea pig books” on food and cosmetics hazards in the 1930s. Consumer advocates’ complaints about physicians’ focus on treatment rather than prevention, poor communication skills with patients, and too-close relationship with corporate interests, especially pharmaceutical companies, anticipate charges that would be sounded even more generally in the 1950s and 1960s. The interwar consumer movement, although weakened by internal quarrels in the 1930s, laid the groundwork for a deep-seated suspicion of organized medicine that would flourish in the 1950s and 1960s.42


40 Stuart Chase and Frederick J. Schlink, Your Money’s Worth: A Study in the Waste of the Consumer’s Dollar (New York, 1927). The generalizations here are based on my research in the Consumers’ Research Inc. Records (Special Collections, Alexander Library, Rutgers University, New Brunswick, N.J.).

41 F. J. Schlink to Katharine A. Kellock, March 12, 1936, folder 14, box 437, Consumers’ Research Inc. Records.

Significantly, during the same decade when campaigns for national health insurance failed, consumer-oriented health reforms enjoyed some success. Although friendlier to business than either consumer groups or the AMA liked, the 1938 acts strengthening the Food and Drug Administration (FDA) and the Federal Trade Commission constitute the most important health-related legislation passed during the New Deal. While other developed nations such as Canada and Great Britain moved decisively toward programs of national health insurance during the 1930s, Americans moved instead to strengthen the individual consumer’s protections within the marketplace of health-related goods. Perhaps because they appeared less ideological and more pro-market, arguments rooted in the need for consumer protection and “getting one’s money worth” proved more effective than those couched in the language of social justice and citizen entitlements.43

Disenfranchised Health Care Consumers

The evolution of American health care institutions between 1900 and 1940 reflected an increasing sensitivity to consumer issues. Physicians and hospitals in large cities competed for an affluent clientele with new and higher expectations of service. Makers of an expanding variety of consumer goods used a multiplicity of health sells to promote their products. Reformers, medical leaders, and legislators fought over how best to assure that citizen-consumers had access to affordable medical care and protection from unsafe products. New professional groups, including medical economists, advertising executives, and consumer advocates, pondered the needs and desires of the modern health consumer.

Yet the increasing attention to consumer issues came at a considerable cost to poorer Americans. As social scientists have long noted, the politics of consumerism tend to privilege the interests of people with money to spend. Notions of “consumer democracy,” with their “one dollar, one vote” mind-set, inevitably neglect those disenfranchised of consumer power by poverty or racial prejudice. In the case of health care, the orientation toward paying patients clearly exacerbated longstanding racial and class inequalities in access to treatment.44

As Charles Rosenberg and Rosemary Stevens have shown, the new economics of medical practice hastened the demise of older notions of medical charity, especially by hospitals. While steeped in paternalism, the tradition of treating the “worthy poor” provided at least a limited safety net for working-class Americans. As the for-


tunes of modern hospitals became increasingly dependent on pay patients, older habits of medical charity came under attack. Physicians who had to compete for patients willing to pay higher prices for their services became extremely hostile toward any effort to provide low-cost care for the poor. General practitioners pressured hospitals and charitable societies to close down their clinics, on the grounds that they undercut a doctor's ability to make a decent living. Despite the fact that such clinics offered invaluable experience for young doctors, especially those seeking specialty training, their numbers were drastically reduced by the early 1900s. Thus forms of medical charity that had long served both educational and community needs became casualties of the growing emphasis on patients as consumers.45

The decline of older notions of medical charity and community service had particularly dire consequences for African Americans. As historians such as Vanessa Northington Gamble and Susan Lynn Smith have shown, twentieth-century medicine's first revolution made it difficult for historically black hospitals and medical schools to survive. Those that did faced chronic underfunding that limited their range of medical services. Meanwhile, the new “white palaces” of modern medicine remained white in a literal sense as well. Segregated hospital care represented a form of medical Jim Crow common in both the South and the North well into the 1960s.46

The disenfranchisement of black health care consumers helps explain the tragic history of the Tuskegee syphilis study, which since the publication in 1981 of James Jones's Bad Blood has become perhaps the best-known medical experiment in American history. From 1932 to 1972, the United States Public Health Service (USPHS) conducted a study, involving approximately six hundred Alabama sharecroppers, designed to document the course of untreated syphilis in black men. Even after the discovery of antibiotics effective against the disease in the 1940s, representatives of the USPHS worked to prevent participants from receiving any treatments that might interfere with the study's goals. It was only halted in 1972 after a journalist published an exposé of the experiment.47

While scholars differ over many aspects of the Tuskegee story, they all agree that its genesis lies in the extreme racial and class disparities of the depression-era South. In a region where little affordable health care was available, public health officials used promises of treatment to recruit participants for the study; then when those promises were not fulfilled, they “naturalized” the absence of treatment, in Susan Reverby’s words, as no worse than what such men might expect in Macon County,
Alabama. Reverby also emphasizes how much the study participants valued the tonics and other palliatives, including burial fees, that they were offered for cooperating. While those products and services seem trivial from a contemporary perspective, they were highly prized by many depression-era Americans, white as well as black.48

