



May 1996

Television Entertainment and the US Health-Care Debate

Joseph Turow

University of Pennsylvania, jturow@asc.upenn.edu

Follow this and additional works at: http://repository.upenn.edu/asc_papers

Recommended Citation

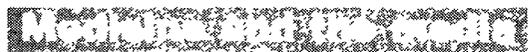
Turow, J. (1996). Television Entertainment and the US Health-Care Debate. *Lancet*, 347 (9010), 1240-1243. [https://doi.org/10.1016/S0140-6736\(96\)90747-3](https://doi.org/10.1016/S0140-6736(96)90747-3)

This paper is posted at ScholarlyCommons. http://repository.upenn.edu/asc_papers/28
For more information, please contact libraryrepository@pobox.upenn.edu.

Television Entertainment and the US Health-Care Debate

Abstract

Some experts on the media say that entertainment can be more successful than news at providing insights into certain institutions, medicine being a good example. US television series that feature physicians as the central characters have been immensely popular. In the early series, dating back to the 1952 debut of *City Hospital*, the physician was an all-powerful hero working in a sparkling centre of healing, with medicine portrayed as a resource freely available to all. The programmes began to change in the 1970s. Plots centred more around the physicians' personal problems than on the patients, but economic and health-policy issues were still rarely discussed adequately. In the end, what viewers come away with may lead them towards false expectations, and they may increasingly blame doctors for decisions that others make and enforce.



Television entertainment and the US health-care debate

Joseph Turow

Some experts on the media say that entertainment can be more successful than news at providing insights into certain institutions, medicine being a good example. US television series that feature physicians as the central characters have been immensely popular. In the early series, dating back to the 1952 debut of *City Hospital*, the physician was an all-powerful hero working in a sparkling centre of healing, with medicine portrayed as a resource freely available to all. The programmes began to change in the 1970s. Plots centred more around the physicians' personal problems than on the patients, but economic and health-policy issues were still rarely discussed adequately. In the end, what viewers come away with may lead them towards false expectations, and they may increasingly blame doctors for decisions that others make and enforce.

Policy makers, academic observers, and journalists in the USA have long accepted the idea that journalism has a key role in the public's understanding of health care. The proposition has served as a rationale for those who want to use the print and electronic press to inculcate good health habits among children and adults.¹⁻³ In the high-stakes health-care debate of the 1990s, it has also led groups representing physicians, senior citizens, hospitals, research centres, and others to try to influence the press's stories about medicine for political purposes. Their aim is to shape public images about the delivery of health care in a system that they and government officials agree is in "crisis".

In this highly-charged atmosphere, tracking the war over images is part of reportage. Journalists now recognise that public discussions of medicine are necessarily political—ie, they are ultimately about the exercise of social power. Coverage of the intrigues that are shaping politicians' portrayals of health-care issues has grown to such an extent that academic observers are expressing concern.⁴ They worry that press analyses of the strategies that groups use to influence the press, the public, and the government about medical policies are drowning out the substance of the debate.

Journalists and academic analysts treat the vivid health-care rhetoric as weapons in a hot debate, yet they virtually ignore the relation of that rhetoric to popular images of medicine in television (TV) entertainment. That is unfortunate, because highly viewed TV presentations of medicine hold political significance that should be assessed alongside news. Like the rhetorical struggles in news about medicine, series such as *ER*, *Dr Quinn: Medicine Woman*, *Diagnosis: Murder*, and *Chicago Hope* are ultimately about power. Every week they act out ideas about the medical system's authority to define, prevent, and treat illness.

In fact, some media scholars⁵⁻⁹ suggest that entertainment can even be more successful than news in giving people a sense of institutions such as medicine. One reason is that fictional dramas and comedies often give their viewers behind-the-scenes pictures of health-care workers that viewers rarely see in short news stories

and that often seem to be quite realistic. By acting out tales of life and death, competency and incompetency, and morality and immorality in persuasive ways, TV fiction about health care can present compelling scenarios about what caregivers might do and what they should do when different types of people get sick.

Supporting this notion is a growing published research on TV's "cultivation" of ideas about the world.^{10,11} Though dealing with health care only rarely,^{9,12} cultivation researchers support an historically rooted perspective on the way TV helps people relate to the institutions around them, including the medical system. They argue that the patterned nature of TV's images, often viewed over the course of people's lives, leads many people to develop expectations of those institutions that are similar to TV's portrayals. They add that the medium is especially influential in shaping perspectives about parts of an institution with which viewers have had few personal experiences.

