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When Pfizer Met McDreamy: A Classic American Love Story Between Medicine and the Media

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When Pfizer Met McDreamy: A Classic American Love Story Between Medicine and the Media

A Dissertation submitted in partial satisfaction of the requirements for the degree of

Doctor of Philosophy

in

Anthropology

by

Jessica Anne Bodoh-Creed

December 2013

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My mother brought me up with a Physicians Desk Reference on the bookshelf and projects at home like making paper mache bacteria. We brought many a positive rapid strep test to a doctor and demanded a prescription with no ifs, ands, or buts. I was bound to end up here because of you.

This project is dedicated to my Sweet Husband, Corey, who created the title for this dissertation and also kept me going through the project and provided boundless support and love in the entire process. You gave me the courage to go back to graduate school in the beginning and I truly would not have found my place without your advice and counsel. We make an excellent team.

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ABSTRACT OF THE DISSERTATION

When Pfizer Met McDreamy: A Classic American Love Story Between Medicine and the Media

by

Jessica Anne Bodoh-Creed

Doctor of Philosophy, Graduate Program in Anthropology
University of California, Riverside, December 2013
Dr. Juliet McMullin, Chairperson

This project undertakes an analysis of knowledge production among American medical media as shaped by neoliberalism, biomedicine, and the larger idea of the healthscape. Issues of accuracy and authenticity are traced through the various sites of medical knowledge to better understand who and what is creating and regulating the information contained within. I follow four lines of evidence to support one singular narrative about media using fictional medical television, pharmaceutical advertising, the Internet and health applications, and celebrity physicians to show how they all contribute to accessible and accessed medical knowledge in the "help your doctor help you" neoliberal philosophy. Together these knowledge production sites create an assemblage of ‘stocks of knowledge’ that encourage personal responsibility, creating what is often called the ‘smart patient’ or Patient 2.0. The methods for this project include polymorphic engagement and studying up, as well as the more traditional interviews, textual analyses, online and archival research and participant observation. Medical fictional television, shows like ER, House M.D., and Grey's Anatomy, have on staff writers and consultants who are also physicians and nurses. These medical professionals are tasked to maintain authenticity as much as possible on set. Direct-to-Consumer pharmaceutical advertising is a controversial process by which consumers often misunderstand the basic
regulations governing pharmaceutical products and advertising claims and safety. The Internet and health information accessed on tablet, smart phones, and computers are entirely unregulated and have been proven to lead to a new trend called cyberchondria, hyperchondria online. Celebrity physicians like Dr. Oz, are performing medicine in very visual and compelling ways, attracting audiences and loyalty to their recommendations. The celebrity physician is not regulated or governed in any way, and often they spend their time speaking about medicine well outside their medical specialty. These four areas of medical media together show the broad implications for this growing healthscape of medical information. The structural assemblage of biomedical information, combined with the push for consumers to be active biological citizens, leads people into a world where often they are not questioning the accuracy or sourcing of the medical information they may then be enacting.
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Introduction

“The typical American visits a doctor several times a year. The same American reads a medical article in a newspaper or magazine several times a month; he or she watches a TV show featuring a medical problem several times a week, and may well encounter medical advertising several times a day. The impact of this constant exposure is profound” (Sandman 1976:378).

Health “happens through a series of choices you make dozens of times each day, choices about what you do and what you ignore” (Besser 2013:2).

This is a story about the love Americans have for their media, especially medical media. We have seen profound changes in how information is created and exchanged over the last few decades with the increased usage of the Internet and the ever-important role of the television in our households. Throughout the push from neoliberalism to ask patients to take control of their own health, the movement created a space for the media to become the educator, not the physician, removing them from their previous primary role. Now “many Americans gain their medical and health information not from their physician or the medical profession but from the media” (Treichler 2007:96).

Knowledge production and the circulation of knowledge are two key areas of discussion within medical anthropology’s discourse and also provides a dialogue about how federal health regulations have changed the nature of debate surrounding it. Neoliberal practices have shaped the issue of biomedicalization within the discourses of knowledge in the media through key openings in the regulatory policies that have allowed pharmaceutical companies to cultivate the mass consumption of pharmaceutical products in the United States. Through these processes of medicalization and marketing, there has developed a “help your doctor help you” discourse in medicine. This follows an increase in the number of medical non-fiction television programs and dedicated channels that are
playing on our televisions. The medical television drama has been a consistent subject since the airing of Medic in 1956 and the hit shows Ben Casey and Dr. Kildare in the 1960s partly because of the nature of medicine and the possible inherent drama in the range of storylines (Turow 2010: 5, 70). As neoliberal philosophies enter in the 1980s, the medical storylines, many of a non-fiction nature, with dramatizations, show the patient and doctor as both heroes in saving the day, quite a change from the traditional narrative of the doctor as the sole source of medical information and authority. “Radio, newspapers, magazines, and films became common sources of health information” and this articulates the changes in how Americans get their medical information (Clarke 2010:114). Our love story begins with the history of medical media and seeks to understand why these stories and knowledge are so enticing that Americans watch, read, follow and learn from everything from Dr. Oz to ER to ads for Viagra.

This dissertation seeks to explore the world of medical media in the United States and look to see who is behind the information and knowledge that is systematically manufactured and created for audiences. My argument here is three fold. First, neoliberalism, biomedicine, and biosociality, combine to create a healthscape, or an institutionalized system that pulls people into a biological world where consumers are repeatedly coming into contact with health information, and are now responsible for their own health through a sense of self-reliance or responsibility and personalized purchasing decisions. By placing the responsibility on the public, the institutions refrain from having any of their own responsibility and generally have not created any methods or safeguards for the public. Second, through these combined systems, knowledge is generated for
consumers and the American public has embraced the process by which information is gathered from sources like medical fictional television, the Internet, pharmaceutical advertising, and celebrity doctors. As studies will show, these are very common sites for knowledge consumption for the American public, as they are ever-present in daily lives and surround normal activities. As a part of the healthscape, these sites of knowledge production are integrated into our lives in a very smooth, unquestioning way. Thirdly, accuracy and authenticity of this assembled knowledge remains often unquestioned by the general public. This may be the most important part of this research because in working with the people who make medical television, I discovered a unique system in the television industry whereby they self-regulate their accuracy as much as they can. From my other dealings with people in pharmaceutical advertising, Internet health apps, and celebrity physicians, there is no other group that works to regulate the information generated there or has any real motivation to do so. This creates an unsafe space for the consumer who may believe, as statistics will show throughout this research that they trust the FDA or Dr. Oz or WebMD, often when they should not. As I was studying these processes of knowledge production, I realized how situated together these various forms of media are and completely integrated by the people who produce said knowledge. It is all mixed together yet these forms of media all stress some of the same information about being a ‘smart patient,’ about “helping your doctor help you,” and give appropriate ways of being in the biomedical world.

The ways in which these mediums can connect to consumers will vary, but they are encountered often on a daily basis, often without much thought. My data shows that
while fictional medical television has a moveable staff of real physicians and nurses who work everyday on shows that have a medical scene to make it as accurate as possible within few constraints, on the other hand, the FDA is overwhelmed by Direct-to-Consumer-Advertising or DTCA and has a small staff that reviews most ads after they have already been released. I asked all of my television informants if they knew that pharmaceutical DTC Advertising was limited to the US and New Zealand, all but two had no idea and those that knew were physicians. Studies show that the general American public trust DTCA and they often believe that they have been authorized or certified in some way by the FDA, a fact that is not true. The Internet is overrun with information and there are very few controls for maintaining any semblance of accuracy or trustworthiness from the public, especially when it comes to health. Many people I encountered in this research spoke about scaring themselves online into thinking they had some horrible illness, a phenomenon now known as cyberchondria. And celebrity doctors, like Drs. Mehmet Oz, Sanjay Gupta, and Drew Pinsky, highlighted in this research, are sometimes so busy making themselves famous that no one stops to consider what their trained medical specialty may be and what exactly it is that they are advising people to do. Americans are so bombarded by medical information that it is seemingly everywhere around us for our unquestioned consumption.

Magazine articles, television programming, radio content, news media, and the Internet become sites for gaining advice, getting answers, and escalating the speed of information that may add to the likelihood that consumers engage with these sites instead of their doctors. In one such magazine article in Real Simple, a lifestyle magazine, the
author purports to be giving the readers “the sort of advice [physicians] share with their friends and families over cocktails or home-cooked meals and the things they wish all their patients [would] heed year-round” (Wadyka 2009:171). The article then details advice like charred meat may have more carcinogens, “never suck on lemons,” get “your feet measured every few years,” have a “strong social network,” and stay on top of your family members’ medical conditions by having a “powwow with your family” (Wadyka 2009: 172-6). While these are things about which everyone may not be mindful of or which they may not keep track, the information is given in small bullet points with short explanations and it contains more than 30 pieces of advice. This is only one example of the advice of medical knowledge that we now come into contact with every day. These seemingly small doses may not always resonate with readers but it demonstrates how much health information exists all around us.

Americans more than ever learn things from TV, the Internet, magazines, and newspapers and one of the best examples comes from Oprah and Dr. Oz. During an episode of The Oprah Show in 2007, Dr. Oz answered a question from an audience member about allergies and provided an easy solution: the neti pot. The neti pot in a small, often porcelain pot that when filled with water and a small amount of salt, pushes the solution through the sinus passages to clean and rinse them. “When Dr. Oz first introduced Americans to this natural remedy for sinus pain and congestion, they flew off drugstore shelves! Now, Oprah says she can't go anywhere without hers” (Oprah.com). I saw that episode live on television and watched in awe as news articles later described how neti pots were selling out of stores and online retailers. Then I came across an article
in 2010 in a health magazine that suggested that neti pots might not be useful to allergy sufferers across the country reporting that “people who used the [neti pot] every day for over a year experienced 62 percent more sinus infections” (Shape Magazine 2010). Dr. Oz’s recommendation drove massive consumership of the neti pot, and while he is a cardio-thoracic surgeon, his advice was taken by many people as a health recommendation they should try, even if it was to their detriment without any further questioning.

Foucault contends that “human beings are made subjects” who follow the structures of biopower and biohistories of medicine (Foucault 1994:126). These subjects are constructed by the neoliberal philosophy pushing people to be more active biological citizens by taking the advice of celebrity physicians like Dr. Oz. “The health consumer of advanced liberalism is positioned not as a passive, cultural dope but as an active, enterprising and self-caring subject capable of selectively consuming health products and selectively reading his or her own health messages” (Bunton and Petersen 1997:10). The subject becomes this active consumer that is engaged with the knowledge being passed down to him or her and this creates a biohistory. The consumer receives messages about their health from unexpected sources and the media is a big part of this medical influence on how to be in the world. Clarke argues “that developments of ‘things medical’ in the past and today are not only accompanied by and reflected in popular cultural iconography—multiple media—but also were and continue to be in part generated and produced by and through them” (2010:104). Media like television, advertisements, and the Internet have become such integrated forces in Americans’ lives that their influence,
while known and often studied, is not questioned in the central truthfulness to the audience. Just like newspaper retractions, not always noticed the next day, mistakes are not publicized and people often have no way of following rebuttals, changes, or updates to this medical information. The medical knowledge and advice on being a good, biological citizen comes from a multitude of sources that Americans often take to heart.

Medicine, according to Foucault, was expected to propose standards of conduct for individuals and “it was necessary to equip oneself with a medical knowledge that one could always use…to ensure self-reliance” (Foucault 1986:100). This self-reliance is an important parallel to personal responsibility and the rights of the modern subject in Neoliberalism; “one of the basic principles of the practice of the self: be equipped with, have ready to hand, a ‘helpful discourse,’ which one has learned very early, rehearses often, and reflects on regularly. The medical logos was one such discourse, dictating at every moment the correct regimen of life” (Foucault 1986:101). The doctor’s role in medicine was to be the information source for the medical discourse and that has begun to be subverted by the educating of patients in new ways, and the emergence of the expert patient. Turow writes about the presence of the physician on television as iconic for the public and along with the general respect for the profession, both have contributed to public interest in watching a drama centered around medicine (2010). These medical standards the public is supposed to adhere to, coming through media sources, are driving action in either consumership of products or the production of health activities.

Medical information is shared through social interactions, but we also have in common something that sits in most living rooms that grabs our attention on a daily basis.
Most people do not think critically about their television habits, about their choices in programming, or about the background noise radiating from the television set. “In the United States, commercial television is the most shared storyteller” (Turow 2010:5). Because television is a shared experience, previously discussed at the water cooler at work, and now on Facebook or Twitter, Americans engage with the programming and the information without even thinking about it. While there is a distinct history of medical television since it’s popularity as a medium, the programs have focused in different ways on the physician. In the Post WWII beginnings, “it was focused on the care of acute problems, carried out in a modern hospital, using high tech instruments” but, by the mid-1980s, TV series “looked in new ways at doctors’ personal lives…[and] much melodrama revolved around the doctors’ intense personal angst” (Turow 2010:3). This changing nature of television mirrors the modern political movement of neoliberalism. Coming out of WWII, people needed to see the ‘modernity’ in modern medicine because developments were coming rapidly in medicine and far more was being offered to the patient. By the 1980s, people were well informed about their medical care options but were interested in what was going on behind the scenes in a hospital. By the 1990s and 2000s, the interest in medical knowledge and the consumption of medical dramas coincided within television programming whereby shows began giving medical information and technical jargon, including medications for treatment, within the programming and some programming moved in soapier directions than others¹.

¹ The differences in these two types of shows can easily be seen when comparing ER and Grey’s Anatomy for their relative amounts of medical information of patient characters and relationship information about principle characters.
Some medical shows seem to tap into a moment for the public, like *M*A*S*H*, a Korean war drama airing during some of the social unrest with the Vietnam War or *Combat Hospital*, a medical show about a fictional base in Afghanistan while the war there was still ongoing in real life. Both addressed issues that were relevant to the social zeitgeist and issues around it. Often the public has looked to shows for the new, flashy technology and for the boundaries of what is possible, like with the shows *Bones* or *CSI*. Most of the technological capabilities of the ‘Washingtonian’ on *Bones*, the medico-forensic setting for the show, are not a reality for most underfunded medical or forensic laboratories, and often many are made up for television, figments of the writers’ imaginations.

For most of the time that medical fictional programming has existed, there have been safe checks by groups like the American Medical Association or the Los Angeles County Medical Association to adequately check the accuracy of the information portrayed within the program (Turow 2010:45, 89). Also, they worked to safeguard the public against storylines they deemed too graphic or upsetting for the public. As a comparison, an opening scene of childbirth on *Medic* in 1956 was deemed “offending” and even the Catholic Church weighed in on the “too realistic” storyline (Turow 2010:65). Set that against the first season of *ER* in 1994, where the show won an Emmy Award for an episode titled “Love’s Labor Lost” in which a woman dies in childbirth in the emergency room after a graphic attempt at vaginal delivery and then has a rudimentary caesarian section by untrained physicians because of the emergent nature of the pregnancy.
We are drawn to the medical drama because of the life and death nature of medicine and the mysterious nature of hospitals, full of locked doors and closed curtains, where bodies are manhandled and people trust strangers because of their education and certification by the medical institution.

“The conflicts in the hospital—and there were many—came from three sources: the gut wrenching physical problems of patients, the ethical dilemmas that often rode along with these physical problems, and the interpersonal angst of the doctors and nurses that flowed from the patients and the problems they brought to the hospital” (Turow 2010:340).