Thus the Tuskegee experiment stands as testimony to the inequities fostered by the uneven evolution of twentieth-century health consumerism. Barred by extreme poverty and racial prejudice from participating as bona fide players in the burgeoning health care economy, participants bartered use of their bodies for the tonics and other benefits, including payment of their burial costs, that they were offered for cooperating. But even in rural Alabama, knowledge of more effective—and expensive—treatments began to circulate and inform people’s expectations of care. At least some study participants realized that they were being shortchanged and devised their own strategies for getting better health care goods and services. Yet, confident of their own vision of the public good, practitioners of state medicine felt little concern about the quality of treatment provided the study subjects. The history of Tuskegee constitutes a powerful reminder of the underside of the “golden age,” particularly the forms of economic disenfranchisement experienced by many poor and nonwhite Americans.49

From Grand Expectations to Health Care Crisis

Thinking about patients as consumers adds much-needed depth to historical accounts of American medicine’s rise to professional sovereignty in the first half of the twentieth century. Far from being an untroubled age of medical sovereignty and patient acquiescence, the interwar decades seem remarkably turbulent. While the authority of modern medicine undoubtedly increased, creating “grand expectations” of its performance, the profession’s authority encountered resistance from many quarters. In the post–World War II period, reformers and physicians clashed over issues that sound surprisingly familiar. Rising health care costs not only fueled an intense debate about health insurance as a counterbalance to the new medicine’s status as a luxury good; they also prompted new concerns that middle-class Americans were not “getting their money’s worth” from their doctors. Even as the conviction grew that modern medicine had valuable services to offer, many Americans continued to pursue their own health regimens, seeking autonomy from direct medical control through the use of over-the-counter cures and alternative health advisers. Meanwhile, commentators noted with alarm that the dynamics of modern consumer culture seemed continually to offset the gains of modern medicine. The supposed “conquest” of infectious diseases left doctors

48 Susan M. Reverby, “Rethinking the Tuskegee Syphilis Study: Nurse Rivers, Silence, and the Meaning of Treatment,” in Tuskegee’s Truths, ed. Reverby, 365–84. Reverby believes that Eunice Rivers, the African American nurse employed in the study, may have aided participants in finding outside treatment.

49 Inmates of prisons, mental hospitals, and orphanages were especially at risk for becoming participants in nontherapeutic human experiments. See Lederer, Subjected to Science, esp. 126–38.
facing diseases of affluence that would be harder to erase, given their association with modern comforts.\textsuperscript{50}

Thus a closer look at medicine’s “golden age” suggests that the dynamics of a modern consumer economy began to complicate the practice of medicine long before the prosperity of the post–World War II era. Both the patients’ rights and managed care revolutions of the last few decades appear to have long historical roots. How those issues played out after World War II is beyond the scope of this essay. But by way of conclusion, let me point to some ways of tying consumer-related themes to the major health care developments of the second half of the twentieth century.

As historians have long noted, the expansion of private hospital and health insurance after World War II gradually made medical care more affordable for many Americans. But the extension of private health benefits tied to employment only accentuated concerns about those still excluded, largely the poor and the elderly. The debates of the 1930s about expanding health insurance recurred during the 1960s, but this time the welfare reformers had more success. In 1965 passage of the Medicare and Medicaid acts established the principle of federal responsibility for closing the accessibility gap. Yet, ironically, the dramatic extension of health care coverage between 1950 and 1970 only enlarged the scope of consumer discontents.\textsuperscript{51}

One source for those discontents lay in the explosion of new health care products and services. After 1940 private and public investments in medical research began to yield dramatic new benefits for treatment, chief among them the discovery of penicillin and other antibiotics. With these new “miracle drugs,” American doctors gained a class of remarkable remedies that could not be gotten over the counter. While less dramatic in their results, advances in cardiovascular care in the 1950s and early 1960s promised more hope for victims of heart disease. Media coverage of these and other medical “miracles” ensured that many Americans knew about the advances long before their medical plans covered them. By constantly introducing new and more expensive medical goods and services, doctors, hospitals, and pharmaceutical companies created a strong upward pressure on expectations of treatment. With a small group of patients always able to afford the most expensive of care, the standard for what patient-consumers could reasonably expect from their health care providers was always moving up.\textsuperscript{52}

Historians as yet know little about how this cycle of rising costs and expectations

\textsuperscript{50} See James T. Patterson, \textit{Grand Expectations: The United States, 1945–1974} (New York, 1996). His argument has informed my reading of health care developments in this period. The limits of the twentieth-century “conquest” of infectious diseases have been shown by the AIDS epidemic.


affected patient attitudes toward the medical profession. Physicians certainly enjoyed great respect in the 1950s, outranking even Supreme Court justices in Gallup Poll rankings of popular esteem. Yet even a cursory review of the popular literature of the period suggests that the resentments evident in the 1930s had by no means disappeared by the 1950s. Consumer advocates continued to complain about the “doctor business,” as Richard Carter put it in his 1958 book by that title, and to urge patients to spend their health care dollars wisely. Early environmental activists such as Rachel Carson questioned medical authority and publicized the dangers of pesticides and food additives, echoing charges first raised by 1930s consumer activists.53

