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Doc Shows Give Wrong Health-Care Diagnosis

By JOSEPH TUROW

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ity the Clintons and their
supporters in the health-care
debate. Now they even have
part of the new prime-time
television lineup against them.

Despite misfires with network
medical dramas in recent years,
NBC and CBS are again taking a
stab at behind-the-scenes views
of doctors' work with "ER" and
"Chicago Hope." Critics have
lauded both programs for acting
and writing. "ER" has been a
ratings winner.

For health-care
reformers, though,
neither show can
be good news. It
would not be
surprising if
people who watch
them come up wondering what
the reformers' fuss is all about.

Consider how both shows act on
the state of health care in America.
Here are three propositions that
those who are trying to reshape
medicine accept as gospel. Look at
what "ER" and "Chicago Hope"
have to say about them.

Proposition 1: Major U.S.
hospitals are suffering deeply under
the weight of uninsured individuals
who are flooding emergency rooms
and filling expensive beds.

What suffering? Both of these
TV citadels look and sound great.
Floors shine, walls look modern,
equipment is terrific, the morale
impressive. The E.R. in "ER" is a
bus, even frenetic pace, but the
program does not reflect
reformers' claims that lines are
unbearable, infectious diseases
rampant, demands overwhelming.

The one mention of scarcity in
"ER"s" first four episodes turned
out to be more the prelude to a
surprising romance than a medical
point. A female E.R. doc exchanges
angry words with the male director
of the psychiatric ward about his
refusal to admit a welfare patient.
But the psychiatrist argues that
the ambiguity of the patient's
symptoms, not the cost of care, is
the relevant roadblock. Anyway, the
entire episode disappears into a
startling scene where the two
physicians who argued are shown
sharing a bed.

"Chicago Hope" uses the issue of
money to heighten drama fairly
frequently, but money always
looms. In one episode, the hospital's
budget director and some of the
board of directors prattle on about
the high costs of certain uninsured
surgeries that a surgeon wants to
perform. In the end, though,
the medical director
overshadows them by saying angrily
that he will recoup the
million-dollar cost from the
research grants of some of his
fancy physicians. It seems that
there is always some pot of gold
to help a patient's rainbow.

Proposition 2: Uninsured
Americans, especially disadvantaged
minorities, suffer due to lack of care.

Not in these shows. Both are
veritable melting pots of
ethnicities, but nobody asks
anybody for insurance cards and
health professionals who don't
presume to treat all patients equally
in trouble.

In "Chicago Hope," for example,
a resident is reprimanded by a
surgeon for hesitating to deal with
a bleeding white prostitute
who admits being HIV positive.

Not only does the resident
apologize, but the surgeon tries to
help the prostitute fight infection
by carrying out a hugely
expensive experimental bone
transplant. At the end of the
episode, she is lying on a gurney
next to a middle-aged black man
who also has undergone a
generous experimental operation
to give him an ape's heart until a
human donor can be found.

Equal-opportunity care-giving
here.

Proposition 3: To maximize the
value of scarce medical resources,
high-tech medicine must be
de-emphasized in favor of primary
physicians and managed care.

Here, of course, is where debates
about various health-care
proposals run rampant. Is it good
that government and corporate
policy-makers want teaching
programs to turn out fewer
specialists and more family
practitioners, general internists
and general pediatricians? Should
we be comfortable that companies
are channelling their employees
into health maintenance
organizations, where primary
physicians are coordinators of care
and gatekeepers to specialists?

In "ER" and "Chicago Hope,"
there is no debate. For these
shows, high-tech, hospital-based
medicine is not just the best
medicine, it is the only medicine
worth dramatizing. In their worlds,
primary-care doctors simply don't
exist and HMOs hardly rear their
heads.

What counts in "ER" is
multiple crises that shift back
and forth with nothing MTX-like
tension at the edge of chaos, when
life hangs in the balance and cost
is a dirty word. In "Chicago Hope,"
what counts is the gleaming
operating room where
state-of-the-art doctors use
state-of-art machinery to advance
science, along with their egos.

"ER"s" physicians never deal
with health maintenance
organizations or any other type
of insurance company. One way or
another, their patients show up and
receive help. As for "Chicago
Hope," one gets the sense that this
is a place where other specialists
who have run out of options send
their patients. Somehow the
hospital gets paid.

Yet "Chicago Hope" did build
part of an episode around the
problem that a gifted neurosurgeon
has with an HMO. The patient, a
friend of the surgeon's secretary,
goes to him for a second opinion
about a huge tumor in the front
of her brain. Confident that the
HMO's neurosurgeon cannot
perform the operation successfully
(though he says he can), the
Chicago Hope doctor offers his
service. The HMO refuses to use
him, however, even when the
doctor volunteers to reduce his fee
to the HMO's rate. The HMO's
executives, it turns out, do not
want to set a costly precedent
where their patients take surgery
outside the plan.

Finally, the HMO neurosurgeon
admits his insecurity regarding
the procedure, and Chicago Hope's
lawyer threatens to help the
patient mount lawsuits if anything
goes wrong. The managed-care firm
allows the right doctor to perform
the operation, and it is totally
successful.

Despite its upbeat ending, the
story is likely to scare the pants off
HMO members. Yet it fits comfortably into the
general philosophy that "Chicago
Hope" and "ER"—act out about
medical care in the United States.
That, at its best, it is a high-tech
crunch between nightingale
physicians and disease; that it is
generally available to people when
they need it and that administrators and policy-makers
simply ought to give doctors the
right tools and get out of the way.

These are highly controversial
notions, greatly at odds with the
consensus of most contemporary
health policy analysts. It is difficult
to know whether the story lines
that convey them reflect a
principled stand on the health-care
debate by the programs' creators
and producers; more likely, they
flow out of a long history of
docent schemes, from "Ben
Casey" to "The Bold Ones," from
"The Lazarus Syndrome" to
"MASH" and "St. Elsewhere."

The traditional TV-doctor
formula may well have a great
heritage of engrossing drama. Yet it
carries in it the beliefs and
challenges of an era that no longer
exists. From a ratings standpoint,
that may not be a problem. To
groups trying to educate the public
about ways to address the
difficulties of a new medical
environment, it is a major problem
indeed.

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