As television became more open to varied, diverse, and often graphic programming, advertising was moving in a more aggressive fashion as well. Pharmaceutical advertising “has both a long history and a measurable impact” (Singer 2008:137). Beginning in the 1800s, drugs makers began to realize the impact advertising could have for them and “by the latter part of the 1800s, some of the bigger patent medicine manufacturers were spending hundreds of thousands of dollars or more a year on advertising” (Singer 2008:140). What follows are huge developments in drug discoveries like penicillin and the medical use of plant products like cocaine and other opiates to treat disease and create markets for medications (Singer 2008). The more pharmaceutical companies made advances in research, the more they began to push for broader ability to speak directly to consumers about their products. One of the first major moves was by Pfizer, who “launched a public relations campaign in the early 1980s called Partners in Health Care, to increase awareness of underdiagnosed conditions such as diabetes, angina, arthritis, and hypertension” (Donohue 2006:675). Pfizer utilized a method that has now become common whereby “the ads did not mention any drugs by name, [but] they prominently
displayed Pfizer’s name in the hope that consumers who visited their doctors might ask for one of the manufacturer’s products for those conditions” (Donohue 2006:675).

The primary force regulating the messages put out in the world by pharmaceutical and food companies is the Food and Drug Administration or FDA. The FDA is charged with protecting people from harmful products and regulating the safety of consumable goods. The FDA’s ability to do its job can be helped or hindered by those on the inside including lobbyists, the companies themselves, consumer groups, advocacy groups, and experts within these fields. In order to change the FDA’s regulation of pharmaceuticals, one really important person stood in the way of more advertising, David Kessler, the head of the FDA in the early 1990s. Kessler wanted more and more regulation of many areas of oversight from the FDA into consumer products, not just pharmaceutical ones. Literally “a few months after David Kessler left the FDA [in 1997], the agency released the Draft Guidance for Industry: Consumer-Directed Broadcast Advertisements” (Donohue 2006: 685). Before 1997, the FDA “required [pharmaceutical companies] to include full information about side effects in their ads. That made thirty-second spots difficult—even counterproductive. A drug could sound pretty scary with a rapid-fire listing of side effects” (Angell 2005: 123). Then with new legislation, the FDA created guidelines that made print and television advertisements or Direct-to-Consumer Advertisements (DTCA) more manageable for companies and broadened the advertisements’ previous restrictions. With these changes the idea became one of ‘patient education’, whereby advertisements would then tell people about both diseases and medications, thereby taking over both an advertisement and informational presence.
“Advertorial is a technical term for this process: quasi-educational spots whose function is to teach about specific disease symptoms and mechanisms” (Dumit 2012:63). With this dual function, regulating the pharmaceutical companies became an interesting dilemma.

The FDA has four requirements for television ads: list the 1-800 number, give the website for the drug, direct the consumer to your print advertisement, and tell them to seek more information from doctors (FDA Guidelines). Because the DTCA is no longer required to give a full listing of side effects, which are supposed to be available online, in the package insert, through your doctor, or the company’s toll free phone line, the ads can be delivered in thirty seconds or less. This has prompted a dramatic increase in television advertising by companies, many of which run multiple ads on multiple channels throughout the day targeting specific groups through programming choices. For example you will find more pharmaceutical advertisements during news programs like 60 Minutes, which reflects a targeting of often older, more informed consumers.

With the changes directed in the guidelines, the FDA allowed a space whereby the pharmaceutical companies could advertise all of the required language of risks and benefits to consumers in a small window or time or space, thereby making is plausible to have magazine or television advertising. “Since 1997 when the FDA removed many of the regulatory restrictions that had prohibited direct-to-consumer advertising (DTCA) of prescription drugs in the United States, we have been bombarded daily by an ever-growing storm of the multimedia promotion of drugs” (Paluzzi 2009:255). Pharmaceutical companies as they form fewer and larger conglomerates have worked to ensure that consumers are increasingly informed about their products. “Spending on
direct-to-consumer advertising of prescription drugs increased dramatically from $166 million in 1993 to $4.2 billion in 2005” and by advertising both to physicians and consumers, the pharmaceutical companies then control the information circulating in the market about the possible products and medical conditions that need their treatments (Donohue 2006:659). The doctor and patient become caught up in the multi-layered informational processes developed by pharmaceutical companies to address both target markets.

Pushed to go online for more information through a company website, consumers move to the Internet for their information, and they may frequently encounter a difficulty in knowing who made the website and whether to trust the information contained within it. Googling a drug name can lead to the company’s website, patient group websites, advocacy group websites, pharmacy websites, overseas sales websites, homemade websites with questionable origin or any other multitude of sources. There are a few reliable websites recognized by most to be credible. One magazine article advises you to “google your diagnosis and see if your symptoms match up with the symptoms listed for it on reliable websites. (Look for one that end in .gov or .edu or that belong to well-established groups like the American Cancer Society)” (Cohen 2010:142).

The Mayo Clinic or the Centers for Disease Control tend to have accessible and reliable public health information. Websearchers need to be careful with their searching habits because in the same way that whitehouse.gov and whitehouse.com send you in two very different directions (the first is the legitimate website and the second is a pornography site), there are some very problematic health literacy websites that exist
online in competing arenas. Authenticity and authority become central questions for this modern quest for information. Who do you trust? Many people online trust the idea of crowd-sourcing. There are a multitude of question and answer forums where people post a question and wait to see what the general consensus is of everyone who answers it, whether they be medical professionals or not. Our online lives have become even larger with the advent of the smart phone and almost constant web accessibility.

When consumership above all else is cultivated in advertising and access is granted to privileged knowledge online, doctors can become nothing more than prescription pad holders and barriers to a purchase that has been influenced by marketing. People often diagnose themselves using the Internet without the hassle of a physical exam or an expert. An increasing issue is that of cyberchondria, where medical online searches escalate into serious searches about devastating illnesses, based on medical diagnosis search engines like WebMD spitting out that a stomach ache could be stomach cancer. Panic ensues by the searcher, and in a world when “8 in 10 American adults have searched for healthcare information online” that panic can easily be assuaged or encouraged, perhaps even manipulated, by further google searches (White and Horvitz 2008). If the Internet cannot help you, maybe Dr. Oz can. The rise of daytime medical non-fiction health shows in the 1990s began with several health-based channels owned by the Discovery Network, and gave rise to shows like The Dr. Oz Show and The Doctors. Non-fictional television has become extremely popular (and cheap) daytime programming that consistently will draw in viewers in ways daytime soaps and general talk shows do not.
All of this television watching, advertisement reading, online searching and notions of personal responsibility, created this project and began to show the tangled lines of information we encounter that can be confusing and even contradictory. In tackling the issue of knowledge creation around medicine and media, these disparate pieces come together through the common thread of media in what is called a healthscape (Clarke 2010). Americans have become so used to this process that no one stops to look to see what it could all mean for the public, and what the complications of the authenticity, reality, or accuracy of the information could be for all of those bodies, both social and personal. By investigating the sources of pharmaceutical advertising, several Internet applications and health sites, famous physicians, celebrities and medical television staff, I hope to bring to bear a better understanding of the phenomenon created out of neoliberalism, biomedicine, and biosociality for our perceived knowledge about ourselves and our bodies with regards to the issues of accuracy, authenticity, and trust in this production of knowledge.

Methods

When I began this project, I set out to study the ways in which people gather and take in medical information. The multitude of options is at once overwhelming, but also connected. People talk to friends, family, and their own doctors, and as well some of the public may have medical training that exists somewhere between experiences with the medical system or formal medical training. The directions or possibilities are endless. I wanted to really get at the media in this project because the information available to consumers within these mediums of advertising, online, and television programs have
been studied before in other disciplines and there are some established works to draw upon, in addition to my own ethnographic research. I used Leo Chavez’s *The Latino Threat* (2008) as a model for this type of anthropological study because his book on immigration draws on four lines of evidence and admits to the many challenges in sourcing all possible options for a topic as large as immigration. Similarly I was challenged to bring to bear a semblance of understanding for an audience over such a large topic as the ‘media’ with so many possible influences. I chose four lines of evidence that brought some real grounding to this topic of media and medicine while at the same time acknowledging that there are many other directions another anthropologist might have chosen, given a different set of questions or framework. With that being said, the project is organized with a developing storyline of medical knowledge leading into the four selected lines of evidence.

I began this research in 2009 and along the way I worked on the methodology because of challenges in the informant populations. This project employs a method called “studying up” whereby the people being sought for information are in a more privileged position than the researcher and do not have an obligation to speak with anyone (me) about anything (Gusterson 1997, Nader 1969). I chose a project that required *some* engagement from the entertainment industry, federal regulators, and pharmaceutical companies, some of whom did not choose to speak with me nor invited me in to watch them work. “The powerful are out of reach on a number of different planes: they don’t want to be studied; it is dangerous to study the powerful; they are busy people; they are not all in one place and so on” (Nader 1969:302). The difficulty of studying up within
this project is also an obstacle to traditional participant observation as an anthropological methodology. “Participant observation is a research technique that does not travel well up the social structure” (Gusterson 1997:115). I was not generally allowed on television sets to watch my subjects in action or to come to their workplace because of security concerns in television over upcoming storylines and secrecy in many different industries about their inner workings. I was able to get many and often multiple interviews when needed among those who were enthusiastic to be my informants. The people who chose to speak with me about their jobs were more than willing to do so and often very giving with their time, in person and over phone or email. There were many who refused interviews, or their PR person did so on their behalf most of the time. These gatekeepers were a major challenge in this work, in an industry where most people have “people” and are unlisted, not findable, and intentionally difficult to contact. I chose with my methodology to follow Gusterson into his “polymorphous engagement [as a] means [for] interacting with informants across a number of dispersed sites, not just in local communities, and sometimes in virtual form; and… collecting data eclectically from a disparate array of sources in many different ways” (1997:116). I found this to be most useful for my work across the pharmaceutical and television industries. I began my work with my informants by first connecting through one person I already knew who had worked on several medical television shows and this person lead me to my first key informants. From there I utilized my current location of Los Angeles and the many friends I have in the entertainment industry, plus tricks of the trade like IMDBPro (an entertainment industry database) to find more informants. As I met more people, I gained an increasing
legitimacy with people that I was in fact an academic and not a super-fan or someone looking to meet famous people and get on set (this is part of the reason I did not push my generous contacts to watch them on set, as it would be very risky for them).

Over the past four years but really beginning in 2011, I spoke to many physicians, television medical writers, television medical technical advisors and product placement facilitators, actors who played doctors on television shows, and medical television producers and directors. Collectively they work and have worked on shows like ER, St. Elsewhere, M*A*S*H, Grey’s Anatomy, Combat Hospital, Chicago Hope, Bones, Royal Pains, House M.D., Nip/Tuck, Off the Map, Doogie Howser M.D., Monday Mornings, and many other shows that are non-medical but have occasional medical storylines, in addition to countless commercials and feature films. I visited two television sets, one with a medical advisor on a non-medical show and a second with producers to a specifically medical show. I also interviewed a head researcher at Microsoft, the founders of two internet start-ups working on health technology, one person currently at the FDA in the Office of Prescription Drug Promotion (OPDP) and I attempted to speak with many more people who work for pharmaceutical companies, other current FDA personnel, retired FDA employees who now work in consulting or at a think tank, and spokespeople at PhRMA the pharmaceutical industry’s lobbying organization. By stating that I ‘attempted’ to speak with people, I mean that I sent easily more than 50 emails total, made phone calls, and reached out to contacts over protracted periods of time without any success and often no response or reply. There is no real vested interest for any of these groups to engage with me or my research, and most chose not to do so. I understood this
would be a challenge with this project and I can admit that I thought in the beginning that many more people would want to speak with me about my thoughts and analysis of their advertising or television shows. I realize it was naïve, but it was also hopeful. That hope is what kept me reaching out to people and also what eventually lead me to having the legitimacy that I did with those who ended up working with me.

Beyond the interviews and the people who I worked with, I created a collection and resulting database of pharmaceutical advertisements. There were two major components and three minor components. The first major component is an eleven-year (2002-2013) print database of advertisements from magazine and newspapers. The second major component is a five-year (2009-2013) transcription database of television advertisements. The three minor components include help-seeking ads for particular diseases, pet medication advertisements, and mock pharmaceutical advertisements. This collection required a multitude\(^2\) of magazine subscriptions that I personally collected over the most recent six years and archival work to retrieve advertisements from past magazines going back to 2002. Even this took some negotiating and personal connections to facilitate because most libraries do not save hard copies of popular magazines and access was difficult to come by.

These polymorphic engagement methods were supplemented with scattered bits of research from a large amount of sites. I tackled quite a bit of online research along many lines, from health apps or applications, web searches, reading the entirety of the FDA’s not very user-friendly website several times, searches for Congressional reports

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\(^2\)I subscribed to *Time, Newsweek, People, US Weekly, Smithsonian, National Geographic, Health, Fitness, Prevention, Esquire, Elle, Sports Illustrated, Outside*, and was offered contributions from magazines like *Golf, Men’s Health, Ladies Home Journal* and others from friends and family who collected on my behalf.
and the request of my Senator’s help in finding more information about some FDA regulation, Government Accounting Office reports, watching a lot of medical fictional television (some good, some bad, some old, some new), watching about 6-8 hours a week of non-fiction television including shows like The Doctors, The Dr. Oz show, the nightly news most nights and anything I came across that was about and around the medical arena on television. The multitude of polymorphous methods utilized gives the broadest perspective achievable on this topic which searches to explain medical media while acknowledging the difficulty in finding access to first hand information. Most often information was sourced as close to first hand as possible and then often backed up by several second hand sources.

**Anthropological Inquiry into Television**

There is an immense difficulty in the ability to do research on the structure of television and other types of media in the entertainment industry. The modern entertainment industry is set up where everyone that is a power player has at least one assistant to purposefully act as a gatekeeper. The system is set up to keep people out who do not belong. Anthropology has attempted to study Hollywood and its influence since Hortense Powdermaker’s original work in the 1940s. Much of this research is on the organizational level and identifying key players where Powdermaker gives readers the archetypes of what a producer, director, and actor/actress look like, act like, and what they are in control over within film production (1950). These anthropological studies on

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3 I have easily watched more than 1000 hours of medical television. *ER* ran for 360 episodes over 15 years, and *Grey’s Anatomy* is airing their 200th episode in the Fall of 2013 in Season 10. Then add in 6 seasons of *Chicago Hope*, 8 seasons of *House M.D.*, 8 seasons of *Scrubs*, A few Marcus Welby M.D. and St. Elsewhere episodes available on iTunes, and 1 season each of shows like *Off the Map*, *Monday Mornings*, *Mercy*, *Combat Hospital*, *Mob Doctor*, *Saving Hope* and others.
Hollywood are few and far between, but there are a few examples that float just outside of the industry, where anthropologists gained access to relevant side areas of work or studied more accessible items within Hollywood. Sherry Ortner has recently researched independent films because of a difficulty getting access into the traditional Hollywood studio and her book is even titled, *Not Hollywood* (2013). Scott Frank has been writing articles on everything from the headshot photograph as an artifact of Hollywood to the dwindling studio library (2004, 2012). Also, there have been edited volumes of film analysis, even medical film analysis, but they often cannot access the key players that created the films, and only analyze the resulting film (Colt, Quadrelli, and Friedman 2011, Reagan, Tomes, and Treichler 2007). Powdermaker’s work has little relevance for a comparative study today because of how much change has taken place in Hollywood’s organizational structure (studios no longer work in the same way with contract actors and they control far less now, often buying films rather than making them) and the audience’s greater access to information about films and film production. There are now regularly pictures on the Internet and in magazines of film sets and productions that may not come to theaters or televisions for months or years.

Anthropologists have struggled to access Hollywood for formal, updated ethnographic research and therefore any comparative work is slim, especially for comparing something as specialized as medical television productions. Corinna Kruse’s work on the show *CSI* focuses on an analysis of the episodes and the presentation of forensics, without any input from the staff or crew of the show and this is typical because of the inability to access such persons (2010). The creators of such programming and the
key staff will inevitably influence the forthcoming films and television shows. These creators, staff, and crew members should be studied to better understand these issues of authenticity and accuracy when consumers of this media are being pushed so hard to take in this information and become better biological citizens. That is why this project and the amount of access that was achieved is so remarkable. The people and studios who make television decide what we want as consumers. An informant who worked on *ER* described the studio’s hesitation with having a show that had such a vast amount of medical jargon as dialogue. That was a huge problem for them and the producers really had to explain that not only did they think the TV audience was ready for it, but that the studio should think of the “medical language as like wallpaper. It’s just there. It’s the background.” And they proved quickly that Americans wanted that fast paced, quick, specialized jargon with their viewing habits. Knowing the background on decisions like this, that are made far before an audience ever sees a show, gives a greater perspective on the structural influence and powers at work when it comes the media we will consume.

