Doctor in the house: the Internet as a source of lay health knowledge and the challenge to expertise

Michael Hardey

School of Nursing, University of Southampton

Abstract This paper investigates the new and unique medium of the Internet as a source of information about health. The Internet is an inherently interactive environment that transcends established national boundaries, regulations and distinctions between professions and expertise. The paper reports findings from a qualitative study of households who routinely used the Internet to access health information and examines how it affected their health beliefs and behaviours. The public use of previously obscure and inaccessible medical information is placed in the context of the debate about deprofessionalisation. It is shown that it is the users of Internet information rather than authors or professional experts who decided what and how material is accessed and used. It is concluded that the Internet forms the site of a new struggle over expertise in health that will transform the relationship between the health professions and their clients.

Keywords: Internet, expertise, lay knowledge, medicine, non-orthodox therapies, professions

Introduction

One of the central areas of debate in medical sociology concerns the nature of the relationship between those with medical expertise and their patients or clients. Since Parsons’s (1951) account of the ‘sick role’ the general picture that arises out of accumulated research findings is one of patients more or less (depending on such variables as social class, race and gender) being transformed into disembodied cases depicted in a medicalised discourse. The literature has provided various accounts of the way medical professionals use their ‘social monopoly of expertise and knowledge’ (Turner 1995: 47) to manage encounters and perpetuate their position of power. Nevertheless,
the processes of proletarianisation and deprofessionalisation have been identified as a threat to the dominate position of medicine (Elston 1991). Proletarianisation represents the process whereby organisational and managerial changes divest professions of the control they have enjoyed over their work. This is reflected in claims by some advocates of ‘cybermedicine’ that new technology is being used by administrators to restrict doctors’ autonomy (Slack 1997). At a more general level deprofessionalisation is associated with a demystification of medical expertise and increasing lay scepticism about the health professionals (Haug 1971, Beck 1994). In Britain these changes have been reinforced by the redefinition of patients as ‘consumers’ that began in the 1970s and became a central plank of state policy in the 1980s, with a series of interventions into the health services signalled by the White Papers *Working for Patients* (DOH 1989) and *The Patient’s Charter* (DOH 1991) that offered to ‘empower’ the users of health and social services. The realignment of public services around market mechanisms was essentially driven by the informed decisions of the consumers of health care (Shackley and Ryan 1994). As part of a vision of a networked society the Green Paper *Our Healthier Nation* (DOH 1998) anticipates a government Internet resource, ‘Wired for Health’ as a source of health information for schools and colleges as well as the public. The focus on the provision of information is also reflected in the *Patient Partnership Strategy* (NHS Executive 1996) and *The New NHS* (NHS Executive 1997) which places an emphasis on patients’ active involvement in discussions about their health. This inclusive approach is also evident in the patient-centred models of care used in general practice (Laine and Davidoff 1996).

A central theme in the move towards consumerism is the need to provide clients with information; a theme prominent in Giddens’s (1991) account of life in our ‘late modern’ society. Giddens suggests we live in an information-rich society in which life plans and strategies have to be negotiated via a potentially confusing mass of competing and sometimes contradictory sources of information. As he makes clear this applies just as much to those who are ill as it does to those who are healthy. In a fictional account of a woman’s search for information about her back pain, for example, he describes how she finds information from various sources that provide a diversity of material from which she can make ‘a reasonably informed choice’ (1991: 141). What is of most interest in his account for the purposes of this paper is that one important source of information was the Internet. Like the participants in the study reported in this paper Giddens’s subject was engaged in those core activities of the reflexive consumer of evaluating and at times challenging expert knowledge (Lupton 1997).

