October 1985

Curing Television's Ills: The Portrayal of Health Care

Joseph Turow
University of Pennsylvania, jturow@asc.upenn.edu

Lisa Coe
Fleishman Institute

Recommended Citation
Turow, J., & Coe, L. (1985). Curing Television's Ills: The Portrayal of Health Care. *Journal of Communication,* 35 (4), 36-51.
https://doi.org/10.1111/j.1460-2466.1985.tb02971.x

NOTE: At the time of publication, the author Joseph Turow was affiliated with Purdue University. Currently January 2008, he is a faculty member of the Annenberg School for Communication at the University of Pennsylvania.

Curing Television's Ills: The Portrayal of Health Care

Abstract
Content analysis of TV programming across day- and night-time genres shows drugs and machines as the ubiquitous modes of healing, with doctors diagnosing incorrectly only three percent of the time.

Comments
NOTE: At the time of publication, the author Joseph Turow was affiliated with Purdue University. Currently January 2008, he is a faculty member of the Annenberg School for Communication at the University of Pennsylvania.

Curing Television's Ills: The Portrayal of Health Care

by Joseph Turow and Lisa Coe

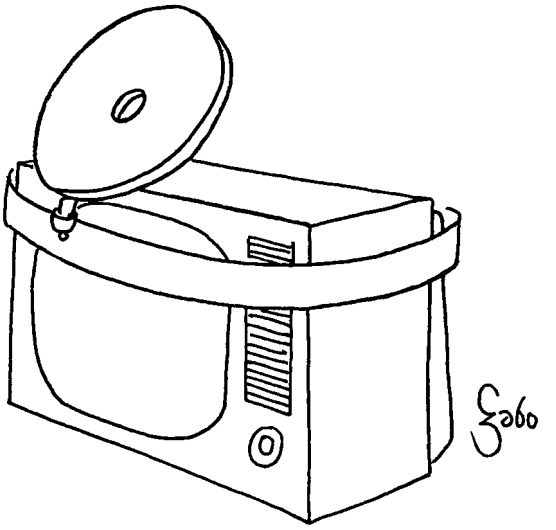
Content analysis of TV programming across day- and night-time genres shows drugs and machines as the ubiquitous modes of healing, with doctors diagnosing incorrectly only three percent of the time.

Much writing about television's depictions of health care takes as its starting point a concern that the medium be used to inculcate good health habits among children and adults (16, 29). There is, however, another approach to TV's contribution to health care, one that demands a different kind of program analysis. It is that beneath any concerns for health education lie broader notions about the medical institution's power to define, prevent, and treat illness in society (see 12).

This latter view argues that U.S. network television's major contribution to public perceptions of health lies in outlining the accepted and the contested options for professional health care and in repeating dramatically, through news and entertainment, lessons about for whom society should care, why, when, and how. It is to this shared national agenda that politicians most strongly feel a need to respond publicly when formulating health care policy. When certain issues do not make TV's ledger, politicians feel less compulsion to reach a national consensus about the problems and more of an incentive either to ignore them or to flow with solutions demanded by special interests.

While a number of significant contributions have been made toward advancing this perspective (for example, 5, 12, 13, 14, 18), no systematic, issue-guided analysis of TV programming exists that can be used as a platform for inquiring more deeply into the medium's implications for the health care system's structure and power. Our study represents one step in this direction. Specifically, we inquire into the extent to which profound changes that have transformed the U.S. medical system during

Joseph Turow is Associate Professor of Communication at Purdue University. Lisa Coe is an account executive at Fleishman Communications, Palatine, Illinois.



the past decade have found contemporary expression in the treatment of illness on network TV. The analysis of a large block of network television news, entertainment, and commercials reveals a huge gap between actual changes in the structure of medical care and TV's portrayal of that structure. The findings raise important questions about the consequences of this disjuncture for public policy. In addition, they raise the more general and hardly examined issue of the mass media's coverage of institutional change.

Public and private policy making on medical issues during the past decade and a half have been propelled by two major considerations: the increasing relative importance of chronic as opposed to acute illnesses, and the rising costs of U.S. medical care in relation to other segments of the economy.

The first consideration, chronic or long-term illness, has been characterized by the Robert Wood Johnson Foundation as a "mounting problem," one of "the longer-term trends that will have a major influence on [U.S. society's] health care arrangements" (17, pp. 11–12, 16–17). A growing aged segment of the population, free from acute (short-term) problems (thanks, in part, to medical science), has survived to meet a panoply of chronic difficulties—cancer, heart disease, diabetes, senile dementia, and more. Too, the success of intensive care procedures in saving young and old people who would have died a few years earlier has resulted in a broad range of difficulties for those who have survived, their relatives, and their friends. To medical ethicists and a growing number of self-help organizations, the increased presence of chronically ill people underscores the importance of aiding all involved

in taking into account the social and psychological, not only biomedical, aspects of an illness: from its discovery through critical care management, through the integration of the chronically ill person into a long-term institutional setting or (not uncommonly) into mainstream society (see, for example, 2, 3, 7, 9, 17, 25, 33).