**Overview of Chapters**

Chapter One speaks to the theoretical framework I will be utilizing and the background information necessary for understanding the atmosphere that lead to the development of Direct-To-Consumer Advertising and the creation of such a large interest in medical television that an entire channel like Discovery Health was created. The idea of personal responsibility is crucial to understanding why an audience would remember medical information from a TV show and explaining why no one else, besides New Zealand, allows pharmaceutical companies to advertise to the public. We have been
taught that the world is risky and you need to become an active patient to “help your doctor help you.” Neoliberalism, as an economic construct, has filtered through into the public rhetoric of personal responsibility in many other areas of life, including health. It is this framework that provides the underpinning in which biomedicalization becomes overbearing for the patients’ own role in their health decisions and shapes the process of healthscapes as an overriding process of knowledge and discourse. As well, pharmaceutical advertisements push people to become informed and knowledgeable about their medications and to have the recall to remember the product name and condition being treated, in order to “ask your doctor about X product.” Media knowledge is an especially important idea and the presence of such information building is a current running through this entire project. Finally, the CSI Effect is described as an example of the ways in which media has been shown or projected to change real world perceptions based on fictional television programs, creating a phenomenon I call the ‘ER Effect’. In combination with authenticity and mimesis, questions begin emerging about the issues with perception of truth in media.

Chapter Two follows television medical media over time, whereby medical shows have been on television almost since the creation of television, and discusses the new and changing role of the physician and nurse television writer and consultant. Most medical television shows since ER in the mid-1990s, created by physician and sci-fi author Michael Crichton, have had a dedicated staff of clinicians to guide the actors and crew in an increasingly important imperative for medical authenticity. The historical development
of the industry brings to light the self-regulatory aspect that developed singularly in television.

Chapter Three looks at the way in which television production as a process shapes the eventual outcome for the show. The medical advisors and writers make the show work for the writers with all of the drama they need, but they also oversee the medicine so that the realism and accuracy are also present. This is a small community of medical professionals who have become integral to having accurate portrayals of medical situations across television, movies, and commercials but their jobs are complicated and require navigating the world of television very carefully. Included are lessons learned from these professionals about how they work towards authenticity in the writing and on set for shows.

Chapter Four looks at pharmaceutical advertising in magazines, newspapers, and television. The FDA allows three types of Direct-To-Consumer Advertisements (DTCA) of prescription drugs: “Product claim ads: These name a drug and the condition it treats, and talk about both its benefits and risks. Reminder ads: They give the drug's name, but not the drug’s uses. Help-seeking ads: These describe a disease or condition, but don't recommend or suggest specific drugs” (FDA Direct To Consumer Ads 2013). I created a database of 762 magazine and newspaper print advertisements across an 11-year period, as well as 86 television advertisements across a 5-year period. All three types of FDA regulated advertisements are found within this collection. Also in this collection are the new market of pet medication ads, typically for flea and tick treatment or heartworm prevention, and mock pharmaceutical ads from places like Saturday Night Live. Close
attention is paid to the language used within advertisements and the interpretations and interpellations of imagery alongside language in these ads. There were several advertisements that were prime examples of companies showing a ‘smart patient’ doing research into their drugs or talking to a family member about the drug.

Chapter Five encompasses the Internet as a consumer resource, paying special attention to the presence of health “apps” or online applications for savvy consumers on their smart phones and hand-held devices like the iPad or a tablet. Our new world of information is based on technology and unlimited access to such websites, knowledge, and information that the consumer should have the ability to create for themselves a healthy body. Cyberchondria, or online hypochondria, is discussed alongside two new websites, FindZebra.com and CrowdMed.com that were created in 2013 for physicians to diagnose rare diseases. Together they represent two sides of the same coin. One side is for people who diagnose themselves as having a rare disease that they most often do not have, and the other side where people who have do not have a diagnosis but can find a way to get help for their rare or orphan disease.

Chapter Six addresses the presence of non-fictional television that is ever present, from health stories on the nightly news to entire channels devoted to health programming. From these real stories of life and death, of medicine and doctors, people watch medical storylines unfold on programs like The Dr. Oz Show to get help with their lifestyle or health problems. A focus is placed on the physicians who have become “America’s Doctors” like Dr. Sanjay Gupta of CNN and Dr. Drew Pinsky of MTV, Loveline, and his multitude of consulting work for media outlets. Also, equally important is the role that
celebrity plays in the public’s consciousness when Katie Couric gets a colonoscopy on live television and Angelina Jolie writes an opinion piece in the *New York Times* about her decision to have a preventative double mastectomy, and we respond to these stories and it creates both knowledge and action.

The conclusion provides the final thoughts from this research and looks towards the future, with further areas of study or possible projects that could not be included in this research. Topics include medical radio, self-help books, spurious medical information, and online biosocial groups that exist in communities on the Internet.

Also included are two appendices that have information I collected but were not used in the project or analysis. I asked all of my informants who worked in creating medical television, actors, directors, writers or on-set consultants, what their favorite episode of medical television was either for the medicine or the way the episodes played on television and that can found in Appendix A. Also, I noticed the historical and contemporary use of fake or spoofed pharmaceutical drug advertisements on *Saturday Night Live* going back to 2000. I created a database of those ads, which are very funny, and can be found in Appendix B. Lastly, Appendix C includes information from an informant about a BBC show called *Embarrassing Bodies*. This show features people exposing their deepest darkest medical secrets on television, much like the way Americans expose themselves on medical shows, but in a much more graphic way. This show could be part of the future of medical reality programming that can often make the leap from British programming to American programming. I think of this project as a sort of DVD collection of information on media and medicine, and these appendices are my
‘Special Features’ extra on the DVD. These are just a little something additional for the reader that might interest you, as it interested me while I was doing research, and entertain you for a minute at the end like any good special feature, which contains additional footage that hit the cutting room floor.
Chapter One: “Oh, I Know All About That”: How Consumers of Medical Media Get their Information

“The cultural and material authority of biomedicine’s productions of bodies and selves is vulnerable and dynamic and constituted through multivalent discursive strategies and social forms” (Cartwright 1995:228).

“Unfortunately, sometimes medicine is predicated on partial truths, or as Stephen Colbert calls it ‘truthiness’… How do you know what to believe? It’s not easy” (Besser 2013:3).

Knowledge comes from many sources, some of it formal, much of it informal. Byron Good writes that “medical knowledge is at the same time social knowledge” (1994:115). This social knowledge derives from social interactions from friends, family, etcetera, and has the potential to be in conflict with more traditional, institutional knowledge. Much informal knowledge from social interactions and outside sources come in the form of factoids or small facts with no particular definable source or point of origin. “Much of our knowledge we have accumulated by learning from others” (Barth 2002:2). In this way, people take and give knowledge to each other that has been learned over time. An important factor is often the origin of the information, and trust in the reliability of this person or provenience. We prioritize some sources over others and often the information strikes us with more importance either because it directly relates to our situation or has pertinence for others in our lives. “A person’s stocks of knowledge structures that person’s understood world and purposive ways of coping in it” (Barth 2002:1). If the information has meaning for us, we may often retain it and relate it to our own lives. For instance, if a television is playing in the background and someone catches a mention of “Alzheimer’s Disease” that may pay more attention to this specific information because their grandmother has it or likewise ignore it if they feel it does not
pertain to them. Accuracy and authenticity of knowledge and information become something judged individually as to how much trust to place in the source. If the source is in some ways seemingly valid for the person receiving it, it may hold more weight than a piece of information given by someone or somewhere with less reliability.

There is a multitude of “ways of knowing or varieties of expertise” (Epstein 2008:518). Just because knowledge has been dispensed, does not automatically lead to knowing, as the process of internalizing information cannot often be measured. Information and evidence given to a consumer may overlap with each other, sometimes backing each other up or may often be in contrast. These varying sites of knowledge production are seen as “different bodies of knowledge in a somewhat empirical fashion, [whereby people are] using them simultaneously and at other times [are] moving from one kind of medical treatment to another in the quest for efficacy” (Kingfisher and Millard 1998:449). While we draw information from varied and vast resources, the authority of this medical knowledge should be questioned. “Even your most well-meaning friends, neighbors, and colleagues can be stumbling blocks on the road to better health” (Besser 2013:3). Besser is a public physician for ABC News and while writing a book advising people on simple answers to their complicated health problems, he acknowledges that those around us contribute information to our stocks of knowledge, not always to our benefit.

Discerning what the particular knowledge means for each person is a difficult task, because each person internalizes different amounts or levels of knowledge in different ways. If some knowledge is privileged, then it has power for the consumer.
Foucault writes that “power produces; it produces reality; it produces domains of objects and rituals of truth” (1977:194). For the consumer then, a privileged source like a parent who is a physician may be more reliable and more truthful to them rather than a celebrity physician on television who seems distant and general. On the other hand, if one feels they cannot trust the medical institutions, as some do, then a celebrity doctors seemingly benevolently dispensing medical advice might be more reliable than the family doctor. It is the method of distribution that is then easily studied and observed without judgment over the amount of influence. “Distributions of knowledge—its presence or absence in particular persons—and the processes affecting these distributions can become objects of study” (Barth 2002:1). The focus of this research is to look at these media-based methods of distribution and to analyze the authenticity and accuracy behind each form and movement of medical knowledge. Within this analysis, it must be understood that “experience is a category of knowledge” and is a valid source for many people within their consideration of taking in new knowledge (Epstein 2008:517). It is complicated by the fact that “patients and their relatives [can be] subscribed to multiple bodies of knowledge about illness and misfortune” (Kingfisher and Millard 1998:448). It is within this multiplicity that things get convoluted. Because there is both traditional knowledge through education and training and lay knowledge from experience, the audience for media information may already be more receptive to incorporating this information into their stock of knowledge.

**Neoliberalism**

Within anthropology, culture operates on the premise that people of a particular
group share the same basic information and understanding in order to effectively communicate with one another. Through the same premise, shared “knowledge provides people with materials for reflection and premises for action” (Barth 2002:1). The notion of shared actions in culture allows for an analysis of the productions of knowledge and the resulting identification of joint behaviors within medicine that have been created over the last 40 years of neoliberal movements. Barth argues that “a great deal of every person’s knowledge [is] conventional, constructed within the traditions of knowledge of which each of us partakes” (2002:2). This centralized knowledge is disseminated through institutions and governmental regulations like policy and mass media outlets in such a way as to provoke behavioral modifications and adjustments of the population.

“Liberalism in America is a whole way of being and thinking… [but] it is also a method of thought, a grid of economic and sociological analysis” (Foucault 2008:218). The production of knowledge has become fundamental to Western society and has challenged medical anthropology to focus on seeing the underlying structuration that created it.

David Harvey’s work shows that “Neoliberalism has, in short, become hegemonic as a mode of discourse. It has pervasive effects on ways of thought to the point where it has become incorporated into the common-sense way many of us interpret, live in, and understand the world” (Harvey 2005:3). The social principles that come with the larger, more visible political and economic framework often go unquestioned. The job then is to see how “American neo-liberalism [functions] as a principle of intelligibility and a principle of decipherment of social relationships and individual behavior” (Foucault 2008:243). The medical knowledge and healthy behaviors demonstrated in spaces like
media follow the guiding principles of neoliberal deregulation, freedom, mobility, and individuality that are openly encouraged of consumers.

“Neoliberalism “include[s] individual responsibility and liability; independence from state interference (which often places this regime of rights in severe opposition to those defined within the state); equality of opportunity in the market and before the law; rewards for initiative and entrepreneurial endeavour; care for oneself and one’s own; and an open marketplace that allows for wide-ranging freedoms of choice of both contract and exchange” (Harvey 2005:181).

Within the neoliberal framework, “medium and message… are powerfully intertwined in the communication of this knowledge” (Simpson 2000:14). Both the medium and the messages produce all kinds of knowledge for consumption by the public but neoliberalism relies on the medium as a conduit to the people. Neoliberalism “requires technologies of information creation and capacities to accumulate, store, transfer, analyze, and use massive databases to guide decisions in the global marketplace” (Harvey 2005:3). In medicine, corporations and media conglomerates use these technologies to accumulate information about their possible consumers and also as conduits for the knowledge that they are disseminating to the public.

A significant aspect of neoliberal philosophy is the power of the individual to self-regulate and to follow guidance from the state. “While personal and individual freedom in the marketplace is guaranteed, each individual is held responsible and accountable for his or her own actions and well-being” (Harvey 2005:65). It is this right to freedom in the marketplace that has driven the message of personal responsibility within a multiplicity of outlets, including economic, political and medical systems. “Neoliberalism asserts that everyone, rich and poor, benefits from the unrestricted free trade of commodities and the free flow of capital around the planet” (Singer 2008:12-3).
The common good of the people will come from this deregulation of governmental intervention into life and the medical system has promulgated the message of individual rights and responsibilities by asking people to “take control of your health” and to “help your doctor help you.” While the media carries this message, it also comes from the larger institutions in health care, such as pharmaceutical corporations and media programming, which provide a growing amount of information to doctors and consumers. Knowledge is historically and culturally constructed illuminating the extensive foundations in knowledge production in anthropological discourse, further shows the extensive framework for considering how knowledge is produced (Foucault 1973, 1984, 1994, 2003, 2006, Lupton 1994, 1997, 1999a, 1999b, Douglas 1966, Clarke 2010). “Medical knowledge is not conceived of as autonomous but is rooted in and continually modified by practice and social and political change” (Lock and Scheper-Hughes 1996:44). Foucault plays an integral role in theorizing about medicine and how the medical system has exercised an element of control over people through government power, with the notion of individuality through the role of the subject as saturated with knowledge and then how this is produced and shaped from above. He writes that “American neoliberalism seeks rather to extend the rationality of the market, the schemes of analysis it proposes, and the decision making criteria it suggests to areas that are not exclusively or not primarily economic” (Foucault 1994:207). As this economic structure infiltrates culture, it changes the power/knowledge systems of thought and shows itself in places like medicine, history, and institutions. These institutions through powers like that of the sovereign have “the power to make live and let die” which ultimately controls the
bodies of the population (Foucault 2003:241). It is through the disciplinary forces of sovereign power that bodies are subject to the rule of law. “Discipline tries to rule a multiplicity of men to the extent that their multiplicity can and must be dissolved into individual bodies that can be kept under surveillance, trained, used, and if need be, punished” (Foucault 2003:242). Additionally, it is this form of power, in discipline, that creates a subjugated population that can be manipulated for the good of the larger group; also this singular source produces knowledge of how to behave within the world in a correct and proper manner. It is this “potential of neoliberalization, privatization, and personal responsibility” that drives behavioral changes within the population (Harvey 2005:171). The combination of these forces, paired with governmentality, show the larger social, political, and economic project at work.

“The strategies of governmentality, expressed in the neo-liberal states that emerged in the west in late modernity, include both direct, coercive strategies to regulate populations, but also, and most importantly, less direct strategies that rely on the individuals’ voluntary compliance with the interests and needs of the state. These strategies are diverse and multi-centered, emerging not only from the state, but also other agencies and institutions, such as the mass media” (Lupton 1999a:87-8).