The Internet is a relatively new, unique and extremely rich source of information that is available to anyone with access to a computer that is linked to a network. It has a short history that began in 1969 when four computers in the United States were linked together so that military information could pass between them (Hobbs 1994). Until the end of the
1980s communication between computers was largely confined to text-based email. At the European Nuclear Research Centre (CERN) the need for a simple computer-based tool to support the co-ordination of research projects led to the development of what was called a ‘browser’. In a break with past approaches to computer communication the browser was designed on the assumption that users should be allowed to search for information rather than be reliant on authors deliberately distributing it to them (King et al. 1997). The concept was christened the World Wide Web (WWW) at CERN in 1990. In 1993 a browser application called Mosaic that provided a graphical user interface and the seamless integration of text and graphics caught the attention of the popular press. Two years later the WWW was a core topic at the G7 meeting of the world economic powers. Today almost the entire globe has access to the Internet and many businesses and households are linked directly to it (Holderness 1998). The Web browser is now familiar to anyone who has used the Internet and often provides the model for the interface to library catalogue systems and electronic learning material. It enables users to access both the WWW and use other resources such as email and newsgroups that constitute part of the broader Internet.

The rapid expansion of the Internet has been fuelled by fierce competition within the computer industry that continues to drive down the price of high-performance computers and telecommunications equipment. In Britain the introduction of a competitive telecommunications market has seen the expansion of cable and satellite communications systems. This provided the basis for the delivery of digital consumer technology and opened up new markets for Internet Service Providers (ISPs) that connect homes and organisations to the Internet. At present the ownership of home computers and use of the Internet at home reflects the social class hierarchy. The General Household Survey recently reported that 64 per cent of households in social class one and 48 per cent of households in social class two owned a home computer in 1996. Although there is a higher rate of domestic computer ownership in the United States a similar pattern is evident, with lower income households being less likely to own a computer (Bikson and Panis 1997). However, in both cases there is a rapidly increasing rate of computer ownership and domestic use of ISPs. Furthermore, the convergence of digitally-based consumer services provides the means to incorporate access to the Internet within familiar broadcast media. There is also evidence that falling costs and increased ease of use has undermined educational and gender barriers in the adoption of home computers which are being perceived as another ‘technology appliance’ (Lin 1998). It should also be remembered that many people have access to the Internet at work or through the increasing number of cybercafes and computers in public libraries and schools.

This paper argues that the Internet constitutes a new and unique medium in which expert knowledge is accessible to anyone with a computer linked to a network or modem. Medical dominance is challenged not only by exposing exotic medical knowledge to the public gaze (Good 1994) but also by the
presence of a wide range of information about and approaches to health. At the heart of medical autonomy is exclusive access to ‘expert knowledge’ (Giddens 1991) and the ability to define areas of expertise and practice. The Internet provides a possible threat to this situation. Anyone with a few technical skills and access to a suitable computer can add to the mass of health information on the Internet (McKenzie 1997). Users need only know of a convenient starting point that is likely to have a link to the desired resource or use any one of a number of search engines such as Yahoo and Lycos as well as various specialist health resources (e.g. Medical matrix, CliniWeb, OMNI) that provide annotated hierarchical links. Pallen, writing in the British Medical Journal, describes a search for the unusual condition of Recklinghausen’s neurofibromatosis which

... was completed in two minutes and provided links to seven web pages at four sites. One particularly informative site at the Massachusetts General Hospital provided a description of the condition, complete with magnetic resonance scans, information about clinical services, research, conferences, and self-help groups (1995: 1552).

The challenge presented by self-help groups to medical dominance can be traced back to the late 1960s. Since then they have grown to such an extent that few chronic illnesses are not represented by a national if not international group. A search for information about cancer, for example, will provide links to sites that range from centres of clinical excellence to individuals advocating unconventional approaches to treatment. Commonly used search engines do not discriminate between material provided by those with clinical expertise and those for instance advocating astral healing. A search conducted for information about cancer may take users to a site that provides evidence about cures based on ‘dissonant energy waves’.1 This site advocates the approach of a biologist who believed that energy waves could destroy cancers and that his work was suppressed by ‘medical interests’. Herbal remedies are advocated as a cure on another site, while users are encouraged to purchase a book of potential cures elsewhere on the Internet.2,3 The search may also find OncoLink4 which provides up to date clinical trial and treatment information, as well as acting as an educational resource for cancer patients and their families (Buhle et al. 1994). This has hyperlinks to the British based Cancer Web which provides a range of material for patients and practitioners as well as links to support groups.5 Pressure groups of all kinds have quickly colonised the Internet and warn users of threats that range from global ecological dangers to the consumption of genetically modified food.