The second area of major concern—the rising costs of medical care—is to a considerable extent related to the public and private expense of treating an aging population with chronic problems. But costs have outpaced inflation in all parts of the medical system. By the mid-1980s, health care was consuming 10 percent of the U.S. gross national product (6, p. 17). Many government and business leaders considered the situation intolerable.

The root causes for the spiraling cost increases are a matter of acrid dispute (for a historical perspective, see 30). Regardless, concern over rising health care costs have sparked two major approaches by government and big business that are changing the structure of U.S. medicine. The first approach limits federal Medicare payments to hospitals according to predetermined disease categories called diagnostic related groups (DRGs). For example, a hospital that admits a 68-year-old man with a specific heart problem would receive a certain amount to pay for that patient, whether it actually needs more or less. The Medicare program is limited to people 65 years and older, but a number of state governments, spurred on by big business and the insurance industry, have been trying to apply this cost-limiting idea to patients of all ages. While the DRG regulations and related rules are still evolving and their full implications are impossible to determine, it is clear that they inject new incentives into the physician-hospital relationship (see, for example, 10, 11, 20, 21, 22, 23, 26, 27, 31, 33, 39). Whereas until just a few years ago hospital administrators working in an era of broad insurance coverage encouraged physicians to use hospital technology liberally, the new DRG regulations have created an economy of scarcity. That demands frugalness on the hospital's part and creates an important tension between the hospital administration and attending physicians on the desired approach to patient evaluation and treatment. Administrators now encourage a kind of competition among doctors in their use of hospital resources, with the implication that physicians who hinder the hospital from profiting from patient care will not long retain admitting privileges (15, 32).

The second major approach to cost containment, one used by both the public and private sector, encourages the growth of medical delivery systems with lower per patient costs than those of private physicians and general hospitals—for example, health maintenance organizations, independent practice associations, preferred provider organizations, outpatient surgical facilities, hospital-owned hotels for relatively low-cost patient recovery, and "doc in the box" quick medical care facilities. Each arrangement brings its own incentives and disincentives for certain approaches to patient care. The competitive environment has

also led established hospitals in many areas to compete fiercely for patients (for example, middle-class pregnant women) whose ability to pay has not been shaped by declining federal and state payment schedules. The poor and unemployed are clearly not part of those target groups, and in a number of localities—Detroit and Tampa are two examples—the scarcity of resources for them has reached crisis proportions (8, 10, 19).

The foregoing sketch implies that much of the public and private response to health care costs can be understood in terms of the twin concepts of scarcity and competition. Also implied is that health care decisions are interrelated at the societal level—that they have sociopolitical as well as individual implications. In an era in which the development of expensive technology is allowing people with chronic illnesses to live longer and (sometimes) better than ever before, defining medical care as a scarce resource raises moral and logistical, as well as economic, questions (1, 37). The same is true about the new competitive environment that is changing the structure of care for acute and chronic problems. In the United States a variety of major forces representing big business, labor, the aged, organized medicine, and the hospital, insurance, pharmaceutical, and medical technology industries are grappling furiously at the federal and state levels over the emerging system and its outcome (27, 28).

But to what extent does network television incorporate these debates over the changing dimensions of illness and the changing structures of health care into programming? To what extent are these new circumstances—the increased prominence of chronic illness, the approach to health care as a scarce resource, and the injection of private competition into the scene—shown to have consequence for the way sick people are handled in a variety of medical and nonmedical settings? What are the implications of these TV presentations for public and professional response to the dynamics and politics of change in the medical institution? The purpose of this study was to answer these questions.

Our way into the problem was to explore how "ill" people—individuals or collectivities depicted or talked about—are "treated" on television.

We defined "treatment" broadly to mean any attempt by an individual or an organization to address an ill person's physical or emotional state, through medical or nonmedical means. Drawing on the widely cited definition by Parsons (24), we defined "illness" on TV as the impairment of a person's bodily functions so as to adversely affect the performance of "normal" social roles. Chronic illness is bodily impairment that adversely affects normal roles for an unforeseeable length of time. Acute illness, by contrast, is depicted as having an end in sight, whether it is a cure or death resulting from the illness. Since TV portrayals can depict the progress and outcome of the same illness in a

variety of ways, we designated an illness as acute or chronic only after noting the way it was handled in the context of an "illness episode."

An "illness episode" was our major unit of analysis. We defined it as the portrayal of any activity by an individual or organization toward an ill person (or collectivity); or of any activity by an ill person (or collectivity) toward an individual or organization. Also included in the notion of an illness episode were portrayals of two or more individuals discussing the way to cope with the illness of others.