Far from being completely new developments, the varied patients’ rights movements of the post-1960 period built upon a widening consumer sensibility about health care issues. In the anti-institutional climate of the 1960s and 1970s, both strands of interwar health activism—the social welfare reformers’ desire to widen access to medical services and the consumer activists’ emphasis on improving the quality of those services—found new supporters among younger Americans. Increasingly well educated and willing to question authority, the baby boom generation challenged older models of medical paternalism from multiple directions. The second-wave women’s movement attacked medicine’s patriarchal values, while a revived consumer movement led by Ralph Nader criticized its overemphasis on acute care over prevention. Antismoking activists took the AMA to task for its tepid support for regulation of cigarette advertising and manufacture. A broad-ranging patients’ rights movement pressed for fundamental changes in research and treatment protocols.54

The various manifestations of “patient power” quickly brought stunning changes in how medicine was practiced. Even a brief listing of the patient-oriented reforms institutionalized between 1970 and 1990 is impressive: review boards for cases of involuntary hospitalization, consent forms for surgery and other medical procedures, package inserts listing drug side effects, sweeping reviews of the efficacy of over-the-counter drugs, and tightening controls over human experimentation. Last but not least, patient advocacy groups gradually gained new power in policy arenas, first in the area of mental health, later in shaping AIDS policies.55

Yet the rise of “patient power” has increasingly been deflected by rising health care costs. Since the 1960s, those costs have risen at a much higher rate than those of other goods and services. Third-party payers, first the federal government in the 1970s, then corporate America in the late 1980s, began to demand more fiscal accountability from physicians and hospitals. Policy makers began to


54 For an overview of these developments, see Rothman, *Strangers at the Bedside*. For two important manifestos for change, see the Boston Women’s Health Book Collective, *Our Bodies, Ourselves* (New York, 1973); and Ivan Illich, *Medical Nemesis: The Expropriation of Health* (New York, 1976).

55 On patient advocacy in mental health, see Tomes, “From Patients’ Rights to Consumers’ Rights”; on patient advocacy in the AIDS movement, see Epstein, *Impure Science*. 
advocate "managed care," a term loosely applied to methods of monitoring the costs and quality of care through third-party review of medical decision making. Over the last decade, American medicine has been brought under a widening range of regulatory and fiscal constraints designed to hold down health care expenses.56

Reflecting a long tradition of tying health care reform to consumer interests, advocates of managed care have argued that the new regulatory regimes are in consumers’ best interest. In theory, managed care aims to redirect resources toward prevention and to encourage more efficient forms of diagnosis and treatment. But in practice, the contradictions inherent in trying to reduce the costs of health care while simultaneously improving its quality became all too apparent in the 1990s. Negative publicity about so-called drive-through mastectomies and childbirths have heightened public concern about the principles of managed care.57

Under pressure from both patients’ rights and managed care advocates, physicians and hospitals have proved the most vulnerable elements of the late-twentieth-century health care industry. Despite the considerable political power that organized medicine still commands, doctors remain a highly diverse and individualistic group hard to organize into an effective counterweight to governmental or corporate lobbies. Having become heavily dependent on third-party payments, physicians and hospitals have found it hard to resist the regulatory pressures exerted by the federal government and private industry.58

In contrast, pharmaceutical companies and makers of medical equipment have proved more resistant to cost-cutting imperatives. Pharmaceutical companies have been particularly aggressive in appealing to consumer interests to justify the high price of prescription drugs. Patients benefit from new drugs, so they argue, and drug companies must bear the considerable costs of developing them, especially given the FDA’s exacting requirements for demonstrating their safety and efficacy. The Food and Drug Administration justified its 1997 decision to loosen restraints on direct-to-consumer advertising of prescription drugs on the grounds that such advertising helps acquaint patients with the best treatments available. Now a wave of sophisticated advertisements are making Americans aware of new drugs and treatments, thus keeping the cycle of rising expectations and costs going.59

It is too soon to tell where this latest round of consumer battles over health care will end. As this essay has demonstrated, contemporary debates have their roots in

56 For overviews of these developments, see George Anders, Health against Wealth: Hmo’s and the Breakdown of Medical Trust (New York, 1996); Dranove, Economic Evolution of American Health Care; and Peterson, ed., Healthy Markets?

57 For the argument that managed care advances health consumers’ interests, see George C. Halvorson, Strong Medicine: An Expert’s Prescription—Right Now, for Better and Cheaper Health Care (New York, 1993). For criticisms of that argument, see Anders, Health against Wealth.

58 See Starr, Social Transformation of American Medicine, esp. 379–419.

the tangled historical relations between the rise of modern medicine and the rise of modern consumer culture. So long as those relations persist, some version of those dilemmas will continue to exist as well. Historical narratives that concentrate only on elite policy makers can never capture that complexity. Thus as future generations of scholars come to rewrite the history of twentieth-century medicine, they will surely have to accord the politics of consumerism a prominent place.
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