The presence of mass media in the statement above speaks to the methods by which governmentality seeps into life through seemingly benign institutions like media. “As Foucault and exponents of the ‘governmentality’ perspective have described a huge network of expert knowledges has developed, accompanied by apparatuses and institutions built around construction, reproduction, dissemination and practice of these knowledges” (Lupton 1999b:4). These expert knowledges, like that of medicine, prescribe not only medications but also behaviors for the public to adhere. Through
surveillance of the population, there has been “the emergence of techniques of power that were essentially centered on the body, on the individual body” (Foucault 2003:242). The reason these are effective in controlling people is that “power is exercised because subjects are able to react to expert knowledge” (Bunton and Petersen 1997:9). The power/knowledge in society comes from one central, recognized location and use these tactics to modify behaviors in biomedical situations. One tactic is the medical gaze, which is seen through “that of a doctor supported and justified by an institution, that of the doctor endowed with the power of decision and intervention” (Foucault 1973:89). Public doctors, like those on television, use this medical gaze or what Clarke calls “things medical” to include in and within medical everyday practices things normally considered non-medical (2010:108).

Through Neoliberalism and open regulatory frameworks, “illness becomes profitable…[and] illness is consequently intertwined with the whole economic problem of profit” and this is a benefit to corporations that exist to make a profit off of the continued presence of sick people like most companies in the biomedical system (Foucault 2006:313). A central concern coming out of neoliberalism, and the push for people to take control of their own health, focuses on what knowledge is being produced, circulated and received by the public and the implications of this cycle. “The corporatization, commodification, and privatization of hitherto public assets have been signal features of the neoliberal project. Its primary aim has been to open up new fields for capital accumulation in domains formerly regarded off-limits to the calculus of profitability” (Harvey 2007:35). Often this knowledge is a call to action but much of it is
simply circulating for the taking by a now receptive public. The multitude of knowledges become an assemblage that “define new material, collective, and discursive relationships” (Collier and Ong 2005:4). The health assemblage, with its “things medical” is broadening and creating a collective of increasingly larger medical information that are the consumer’s responsibility.

**Healthscapes**

These medical public discourses shape information flows or -scapes, using Appadurai’s frame of analysis, which incorporates mediascapes as a primary landscape of information movement (1996:35). “Audiences for public discourse are produced by the circulation and reception of the discourse and the material underpinnings that shape these practices” (Briggs 2003:289). It is the circulation and reception of information and knowledge that is of particular interest, whereby media “tend to be image-centered, narrative based accounts of strips of reality… and can [form] imagined lives” (Appadurai 1996:35). It is these imagined lives that allow for people to relate to media outlets like television programming, advertising, and the Internet. Because these forms of knowledge have been created to interest an audience, generally the wider the better, people can often see themselves in the place of the characters or images or forum posts. It is this relatable quality that draws people towards media, bringing viewership that excites advertisers (online, on television, and in print), and also drives everyone from studio executives to advertising agencies to strive for more of the viewing market. The information contained within programming or content needs to be enticing to draw viewers to their information and away from the now abundance of images, programming, and websites available to
consumers. “Mass media clearly plays a role in how information is shaped by what gets covered in the first place” and what kind of exposure or viewership becomes cultivated (Hartley and Coleman 2008:111). It is a question of what is compelling for the audience and how to get your information or message across to those viewers. “The impact of television in our society cannot be overstated” (Vandekieft 2004:215). When speaking about health information specifically, the audience is sought because of their interest in the topic, but often we do not know how people will interpret, understand, or reproduce this information. “Knowledge about health…is constantly on the move, being created, transformed into information, circulated, received, put into action…and this movement is goal-driven, meaning it should be constantly circulating among individuals, populations, and society” (Briggs and Hallin 2007:58). This is exactly why public health departments study their messages and how they move in a community.

An important concept derived from Appadurai’s scapes for more specific medical analyses is that of Clarke’s healthscapes.

“Healthscapes are ways of grasping through words, images, and material cultural objects, patterned changes that have occurred in the many and varied sites where health and medicine are performed, who is involved, sciences and technologies in use, media coverage, political and economic elements, and changing ideological and cultural framings of health, illness, healthcare and medicine” (Clarke 2010:105).

Healthscapes include the four areas under analysis in this research and Clarke specifically discusses fictional medical television, the Internet for medical searches, and pharmaceutical advertising. Celebrity physicians and their influence are not covered under Clarke’s healthscapes, but I argue that when thinking about the many situations that create exposure to medical media, people who are public voices become influential
figures in distributing this knowledge. “Healthscapes include whatever is imaged and imagined as things medical” (Clarke 2010:108). Throughout the movement of knowledge about health and “things medical” the world is changing for audiences who receive such knowledge in multifaceted manners. “Healthscapes in this sense approximate Foucauldian discursive regimes, appropriating and integrating all kinds of imagery and media into legitimate work—from globe hopping TV doctor shows to pharmaceutical packaging materials” (Clarke 2010:106). Images become important tools for communicating to audiences about appropriate behavior and actions. Healthscapes “focus on all kinds of things medical as forming assemblages, infrastructures of assumptions as well as people, things, places, and images” (Clarke 2010:141). These assemblages occur in patterned ways throughout our world, and especially our media. The repetition of encounters in my research of the same people working across multiple platforms to interact with audiences was astounding. The same physicians who work on television shows also write newspaper columns or do radio shows and the celebrity doctors who diagnose us do so on television, the radio, the Internet, and all kinds of expected and unexpected platforms.

The frequency with which Americans come into contact with health information or health based media is only growing. “Healthscapes vividly demonstrate how in the U.S. biomedicine has become a public ‘cultural good’ like public education [and]… how healthcare and things medical more broadly are increasingly in our neoliberal times consumer goods” (Clarke 2010: 142-3). There was a public health campaign in 2012 in the greater Los Angeles area aimed to reduce soft drink consumption. One of their
billboards was right by the university campus where I was teaching courses and I asked one of my classes of about 150 students one day if they had seen it. The billboard was part of the larger campaign and could be seen on buses and billboards across town with a visual of packets of sugar and the words, “You wouldn’t eat 26 packets of sugar. Why would you drink them?” My class had overwhelmingly seen the billboard and their responses to it varied from shoulder shrugs of ambivalence to comments of disregard. They were not really enthused about the campaign and while they noticed the billboard, it did not make an impact with them. The campaign was not very graphic or threatening or exciting or informational. They knew that soft drinks were bad for you and this information was not anything new or interesting for them. Most often public health campaigns that hit home are scary like the new anti-smoking television advertisements that show former smokers with tracheotomy holes or scars down their chests. When fear is created in the public, you have a chance of scaring someone into changing their behavior. Americans fear being sick, but we are also often cavalier with our behaviors with rising levels of childhood and adult obesity. “Health in America is defined by this double insecurity: never being sure enough about the future—always being at risk—and never knowing enough about what you could and should be doing” (Dumit 2012:1). The basis of neoliberalism is to push people towards the behaviors that will help them strive for healthy or good ones over others. People may know what they can do, but it seems out of reach because a lot of the time it is expensive, making this often a class issue.

In this neoliberal world where you can purchase health, the consumer becomes able to legitimize themselves through these purchases. Things like gym memberships,
pharmaceutical prescriptions, a multitude of medical tests, and supplements or vitamins, can all be signs of a knowledgeable and medically informed consumer. “In commodity cultures, health becomes another commodity, and the biomedically (re)engineered body becomes a prized possession” (Clarke et al. 2003:171). You can make purchases towards the prize of health and put on display for others your ‘expert patient’ status. “Health is an important symbolic domain for creating and recreating the self” (Crawford 1994:1347). To create the self, one must be both active and conscious of the goal and the expected outcome for oneself. “Health becomes an individual goal, a social and moral responsibility, and a site for routine biomedical intervention” (Clarke et al. 2003:171). This responsibility drives others to become participatory in your health, with physicians discussing your conditions with family members, and with people discussing the weight or potential health of others often publicly; much like the case of New Jersey Governor Chris Christie, whose significant and much debated weight issues led to him not only proudly eating a donut on a late night talk show but then less than a month later getting the lap-band procedure for weight loss in February of 2013 (Park 2013). We become invested in others’ health and the common good, sometimes with charitable intentions, sometimes to judge others for their private health failings. Further, the goal of health becomes a collective consciousness. “The biomedical governmentality to ‘know thyself’ that is associated with such bodily techniques often relies on a neo-liberal consumer discourse that promotes being ‘proactive’ and ‘taking charge’ of one’s health” (Clarke et al. 2003:181). We become a group gathered to do good for ourselves and others around us towards the common goal of health.
In 1999 Alan Holmer, the then head of PhRMA, which is the lobbying arm for pharmaceutical companies, wrote an opinion piece on Direct-to-Consumer Advertisements in the Journal of the American Medical Association where he discussed “participatory health care—consumers assuming more responsibility for their own health—[that he believes] is changing the nature of the patient-physician relationship” for the better (381). He describes this as a “mutual partnership” than “can lead to better health outcomes through appropriate use of safe and effective prescription medicines that save lives, cure disease, and alleviate pain and suffering” (Holmer 1999:381). This participatory health care is nothing new, as it is part and parcel of neoliberal economic policies but it brought to the medical establishment a way to view this engagement with their patients and consumers. We are supposed to take this newly found commonality and create new ways of being by striving for this almost unreachable goal of perfect health. “After discussing your medical history, diet, what medications and supplements you’re taking [with your physician]” then the patient has the ultimate responsibility of taking control, taking your medications, and taking action (Wadyka 2010:225). “Terms such as ‘health maintenance,’ ‘health promotion,’ and ‘healthy living’ highlight the mandate for work and attention toward attaining and maintaining health” (Clarke et al. 2003:172). These words have become a framework for the pushing of health back onto the patient. Physicians become merely clearinghouses for prescriptions and the focus goes back onto the rightful place, within the patient them self.

By connecting to others, online or with those around us, either friend or family, we create and support feelings of community. The concept of biosociality encompasses
this feeling of community, whereby people will group themselves based upon biological commonalities they share (Rabinow 1992). These new found biosocial groupings can be sourced by proximity, by disease, or by emotions and feelings either of isolation or an amalgamation of these things. “Enhancing community participation in public health has become an increasingly important focus…” in modernity (Briggs 2003:288). By being in these groupings or communities, we have become easy targets for those who want to direct specific messages. “Personal empowerment, broadly understood as the development of personal involvement and responsibility has become a strategic issue in health policy” (Lemire, Sicotte, and Paré 2008:130). Policies and potential outreach are easier for companies or government entities when consumers exist together under a commonality like in biosocial groupings. Our lives are infiltrated by a “largely an insidious and often undramatic phenomenon accomplished by 'medicalizing' much of daily living, by making medicine and the labels 'healthy' and 'ill' relevant to an ever increasing part of human existence” (Zola 1972:487 italics added). We seek out support from each other in this daily struggle in the creation and recreation of biosocial grouping in person and online.

So much of our lives have become a concern for medical authority. “Professional dominance and medical monopolization gave medicine jurisdiction over virtually anything to which the label ‘health’ or ‘illness’ could be attached” (Conrad and Leiter 2004:159). So now everything from stress or risk factors to actual diseases and conditions can be medicalized and coordinated for a targeted public health strategy or company marketing. “The whole body has become medicalized, piece by piece” (Conrad 2005:8).
With that notion of parts and not a whole, each distinct thing individually can be a separated and biomedicalized. Stress can be seen in digestion and both can now be treated individually, with gastroenteritis drugs and mechanisms for controlling stress. Just look to health applications like WebMD telling consumers that “gastritis is an inflammation of the stomach lining caused by alcohol, aspirin, spicy foods, stress, excess acid, or a virus” (WebMD 2013, italics added). The multitude of causes leads to many treatment options that are possible and often pharmaceutical in nature.

The circulation of pharmaceuticals “reconfigures knowledge both about illness and about the effects of medication” (Lakoff 2008:743). We are now being informed about all of our parts and all of the available treatments for each distinct, individual outcome and while we have access to information, where this information comes from and who produces it becomes an ever-greater question. “Patients have become more knowledgeable, demanding, and critical of medical care” but in this quick education, patients do not always know or understand the consequences of their actions or medications (Conrad and Leiter 2004:159). “Pharmaceutical manufacturers are circumventing physicians’ control over knowledge regarding available drugs” (Conrad and Leiter 2004:170). Physicians still remain as the gatekeeper for prescription medication. They are the ones whose medical knowledge is still privileged and respected. The patient often knows enough to make decisions, but not enough to make completely informed ones. It is this risk to the patient that requires a physician to be the intermediary, even now with Patient 2.0 sitting in the waiting room with information at hand. With the role of the physician secure, we must recognize that there are “consequences of viewing
the targets of health promotion campaigns as ‘consumers’” (Epstein 2008:506). The consumers are becoming successful biological citizens with medical knowledge at their finger tips.

**(Bio)Medicalization and Knowledge**

The Neoliberal philosophy of personal responsibility has contributed to what is often given as the basic definition of biomedicine.

“Biomedicine incorporates certain core values, metaphors, beliefs, and attitudes that it communicates to patients, such as self-reliance, rugged individualism, independence, pragmatism, empiricism, atomism, militarism, profit-making, emotional minimalism, and a mechanistic concept of the body and its repair” (Baer, et al. 2003:12). These characteristics stem from a neoliberal framework that connects the individual to choices, decisions, and then repercussions for which he or she is responsible.

Biomedicine is a deeply connected part of American culture and is creating ways for people to understand their own bodies and the world around them on a biological basis from germs to viruses to organs and systems. “*Biology is not external to but very much within culture*, and to discuss how clinical medicine constructs persons, patients, bodies, diseases, and human physiology” is centering the information and knowledge that people carry with them in culture (Good 1994:66 italics in original). For medical anthropology then “the task at hand is not simply to demystify knowledge, but to critically examine the *social conditions of knowledge production*” as this project seeks to undertake (Young 1982:277 italics in original).

(Bio)medicalization has been an important concept in recent years among anthropologists, sociologists, and public health scholars as the medical industry has
begun to creep into areas of public life previously untouched. Neoliberalism has allowed companies the ability to open markets for consumers to make more informed decisions than ever before in all areas of life, and this has been especially true in medicine. “One factor driving medicalization is the profit to be made from discovering new diseases in need of treatment” (Baer, et al. 2003:14). This economic profit motive has become ever available to companies through processes of neoliberalism as the lack of regulation and the creative ability to market products directly to consumers begins to play a large part in how the medical system in the United States functions. Processes of medicalization have two central factors for this analysis: “first, …the power and authority of the medical profession” and “second, medicalization sometimes occurred through the activities of social movements and interest groups,” (Conrad 2005:4). We should always be mindful of who is directing information towards us and think about the goal of that group; is it marketing information to sell me something, is it information that I might find useful to keep in mind, is it pushing me towards action? “Other contributing factors… pharmaceutical innovations and marketing” should also be considered because of their influence over the larger population (Conrad 2005:4). While it is good for people to know more about their own bodies and be able to be patient advocates for themselves and others, the relentless quest for health is not inborn, it is coming from outside of our bodies.

Processes of (bio)medicalization allow for companies to educate consumers about conditions and diseases, along with possible treatments available to them. More than ever, physicians are faced with patients who believe they are medically well-informed.
“Medicalization also contributes to increasing social control on the part of physicians and health institutions over behavior” (Baer, et al. 2003:14). Public health rhetorics have begun campaigns of health information to targeted risk groups to change and alter their behaviors. Scholars in this area are seeing that the production of knowledge on the part of governments, corporations, and institutions are creating awareness to biological processes that medicine has deemed appropriate for consumption that has naturalized these processes. Medical anthropology has realized “that biomedical categories unconsciously color our thinking to an extent to which we may be unaware” (Browner 1999:136). Further, Browner discusses the “trend among [medical anthropologists] to study entities as they are conceptualized by biomedicine” (1999:135). Our world is processed through medicalization language and processes as they become integrated into the public rhetoric.

“The past few decades have seen many in public health talk about ‘health promotion,’ most researchers and practitioners still tend to conceptualize ‘health promotion’ most often as ‘disease prevention’ and focus primarily on changing individual behavior to reduce the risk of disease” (Levin and Browner 2005:746). Prevention masks itself as informatics when it is used primarily to target people in groups for altering behavior and promoting knowledge that brings biology to the forefront of consumer health concerns. Further “Western biomedicine has become a distinctive sociocultural world, ubiquitously webbed throughout mass culture” (Clarke et al. 2003:163). Mass information becomes mass culture as it is integrated into our lives.