The length of an illness episode was limited by definition to not more than the length of a scene or news story; a different scene meant a different illness episode. Because an illness episode by definition involved one dyad, entertainment scenes or news stories that noted the interaction of a number of ill and healthy people might yield several illness episodes. In addition, because an ill person might interact with a number of individuals or organizations during the course of a program, the person's illness episodes could accumulate into a string we called an "illness series." We expected that, the more episodes that comprised an illness series, the more varied would be the attention devoted by TV to that specific person and problem.

We examined the treatment of illness on ABC, NBC, and CBS during the first two weeks of November of 1983. Focusing on one network a day in rotation, we videorecorded the morning news program, two hours of soap operas (on weekdays), the evening news, and prime time, all including commercials. Then, after testing the reliability of an extensive coding scheme based on the concept of an illness episode (Scott's Pi = .87 with two coders), we systematically noted those aspects of the episodes that would illuminate the way TV deals with the changing dimensions of illness and the changing structure of health care.

The examination of 90.5 hours of network television over 14 days revealed 723 interactions in which ill people appeared.

Commercials contained 34 percent of the illness episodes and afternoon serials 18 percent. Prime-time fictional programming contained 33 percent, with evening serials (such as "Dynasty" and "St. Elsewhere") having 11 percent, evening series 14 percent, and movies 8 percent. Evening news broadcasts accounted for only 3 percent of the illness episodes, while news magazines (morning and evening) accounted for 12 percent. No matter what the programming, though, illness tended to take center stage when it appeared. Overall, 639 or 88 percent of the interactions in which ill people took part revolved in some way around their maladies. This figure was 98 percent in commercials, 96 percent in evening news and serials, 92 percent in news magazines, 82 percent in afternoon serials, 74 percent in prime-time series, and 71 percent in movies.

The 723 illness episodes involved 380 "patients," whose numbers varied greatly in the different program types. Commercials had a total of 245 patients; the evening news, 15; news magazines, 46; afternoon serials, 35; evening serials, 21; evening series, 32; and movies, 6.[1] When they could be determined, the demographics of the ill population were found to parallel those typically found on network TV: male (58 percent of the 296 whose sex could be noted), non-ethnic white (89 percent of the 281 whose ethnicity could be noted), and white collar (60 percent of the 84 whose occupation could be noted). Even though people over the age of 65 confront the highest illness-related expenses and the most major illnesses in U.S. society (6, pp. 25–27), only 5 percent of the 214 patients whose age could be determined were over 65.

We used 29 categories to encompass the problems that afflicted people in our TV sample. Table 1 presents the distribution of these illnesses in three ways. The first, a listing of the illnesses afflicting the 380 patients, is a straightforward measure of attention to medical problems on TV. The second, which lists the distribution of illnesses according to the 723 illness episodes, is perhaps a better indication of the programs' emphases on particular illnesses; patients with certain illnesses were more likely to be depicted in a greater number of illness episodes than were patients with other illnesses. The third way of depicting the distribution of illnesses on TV presents their occurrence in the 132 patients who appeared outside the commercials—that is, where the most serious illnesses tended to show up.

The first column in Table 1 shows that the illness that hit TV's population most frequently was the common cold (affecting 27 percent of patients), followed by headache/fever, skeletal-muscular problems, gastrointestinal discomforts, and arthritis. Together, these five illnesses affected 219 (58 percent) of the 380 patients. Not surprisingly, 204 of those 219 patients (93 percent) showed up in commercials for pharmaceuticals.[2]

A look at the 723 illness episodes changes the emphasis somewhat. The second column of Table 1 shows that cold symptoms still ranked

[1] The number of patients appearing in commercials was large compared to the numbers on other types because all but three of the commercial illness episodes dealt with different people. By contrast, a few entertainment and news programs depicted the same patients across a large number of illness episodes. It might also be underscored that this study was conducted during November, a typical time for the common cold. Perhaps products to alleviate "cold symptoms" and "headache/fever" are particularly evident on TV during this time.

[2] Of the 380 patients, 199 (52 percent) stood out as individuals, while 181 (48 percent) were collectivities, that is, specific groups of patients (e.g., lepers in a colony in Hawaii) or general abstractions (e.g., people with head colds). The large number of collectivities might be taken to mean that programs consistently dealt with illness on broad intellectual, perhaps even sociopolitical, terms. This was not the case, however, since 159 (88 percent) of the collectivities appeared in commercials as mere surrogates for consumers of the persuasive message.