This paper therefore examines the Internet as a source of knowledge about health in relation to the broader sociological debates about deprofessionalisation and consumerism. The paper draws on a qualitative case study of people who use the Internet as a source of knowledge about health.
Although of limited scope it is probably the first attempt to examine in depth how people with no persistent chronic illness use the Internet as a source of information about health.

The study

There are few empirical studies of Internet users, and methodologies for studying information and communications technologies are diverse and range from email surveys to ethnomethodological approaches (December 1996, Slack 1998). The research that forms the basis for this article follows a case-study approach which is particularly useful when examining new phenomena (Yin 1994). An invitation to take part in the study was sent to subscribers of three different email lists that contained members largely confined to the south of Britain. The invitation was also sent to subscribers of a locally based ISP. This invitation contained information about the study and appeared in users’ email utility as a ‘health on the Net study’. Users who responded to this initial request were sent a letter outlining the project and a short questionnaire so that they could be screened for inclusion in the research. Questions about household composition, locality, employment and health were asked. This exercise produced a group of 28 potential participants who were from Kent to Cornwall. Nine households, who were willing to participate in at least two interviews over a year and lived within reasonable travelling distance, constituted an initial sample. Contact was made by telephone to confirm participation in the study and to arrange interview dates. To take advantage of a snowball approach, at the end of each initial interview participants were asked if they could suggest another household that could be approached to take part in the study. This strategy was used to include households not reached by the initial request for participation. Three households were subsequently sent the screening questionnaire and one household was recruited to the research. Households that fulfilled the characteristics for inclusion in the study but were not interviewed have taken part in an email based survey. Two pilot interviews were undertaken for both phases of the research. As they were not substantially different from the other interviews, they were included in the general sample.

Two interviews in participants’ homes were undertaken with each household over a year with both parents present where there were children. They covered a range of issues related to health and the Internet. The majority of interviews lasted between one and two hours. Research notes were also kept as respondents were asked to demonstrate the use of their computers and some of the resources that they had discovered. The interviews were transcribed, and recurring themes and issues were identified in the resulting data following a grounded theory approach. This technique is based on the generation of analytically-based categories through the ‘constant comparative method’ that validates the categories against they data they are grounded in.
(Strauss and Corbin 1990). Research data remain confidential and the names used to report findings in this paper have been changed. While it is not possible to generalise from such a small scale study the experiences and concerns reported here may not be untypical of Internet users.

The final case study consisted of ten households in the South of Britain. The main income earners were aged between 28 and 52, worked full time in managerial and other jobs that are classified as social class one and two. This reflects the current relationship between social class and the ownership of home computers. Five women worked full time, only one of whom worked at home. None of the households contained a family member with a chronic condition except asthma and eczema which were present in four instances. All the families regarded themselves as ‘healthy’ apart from the ‘usual’ childhood complaints. None of the participants regarded themselves as ‘experts’ in relation to computers and no household had owned a home computer with a modem link for more than 16 months.

### Reading the Internet

Using the Internet is an inherently interactive process that involves users in a continual process of decision making. The WWW is underwritten by hypermedia protocols that through a browser enable users to point and click their way across the Internet. Users are actively involved in the construction of a narrative which they read as they search through the Internet for information. By ‘read’ I mean to include text and other forms of information that users may identify on the Internet. The reader in a hypermedia environment uses search strategies and hyperlinks to trace paths through a virtual space of endless possibilities. Participants in the case study were familiar with the use of Web browsers and routinely used search engines to identify information. The process of finding information is anchored in experiences of print media:

> Even the kids know how to search for stuff they’re interested in. The only frustration is the time it takes sometimes. Though if you think about how long and difficult it can be to find something in a book or a library the Internet is far more efficient. Of course you also know that whatever it is you are looking for it is bound to be there somewhere.