Foucault argues that basic areas of life, especially things like sexuality were first targeted historically for the medicalization of human actions. “Medicalization—that is,
the fact that starting in the eighteenth century human existence, human behavior, and the human body were brought into an increasingly dense and important network of medicalization that allowed fewer and fewer things to escape” (Foucault 1994:320).

Medicalization is an important part of the production of knowledge about health information for consumers and one that anthropology should continue to focus on. Rhodes argues that the naturalization of biological processes into mechanisms that are understood in medicine as diseases may open a space for “anthropological analysis” that can be productive (1996:172). As anthropologists tread within the area of medicalization, the biological knowledge that medicine has produced is understood in varying ways. These “spheres of communicability… are multiple, competing, overlapping, and shifting” defined by the audiences or communities being directly sought out and just as Clarke sees as part of the whole process of healthscapes (Briggs 2005:274).

“First, the concept of health is absolutely central to modern identity… second, since the mid-1970s health and its pursuit have become increasingly valued and thus have become a crucial terrain upon which contemporary, personal identity is fashioned. Third, the ‘healthy’ self is sustained in part through the creation of ‘unhealthy’ others, …[and] finally, …that an adequate engagement with the stigmatizing practices and the perceptions on which they are founded will be aided by rethinking health itself” (Crawford 1994:1348).

We are taught to rethink our selves, our health status, and our possibilities toward action. Americans’ healthy selves are defined by biomedical options and procedures available and used by consumers. Biomedicine, as created through medicalization and neoliberal philosophical developments, gives consumers a way to communicate and interact with the medical world around them. “Communicability is a central dimension of self-regulation in that individuals structure their schemes of self-surveillance and self-control
by interpellating themselves as producers, disseminators, or receivers of particular types of discourse” (Briggs 2005:274). We should be concerned with “contemporary subjectivity, rationalities, technologies, forms of embodiment, forms of care for the ‘self,’ and schemes of self-surveillance and self-regulation” (Briggs and Hallin 2007:43). We are being brought into very particular conversations of health through targeted promotion, whereby communities are directed to do certain things or buy specific products. “Public health institutions attempted to extend their biocommunicable control over public discourse about social issues medicalized as health concerns by drawing on the increasing influence of capital over public culture—as exercised through advertising agencies and the commercial media” (Briggs 2005:275).

Biomedicine helps consumers to see themselves and their own experiences within the stories, discourse, and media portrayals that show patients interacting in appropriate ways with medicine. Clarke argues that “in deeply significant but largely ignored ways, contemporary American biomedicalization itself is imbricated with popular and visual cultural materials, representations, and media coverage of things medical” (2010:105). These images and imagery of “things medical” give perspective and grounding for patients or soon-to-be patients to better understand the biomedical world. The pattern of behavior values the telling of and expression of medical stories, the basis for a lot of Dr. Oz’s shows where people ask their own embarrassing health questions. This is also the process seen in medical fictional television where physician writers share their own stories from their medical practice that are then performed by actors. “Both television and medicine… became part and parcel of everyday living—integrated, naturalized,
coconstitutive—during the deeply transformative medicalization healthscape” (Clarke 2010:122). The narrative of biomedicine invites the value of seeing and telling health related stories and information to each other and an audience. “Patients’ knowledge is influenced by the popular presentation of biomedical facts and the information (‘health education’) received in clinical practice” (Maretzki 1985:28). This clinical practice has become public with the rise of television, celebrity physicians like Dr. Mehmet Oz, Dr. Sanjay Gupta, and Dr. Drew Pinsky who dispense medical advice on television, the radio, on Twitter, and over the Internet. In noting their influence, Drs. Oz and Gupta both have over 3 million Twitter followers and Dr. Drew has over 1.7 million followers. Dr. Oz repeatedly asks viewers to submit health questions publicly over Twitter and uses them on *The Dr. Oz Show*. “While there is always an overarching pattern of (bio)medicalization, always there are many other things going on” (Clarke 2010:110 italics in original). The combination of media’s growing influence and the tangle of control over knowledge production, audiences are interacting with health information in these new ways without always considering that these public health rhetorics go hand in hand with direct marketing. Americans are encouraged towards health promotion either with behavioral changes or products in these exchanges, usually in combination with support from pharmaceutical companies or amalgamated with viewing of pharmaceutical ads online, in print, or on television.

Peter Conrad, a sociologist, has written extensively on the subject of medicalization, focusing on how the recent changes in conceptions of what are now medically treated diseases were once previously conditions for which people would never
seek help from a doctor. He writes that “medicalization studies…focus especially on the creation, promotion, and application of medical categories (and treatments or solutions) to human problems and events” and he uses human growth hormones, male pattern baldness and attention-deficit/hyperactivity disorder as case examples (Conrad 2007:13). Within Conrad’s analysis, medicalization consists solely of biomedicine practices and he points out that recently this trend has turned patients into consumers for the benefit of a commodification of health (2007:14-5). “Individuals as consumers rather than patients help shape the scope of, and sometimes the demand for, medical treatment for human problems” (Conrad 2007:140). As the personal responsibility for individuals in neoliberalism grows, the processes of medicalization drives people to accept more easily the idea that their problems can and should be treated by biomedicine.

The presence of companies, specifically pharmaceutical companies and health care institutions, working with the FDA and lobbying legislative bodies shows their ability to control the system and make spaces within the governmental discourses on disease and treatments as signs of an increasing medicalization of knowledge (Conrad 2007). Echoing the views of Lupton and Foucault, Conrad writes that “medical surveillance, another expanded form of medical social control, has led to an increasing number of individuals to become objects of medical interest, even though they may not be ill” (2007:151). Through neoliberalism all of the audience where knowledge is disseminated becomes fair game as possible consumers are persuaded to purchase these kinds of health products or change behaviors by altering their current ways of life. This starts focused at the individual, but the companies must continually attract new and more
consumers to keep making a profit. “The individual for the most part is the target of medical…interventions [and]…remains a consequence of medicalization” (Conrad 2007:152). It is the individual that is primary within the arena of biomedicalization that developed out of neoliberal promises of personal responsibility and economic freedom.

Conrad quantifies medicalization by showing the dramatic increase in “diagnoses in the Diagnostic and Statistical Manual from 106 in the original 1952 edition to nearly 300 disorders in the DSM-IV, which was published in 1994” (2007:118). For example, the importance of some of these new categories is centered in his point about obesity, and Conrad argues that now “obesity is viewed not just as a risk factor for medical problems like hypertension, heart disease, or diabetes, but as a disease in itself” (2007:119). In fact in 2013, the American Medical Association members voted to have obesity named as a disease, “a move that effectively defines 78 million American adults and 12 million children as having a medical condition requiring treatment” (Healy and Gorman 2013). The speculation over this decision, which does not change the DSM, is that it would provide a physician obligation to address obesity with patients and push insurance companies to reimburse physicians for these discussions and time spent treating obesity. “Past AMA documents have referred to obesity as an ‘urgent chronic condition,’ a ‘major health concern’ and a ‘complex disorder.’ The vote now lifts obesity above the status of a health condition, disorder or marker for heightened risk of disease — as high cholesterol is for heart disease, for instance” (Healy and Gorman 2013). Changes like this show an increasing agreement from the medical community with the processes of medicalization, whereby conditions become diseases of their own. Guidelines for manuals like the DSM
are created by panels of physicians and “physicians remain the experts about medical knowledge and are necessary elements to medicalization” (Conrad 2007:156). The conflict in the system is that panels are often comprised of physicians that are paid sponsors, researchers, or experts for pharmaceutical companies who hold a large amount of influence not only in the marketplace but also in areas of policy and research. “The pharmaceutical companies have become a major player in medicalization” (Conrad 2007:134). The pharmaceutical companies produce information and knowledge that is passed directly to physicians and now with the advent of direct-to-consumer advertising (DTCA) on to consumers.

**Living The Bio Life**

Public health scholars have long discussed the health awareness campaigns that allow targeting of high-risk communities with information about diseases and conditions to be made public knowledge to communities. Deborah Lupton and Alan Petersen show how the idea of a ‘healthy citizen’ drives successful health programs because these citizens take up the cause, inform themselves about their risks, and then take precautions and preventative measures, all goals of public health (2000). It is this notion of personal responsibility and individuation that reify the neoliberal framework and utilize the language of prevention for behavioral modification. “Under the neoliberal approach to government it is expected that the subject qua citizen will conform to the goals of the state voluntarily…both as an obligation and a right of citizens” (Petersen and Lupton 2000:64). The ‘new public health’ that Petersen and Lupton speak of never crosses into biomedicalization specifically or the consumption of pharmaceutical goods, but instead it
pushes for surveillance and intervention for under or overexposed groups of people. To this end though, they recognize that there has been a movement of “‘health literacy’ and ‘health skills’, which are seen to comprise ‘personal health knowledge’” (Petersen and Lupton 2000:69). The creation of knowledge about bodies, bodily practices, and biological processes becomes a center of knowledge production that changes behavior of the public that fall into these identified risk categories. As these categories expand perceived biological and medical problems, “medicine, as it is practiced in Western societies, despite its alleged lack effectiveness in treating a wide range of conditions and its iatrogenic side-effects, has increasingly amassed power and influence” over people’s opinions and beliefs (Lupton 1997:95). With this power of the medical community and rhetoric, comes the subjectification of the patient. “Patients in general, because of their lack of medical knowledge, are placed in the position of vulnerable supplicants when they seek the attention of doctors” (Lupton 1997:96). This can be seen as a form of disempowerment of the patient who is asked to act in their own interest and to educate themselves on a medical level to engage with their physicians in a positive way.

“Most critics [of medicalization] also advocate the ‘empowerment’ of patients (often renamed consumers), encouraging people to ‘take back control’ over their own health by engaging in preventative health activities, assuming the role of ‘consumer’ by challenging the decisions and knowledge of doctors in the medical encounter, joining patient advocacy groups” (Lupton 1997:97).

This empowerment of the patient provides an opportunity for the patient to interact in a medical setting in such a way as to provide their physician with more than just a set of symptoms, but also a wide range of information now collected and seen to be pertinent in their medical history, lifestyle, and possibly their health outcome.
With this engaged consumer, the state and medical system become able to track at-risk groups. Lupton argues that “society is medicalized in a profound way, serving to monitor and administer the bodies of citizens in an effort to regulate and maintain social order as well as promoting good health and productivity” (Lupton 1997:100). Neoliberalism asks people to take personal responsibility but it also depends on the notion that people can be successful and profitable if they take control of their own bodies and futures. “Medicalization is evident in the ways in which warnings about health risks have become common events. People are constantly urged to conduct their everyday lives in order to avoid potential disease or early death” (Lupton 1997:101). Public health relies on people to monitor themselves and their behaviors to ensure the productivity of the workforce and with this comes the promise of health and success that the state needs from the people it governs for neoliberalism to fulfill its promises. Often it is spoken of in medical literature as personal empowerment and there are three ways of thinking about this: “an aptitude to comply with expert advice (the professional perspective), self reliance through individual choice (the consumer perspective), and social inclusion through the development of collective support (the community perspective)” (Lemire, Sicotte, and Paré 2008:130-1). With a multitude of ways to be productive, what health-driven citizen cannot or will not act in their own best interest? As consumers of medical knowledge, our job is to be compliant to the information and the prescribed action, either of future healthy behaviors or towards a health purchase. From other fields like public health and sociology there is an understanding of knowledge production in promotional activities that support healthy behaviors and an informed
public that has become increasingly sophisticated about biological information, terminology, and processes but the greater issues of purchasing powers and behaviors have been missing from these discussions.

With an increasing medicalization and medical knowledge present in the marketplace and among consumers, the public health rhetoric creates artificial groupings of at-risk people. Rabinow basing his ideas on Foucault’s biopower, creates the idea of biosociality (1992:234). Rabinow’s research “focuses on the practices of life as the most potent present site of new knowledges and powers” (1992:236). It is this knowledge and power that are created in people who come together to increase their shared power and knowledge about diseases and health outcomes. These are based in the neoliberal philosophy that when health becomes one’s personal responsibility, some people will take up this as a cause, becoming active citizens in biological knowledge. “Our somatic, corporeal, neurochemical individuality now becomes a field of choice, prudence and responsibility” (Rose 2007:40). While Rabinow bases his concept of biosociality in genetic research and structuration, it has been taken up by others in a more general discussion of medicalization and biological knowledge, as in much of Rose’s work. “The forms of biosociality identified by Rabinow are shaped by more general practices of citizenship and subjectivity in the government regimes that [are] advanced liberal” (Rose 2007:25). These groups are effective in communicating their ideals and collective knowledge to others who might be helped by their work and community. “Biosocial groupings—collectivities formed around a biological conception of a shared identity—have a long history, and medical activism…long predates recent developments in
biomedicine and genomics” (Rose 2007:134). While this may have begun long before the active processes of neoliberalism, as Foucault suggests with the care of the self, it becomes more present and apparent with the modern ability to connect with people through technological means to available sites of knowledge. “Biological citizenship is both individualizing and collectivizing [in that] biological images, explanations, values and judgments thus get entangled with other languages of self-description and other criteria of self-judgment” (Rose 2007:134). This self-judgment is a primary result of the public health framework that wants to encourage a sense of responsibility within individuals who care of about their health and work to gain the knowledge they need to better themselves. Biological citizenship “often involve[s] quite specialized scientific and medical knowledge of one’s condition” that of the healthy citizen (Rose 2007:135).

Rose and Novas connect the idea of biological citizenship to the public health rhetoric of Petersen and Lupton, and Donohue with the notion that “high-risk groups were recruited to their responsibilities as biological citizens” (2005:449). Also, the public health idea of a compliant population that receives the messages of active participation follows this citizenship when “once so informed, [they] are obligated to take appropriate steps, such as adjusting diet, lifestyle, and habits in the name of minimization of illness and maximization of health” (Rose and Novas 2005:451). Rose and Novas do not specifically address consumership in this portion of their analysis, but they speak to the behavioral modifications that will lead to a better and healthier community.

Biopolitics is “not just a question of discourses and technologies, of strategies and tactics” but a discussion without this will fail to understand the discourses that drive and
create mobilization of people (Fassin 2009: 57). In this neoliberal framework, “the state plays an active role in transforming their citizens into a potential resource for the generation of wealth and health” echoing Singer and Rabinow in seeing a governmental role in the behavior modification of the population (Rose and Novas 2005: 451). Throughout this conversation, it does need to be addressed that “not all [people] have equal citizenship in this new biological age” but that will not be the focus of analysis in this research (Rose and Novas 2005:440). While Rose and Novas are using this to point to address the international imbalance of access to information and technology, there is also a case to be made that some U.S. citizens struggle to gain access to this type of citizenship. In writing about the medicalization that has accompanied biological citizens, Rose establishes that “such citizens use biologically colored languages to describe aspects of themselves or their identities, and to articulate their feelings of unhappiness, ailments, or predicaments” (2007:140). Using the idea of citizenship explicitly denotes an active participation component, and Rose asserts that it is not only in the immersion of “oneself in the scientific literature,” giving them the chance to “actively [engage] with biological explanation” but also that the knowledge that can come from places like the Internet that link people to one another who have common problems forming communities (2007:141). Biolegitimacy also gives the biological citizen the tools to be productive in this ‘bio’ life. Biolegitimacy will “emphasize the construction of the meaning and values of life instead of the exercise of forces and strategies to control it” (Fassin 2009:52). Biological citizens are always aiming to make meaning, find a place, find their biosocial grouping, and become a part of biomedicine through community and
biolegitimacy. When community is a primary focus of activities within health practices and knowledge in places like the Internet, there is also the ability for people to find themselves engaged in research and knowledge development in resources online with the help of others. Biological citizenship is the “citizenship of brand culture, where trust in brands appears capable of supplanting trust in neutral scientific expertise” (Rose 2007:143). Brand and product loyalty is created through exposure to marketing information and the large amount of branded information that exists within media and on the Internet. Often this consumership can be more enticing if there are recognizable and trusted faces advising about everything from cancer screening to pharmaceutical products. Raymond Williams, in his history of advertising, describes the early role of public relations and celebrity, “it began in entertainment, particularly with film actors, and it is still in this field that it does most of its work” (1980:183-184). This trend has only grown with the role of celebrity in pharmaceutical advertising where the actor or sports hero become the sales agent to the public. Much of the pharmaceutical advertising I collected contained familiar faces or voices, with everyone from Antonio Banderas, an actor to Phil Mickelson, a professional golfer. Williams likens advertising to magic in the way that it constructs a new reality. “Magic is always an unsuccessful attempt to provide meanings and values, but it is often very difficult to distinguish magic from genuine knowledge” (Williams 1980:189). The physician is supposed to be able to tell the difference between the magic and the knowledge, able to pull away the shiny promises and to explain to the patient why Viagra will give you a heart attack or why your child should still ask if there are peanuts in food from someone else’s house when risking a
life-threatening allergic reaction. Besser, believes that “one of the best things about the Internet is the proliferation of online communities for people with various conditions” (Besser 2013:223). It is within these usually online communities that biosocial groupings and biological citizenship become information distribution centers to others online who may be searching for that sense of community.