Table 1: Illnesses on sampled television programming

	Individual patients (n = 380) %	Illness episodes (n = 723) %	Individual patients, excl. commercials (n = 135) %
Cold symptoms	27	16	—
Headache/fever	16	9	—
Skeletal/muscular	5	6	8
Gastrointestinal	5	2	—
Arthritis	5	3	0.8
Hemorrhoids	4	2	—
Severe trauma (accidents, gunshot wounds)	4	7	11
Cuts, bruises	4	5	7
Mental illness	3	10	8
Heart problems	3	6	7
Leprosy	2	3	7
Alcoholism	2	3	1.5
Birth defects	2	1	5
Drug abuse	1	9	3
Eyesight problems	1	0.7	2
Transplant needed	1	2	4
Neurological problems	1	4	3
Cancer	1	1	3
Autoimmune problems	1	0.8	3
Poisoned	1	0.8	3
Lung problems	0.8	0.4	0.8
Appendicitis	0.8	0.4	2
Mental retardation	0.8	0.4	2
Anorexia nervosa	0.5	0.4	1.5
Diabetes	0.5	0.3	—
Malaria	0.5	1	1.5
Other	1	0.6	1.5
Mixed problems	1	0.8	1.5
Unspecified	4	5	11
Total	98.4[a]	100.6[a]	98.1[a]

[a] Rounding error

first, comprising 16 percent of all the illness interactions. But following cold symptoms were mental illness, drug abuse, headache/fever, and trauma. While mental illness and drug abuse together were problems for only 4 percent of the patients, considerable attention was paid to those patients. For example, a total of 51 out of 72 episodes involving mental illness revolved around the main character of *Ordinary People*, a two-and-a-half-hour theatrical film aired by NBC.

Excluding commercials when looking at patients' illnesses highlights those illnesses depicted in television news and entertainment programs. The third column in Table 1 shows that, for the 135 patients not in

advertisements, the most common illness was trauma. According to health experts, trauma is a major health problem in the United States, especially the kind of trauma that leads to chronic debilitation (35, p. 35; 36). In our sample, however, none of the 48 episodes that depicted trauma approached the problem as chronic. While 12 episodes took an unclear stance, the rest presented dramatic violence that led rapidly to cure or death. The next four most frequent illnesses in the noncommercial sample were skeletal/muscular, mental illness, heart problems, and leprosy. (A chronic problem rare in the United States, leprosy was the focus of a segment of the news magazine "20/20" that depicted a leper colony in Hawaii.)

Heart problems and mental illness are also considered major problems by U.S. health experts. Although physicians generally regard both as having important chronic aspects (2, 9), of the 72 illness episodes that dealt with problems of heart or mind in news or entertainment, 40 (68 percent) dealt with the problem on an acute basis (for example, going into surgery or expressing the opinion that the emotional problem was temporary).

One example from the soap opera "The Young and the Restless" gives the flavor of TV's tendency to ignore the implications of long-term illness. A young adult woman in the program, Traci, overdosed on drugs and ended up in the hospital, where doctors found that she had severely damaged her heart. Eventually, they told her that she would have to take heart medicine for the rest of her life. After her release, however, that plot line was dropped and while the character was heard of again, her heart ailment was not.

Over the course of our two sampled weeks of "The Young and the Restless," Traci's problem was covered in 30 illness episodes, 23 of which treated her overdose as an acute difficulty (suggesting that she would be fully cured quickly) and only 7 as chronic. While Traci's story reflects the acute "tilt" of network TV's handling of illness, her illness series was quite unusual in that it was relatively long and portrayed the reactions of various people to her problem at various times. Many of her illness episodes involved agonized relatives discussing her problem among themselves or with doctors.

By contrast, most illness series in our sample did not have the potential for anything approaching the comparatively textured depiction of Traci's illness. This is because 85 percent of the 380 illness series involved only 1 illness episode, 95 percent involved 5 or fewer episodes, and only 3 series in the entire sample (including Traci's) exceeded 21 episodes. As Table 2 indicates, the three long illness series appeared in two afternoon serials (a drug abuse subplot on "As the World Turns" plus Traci's subplot on "The Young and the Restless") and one movie (*Ordinary People*, which focused on the difficulties of an emotionally ill youngster). Table 3 indicates that afternoon serials and movies were also the program formats most likely to depict patients with "textured" medical problems—that is, problems shown to have both chronic and

Table 2: Program types by length of illness series

	Short series (n = 360) %	Medium series (n = 17) %	Long series (n = 3) %
Evening news	4	—	—
News magazines	12	18	—
Prime-time series	7	29	—
Afternoon serials	3	18	67
Evening serials	4	29	—
Movies	1	—	33
Commercials	69	6	—
Total	100	100	100

Note: A short series denotes 1–5 illness episodes; a medium series denotes 6–20 illness episodes; and a long series denotes 21 or more illness episodes. Within each row, all frequencies are significantly different by the chi-square test, with $p \leq .001$.

acute (or possibly uncertain) aspects to them. By contrast, commercials and news programs tended to zero in on patients more fleetingly than other program formats and were more likely to depict patients' problems as straightforward. In this sense, of course, the treatment of illness merely exaggerates a general characteristic of TV's program formats. Overall, only 21 (5 percent) of all patients had "textured" medical problems.