This perception of the inclusiveness of information on the Internet means that unfruitful or overlong searches for information are regarded as due to the users’ failure to define appropriate key words or use search-relevant resources. A little ingenuity may be required:

> It can take a bit of lateral thinking to come up with the right terminology. It is also important to use the right search engine. I’ve found the Home Doctor page really simple and helpful.
The Home Doctor web site allows users to enter or browse through symptoms that are linked to products available from pharmacists in Britain.\(^6\) A research project in the United States designed a Web site that provided information on the recognition and treatment of cardiac arrhythmias (Widman and Tong 1997). The site included an interactive demonstration and explanation of complex cardiac rhythms and allowed users to send questions to the site’s authors. Over a month in 1995 the site received 10,732 visits for information from some 50 countries. The authors also received and responded to enquiries from users that were almost always appropriate to the clinical nature of the site. This demonstrates that users can not only identify material relevant to them but also use it as a resource to make further appropriate enquiries. The researchers also note that they usually responded to such enquiries within 24 hours which points to a further advantage of Internet-based consultation for users.

When useful material has been identified it often contains hyperlinks within the text and/or highlighted links to other sites that may be of interest to users. A simple mouse click on a hyperlink takes users from one web site to another. This produces what can be regarded as a ‘narrative’ that consists of the material that may be read on the computer screen, stored on the computer and/or printed to resemble a conventional text. This narrative is assembled by the users so that openings, middles, and ends are what s/he desires (Joyce 1995). In a sense, there is no ‘ending’ in hypertext because the reader can link to another text before reaching the end of the original text. The recent introduction of ‘frames’ that break up the screen allow users to hyperlink to other web resources without leaving the original site. The distinction between what is ‘inside’ one site and ‘outside’ it therefore becomes unclear. To the user, material that is accessed through hyperlinks may appear to come from the site that presents the frame. Users may move between web sites that originate in different countries and continents without realising that they have left the site they first accessed. The undertow of commercialism can be detected in the use of frames as they enable the originally accessed site to retain a degree of control over the user (for example, advertisements can be presented to users). Hypertext therefore releases material from the context in which it was written and presented as well as from the control of authors, publishers, national and professional regulations and constraints.

As texts pass seamlessly across different readership groups they are subject to different interpretive strategies. For example, a research scientist may write a paper for a medical audience that is published in the electronic version of a medical journal and is available to anyone with access to the Internet. Furthermore, users may arrive at the paper from a hyperlink within a different source and depart from it in a similar manner. The process of constructing a narrative is comparable with accounts of reflexivity that emphasise continual monitoring, criticism and assessment of knowledge (Beck et al. 1994). A participant explained the process:
It’s not like reading a magazine. You can slip into a skimming mentality which is what the kids tend to do. . . . Unlike a book, you choose what you see and put things together as you go along. One quickly learns to reject the rubbish as you go along. When I’m looking for something specific I usually feel fairly confident when I have got what I wanted.

The struggle over expertise

The equity of presentation offered by the Internet dissolves the boundaries around areas of expertise upon which the professions derived much of their power. Furthermore the illusion of authority given to computer-mediated material may benefit non-orthodox medicine which lacks the symbols of power and authority routinely available to orthodox medicine (Saks 1992). This diversity and the resulting uncertain nature of Internet health information has provided grounds for dismissing the Internet as a ‘serious tool’ for professionals (Information Market Observatory 1995), and for others to represent it as dangerously confusing to clients. At the heart of the debate about the unity and impact of the Internet lies the question of the quality of the material that is available on it. The issue of quality can be used to illustrate how lay users define and cope with the problem and the way it is used by the medical profession to attempt to retain and redefine boundaries around medical expertise.