**Health Movements and Lay Knowledge**

Medicalization and the processes behind the development of increasing medicalization have driven health movements by lay people to push bureaucracy in a specific direction. The disempowerment of lay people from scientific information in the mid-twentieth century propelled people with a vested interest in the medicine to become active participants to the degree that they were able to participate. “Embodied health movements (EHMs) challenge both medical and scientific authority” because the information and knowledge of the movement may be outside of the norms of scientific study or standards of the time (Zavestoski et al. 2004:254). “The remarkable fact is that once [lay people] acquired a certain basic familiarity with the language of biomedicine, activists found they could also get in the doors of the institutions of biomedicine” (Epstein 1996:231, italics in original). Lay knowledge gained some legitimacy after the biological citizens made their information legitimate for biomedicine.

Historically, the movement to gain information from the patient occurred very recently in modern healthcare. “Since the mid-1960s, patients have been encouraged to take a more active role in their own health care, and healthcare providers have recognized the value of engaging patients to participate more meaningfully in their own care” (National Research
Council 2000:59). Donohue, a public health scholar, writes that “the pharmaceutical promotion of prescription drugs to consumers was made possible by the rise of consumer-oriented medicine following the social movements for patients’ and consumers’ rights” (2006:66). In this framework, she demonstrates the historical government regulations and corporate philosophies that contributed to the advent of public health messages and media outlets. Donohue shows that as patient advocacy movements grew in the 1970s and the Reagan administration supported neoliberal activities throughout the 1980s, not only was regulation loosened for the pharmaceutical industry but the information was increasingly welcomed by the public and discouraged by doctors (2006). Both Conrad and Lupton support Donohue’s claims that the regulatory changes going on in the 1970s and 1980s began with campaigns for openness that neoliberalism made available. “Undoubtedly, the neoliberal insistence upon the individual as the foundational element in political-economic life opens the door to individual rights activism” (Harvey 2005:176). This does not suggest that patients and people with lay knowledge are now or were ever encouraged to be partners with biomedicine. The extent of the relationship between expert and lay knowledge being accepted on either side is contingent on different diseases, conditions, and patient movements. Bunton, drawing on Rose, writes that “[neo]liberalism depended upon subjects being active” (1997:225). Both sides usually recognize that “genuine experts on a topic have knowledge that non-experts lack” so it is often the fight of the health movement to convince biomedicine that the lay experts offer something equally valid to bring to the table (Sismondo 2010:180). It is this difference in “styles of knowledge
making” that often concerns biomedicine because there are standards and reliable testing models that anecdotal or crowd-sourced information cannot meet (Sismondo 2010:181).

During the AIDS epidemic and following patient movement, “by becoming lay experts” people with the disease and their loved ones were able to make progress in science and medicine (Epstein 1996:332). The patients themselves became credible because “the markers of credibility were inscribed on [their] own body” (Epstein 1996:333). They became participants in clinical trials and spurred information circulation within and among realms that are often not included from medicine, that of the general population that was infected. For large patient movements like the breast cancer and AIDS movements, “activists challenged the professional monopoly over the production of medical knowledges by insisting on their own participation as they acquired and disseminated scientific information” (Clarke et al. 2003:178). These movements forced biomedicine to accept the intrusion of lay knowledge as a necessary part of the process. “Scientific knowledge allows us to locate real points of application for responsible action” (Bourdieu and Waquant 1992:196). Responsible actions should be applied within the healthscape as it becomes more acknowledged that audiences are greatly influenced by these medical authorities like public physicians or pharmaceutical advertisements.

Medicalization is often strictly a biomedical tool, directing people away from alternative medicine and towards Western traditional medical intervention. “The institutions of medicine and science have been cast as sources of positive authority, agents of progress and benefit” (Zavestoski et al. 2004:263). In a medical crisis, people with a direct link to the disease are key players because of their own intimate knowledge.
of the suffering but are often not considered by biomedicine as bringing much of anything to the table. This changed during the AIDS crisis as clinicians realized that “often, a layperson’s independent research can give her information about a particular topic that is more comprehensive and up to date than that possessed by her doctor” (Kukla 2007:29). Those intimately familiar with the disease have an expertise, either with the illness or with the population of the sick that is now recognized as being both valid and often helpful. “Members of the lay public, in addition to those with relevant credentials, often have expertise that bears on technical decisions” (Sismondo 2010:180). By having some mixture of lay and traditional knowledge, these movements have become models for how to make the combining of knowledge effective and useful for biomedicine.

Following the work of Donna Haraway, Epstein notes that “situated knowledges: partial, locatable, critical knowledges, [are] produced by social actors on the basis of their position or location in society” (1996:337). It is this push and pull over control to knowledge where the neoliberal subject has a crisis. If we are supposed to seek information and information circulates in attempt to reach us, why does biomedicine fight the layperson with an increasing bid for some kind of authority? Even now, “laypeople are sometimes interpellated as eavesdroppers, listening in on a conversation that does not yet include [them]” (Briggs and Hallin: 2007:50). In the beginning, lay knowledge was privileged only because the sick people had a single leg up on medicine, they had the disease and could describe it and detail it for biomedicine. Now, lay knowledge has moved into the ‘expert patient’ whereby the accessible technical, medical information is
mixed with this bodily experience and community knowledge to create the formal Patient 2.0 or ‘expert patient.’ “Patients as consumers face multiple networks of dispersed knowledges and new decision making responsibilities. The cultural pervasiveness of things medical and the normalization of medicalization of both health and illness are palpable in new ways” (Clarke 2010:142). Patient 2.0 is expected to be able to sort this information out into correct/incorrect or true/false or some other guidelines that are generally beyond the bounds of their interest or capability.

The Smart Patient

With the invention of Patient 2.0, health is an action. It is a quest. “Health as a fact-finding mission is too crucial to leave to the experts” (Dumit 2012:186). People need to do something about ‘health’ and this neoliberal call to action has become such an imperative that sometimes consumers become involved in something that may work against their own best interest. “Health professionals ostensibly serving their patients’ interests are in actuality servicing their own institutions’ needs, frequently going against the patients’ interests” (Zavestoski et al. 2004:263). The information that is unearthed by the ‘smart patient’ is not always tracked to the source. For instance we know that adverse reaction information for prescription pharmaceuticals comes from information from clinical trials “based almost entirely on clinicians’ impression of patients’ symptoms—not on patients’ own firsthand reports of their experiences with the drug” even though systems of patient self-reporting like the FDA’s Medwatch program exist (Basch 2010:865). But there are “efforts to improve the responsiveness of science and technology to public concerns need to recognize the ways in which local values interact
with many different stages in the production and application of knowledge” (Sismondo 2010:181). It is this acceptance of a necessity to share knowledge and combine both lay and traditional knowledge that will make Patient 2.0 work conceptually. Furthermore if the patient became empowered “they would be expected to handle most health maintenance questions and health care practices and would be provided with the knowledge and materials to do so” (Kleinman 1980:385). The ‘expert patient’ is encouraged in pharmaceutical advertising in every single ad since mid-2008 to report their side effects on their own to Medwatch, not necessarily to their doctor. In this way, Patient 2.0 can create useful lay knowledge for biomedicine, but on the other side, the ‘smart patient’ may not know how to be useful or actually be provided with the necessary materials to be productive biological citizens.

Patient 2.0 or the ‘empowered patient’ can be and generally are thought of as the new form of health movement in this country because of its noticeably recent naming, but not arrival on the scene. Americans have long been asked to take part in their own health since the 1980s and through pointed actions they are asked to do specific things for themselves or others. One of those are tracking “modifiable risk factors, [are] those things that you can do something about” and medicine focuses heavily on those parts of health, those where patient action has the most benefit (Besser 2013:6). Much of that means healthy eating, exercise, getting enough sleep, getting rid of stress, cutting back or quitting smoking, drugs or alcohol use. “We attribute to the unhealthy other personal qualities that are considered outside the boundaries of legitimate, that it, ‘healthy’ personhood” (Crawford 1994:1364). These are all medicalization processes identified as
‘poor personhood’ and ‘bad’ things people do. The new Patient 2.0 or ‘smart patient’ will understand this information and become a good, healthy citizen. “Expert patients understand that they have to take charge of their medical care from beginning to end, beginning with demanding the right tests and then literally keeping these results with oneself so one can chart one’s progress” (Dumit 2012:185). They will take their statins to lower their risk of cardiovascular disease, they will get yearly check ups with their physician, and they will monitor their risks or symptoms for other possible conditions or illnesses. “The pursuit of health became an arena for the display of the growing bourgeois ideal of taking responsibility for determining one’s future” and issues of personal responsibility of neoliberalism (Crawford 1994:1352). This may be why there are so many magazines with the word ‘health’ in the title or the topic: Health Magazine, Women’s Health, Men’s Health, Health & Fitness, Prevention, Natural Health, Fitness Magazine, Shape Magazine, Eating Well, Fit Pregnancy, and Self Magazine to name a few. “More than 50 consumer magazines about health care appear on the newsstands every month” (Holmer 1999:380). With so much information circulating and a need to create new and relevant topics each day, week or month there is a limit to how much traditional information can be both circulated and understood by the consumer without becoming redundant or too clinical or extraneous. “From clinical trials of new drugs to cutting-edge genetics, biomedical research is riddled with incorrect findings” that are often repeated in these media sources because of this constant hunger for information to process for the consumer (Begley 2011:9). How are patients supposed to know what information is correct when they are often given a very quick summary or a snippet of a
larger issue? Often the information given to patients is incomplete in magazines or on nightly news segments. The nightly news and daytime news programs, both local and national, describe medical studies and important health findings that are delivered in a couple of minutes or less. “This is a world where electronic media are transforming the relationships between information and mediation” (Appadurai 1996:189). Mediating the world of knowledge will always be a difficult practice because of the amount of influence that media has in American society. Television programming and advertising go hand in hand and are connected through program sponsorship and coordinated advertising campaigns. Pharmaceutical advertisements or DTCA give just a brief summary of the most important risks and benefits of the drug. These snapshots of information may be misleading or the consumer may not be paying complete attention and remember the information very differently than it was delivered or described to them.

Knowledge and Pharmaceuticals

As the economic processes of neoliberalism begin to infiltrate the medicalization of conditions, the lack of regulation in the marketplace opens the way for pharmaceutical companies and health care corporations to use the advancement of medicalization as an opportunity to profit from consumers’ newfound knowledge. “The state typically produces legislation and regulatory frame-works that advantage corporations, and in some instances specific interests such as energy, pharmaceuticals, agribusiness, etc.” and this is clearly seen in neoliberal economic and social policies (Harvey 2005:77). By opening the door for looser regulation and restrictions on corporate activities, corporations like “pharmaceutical companies have become a major player in
medicalization” whereby they have increasingly more freedom to incorporate diseases, conditions, and medications into daily life (Conrad 2005:5). One of the important first steps in neoliberal deregulation that occurred for the pharmaceutical companies was the FDA’s actions towards advertising regulation. “Since 1997 when the FDA removed many of the regulatory restrictions that had prohibited direct-to-consumer advertising (DTCA) of prescription drugs in the United States, we have been bombarded daily by an ever-growing storm of the multimedia promotion of drugs” (Paluzzi 2009:255).

Pharmaceutical products and information about them historically were thought to be in biomedical terms above the knowledge level of consumers and were used only with physicians’ advisement. Singer writes that “direct-to-consumer advertising has both a long history and a measurable impact” and in his analysis he considers the first salves and medications that were home remedies brought to market as the primary instance of DTCA (Singer 2008:137). Throughout history though, the pharmaceutical companies as they form fewer and larger conglomerates have worked to ensure that consumers are increasingly informed about their products. This encourages brand loyalty to their products, much in the same way as other industries as previously stated by Rose.

Prescription drugs have become a huge source of revenue, and by advertising both to physicians and consumers the pharmaceutical companies can control the information circulating in the market about the possible products and medical conditions that need their treatments (Donohue 2006:659).

There is a controversy about these forms of information that are disseminated from the pharmaceutical companies. “From the beginning, deception, half-truth, and
grandiose claims have been key elements in the pharmaceutical promotion toolkit” (Singer 2008:139). Pharmaceutical advertising has long been criticized for its use of promotion to consumers because “beneath the controversies, discussions, and attempts to make sense of the current promotion and use of medicines must be the understanding that medicines have become one of the most consistently profitable commodities in history” (Paluzzi 2009:274). Processes of medicalization have driven people to be open to the advertising claims made by pharmaceutical companies. “Ads create new forms of discontent that can only vanish or be cured by new products” (Meijer 1998:237). Further, “advertising manipulates people into being consumers and instills false values” (Meijer 1998:238). The brand loyalty being created is needed to make lifetime users of drugs and make companies ever successful in the marketplace. Medicalization and information about bodily biology has pharmaceutical companies manipulating people who are in these at risk groups of public health, turning them into consumers of pharmaceutical products for conditions once merely conditions of humanity but now official diseases in the DSM. The “overreliance on pharmaceuticals allows us to avoid dealing with problems of family, the lack of public financing for schools, school discipline, and child rearing” (Petryna and Kleinman 2007:9). This connects to the work of Conrad, with conditions like balding and hyperactivity that are treated with medications in this new era of medicalization. Moynihan and Cassels point to the idea of “met un-need” to show how the pharmaceutical corporations are using medicalization to feed drugs to consumer who may not have a physiological disease (2005:31). Medicalization has opened a space for the medicalization of non-medical problems and as individuals seek help for these
ailments, they are becoming a participant in the process by using the information that was created to drive consumership. Further, Biehl in his work on AIDS in Brazil points to the “pharmaceuticalization of public health” which is quite apparent globally, but not often considered locally (2007:1085-6). This pharmaceuticalization pushes medical treatments of pharmaceutical products as a cure all or fix for the general public. Drugs become the solution to life, similar to the original call of Conrad’s medicalization arguments.