Of the 359 patients whose illnesses were depicted in an untextured manner, the short-term and the clear-cut carried the day, as Table 3 shows. Commercials, the program form with the largest number of patients, also had the largest number of patients with acute illnesses (to be alleviated by the advertised product), followed by news magazines, evening series, and afternoon serials. In both news magazines and the evening news, where items on birth defects, AIDS, leprosy, cerebral palsy, and cancer found air time, the percentages of "chronic only" stories were relatively high. Interestingly, none of the patients in afternoon serials or movies had their illnesses depicted as only chronic; the chronically sick people on soap operas typically had "textured" illness series.

Whether the problems they dealt with were portrayed as chronic or acute, all types of TV programming tended to emphasize biomedical (that is, pharmacological or technological) over interpersonal and psychological attempts to deal with illness.

Of the 723 illness episodes, 66 percent involved the suggestion or performance of specific biomedical actions and only 10 percent involved psychosocial coping (12 percent of episodes did not relate to the patient's illness at all, and another 12 percent revolved around the

Table 3: Illness characteristics by program types (in episodes)

	Evening news	News magazines	Prime-time series	Afternoon serials	Evening serials	Movies	Commercials	Total
"Medical texture" of illnesses	(n = 15) %	(n = 46) %	(n = 31) %	(n = 15) %	(n = 21) %	(n = 6) %	(n = 245) %	(n = 380) %
Textured	7	7	16	33	10	34	—	5
Untextured	93	93	84	66	90	66	100	95
Total	100	100	100	99[a]	100	100	100	100
Nature of untextured illnesses	(n = 14) %	(n = 43) %	(n = 27) %	(n = 10) %	(n = 19) %	(n = 4) %	(n = 242) %	(n = 359) %
Acute only	50	42	49	50	68	50	83	72
Chronic only	36	44	29	—	33	—	10	16
Uncertain only	14	14	22	50	—	50	7	11
Total	100	100	100	100	101[a]	100	100	99[a]
Coping vs. biomedical in illness episodes	(n = 22) %	(n = 83) %	(n = 102) %	(n = 129) %	(n = 78) %	(n = 61) %	(n = 248) %	(n = 723) %
Coping	—	8	8	49	21	11	3	10
Biomedical	99	80	62	16	74	76	94	66
Other	1	12	30	35	5	13	3	24
Total	100	100	100	100	100	100	100	100
Location of illness episode (when known)	(n = 8) %	(n = 51) %	(n = 95) %	(n = 115) %	(n = 72) %	(n = 57) %	(n = 51) %	(n = 449) %
Hospital	88	47	36	67	74	5	10	43
Doctor's office	—	4	1	2	3	19	—	4
Other medical location	—	—	—	—	—	—	8	1
Dwelling	—	14	6	5	4	40	39	14
Other nonmedical location	12	35	57	26	19	35	43	38
Total	100	100	100	100	100	99[a]	100	100

Note: Within each row, all frequencies are significantly different by the chi-square test, with $p \leq .001$. [a] Rounding error.

illness in a general manner—describing it or making small talk in the hospital room). Only 2 of the 248 commercials referred to psychosocial coping. Of the 396 noncommercial illness episodes that revolved around illness, only 18 percent depicted psychological aspects of coping with the problem on the part of the patient, family, friends, or health professionals. Table 3 shows that afternoon serials had by far the highest percentage of coping episodes, with evening serials a far second.

Psychosocial concerns about coping made up only 16 percent of the 205 discussions that relatives, strangers, and friends had with patients and only 5 percent of the 177 interactions between health professionals and patients. Other kinds of attempts at this aspect of coping were also infrequently portrayed. Only 43 of the 723 interactions revolving around ill people involved two individuals other than the patient discussing ways to handle the psychosocial consequences of illness. As for the 246 episodes that showed patients trying to cope with illness alone, 203 appeared on commercials, and they all ended with decisions to take drugs. Of the remaining 43 "patient alone" episodes, only 6 saw patients trying to cope psychologically with their own illness. One of these exceptions, on "St. Elsewhere," showed a heart patient listening to classical music to keep her mind off her upcoming transplant. Another, a news report on "Good Morning America," told of a cerebral palsy victim's decision to starve herself to death.

People with chronic problems were significantly more likely than people with acute illnesses to be involved in coping episodes (22 percent vs. 10 percent). However, an examination of the references to coping revealed that, for both chronic and acute illnesses, "coping" often (59 percent of 152 references) meant words of comfort or other efforts at short-term help rather than plans for long-term handling of the problem, plans that could be important in chronic diseases. Further, only 4 percent or 17 of the 475 noncommercial illness episodes depicted one or more patients returning to society. And, in line with TV's emphasis on clear-cut solutions, 12 of these 17 episodes depicted the problems as acute and only 4 as chronic.

In contrast to the rarity and superficiality of a psychosocial approach to illness, especially chronic illness, drugs and machines were ubiquitous as vehicles of healing. Pharmacological treatments were most common, comprising 54 percent of the 478 specific biomedical interventions. Following pharmacology in frequency were mechanical (such as traction—15 percent), surgical (9 percent), diagnostic (4 percent), psychiatric (4 percent), nutritional (3 percent), and other (2 percent) approaches. Both pharmacological and technological approaches were scattered broadly through the news and entertainment programs, although there was an emphasis on the technological (especially the surgical) that was statistically significant. In commercials, however, solutions were almost exclusively related to drugs (91 percent).