There are two main dimensions to this problem of quality. The first relates to Web material that is authored by health professionals and the second concerns the boundary between medical and other approaches to health. A recent study of Internet advice for the home care of feverish children made a comparison between medical guidelines and the Internet advice (Impicciatore et al. 1997). It was found that only four out of 41 sites studied matched medical guidelines in the management of childhood fever. However, as the researchers note, ‘fever in children is rarely harmful, and treatment may not always be necessary’. Part of the problem here is the global nature of the Internet that is highly subversive of national boundaries and guidelines to clinical treatment. It should be remembered that users from countries other than the originating site may experience problems related to the different labels used for proprietary drugs as well as national differences in the recognition of treatments. This raises the question of how and whether lay users are able to manage contradictory or misleading information. Differences with the narratives constructed by users were viewed as problems that were a ‘natural’ characteristic of the Internet:

I think there is room for people to be misled. Some of the things you find simply contradict each other. Actually it only needs a little common-sense to make your mind up about what is useful. . . . At the end of the day you have to rely on your own judgement.
Another respondent was similarly confident in her ability to discern reliable material but had adopted a reflexive approach:

If you are a bit doubtful about something it is a simple matter to ask a slightly different question to get more information. I mean, one thing about the Net is that you only have to think about what you are looking for . . . so one piece of information makes you think a little differently so you get a different slant on what you want. . . . I would say that it (contradictory or misleading information) was not a problem any more than it is on TV or a magazine.

These quotations suggest that users were aware of the quality problem and that they felt they could assess narratives that enabled them to resolve the difficulty. As a participant suggested above, the clinical quality of health related CD-ROMs, advice in popular magazines or ‘family doctor’ books may be no more reliable than much of the information available on the Internet. Furthermore, direct comparison can be made with the medical consultation:

My GP is very busy and does not have time to answer questions fully. Actually it is much easier to think about what you want to ask when you look things up on the Net. I don’t get that nagging feeling that I’m needlessly taking up his time.

The unregulated electronic space of the Internet echoes the diversity of the market for health that existed before medicine secured its professional status (Stacey 1988). Once established the profession invested much time and energy in reinforcing and expanding the boundaries of its practice within the paradigm of natural science. Analysis of case-study material suggests that participants had an inclusive view of health information which is anchored in the diversity of the consumer market:

I’d heard about osteopathy but I hadn’t realised that it would be any use for my back ache. I like to know what I might be letting myself into . . . so it was useful to get the background information, so I felt I could make a sensible choice . . . The osteopath was clearly right for me . . . and I would recommend it to anyone now.

Several participants mentioned how beginning a search to look for information about prescription drugs or symptoms had led them to information about non-orthodox approaches to health:

I was given these anti-biotics but they gave me thrush and I couldn’t sleep. My GP wasn’t terribly helpful but when we looked up anti-biotics we found a lot about what they could do to you . . . you know, side effects
that they don’t bother explaining to you. Anyway we also found a lot about natural treatments that did not involve drugs as such. . . . Allergies are probably a lot to do with my problem so I’m trying this diet we found out about and I’m seeing a homeopath.

As the quotation above suggests, the Internet may act as a conduit to non-orthodox therapy. It can also be instrumental in challenging a course of treatment:

I was diagnosed as having high blood pressure and they gave me these pills. OK I was told I might get some side effects but I felt pretty bad sometimes after taking them. Anyway I found this place in the States [USA] that had a whole lot of information about this drug. Turns out that my symptoms happen to some people and there was this other pill that works better. . . . When I got to see my GP she was surprised about what I knew about the prescription and put me on this other drug which works fine. I actually showed her some print outs from the Web that clearly show these tests that had been run on the drug and the symptoms that people in my circumstances had as a result. She was a bit taken aback but took me seriously and spent longer than I have ever had going through the details with me.

A number of participants reported that they had renegotiated treatment for themselves or their children with their GP on the basis of information they had found on the Internet.

Participants in the study accessed the Internet in the familiar space of the home with only self-imposed limits on time. This is a very different venue from the consulting room with its trappings that reinforce medical dominance (Heath 1984). Embarrassing or difficult questions can be asked and answers may only be shared with the computer. Furthermore, physical location is largely irrelevant to users of the Internet. This provides scope for minority communities to seek information about Ayurvedic, Unani and other approaches to health which may not be easily available where they are resident or not be encouraged by GPs. Those who live in rural areas or in parts of the globe with less developed services for particular conditions can participate in support groups and read information about their health problem. The breakdown of the local/global distinction has also been seen as one of the benefits of telemedicine. However, such narrowband communication is limited compared to the Internet that offers integrated digital media (McGee et al. 1994).