Applied to medicine, these generalisations point to TV entertainment's power to influence viewers' expectations of the norms guiding various types of doctors, nurses, technicians, and administrators to agree or argue over treatments. As an example of the dominant images of health care that viewers experience in entertainment, I will explore the prime-time doctor series.

Doctor series are weekly dramatic or comedic programmes that feature physicians as central characters.¹³⁻¹⁶ From 1952, when *City Hospital* premiered, to 1995, when *ER* climbed to the top of the ratings, over 60 doctor series have aired in the evening ("prime time") on the major TV networks. Many have crossed the Atlantic to appear on European TV. Over the decades, doctor series have presented the clearest, most popular and most enduring scenarios on the home screen about the norms that guide the professional handling of illness. This discussion draws conclusions about the programmes and the forces shaping them from more than 100 interviews with producers, writers, directors, and network executives who oversaw them; the viewing of several episodes from most series; and the reading of scripts and archival materials relating to the shows.¹⁷

An important conclusion is that the images of professional health care in doctor shows have been out of step with the visions that corporate and government health-policy makers have held during much of the late 20th century.

Lancet 1996; **347**: 1240-43

Annenberg School for Communication, University of Pennsylvania,
3620 Walnut Street, Philadelphia, PA 19104, USA
(J Turow PhD, professor of communication)

The established formula

During the first decades after World War II, policy makers and creators of TV doctor shows voiced common expectations from the health-care system. US society, they believed, would best be served by emphasising specialised, hospital-based, high-tech medicine, which was available to all. The idea seemed achievable. By the end of World War II, penicillin and sulphonamides, better vaccines, and improved hygiene had seemingly all but conquered yellow fever, dysentery, typhus, tetanus, pneumonia, and meningitis. The hazards of surgery had been reduced through the increased availability of blood and plasma for transfusions.^{18,19} In 1955, a vaccine for poliomyelitis was approved. In describing the ecstatic national reaction, one observer wrote that "more than a scientific achievement, the vaccine was a folk victory".²⁰

In the context in which accomplishments in medicine were treated by national leaders and the press as folk victories, it should not be surprising that creators of mainstream TV stories should share medical leaders' vision of their profession. They were building on formulas established in movies and radio, in which images of Dr Kildare and Dr Christian set the pattern for the physician-hero totally dedicated to his patient. The creators of both series took care to portray medical doctors as members of a modern elect with great authority over their patients. In their world views, hospitals were citadels for the elect's scientific practice of its duties. Nurses and other staff followed their command.

While *City Hospital* was the very first US network series built around physicians, the first ones to receive the sort of substantial public attention now reserved for *ER* were *Ben Casey* and a television version of *Dr. Kildare*. The two had their debut in 1960 and quickly ranked among the top TV programmes. By the time they left prime time in 1966, *Dr. Kildare* and *Ben Casey* had made such an impression on producers and network executives that they defined the setting, characters, and plots of the doctor series for years to come.

The setting was the hospital, which was portrayed as the sparkling centre of medical healing. The characters tended to be a young male physician, his mentor (also a male), a patient, and assorted other doctors, nurses, and orderlies. The physician-healers were mostly specialists. In addition, they were the rulers of their hospitals. Medical administrators who worried about the cost of care were either absent or irrelevant. In fact, the entire approach in these shows saw high-tech, hospital-based, specialised medicine as being in boundless supply. Scenes that discussed the cost of medical care were extremely rare. The viewer found out little about even the physicians who continued in the series week-to-week. The physician filled the role of *deus ex machina*. The central plot of each episode revolved around the patient's condition, which was typically a combination of physical problems and emotional or social difficulties. The physical disorders were almost always acute rather than chronic; this allowed the plot to climax towards the end of each episode in a dramatic incident (usually an operation) that cured the patient or (rarely) led to death.

The emotional or social difficulties allowed the producers to treat the series as a dramatic anthology

through which they could explore issues. For example, in one episode Dr Ben Casey took care of a girl who, it turned out, was beaten by her father—an opportunity to explore child abuse. Similarly, Dr Kildare took care of a middle-aged man who was dying and whose brother was retarded—an opportunity to explore the difficulties of the mentally handicapped.