Table 3 shows that, of the 51 commercials whose locations could be ascertained, 39 percent took place in the person's home, 51 percent in

some other nonmedical location, and 10 percent within a hospital. Commercials had an uncertain or uncodable location in 197 (79 percent) of 248 occurrences. Frequent demonstrations of self-medication can be inferred from these figures. By contrast, in news and entertainment collectively, of the 398 episodes that could be located (84 percent of the total), 52 percent took place in some part of a hospital. The prominence of the hospital did not differ substantially whether the illness was depicted as acute or chronic, but it did differ across program types. As Table 3 shows, hospital treatment of illness was especially prominent in the evening news, afternoon serials, and evening serials. It was least prominent in the evening series and the movies.

The point to underscore here is that in all programs the hospital showed overwhelming dominance as a location for the *professional* treatment of illness. As Table 3 indicates, only four percent of the illness episodes took place in any professional medical location other than a hospital. All but four of these locations were a doctor's office, and two of those involved a psychiatrist's room in the film *Ordinary People*. This means that, aside from four local ads for a drug dependency center, commercials, news, and fictive entertainment ignored the various kinds of long-term and intermediate care facilities, the numerous forms of nonhospital outpatient surgical or ambulatory facilities, the various types of nonspecialist private practice locations, and the numerous kinds of health maintenance organizations that exist throughout the country. Also ignored were many kinds of medical personnel aside from hospital-based doctors and nurses. Excluding commercials (where only 4 medical professionals appeared and occupations in general were mostly unknown), medical professionals appeared in 214 (56 percent) of the 379 interactions in which occupations were known. Of those 214, 70 percent were physicians, 13 percent were nurses, and 16 percent made up all other categories of health care personnel.

The so-called allied health professions were sparsely and indistinctly represented. Only 11 episodes in entertainment programming depicted practicing medical professionals other than doctors and nurses. Three of these showed ambulance drivers/paramedics, two a physical therapist, one a nutritionist, one an X-ray technician, and the rest persons who fit into only the vague occupational category of "medical personnel." The same vagueness characterized the 12 news spots and 14 commercials in which "other medical personnel" appeared. Optometrists in Sears' optical department ads and, in the news, an occupational therapist, a hospital spokesperson, and an organ transplant coordinator were the only specific jobs that could be noted. Missing entirely from television were nurse practitioners and physician assistants, two controversial and relatively new occupational categories that are having an impact on the structure of primary medical care in the United States (7, p. 50).

Medical care itself was portrayed as overwhelmingly appropriate, nonpolitical, and an unlimited resource. In the 174 circumstances where medical professionals gave specific biomedical orders or carried out

biomedical tasks, they were clearly correct in 78 percent of the cases and incorrect in only 3 percent (2 percent of the cases showed a mixed result and in 14 percent the result was indeterminate). Arguments about the giving of specific biomedical care occurred in only 7 of the 723 illness episodes and dealt with three cases. Two of these were issues in the news: the decision by physicians and parents not to operate to keep a congenitally malformed infant (a "Baby Doe") alive, and the refusal of staff physicians in another city to allow a cerebral palsy patient to starve herself to death in their hospital. The third was the start of a subplot in the prime-time medical serial "St. Elsewhere" that dealt with the desire of a surgeon to perform a heart transplant and the refusal of the city's hospital administrator to allow it for cost reasons. This last illness series was the only one in our sample that dealt with scarce resources. Although broached, the subject was treated quite gingerly and narrowly. At issue was not whether another transplant could be done at all, but whether it could be done at that hospital when other hospitals in the city had been designated previously as transplant centers.

Note, too, that in the few instances in which politics was involved in our TV sample of medical care, it related exclusively to the moral and legal obligations that physicians confront when they treat patients lingering on the edge of life. By contrast, contemporary medical periodicals are rife with examples of how politics in the medical system affects patient care at all stages of illness. The cumulative picture one gets in the medical trade literature—and in recent sociological writings on medicine—is that current political and economic battles are having complex and widespread impacts on the contours of the health of the U.S. population and on the very definitions of illness and health. Yet this key realization found no echo in our TV sample. Instead, news, entertainment, and advertising enacted the quite opposite notion that medical care is an apolitical, unlimited resource, available to all through either quick-acting drugs or economically stable acute care hospitals.

The dominant pattern of illness portrayal in our sample did not confront today's most enduring medical problems.

Overall, network television presented illness as acute and amenable to biomedical treatment. Illness episodes emphasized the short-term and the straightforward. Even when coping was discussed, the patient's long-range plans or reintegration into society was rarely considered.