Drug companies are encouraging “consumers to consider medical causes for their common experiences, most often urging them to consult a physician. [Examples of these kinds of ads show] aspects of ordinary life including sneezing, hair loss, or being overweight—things many people could clearly manage without seeing a doctor” (Moynihan and Cassels 2005:103). While Moynihan and Cassels use the word “clearly” in how Americans can manage their health, I would argue that a substantial portion of the population does not like to manage things like health by themselves, and appreciates medical intervention because taking a pill is a lot easier than exercise for weight loss. This can be seen in the historical cases of products like Fen-Phen and Ally, whereby in a rather disgusting example, Ally can cause substantial anal leakage because of the way it inhibits fat absorption during digestion. These examples link medicalization practices to the consum ership of pharmaceutical products, whereby drug companies are supporting the medicalization of everyday life because worried consumers will buy products for potentially artificial conditions or artificially worrisome conditions. “Successfully marketing drugs to essentially healthy people requires more than convincing people to choose one brand over another; it often first requires convincing them that they may not
be as healthy as they assume they are” (Paluzzi 2009:256). Through medicalization and the deregulation of the pharmaceutical industry, in which the FDA is complicit with the structural needs of the pharmaceutical companies, success is measured in the growing need to fulfill the demands of the informed consumers. “Nearly two-thirds of all patient visits result in the doctor handing over a prescription, and more than half of all adults take two or more medications a day” (Roizen and Oz 2006:142). Doctors are the last remaining control mechanism for consumers to obtain a prescription and they are an integral part of the process. “In the United States, direct-to-consumer advertisements tell us to ask our physicians about particular drugs…and the Internet has made [this] even more complex and difficult to control” (Petryna and Kleinman 2007:15). Technology has opened a space for knowledge production and dissemination to consumers that often allows people to bypass their physicians as a primary source of information. Consumers make up their own minds about what they would like or need often prior to their doctors’ appointment. “Cyberspace knows no…boundaries, expediting the dissemination of medical knowledge, commercial promotion, and consumer desires” (Conrad 2007:144). The Internet is a valuable resource and marketing tool for corporations as they ask people to know their bodies and to find out more about their possible conditions and diseases.

Pharmaceutical companies, in this age of medicalization, encourage the simple act of purchasing and consuming a prescription drug; consumers, within neoliberalism, are asked to take action and to buy health. “After the pharmaceutical has come into the hands of a consumer, it will reach the final stage of its life: someone will use the medicine with its purpose of restoring, improving, or maintaining his or her health” (Van
Der Geest et al. 1996:156). This is the promise of medicalization: a pill can save a life and all one has to do is ask for it from his or her doctor, an action that connects patients to their physician. The simple act of “prescribing a medicine reassures both doctor and patient the ‘something’ has been done about the disease” (Whyte et al. 2002:122). This action completes the neoliberal call, as now everyone has done what they were supposed to do. “The confidence awakened in the patient by the doctor is recaptured in the concreteness of prescription and medicine” (Whyte et al. 2002:123). The consumption of the pharmaceutical product completes the process of medicalization whereby the consumers recognize that they have a condition that ought to be treated with medication and they seek help from their doctor by obtaining a prescription for said medication, on their way to feeling better having used the knowledge that was produced in order to ensure they would follow these specific steps on their path to health. “While physicians still maintain gatekeeping authority over prescription drugs, they are increasingly under constraint” because of the direct access patients have contradictory and confusing medical information because of the preponderance of marketing information treated as authority (Hartley and Coleman 2008:114). “A differential in power is therefore vital to establish the authority of the doctor and encourage compliance on the part of the patient” (Lupton 1994:106). The ‘smart patient’ is still and always will maintain a lay knowledge because they have not been imbued with any ability to actually take action for themselves. Doctors maintain that role, which is stable for now. Technological and biomedical advances like health smart phone attachments to monitor blood pressure,
heart rhythms, cholesterol and other more simple bodily processes may be game changers in the future.

**Media and Knowledge**

We have access to television, magazines, newspapers, and the Internet that all propel information at us. We become passive consumers of information, casually flipping through a magazine or watching television while eating dinner. “In the typical U.S. home the television set is in use for more than seven hours a day” (Gerbner 1998:178). We know that television contains a vast array of programming options from fictional narrative stories to non-fictional news based shows. “Television content… influences mass culture because it provides widely shared common knowledge, beliefs and expectations” (Kottak 1990:9). We have had many widespread cultural moments together when, for instance we collectively wonder, “Who shot J.R.” on *Dallas* or we find ourselves glued to the screen watching the horror of September 11th unfold. These moments are influential and can be landmarks for people in their lives. Americans rely on the television as a source of news but also as a distraction from reality, unless you count the advent of reality television, in which case we are interested in watching others’ realities instead of our own.

When it comes to health or medical programming, there are many options, ranging from channels like the now defunct, but incredibly popular Discovery Health Channel to long running fictional shows like *M*A*S*H*. Media becomes a part of our lives with programming and advertising infiltrating our lives. “Many television stations have a physician dispensing medical news” (Holmer 1999:380). Our information now
comes from all types of media sources because there are increasingly more of them available to us.

“Contemporary forms of imaging play a central role in the way medicine understands the human body and disease. Popular images of medicine, whether in literature, the cinema, television, or print media, draw upon these visual conventions as ichnographies to construct meanings and metaphors that are readily understandable, that translate complex theories for general consumption” (Marchessault and Sawchuk 2000:3).

This is the healthscape of “things medical” that Clarke demonstrates through similar visual imagery and in the same way that the medical fictional television show plays out for audiences (2010:108). The media culture in which we exist creates new forms of information for us, often through images and a reliance on visual metaphors. “Even as television portrays fictionalized, dramatized images of the existing medical culture, its choice of what to portray—and not to portray—simultaneously helps shape public perceptions of medicine that are carried into the clinic and the hospital by patients” (Vandekieft 2004:216). At the heart of what is created in media are the people who make decisions. It is the television writers, the pharmaceutical companies and advertisers, the Hollywood television studios, the physicians who report the news every night on national and local news. Choices are made everyday and they both dictate and create this medical culture.

One example of the kind of news stories that appears in our media health is a Newsweek’s double issue focusing on health in 2010 that was titled “The Science of Healthy Living.” The opening article of the section was titled, “Healthy At Any Age: In the Era of Google, Medical Advice is More Confusing Than Ever. Here’s a Guide to What You Really Need to Know” (Carmichael 2010:48). The confusing thing for people
reading this might be that while the Internet is vast, this section in your magazine is only 30 pages interspersed with advertisements (three of them pharmaceutical ads), seemingly not enough space for a real clarification of most misunderstood health advice. While finding reliable sources online may be difficult, there is no promise that this magazine is not taking recommendations from outside companies who also advertise with the magazine or other companies also under the same ownership umbrella. The text of the article reveals that they are seeking to give some perspective and streamline all of the possible information so the reader does not end up becoming overwhelmed. These magazine writers at *Newsweek* are somehow experts at determining what is the most important information for a typical consumer.

“So how are you supposed to navigate complex health decisions in the face of conflicting evidence? Magazines will tell you to ‘talk to your doctor’ but given how overbooked he or she probably is, you’ll have to press hard for quality time. What might be more helpful is having a few basic guidelines for making health decisions” (Carmichael 2010:51).

They then go on to recommend several self-help books, patient forum websites, and again recommend talking to your doctor before showing a seven page section of x-ray diagrams of humans at various life stages along with bubbles of information pointing to body parts and recommending things like prostate screening or vaccinations (Yarett 2010:53-63).

We know that people are getting information from the media, but it is a wide space, open to direction and control by multiple and competing groups or priorities often without those sources being revealed.

We often draw into question how much people actually learn from television shows. One of the best examples to compare medical television to would be legal
television, close associates in television programming. Anthropologist Laura Nader, writing in 1969, wrote that “most of what we learn about the law we absorb vicariously from TV westerns and Perry Mason-style shows” and the same is true today for medicine and other fields (300). More recently, many scholars and prosecutors cite something called the “CSI Effect” to discuss the effect of forensic shows on real life legal juries. In questioning what the CSI effect is or means for legal cases, “prosecutors claim that the show makes juries less inclined to convict because they have inflated expectations for the comprehensiveness, sophistication and clarity of forensic evidence--all those threads and fibers and DNA traces left behind at crime scenes” (Cole and Dioso 2005). Audiences that watch the forensic or medical-legal show *CSI: Crime Scene Investigation*, on air since 2000 and with two spin-off shows in Miami and New York, have purportedly been paying close attention to the use of DNA testing, crime scene collection, and other forensic processes in their television storylines.

Medical, legal, and forensic shows, with the popularity of *CSI* have been developed since, with shows like *Crossing Jordan, Body of Proof, NCIS* and others, and also now even regular legal shows like *Law & Order* use forensic evidence prominently in their storylines. The medical examiners, pathologists, and forensic scientists are major characters with laboratories full of high tech equipment and fancy techniques to quickly find a clue the killer left behind that will put them behind bars. “On *CSI*, this concern [with credibility and reliability] is handled by completely discounting witness testimony in favor of physical evidence” (Kruse 2010:81). On *CSI*, witnesses and humans lie, science does not. These medical-legal shows are usually procedural shows where the
pattern of the episodes’ story will be repetitive and the episodes are similar to one another (*House M.D.*), a medical show, gets accused of this as well because of its’ procedural nature). On a procedural show, there is a crime committed, often a murder or almost deadly assault, and then the crime scene is mined for any and all evidence that may remain behind. That evidence is then carefully brought back to some sort of crime laboratory, be it local law enforcement or federal like the FBI, and processed in machinery and by trained technicians, while the police do their work in tracking and identifying suspects. “On the one hand, *CSI* is read by both experts and mass media as fictional and not relevant for nonfictional forensic science, but on the other hand, they are concerned that other, nonexpert viewers will (mis)understand nonfictional practices through the prism of *CSI’* (Kruse 2010:87). In a Wall Street Journal article about the *CSI* effect, the authors describe how “experts agree that much of the forensic science depicted on "C.S.I."--40%, according to forensic scientist Thomas Mauriello--does not even exist. And even when the techniques are real, the neatly perfect depictions of collecting, processing and analyzing evidence are not” (Cole and Dioso 2005). The *CSI* effect is a demonstrated outcome of media knowledge on consumers and audiences that can be borrowed for the field of medical television in much the same way this effect has been shown in legal shows.

Even if it is debatable about how much information audiences are taking from the medical-legal shows like *CSI*, it is clear that the general public is more aware than ever about crime scenes, forensic investigative tools like the collection of fingerprints, hair, semen, sweat, and other bodily traces that can link back to the individual who committed
a crime, often a murder. I am not trying to argue that people at home now know what a mass spectrometer does or how what kind of information that can yield, although a slightly more interested or inclined viewer might get that information from a show like *Bones* or *CSI*, but people are generally more aware of these kinds of evidence and the implications. The idea now of the “stupid criminal” is one who does not wear gloves, or a mask, or a condom, or is careless with their hairs, or not cleaning up blood with bleach, mindful of the cracks or blood seepage, which is vastly different from just 10 or 20 years ago. There is simply more information circulating about this from the popularity of the medical-legal, or legal crime shows. I will show the same can be said about general medical shows where audiences know more about new and rare diseases or about treatments for conditions because of such exposure. Through studies about consumers’ knowledge retention about medical procedures and disease information and in-depth research with the medical staff of television shows, I aim to show that the *CSI* effect is similar to the knowledge development that occurs through similar medical programming, something I call the *ER* effect. Whereby after the creation of the show *ER*, medical programming began a quest for more authenticity with accurate medical terminology, more physicians on staff than any medical show that came before, and graphic medicine at its’ finest. With the show *ER*, physicians and public health groups began recording the influence of medical shows on the public through surveys and audience research.

**Authenticity and Narrative Storytelling**

People take in information from all sorts of sources including the Internet, television programming, radio, and advertisements even if their origins or motives are not
questioned enough or at all. Authenticity should be a central concern when discussing the varied and new ways people take in knowledge, especially for understanding how much to believe or trust it. Bruner gives four different definitions for authenticity that at times are standard but somewhat contrary (1994). Authenticity can be “credible and convincing” or “complete and immaculate simulation” or “original, as opposed to a copy” or lastly, “authorized, certified, or legally valid” (Bruner 1994:399-400). The multiplicity of ways to be authentic do not lend easily to a consumers’ mindfulness. Two possible authenticity conundrums come to mind. Think about whether a dramatization on a non-fiction television show gives us all the answers on a medical scenario because that fits well with the credible and convincing definition of authenticity. Or think about a 30 second advertisement that describes a pharmacological process that takes chemists and pharmacists years of expertise to understand, but fits well with the legally valid or certified definition of authenticity. Authenticity is a complicated issue because there are so many ways to make something technically authentic and not a lot of time spent trying to unpack these ideas to determine what this means for the knowledge contained within these messages.

The processes of understanding authenticity come with baggage but processes of mimesis and alteration tear it further open wide. Taussig, taking from Benjamin, describes mimesis as a “copying or imitation” (1993:21). This mimesis or mimicry is ever present in medical media whereby scenarios are replicated or dramatized for public consumption and enjoyment. The structuring idea is that the “mimetic faculty, the nature that culture uses to create second nature, the faculty to copy, imitate, make models,
explore difference, and become Other” is driven through things like storytelling and film in modernity (1993:xiii). I would argue that with mimesis and mimetic production there will always be alterations. Not alterity as Taussig describes, although one could argue that, but alterations in that nothing is copied exactly. There is a push-pull between authenticity and mimesis. If there is a connection between real life and media, it is that people do not have an easy time seeing where the cracks in alteration occur within the mimesis. We know television is make-believe, but we cry when our favorite characters get shot or a helicopter lands on them, and we celebrate when they save a patient or fall in love. The mimesis begins to become reality like Bruner’s complicated path through the idea of authenticity. Authenticity should be something we know when we see it, but as television physicians (actors) suture patients or defibrillate or put in an IV with the accuracy of medical professional this picture becomes complicated. Notions of authenticity are wrapped up in the mimesis carefully constructed for our viewing.

“Authoritative knowledge is not necessarily ‘true’ or ‘correct’ in any ‘objective’ sense but is, rather, a social accomplishment” (Kingfisher and Millard 1998:450). The knowledge is produced by a multiplicity of players and from a set agenda with clear goals, whether they are to gain consumer purchases or viewership. There is a purposefulness with which it is designed for their audience.

Part of the CSI effect, and the echoing ER effect, is the use of its integration in the narrative of television storytelling. Most of the writers, directors, and actors I spoke with told me that at a basic level, they were telling a story. It all came back to the story of the show or the episode. “Stories connect people into collectivities, and they coordinate
actions among people who share the expectation that life will unfold according to certain plots” (Frank 2010:15). These television plots become group or collective narratives that are appealing to people, both sick and healthy. It is “that narrative knowledge and practice are what human beings use to communicate to one another about events or states of affairs and are, as such, a major source of both identity and community” (Charon 2006:11). With the information being tied to a coherent and compelling story, the audience is receptive to the knowledge contained within it. A story “is as common as air” and so it is a familiar and appealing context for the consumer (Garro and Mattingly 2000:9). The ER effect is compelling because of the use of medical authenticity and the narrative of the characters in the storyline.

So many people are involved in creating the story, for television and advertising in particular, and the story goes through many hands before it reaches the audience, not dissimilar to an how an individual narrative comes to life. “No voice is ever singular—every voice contains multiple other voices” (Frank 2010:16). These levels of multiple involvement can lend to the creativity and difference in the narratives, and with medical television you can find something for everyone in the variety of voices given to the individual shows’ stories. From a more soapy and steamy Grey’s Anatomy, to the more structured and medical ER, these medical stories can cover the same ground in different ways. “Whether any story is ever truly new is always contestable” (Frank 2010:15). This idea of ‘new’ stories in medical television relates often to technology, as this is the place where shows present something new and different for the audience, but at a base level the drama will always function the same way for audiences. Seeing someone injured
or sick is compelling and knowing that someone might die is difficult to watch. They tread on the same pull of the heartstrings to make television that will draw in viewers and create characters people will want to follow and fall in love with. “Stories concern action, more specifically human or humanlike action, even more specifically, social interaction” (Garro and Mattingly 2000:10). Watching people is a central tenet of anthropology through methods like participant-observation, but it is a basic human instinct as well. We connect with others, we judge others, we are jealous or angry with others based on their actions, words, and our own observations. “Compelling stories move us to see life (and act out life) in one way rather than another” (Garro and Mattingly 2000:11-12). By creating a world the audience will want to see and experience every week, medical television pulls us into another world and we experience it alongside the characters, enjoying every minute of their joy and disappointment.