The American Medical Association (AMA) encouraged these story lines. The shows' producers and network executives were anxious not to antagonise the medical establishment and wanted the favourable publicity that might come with its approval. In return for showing their organisation's seal at the end of each programme, AMA physicians demanded the right to read every script and make changes in the name of accuracy. To them, however, accuracy also meant a proper doctor's image. During the height of its power in the 1960s, the AMA Advisory Committee For Television and Motion Pictures tried to make sure that with few exceptions the physicians who moved through doctor shows were incarnations of intelligent, upright, all-caring experts. AMA physicians were even insistent about the cars their TV counterparts drove (not too expensive), the way they spoke to patients (a doctor could never sit on even the edge of a female patient's bed), and the mistakes they made (which had to be extremely rare). Whereas most of the prime-time doctor programmes that followed *Dr. Kildare* and *Ben Casey* copied this approach, a few in the 1960s—*The Nurses*, *The Eleventh Hour*, and *The Breaking Point*—built medical dramas around nurses and psychologists as well as physicians. Doctors' organisations expressed anger that the programmes were holding nurses and psychologists to

"The shows' producers and network executives were anxious not to antagonise the medical establishment . . ."

the same status as MDs. These controversies, together with these shows' bad ratings, reinforced the belief of network programmers that, to be successful, medical series would have to centre on physicians who could treat hospital-based physical disorders.

The trick for the creators of a new show was to find a variation on the tried-and-true formula that made it seem a bit different, and hopefully more compelling for viewers than earlier versions. Two of the most popular doctor shows of the 1970s were *Marcus Welby, MD.* and *Medical Center*. These and the programmes that followed them in the 1970s tried to appear urgently "relevant" (a TV buzz word of the 1970s) without being truly controversial. *The Bold Ones*, *Emergency!*, and *Code R* were among the series that attempted to focus on state-of-the-art medical technology—the newest exploratory techniques, cutting-edge emergency medical procedures, experimental surgeries, helicopter transports. A few programmes inserted women and African Americans as continuing physicians. *Quincy* portrayed a trendy police pathologist who was an expert at crime detection.

Change in the formula

Such minor tinkering with the formula made no connections with the major changes in medical policy then taking place. By the mid-1970s, many health-care experts were worrying that the cost of medical care was rising strongly in relation to the gross national product. Private firms began to worry that the costs of covering workers were forcing up the prices of their goods so that they were becoming less and less competitive with

Panel: Assessment of US network TV in 1983

We assessed 90.5 hours of US network programming over 14 days. A key finding was that in both entertainment and news, illness was shown overwhelmingly as an acute event that should be treated by physician-specialists in a hospital setting. Illness episodes emphasised the short term. Coping with illness was not often discussed (and more in news and afternoon serials than in prime time), but the patient's long-term plans for reintegration into society, even when this subject was brought up, was rarely considered. Acute healing via drugs and machines was the mode throughout the TV world, with drugs and machines being ubiquitous methods of healing. Doctors were not only dominant health-care professionals (70% of the 214 who appeared); they were also brilliant, diagnosing incorrectly only 3% of the time.

Of the remaining 64 health-care workers, 13% were nurses and 16% made up an assorted crew of personnel, from ambulance drivers and paramedics to nutritionists to X-ray technicians. Missing entirely from TV were nurse practitioners and physician assistants, two controversial and then relatively new occupational categories that were having an impact on the structure of primary care in the USA. In fact, there was almost no political argument about the arrangement of health care. The only exceptions related to the treatment of patients lingering on the edge of life. We concluded that network TV across all time periods did not reflect the real-life political and economic battles among health-care policy makers that were changing the contours of the medical institution. "News, entertainment and advertising enacted [the notion] that medical care is an apolitical unlimited resource, available to all through either quick-acting drugs or economically stable acute care hospitals."²¹

products from outside the USA. Many questions arose about how health-care money should be funded and whether the traditional medical vision was tenable.

The disjuncture between policy realities and TV images grew. Moreover, when doctor shows did change substantially, the transformation took place not to parallel the outside world but to fit the needs of ratings-conscious executives. The most substantial shift in the formula began in the 1970s and accelerated through the 1980s and into the 1990s. It involved the portrayal of medical professionals. In the traditional programmes, physicians were authority figures dedicated to treating patients with problems. Now the difficulties of physicians, not patients, increasingly became central plot points.

Starting with *M*A*S*H* and spreading to comedies such as *House Calls*, *A.E.S. Hudson Street*, and *E/R* (not the hit of the 90s but a short-lived comedy set in the emergency room) as well as dramas such as *St. Elsewhere*, *Kay O'Brien*, *Heartbeat*, and *Northern Exposure*, patients often served as vehicles through which the physicians' personalities came out under duress. The emphasis on the upscale physicians over the patients was encouraged by the network executives. They saw programmes such as *St.*

Elsewhere reaching prosperous baby boomers who enjoyed watching professionals with problems similar to their own. In interviews for this article, they and the programmes' producers argued that depicting the economic realities of health care would be needlessly boring to audiences.