There were, however, noteworthy differences between program formats on this matter. Afternoon serials and news programs tended to deal with chronic problems and coping much more than commercials and evening serials or series. Similarly, afternoon serials depicted psychosocial aspects of coping (short-term though they were) a good deal more often than the other formats. And, amid all the programming, the theatrical film *Ordinary People* stood out as a startling exception to the typical flow.

It seems likely that different dramatic conventions and production constraints guided the different tendencies of the TV formats toward or away from chronic problems. News programs focus on illnesses that reflect social or personal conflict. Chronic problems become news targets when they tie into biomedical or legal issues and can be encapsulated into short-term, life-or-death drama (see 38, pp. 20–27). The serial format lends itself to the portrayal of illness as chronic because of its continuing story line. In afternoon soap operas the likelihood of chronicity is increased because hospital sets are useful locations for necessarily low-budget productions (4). Prime-time series, on the other hand, have large budgets, more outdoor locales, and the need to wrap up loose ends within a sixty-minute plot. That discourages portrayals of chronic illness. So does the commercial format, since persuasive appeals for nonprescription drugs are likely to imply quick cure.

Finally, movies allow the possibility of a chronic focus because they have more time than typical programs and because their "one-shot" nature means that truly serious problems can befall central characters.[3] In addition, movie producers feel that they must attract audiences by promoting their works as unusual. So, when the creators decide to focus on illness, they have an incentive to feature problems that are controversial and difficult to solve, whether in a "disease of the week" heroic tale or in an exposé of a taboo subject, such as a youngster's mental illness.

While differences between program formats showed up regarding the dimensions of illness, they were starkly absent when it came to sociopolitical considerations. This study found that all the program formats overwhelmingly failed to confront the government and corporate activities that have been changing the contemporary medical system and the public's relationship to it. One road to uncovering the reasons for this failure might lie in considering the relationship that television networks and production firms have had with mainstream elements of the medical system. We can suggest that the relationship has been symbiotic, benefitting all parties. Over time, it has led to formats and formulas that have entrenched certain perspectives about the role of U.S. medicine on TV news, entertainment, and commercials. While the medical world has been changing drastically since those perspectives were set, neither side in the relationship to this point has seen fit to encourage change in the basic approaches to TV's depictions. For the networks and production firms, the standard approach works: it draws requisite audiences efficiently. For the medical establishment, government officials, business executives, and other contending interest groups, the standard approach ensures their continued acceptance by the broad audiences of the nation's most shared medium.

[3] This generalization does not apply to TV movies that are series pilots, since producers' intentions there are to spin the main characters off into their own weekly vehicles.

It may well be, then, that a key consequence of television's contemporary treatment of illness for the medical institution has been to encourage the belief of vested interests that they can negotiate key structural changes in the medical institution outside of the glare of network television. This study represents an inquiry into network television's message system during only one period, albeit a formative one, in the development of the contemporary medical structure. Network television's depictions are not static, and one might well expect that as time goes on indications of the changes will appear in fiction and nonfiction programming. However, the findings here suggest that depiction of the most critical changes will be reflected on network TV only after they have become entrenched politically. For the general public, particularly those who receive the bulk of their knowledge about medical trends from television, the consequence of this eventuality would seem to be the perpetuation in medicine of what Touraine (34, p. 9) calls "dependent participation": involvement in and dependence upon institutional processes without knowing how and when powerful contending special interests have set the basic rules.

These possibilities hold many important implications for the role U.S. network television plays in a profoundly important aspect of institutional change. For the benefit of both theory and practice, they deserve further study.

REFERENCES

1. Aaron, Henry J. and William Schwartz. *The Painful Prescription: Rationing Hospital Care.* Washington, D.C.: Brookings Institution, 1984.
2. Ahmed, Paul and George Coelho (Eds.) *Toward a New Definition of Health.* New York and London: Plenum, 1979.
3. Caplan, Arthur, H. Tristam Engelhardt, Jr., and James McCartney (Eds.) *Concepts of Health and Disease.* Reading, Mass.: Addison-Wesley, 1981.
4. Cassata, Mary B., Thomas Skill, and Samuel Osei Boadu. "In Sickness and in Health." *Journal of Communication* 29(4), Autumn 1979, pp. 73–80.
5. Cook, Fay Lomax et al. "Media and Agenda Setting: Effect on the Public, Interest Group Leaders, and Policy Makers." *Public Opinion Quarterly* 47(16), Spring 1983, pp. 16–25.
6. Council on Long Range Planning and Development. *The Environment of Medicine.* Chicago: American Medical Association, 1984.
7. Cousins, Norman. *Anatomy of an Illness as Perceived by the Patient.* New York: Bantam, 1979.
8. "Detroit Community Hospital Faces May 31 Rescue Deadline." *American Medical News* 27(19), May 18, 1984, p. 39.
9. Engel, George. "The Need for a New Medical Model: A Challenge to Biomedicine." In Arthur Caplan, H. Tristam Engelhardt, Jr., and James McCartney (Eds.) *Concepts of Health and Disease.* Reading, Mass.: Addison-Wesley, 1981.
10. Finley, Thomas. "Concerted Effort Needed to Control Health Costs." *American Medical News* 27(11), March 16, 1984, pp. 18–19.
11. "Former HEW Secretary Says Chrysler's Health Care Costs Too High." *American Medical News* 27(10), March 9, 1984, p. 28.
12. Gandy, Oscar. *Beyond Agenda Setting.* Norwood, N.J.: Ablex, 1981.