The medical profession anchors the problem of quality within a natural science model that is reinforced by the concept of evidence-based practice and the traditional role of the professions as a protector of the public interest (Saks 1995). A particularly apt example of this is provided by the Quackwatch site.7 Constructed by a retired psychiatrist and sympathetic
doctors in the United States the mission of Quackwatch is to warn users about what is regarded as unscientific or inappropriate health information. The site rejects all but ‘proven’ medical material following a review by clinicians, and includes examples of unsound health material. In doing this the site appears to follow a strict evidence-based hierarchy that gives priority to material based on randomised controlled trials. Over a hundred dubious practices are listed and include acupuncture and traditional Chinese medicine. In a good example of boundary keeping the site also offers selective and sometimes vitriolic comments together with a commentary emailed to it by users advocating alternative approaches to treatment. There is little evidence for ‘new modesty’ (Beck 1994) about medical expertise in the Quackwatch site that discredits all but narrowly defined health knowledge.

Perhaps more representative of the response from the medical profession are the calls for the creation of an international standard for Internet health material. The provision of a ‘gold standard’ or ‘kitemark’ for health related Web sites would allow the medical profession to establish boundaries around the medical expertise that is represented on the Internet. Institutes like Mitretek (1998) have developed criteria for assessing the quality of health information that include clear statements about sites’ objectives, intended audience and accuracy of content. However, organisations that provide a rating system may not make the criteria on which reviews are based explicit. A survey of 47 instruments used to indicate quality revealed that only 14 made the criteria used explicit (Jadad and Gagliardi 1998).

Discussion and conclusion

The potential of the Internet as a source of health information has yet to be widely recognised. A recent review of evidence-based information for clients concluded that it was ‘too early to know whether it will be a widely used source by patients for health information’ (Hope 1996: 20). Theoretical and popular analyses of information technology, however have focused on its ability to change economic and social relationships in an egalitarian direction (e.g. Bell 1974, Toffler 1980, Castells 1996). At a micro level it has been argued that ‘by the mid-1990s, people can be expected to view personal computers as knowledge sources rather than as knowledge processors . . . gateways to vast amounts of knowledge and information’ (Tennant and Heilmeier 1991: 123). The participants in this study took advantage of their computers to find health material in this ever-expanding body of knowledge. They did this in the familiar space of the home, largely with only self-imposed limits on time. This is a very different venue from the consulting room. Embarrassing or difficult questions they wanted to ask were shared only with the computer or anonymous others.

The Internet as a global market that offers new opportunities for consumerism continues to attract much media attention and considerable
investment in electronic commerce. Access to the global health market enables users to undergo, for example, cosmetic surgery in Eastern Europe or visit India for hip replacement operations. This suggests that the ‘local’ medical encounter and medical expertise should be seen in the ‘global’ context. It is therefore possible for individuals from different traditions to access ‘local’ expertise about, for example Ayurvedic or Unani approaches to healing from practitioners situated in communities where these are the predominate models of healing. This multiplicity of therapeutic regimes, self-improvement guides and self-help groups provides resources for users to construct and reconstruct narratives to maintain or alter their sense of self-identity in a manner which goes way beyond that implied by Parsons’s sick role (Giddens 1991, cf. Parsons 1951). Advice and advertising about diets, exercise plans, muscle building drugs and so forth continue to proliferate on the Internet. The capacity of the Internet to reassure people anxious about the ‘external’ and ‘internal’ health of their bodies is central to this process and the Internet provides a unique resource for users to cultivate their bodies within a discourse on ‘lifestyle’ (Shilling 1993). Such tendencies challenge the efforts of national governments’ attempts to erect barriers to the importation of drugs that are not licensed locally or, as in the recent case of Viagra, have an uncertain status in local health care systems.