In 1983, Coe and I showed that the traditional approach to medicine lingered not only in doctor programmes but in TV entertainment generally as well as TV news (see panel).²¹ Unfortunately, there has been no further research to quantify how contemporary TV compares with the TV of the early 1980s when it comes to health-care presentations. Close observation

of TV entertainment and news, however, suggests that many aspects—the focus on physicians, acute issues, high technology, and hospital care—remain the same. An important difference relates to debates about health policy. In 1983, cost issues in health care were invisible in both news and entertainment even though they were important considerations in the halls of Congress and in the private sector. When Bill Clinton elevated the structure of health care to a national issue during the 1992 presidential campaign, the discussion of medicine as a scarce resource suddenly entered TV's journalistic agenda.⁴ Its presence in news continues, though time devoted to it waxes and wanes depending on the politics of the moment.

Doctor shows and the health-care debate

The controversies over financing and delivering health care are rarely reflected in entertainment, however. In some doctor shows, producers seem almost to have shaped their programmes to avoid dealing with these subjects. In *Dr Quinn*, they avoid the issue entirely by placing the programme in the western USA at the turn of the century. *Diagnosis: Murder*, which is about a forensic pathologist, need not develop plots about the health care preceding death. *ER* also skirts the problem by emphasising the inside of the emergency room as a place where acute issues of life and death dominate all thinking. Intake personnel do not check in patients with questions about their health insurance. Nor is there discussion of hospitals routing ambulances away from their emergency rooms if the patients cannot pay. The health system that provides the context for real-life emergency rooms simply does not exist in the programme.

When issues of medical scarcity do get discussed, they are invariably scorned as solely the product of greed and irrelevant to proper care—as concerns that good doctors do and should dismiss. In one *Chicago Hope* episode, when the administrators of a health maintenance organisation (HMO) try to dictate care to a hospital surgeon, the surgeon and the hospital's lawyer coldly put the representatives in their place, even though this action might cost the surgeon and hospital lots of money. *Picket Fences* adopts this same attitude in a subplot of the 1995–96 season in which an

aggressive health-care executive persuades a small-town paediatrician (a programme regular) that she must join the HMO to survive. The paediatrician relents, but in the climactic episode of this subplot she finds that the nurse/office manager whom the executive assigns to her is a bureaucrat from hell. First, the nurse books patients so tightly that the paediatrician cannot cope and then limits the number of tongue depressors the physician can use so she will not give them to children as playthings. Finally, the exhausted and angry physician confronts the HMO executive (also a woman) and angrily threatens to quit if things do not improve. Ultimately, the paediatrician wins.

“Week after week, what counts is the gleaming operating rooms where state-of-the-art doctors . . . use state-of-the-art machinery to advance science . . .”

The *Picket Fence* subplot clearly portrays managed care and arguments of scarcity as an act of greed perpetrated by people who can be made to back down. So does the *Chicago Hope* episode in which the scorn of physicians and a judge seems to destroy the legitimacy of arguments in favour of managed care. *Chicago Hope*'s hospital itself can be taken as "evidence" that scarcity as a rationale for managed care is not a real social issue. Behind the scenes, physicians never complain of scarce resources. Week after week, what counts is the gleaming operating room where state-of-the-art doctors and a few other health-care professionals (mostly love-interests for the physicians) use state-of-the-art machinery to advance science and argue about their personal problems. Moreover, although the doctors in *Chicago Hope* do make mistakes, they are fiercely and successfully independent about their medical prerogatives. That applies to outside political influences.

It is difficult to know whether the storylines that ignore implications of scarcity and the ones that scorn it reflect a principled stand on the health-care debate by the creators and producers of these programmes. More likely, these storylines flow out of the long history of doctor-show plots from *Ben Casey* to *The Bold Ones*, from *Emergency!* to *M*A*S*H* and *St. Elsewhere*. Nevertheless, even as they generally disregard the changes in medicine—or perhaps precisely *because* they generally disregard it—doctor shows weigh in with a consistent position about the contemporary health-care debate. The position is that the verities should not change, that empathetic physicians ought to keep controlling health care, and that all sorts of medical care, including the high-tech type, ought to be available quickly to all whenever needed.

Public perception

There has been no research on what messages viewers with different backgrounds draw from such programmes when the news and personal experiences present them with a fundamentally different reality. One possibility is that the portrayal of TV's medical ideal frustrates and embitters people, since the dramatised alternative seems more attractive than their contemporary "real life" situation but is ultimately out of reach. Another possibility, not exclusive of the first, is that TV's entertainment portrayals of health care make it more difficult for people to understand the health-care debate. They may be confused by their own personal health-care experiences, since they are at such odds with decades of familiar TV images. Still another possibility is that TV's medical images encourage some viewers not to allow politicians or physicians to plead scarce resources as a way to diminish the quality of care. They may use TV doctors and medical care as a norm against which to hold the medical establishment responsible, and they may determine to hold leaders' feet to the fire to find solutions that reconcile resource concerns with those norms.