13. Gerbner, George. "Teacher Image in Mass Culture: Symbolic Functions of the 'Hidden Curriculum.' " In David Olson (Ed.) *Media and Symbols*. Chicago: National Society for the Study of Education/University of Chicago Press, 1974.
14. Gerbner, George, Michael Morgan, and Nancy Signorielli. "Programming Health Portrayals." In David Pearl, Lorraine Bouthilet, and Joyce Lazar (Eds.) *Television and Behavior,* Volume 2. Rockville, Md.: National Institute of Mental Health, 1982.
15. Golin, Carol. "Trouble Ahead for MDs, Hospitals." *American Medical News* 27(18), May 11, 1984, pp. 3, 41–42.
16. Hamburg, Beatrix and Chester Pierce. "Television and Health: Introductory Comments." In David Pearl, Lorraine Bouthilet, and Joyce Lazar (Eds.) *Television and Behavior,* Volume 2. Rockville, Md.: National Institute of Mental Health, 1982.
17. Robert Wood Johnson Foundation. *Annual Report*. Princeton, N.J.: Robert Wood Johnson Foundation, 1983.
18. Krause, Elliot. *Power and Illness*. New York: Elsevier, 1977.
19. Lefton, Doug. "Public Hospital Limits Care to Tampa's Poor." *American Medical News* 27(15), April 20, 1984, pp. 1, 23–24.
20. Lefton, Doug. "FTC Probe in Arizona: Did Hospitals Pressure Honeywell?" *American Medical News* 27(22), June 8, 1984, pp. 1, 24.
21. Lefton, Doug. "In Competition with Private Hospitals, Public Hospitals Go After Private Patients." *American Medical News* 27(26), July 13, 1984, p. 10.
22. McIlrath, Sharon. "MDs Targeted by Budget Trimming Efforts." *American Medical News* 27(13), April 6, 1984, pp. 28–29.
23. McIlrath, Sharon. "DRGs Seen Boosting Outpatient Care, Competition." *American Medical News* 27(24), June 22, 1984, p. 14.
24. Parsons, Talcott. *The Social System*. New York: Free Press, 1951.
25. Pellegrino, Edmund. "The Sociocultural Impact of Twentieth Century Therapeutics." In Morris Vogel and Charles R. Rosenberg (Eds.) *The Therapeutic Revolution*. Philadelphia: University of Pennsylvania Press, 1979.
26. Rust, Mark. "Ethicists Devoting Increased Attention to Financial Issues." *American Medical News* 27(26), July 13, 1984, pp. 3, 43.
27. Rust, Mark. "New Medical Economics Are Emerging." *American Medical News* 27(26), July 13, 1984, pp. 41–42.
28. Sandrick, Karen. "Supportive Care Guidelines Stir Debate." *American Medical News* 27(20), May 25, 1984, pp. 3, 23–25.
29. Solomon, Douglas. "Health Campaigns on Television." In David Pearl, Lorraine Bouthilet, and Joyce Lazar (Eds.) *Television and Behavior*, Volume 2. Rockville, Md.: National Institute of Health, 1982.
30. Starr, Paul. *The Social Transformation of American Medicine*. New York: Basic Books, 1983.
31. "State Seeks Reinstatement of Balance Billing Plan." *American Medical News* 27(15), April 20, 1984, pp. 1, 45.
32. Sullivan, Tony. "DRGs Spur New Player on Team." *American Medical News* 27(4), January 27, 1984, pp. 3, 21–22.
33. Swartz, Donald. "Dealing with Chronic Illness in Childhood." *Pediatrics in Review* 6(3), September 1984, pp. 67–73.
34. Touraine, Alain. *The Post-Industrial Society*. New York: Random House, 1971.
35. Trunkey, Donald. "Trauma." *Scientific American* 249(2), August 1983, pp. 28–35.
36. Vaughan, Victor, R. James McKay, and Richard E. Berman (Eds.) *Nelson Textbook of Pediatrics* (11th ed.). Philadelphia: Saunders, 1979.
37. Weil, Max. "Boom in Critical Care Raises Economic, Ethical Dilemmas." *Emergency Medicine*, February 1984.
38. Winsten, Jay A. "Science and the Media: Telling the Truth." *Health Affairs*, in press. (Manuscript available from the author at the Harvard School of Public Health.)
39. Wohl, Sidney. *The Medical-Industrial Society*. New York: Harmony Books, 1984.