It would be wrong to prioritise a model of modernistic health consumerism mediated by the Internet whereby users become detached from the emotional and caring dimensions of health in the face of a sea of information. Rather, the resources available on the Internet encourage pluralist approaches to health. At one level the information available transcends established scientific, political and professional boundaries and at another interactive resources create the space for the construction of new narratives about health and lifestyle. Within newsgroups, chat rooms and other interactive resources people ‘open up’ to others in an environment where anonymity promotes trust in strangers. Such electronic communities offer new opportunities for people with chronic or debilitating conditions to participate on an equal basis in community life. Global self-help groups provide a space for strangers who are bound within an environment that minimises the ‘gamble’ (Giddens 1991) involved in sharing intimate feelings. The anonymity of such places provides fertile ground for giving meaning to life crises or what Giddens refers to as ‘fateful moments’. This reflects the roots of electronic health information which can be traced back to the email-based on-line support groups that emerged in the 1980s and were often originated by people with HIV/AIDS. Such resources have developed into sophisticated collaborations between health professionals and user groups like the European based SEAHORSE project that provides information and support in relation to HIV/AIDS and acts as an interactive conduit for the sharing of expertise. ‘Expertise’ here is defined holistically to include lay knowledge whether from patients, carers or family members.
The research noted in this paper supports Giddens’s contention that ‘provided that the resources of time and other requisites are available, the individual has the possibility of a partial or more full-blown reskilling in respect of specific decisions or contemplated courses of action’ (1991: 139). This exposure of the health profession’s knowledge base to the public gaze represents the challenge to medical expertise envisaged by Haug’s (1973) notion of deprofessionalisation. Moreover from within the medical paradigm the provision of detailed information about treatment has been shown to be welcomed by patients and to be associated with measurable improvements in health (Weinman 1990). In a recent review of the research literature Coulter (1997) concluded that there was a demand from patients for more information and involvement in their treatment. In the process of ‘reading’ described here, users dynamically assess the usefulness and quality of the information they collect. This protects them from information overload because they actively decide when they have read enough material for their needs. In line with the original idea behind the design of the browser it is the users of information rather than authors or professional experts who decide what is delivered to them. This represents a break with the print-based tradition of health information that is devised by health professionals and often distributed by them so that they control the content and flow of information (Buckland and Gann 1997). The basic design of the Internet therefore represents a challenge to previously hierarchical models of information giving. This shift in control is central to the deprofessionalisation thesis and may be seen as contributing to the decline in awe and trust in doctors. The internally referential and provisional nature of medical knowledge and the division between experts is evident in the debate about the quality of Internet health information. Lay challenges to medical expertise noted in this paper produced a re-negation of treatment and in some instances the use of non-orthodox therapies. The blurring of boundaries between orthodox and non-orthodox beliefs encourages a definition of health that embraces spiritual and emotional dimensions often marginal in conventional medicine. However, it would be wrong to conclude that Western medicine becomes simply one option which consumers can choose to include in the construction of meaning about health, and to incorporate in self-care strategies. The dominant discourse about health and healing on the Internet is Western, and, as has been shown here, there are ranges of activities under the umbrella of ‘quality’ that are being used to limit the space or credibility given to non-Western medical knowledge. Further research is needed to understand how and whether doctors view patients’ use of the Internet as a threat to their clinical autonomy or as a resource to promote a partnership in care.

Address for correspondence: Michael Hardey, Building 4, Level 4, Highfield, University of Southampton, Southampton SO17 1BJ
e-mail: M.Hardey@soton.ac.uk

© Blackwell Publishers Ltd/Editorial Board 1999
References to Internet sites

1 <www.kalamark.com/essiac/sunrest/html>
2 <www.healthfree.com/schulze>
3 <www.ismall.com/zheng/prorder.html>
4 <www.oncolink/upenn/edu>
5 <www.graylab.ac.uk/cancerweb.html>
6 <www.medetail.co.uk/home-doc>
7 <www.quackwatch.com/index.html>

References


© Blackwell Publishers Ltd/Editorial Board 1999