The AMA acts as if it is betting on the latter possibility. The AMA's direct power over doctor-show scripts faded in the early 1970s. The programmes still rely on physician-consultants, however, and by several accounts the organisation's leaders have not tried to work through them or through the producers to bring the new realities to the home screen. AMA executives may believe that the utopian images of physician authority in doctor shows help real-life doctors in their bids to retain political and

economic power in the new medical world. That may well be the case in the short term. In the long run, however, the behind-the-scenes world that viewers see on TV may lead them to expect physicians to have more power over health care than they actually have. Not knowing much about the backstage politics and structure of health care, the public may increasingly blame physicians for decisions that others make and enforce.

Time will tell whether organised medicine's passive approach towards TV entertainment will help or hurt physicians. In the meantime, all health-care workers should be aware that their patients often come to their offices with years of dramatic and comedic stories about the medical system swimming in their heads. In their initial encounters with patients, health-care workers might try to determine whether and how those stories affect the mental "scripts" that the people bring with them. Building into the initial encounter a few questions about how news and entertainment stories have affected the patient's expectations of professional care-givers may lead to a new understanding of the fears and hopes that members of the public bring to an institution undergoing tumultuous change.

References

- 1 Hamberg B, Pierce C. Television and health: introductory comments. In: Pearl D, Bouthelet L, Lazar J, eds. *Television and behavior*. Vol 2. Rockville, MD: National Institute of Mental Health, 1982.
- 2 Solomon D. Health campaigns on television. In: Pearls D, Bouthelet L, Lazar J, eds. *Television and behavior*. Vol 2. Rockville, MD: National Institute of Mental Health, 1982.
- 3 Kreps G, Thornton B. *Health communication: theory and practice*, 2nd ed. Prospect Heights: Waveland Press, 1992.
- 4 Jamieson K, Cappella J. *Media in the middle: fairness and accuracy in the 1994 health care reform debate*. Philadelphia: Annenberg Public Policy Center, 1995.
- 5 Atkin C, Arkin EB. Issues and initiatives in communicating health information to the public. In: Atkin C, Wallack L, eds. *Mass communication and public health: complexities and conflicts*. Newbury Park, CA: Sage Publications, 1990: 13–40.
- 6 Gerbner G. Teacher image in mass culture: symbolic functions of the hidden curriculum. In: Olsen D, ed. *Media and symbols, Part I*. Chicago: National Society for the Study of Education, 1974.
- 7 Giddens A. *Modernity and self-identity*. Cambridge: Polity Press, 1991.
- 8 Meyrowitz J. *No sense of place: the impact of electronic media on social behavior*. New York: Oxford University Press, 1985.
- 9 Pfau M, Mullen L, Garrow K. The influence of television viewing on public perceptions of physicians. *J Broadcast* 1995; **39**: 441–58.
- 10 Gerbner G, Gross L, Morgan M, Signorelli N. The 'mainstreaming' of America. *J Communication* 1980; **30**: 10–29.
- 11 Morgan M, Signorelli N, eds. *Cultivation analysis: New directions in media effects research*. Newbury Park, CA: Sage Publications, 1990.
- 12 Gerbner G, Gross L, Morgan M, Signorelli N. Special report: health and medicine on television. *N Engl J Med* 1981; **305**: 901–04.
- 13 Alley R. Medical melodrama. In: Rose BG, ed. *TV genres: a handbook and reference guide*. Westport, CT: Greenwood Press, 1985: 73–90.
- 14 Turov J. *Playing doctor: television, storytelling and medical power*. New York: Oxford University Press, 1989.
- 15 Turov J. 'James Dean in a surgical gown': making TV's medical formula. In: Spigel L, Curtain M, eds. *The revolution that wasn't televised*. New York: Routledge, 1996.
- 16 Kalisch P, Kalisch B. *Images of nurses on television*. New York: Springer Publishing, 1983.
- 17 *Playing doctor: television, storytelling and medical power*. New York: Oxford University Press, 1989.
- 18 Starr P. *The social transformation of American medicine*. New York: Basic Books, 1983: 336.
- 19 Stevens R. *American medicine and the public interest*. New Haven: Yale University Press, 1971.
- 20 Starr P. *The social transformation of American medicine*. New York: Basic Books, 1983: 347.
- 21 Turov J, Coe L. Curing television's ills: the portrayal of health care. *J Communication* 1985; **36**: 5–1.