For medical storylines, the patient characters are seen in a very medicalized view because of the hospital setting and often biomedical solutions that are provided. “Health became a concept for describing its normal state” of life, but watching characters on television being through a process of sickness and back to health allows for this process to be clearly shown (Crawford 1994:1350). You only really see healthy people on a medical television show that are doctors or hospital staff, as everyone else is there because they are sick and will then leave the show once they are healed. It is how these doctors and medical staff set about the ‘doing’ of getting people healthy that brings people to these shows. There is a “concern for the pragmatics of narrative, how interlocutors are ‘doing things with stories’ and how, therefore, narratives carry rhetorical
weight’ (Garro and Mattingly 2000:5). These are narratives of life and death on medical television, almost nothing is more fascinating for people at home that are often not a part of this world, but want to look in at the goings on in a hospital for one hour a week.

Narrative storytelling in television is also used in particular when portraying a physician making a diagnosis, often a favorite part for the audience at home and a concern for most people about when they are sick. Patients want a diagnosis; they need a diagnosis. This is especially true for a show like House M.D., which is predicated on the premise of Dr. Gregory House as the Sherlock Holmes of medicine. Dr. Lisa Sanders, a writer for House M.D. and the New York Times ‘Diagnosis’ column, has a book about the difficulty for physicians of making a diagnosis and in it she describes a physician called in for a consult (2009). The narrative goes like this, the patient is very sick and many other doctors have treated her so far, ordering many tests all of which do not give a clear indication. This doctor does not look at the patient file. He begins again at the beginning to see what he would have done without any distractions from what others may have thought and eventually solves the case with this method (Sanders 2009:xvii-xxi). This same premise of diagnosis utilized on medical television is what makes Dr. Gregory House makes such a compelling character. He is the doctor who starts from the beginning and works in the patients’ best interest to give the patient a diagnosis. Dr. House may be flawed, he is a drug addict after all, but he fights for the patient and it is that dedication to finding the truth that creates a trust from the audience in this physician. ‘Doctors take pleasure in recounting the completed story of their complex diagnoses, stories where every strange symptom and unexpected finding, every mystifying twist and nearly
overlooked clue, finally fit together just right and the diagnosis is revealed” (Sanders 2009:xiii). It is this type of role for the narrative, like is real medicine and in television that comes, with something like a diagnosis.

Narratives and medical knowledge go hand in hand in advertising and television because there is an irresistible and essential piece of humanity that is created, both for the characters and the audience. Everyone is invested in the patient outcome. With television especially, if you become uninterested, you simply stop watching the show. This is what the makers of television want to avoid. They want to make narratives that give you insight and information into their special and specific setting, whether it is a general medical show or a medical-legal show, and keep you watching. Narratives in advertising work much the same way to appeal to a relatable lifestyle, condition, or expectation of health. The ER effect relies on the creation of a medical television show like ER that gave the audience the complete visual and auditory medical experience along with interesting characters and life and death medical stories.
Chapter Two: “I love that show too! Did you see last night’s episode?” Watching Television Medicine’s History and Authenticity

We have become a television centric society, gathered around at all hours and especially for primetime shows. “Television is the source of the most broadly-shared images and messages in history” (Gerbner 1998:177). While our modern television experience can provide us with a multitude of channels and possibilities to entertain us, it is an influential and cultural phenomenon. “Television is one of the most powerful information disseminators, public opinion molders, and socializing agents in today’s world” (Kottak 1990:11). The medical television show has become a popular storyline and control over the content has wrestled between studios and public health entities. “Fictional depictions of doctors and medical procedures in the media clearly have an impact on both the delivery of health care and patient expectations of their physicians” (Friedman 2004:5). It is this sourcing from television that produces a concern over the content of television shows with regards to public health information. Medical groups would be very worried if there was ever some sort of dissemination of information that was fundamentally incorrect and a possibility that anyone could pick that up and think it to be true. Imagine what could happen within the public if a TV program said that perhaps, ‘HIV could be transmitted through shaking hands’ or ‘some types of cancer are communicable through sneezing.’ Treichler, citing the Centers for Disease Control, states that “88 percent of the American public obtains health information from television” (2007:97). It is this fundamental idea that people learn things from television that produces issues of accuracy and authenticity on television and an investment from
outside groups and inside staff to maintain a level of propriety about the knowledge they are circulating.

Television is mostly about entertainment, but often what makes television compelling is the sense of reality and empathy with the characters. “Stories work with people, for people, and always stories work on people, affecting what people are able to see as real, as possible, and worth doing or best avoided” (Frank 2010:3 italics in original). Narrative storytelling, like that of television, is always going to act on people because we become invested in the stories and the characters. If we were not invested, we would not watch the shows. “Stories have the capacity to arouse people’s imaginations; they make the unseen not only visible but compelling. Through imagination, stories arouse emotion” (Frank 2010:41). My father always told me that for TV and movies, “you have to buy into the plot,” and this is very true. If you have bought into the story, it can become very compelling to the audience. It will spark viewership and fans will communicate with actors and characters on television shows by writing, calling, and emailing with questions or comments, it sparks blog posts or Internet rants, it can even drive people to studio tours or set tours or to meet actors doing appearances. Just look at the fan base for shows like *Friday Night Lights* and *Community*, both were cancelled by the studios and then brought back because of public fan campaigns.

Medical shows populate the landscape of modern television and have had a prominent place in the nightly television drama since the 1930s. “TV’s Holy Trinity—lawyers, cops, and doctors… all three have the capacity of dealing with life-and-death situations. You’re not going to find people who are interested in watching a show about
an electrical engineer or a carpet cleaner” (Edwards 1984:781). Although *Breaking Bad* shows us that a high school chemistry teacher makes a compelling character after he has turned into a drug lord and mass manufacturer, but at that point he is less teacher and more criminal. Medicine’s inherent drama is not only fascinating to watch but can be applicable to the audience’s life or someone they know. “In most fictional television programmes, sickness is treated, usually competently and successfully, by doctors in hospitals using the latest technology and fast-acting drugs” (Lupton 1994:57). It is these often flashy, fast talking physicians that we love because they fix people, and quickly, often in 22 or 44 minutes. Often these medical shows feature doctors in the most rapid paced specialties or the ones with the most at stake to ramp up the drama. “Television has favored physicians who are general practitioners or surgeons” (Hudson Jones 1981:187). This is true for *Grey’s Anatomy*, which features surgical interns, and for shows like *Three Rivers*, which featured a transplant surgical team and *Monday Mornings*, which featured mainly emergency room doctors and neurosurgeons.

Americans love shows about doctors and the good thing for the costume and props crew for television shows is that they are very easily identifiable by their signature dress. “The status of the doctor is usually indicated by his or her white coat, signifying authority…and the stethoscope, [the] ultimate symbol of medical technology” (Lupton 1994:57). The stethoscope is a funny prop on television because most real life doctors talk about how they never wear their stethoscope around a hospital or medical practice. It generally always belongs in a coat pocket, but this kind of analysis of medical show process and procedure is quite common among the audience, now usually online, and
among physicians themselves in medical journals. The depiction of medical doctors on television has been widely studied in communications literature and their presentation has evolved over time (Turow 2010; Clarke et al 2010, Karpf 1988). The same principle operates with something as small as the color of scrubs that different doctors and nurses wear on television. On Grey’s Anatomy, in the beginning the obstetrician/gynecological surgeon character of Addison Montgomery Shepherd always wears pink scrubs but evolves to just wearing blue scrubs like the other doctors. The interns at Seattle Grace also comment about how soft dermatologists and the “gyny-squad” are when they hang out on the posh and comfy dermatology lounge or point out the doctors whose job is just the simple task of delivering babies, not operating on critical cases like they do. The colors of the differing scrubs reflect that difference with something as simple as pink or blue. Even on ER, Nurse Carol Hathaway comments in the first season that she had a dream of getting married in a salmon dress because of how often she is in salmon (pink) scrubs, which all of the nurses wear. Scrubs signify your role on medical shows in a visual denotation so that the audience does not have to think about who they are and what their ‘rank’ is as a physician or nurse.

We watch medical shows to see the main characters, generally always doctors, doing their best to save patients. They are expected to use their traditional medical training, learned in medical school and save lives. “Deeply rooted in the cultural history of American medicine, this ongoing discourse about the competency of doctors has shaped, as it has been shaped by, the evolution of the profession and the health care system” (Good 1995:2). Doctors receive classroom and clinical training that ultimately
drives how doctors will interact with their patients, and the ways that the science of biomedicine will be taught by doctors to their patients when explaining disease and treatments. It is this traditional, medical knowledge that physicians receive in their training that becomes the gold standard. “Circular innovation is ubiquitous in American medical education, reflecting in part dynamic transformations in biomedical knowledge and techniques and in part the political economy of how that knowledge is produced and taught” (Good 1995:121). The medical storylines gives the audience a window into the world of doctors, whereby we see what they have learned (or have not yet learned), what information they use to solve medical mysteries, and who they go to for help within a hospital or clinical setting. “Fundamental and essential knowledge in Biomedicine is thought to be produced and shared among physicians” (Hahn 1995:151). Going even further, Hahn simply writes that “the physician is the critical element in healing” (Hahn 1995:286). Medical shows whole-heartedly agree that doctors should be the focus of a television audience. They frame shows around a singular physician or a group of physicians in a given hospital, but few and far shows have deviated from this process with much success. There have been a few shows focused on nursing like China Beach or HawthoRNe but they do not have as long of a run or get as much attention. One of my television writer informants told me that “doctors are the interesting part of medicine. They do all of the medicine.” When I brought up how important others are in a hospital like nurses, the television writer said, Yeah, but [doctors] do the medicine. They fix the patient.” This was a common theme in my discussions with television writers and producers.
Anthropology has yet to study this phenomenon by looking to the main contributors or key players at work in television, nevertheless medical television. It is an important area because we know through surveys and pop culture that audiences pick up on this information. How much and what kinds of information will always be debatable, but the potential for knowledge building is there. By knowing what kinds of people are creating the shows, we can begin to see the processes that give rise to roles, and medical storylines are used more often than others. If the sentiment is, and it is, that doctors do the doctoring which save lives, then that will ultimately become the priority for showing heightened drama and interesting scenes to audiences and advertisers. Medicine already has life and death built into the scenario, so it is compelling at a basic level. By better understanding the processes involved in the creation of more medically authentic television, it becomes easier to see why American medical television changed over time to look more realistic and diverse. We have moved from a very white, male, upper class, small medical practice on *Marcus Welby, M.D.* to an urban, ill-funded, County facility, with an ethnically diverse and gender balanced staff on *ER* within 30 years. America and Americans changed over that time, and so did the writers and producers making those television shows.

**A History of the Medical Show**

Television shows that are the most compelling for audiences are often full of interesting narrative story lines, fascinating characters, and something intangible that creates a bond between the audience and the show. Studio executives are constantly seeking that bond as they cycle through pilots (the first episode of a television show),
looking for the next best thing they think audiences will love. After a pilot is picked up by a studio, they will order more episodes to be filmed and then after those air and either sink or swim, finding an audience, tinkering with the time slot or changing up the cast or crew, then a decision is made whether the shows will continue. Some of the longest running shows and best loved are medical shows. The Writers Guild of America (the WGA), released a top 101 best written television shows as voted by their members, all professional film and television writers. Of the top 101, many of the most popular medical shows made the list with at #5 M*A*S*H, #28 ER, #29 Cosby Show, #46 St. Elsewhere, and #75 House M.D. (Day 2013). There were also some shows on the list that cross into medicine by being medical-legal shows that focus on pathologists and forensics, alongside law enforcement, like #44 Law & Order and #67 Dexter (Day 2013). While I do not address the writing or medical consulting for forensic shows much in this research, many of my informants have worked on or consulted for several of those shows as well. I limited the scope for this project just to traditional medical shows, but it is worth a mention that the sets are often similar, showing medical examiners offices, laboratories, hospitals and that there are medical authority characters prominently featured as well like medical examiners, hospital pathologists, forensic experts, clinical laboratory scientists and laboratory staff.

Traditional medical television has been popular since its advent in the 1950s. This analysis looks towards issues of accuracy and authenticity on medical television, and a full analysis of the history and context of the development of all medical television can easily be found in work from Joseph Turow (2010). From the beginning, there was
pressure to have the storylines and medicine be very accurate, sometimes from key players on the show, often from groups outside of television. The portrayal of the field of medicine was seen a one part public relations and another part advertising, and there was an acknowledgment of the power of television and a concerted effort by invested parties to have a voice in the creation or at least oversight of such programming. “Medicine’s growing cultural authority made the hospital, clinic, and laboratory attractive to filmmakers; so too did the potential of dramatic scenes involving injury, death, sickness, and self-sacrifice” (Lederer 2007:295).

The specific way that physicians were portrayed on television was of concern, and the early trend was quite clear. “City Hospital, the initial doctor show launched in 1952, portrayed doctors as omnipotent healers who represented the authority within the hospital” (Quick 2009:39). Even from the start, key individuals involved in medical television set a standard that others followed of a large concern for understanding and truth in medicine. James Moser, the creator of the show Medic in the 1950s was so obsessed with realism that “he wore a hearing aid when writing about deafness, he lay in an iron lung before turning out a script on polio and he haunted the corridors of Los Angeles County Hospital in search of…realism” (Turow 2010:44). Not everyone was as dedicated as Moser, but his quest for authenticity is legendary and was influential.

The influence of TV doctors can be seen in the popularity that these actors and characters gained in real life with the audience. “At the height of [Marcus Welby, M.D.’s] popularity, the show elicited approximately five thousand letters a week from people who wrote Welby to ask for his help in dealing with their ills” (Hudson Jones 1981:183). It is
not common now, because the sense of reality versus fiction is more present in our television audience, but shows still get thousands of emails and letters from fans. With audiences so enamored with Welby, the medical community became very involved in medical television behind the scenes. In the 1950s, the American Medical Association and the Los Angeles County Medical Association began work with television shows to look at the accuracy of the medicine contained within them (Turow 2010:45-7). At the start, “a twenty-one person committee had to pass on every script” which became overwhelming and very slow and so they transitioned to only five people (Turow 2010:59). This kind of oversight was not at the request of those working on the television shows. This was a form of control over television that the medical associations wanted and attempted to enact, with much success initially, in order to preserve the status or esteem of being a doctor in real life. Academic degrees, like a medical degree, establish a preponderance of ability, knowledge, and capital that can often be unparalleled by others in society because of the specialization it requires to obtain. “It is written into the tacit definition of the academic qualification formally guaranteeing a specific competence…that it really guarantees possession of a ‘general culture’ whose breadth is proportionate to the prestige of the qualification” (Bourdieu 1984:25). Doctors are imbued with authenticity from the institutions that legitimize their academic training and certify their ability to perform health maintenance practices through their exclusive access to this medical knowledge. These agencies were working towards their own members’ best interest in continuing the power, prestige, honor, and authenticity that physicians have as the ultimate medical authority.
Remarkably, the process for finding medical plots has not changed very much over time. Turow describes the process in the 1950s that, “producers and writers poured over newspaper articles and medical journals. They talked to technical consultants, to the AMA advisors, to physician friends” and this still hold true today as source material, it is just that the Internet now makes this faster, easier, and more accessible (2010:93). Research has always been a key to making medical television, which can sometimes have more drama than medicine, but several people usually vet the medicine before anything filmed. “Film makers worked closely with medical professionals in order to achieve ‘realism’ on screen” (Lederer and Rogers 2003:495). Realism is often a concern not just by the medical associations and consultants who have a vested interest in this, but by the show creators and runners who want to make sure the audience is enticed to keep coming back week after week. A writer who called physicians for confirmation about a specific surgery that was used in an episode, described to me that physicians would also offer stories or anecdotes about patients or cases they had encountered that might be used within the series on other episodes. There are multiple ways that medical storylines became integrated into shows.

In the 1960s, *Ben Casey* and *Dr. Kildare*, which both ran from 1961-1966, competed for audiences and brought the medical television drama to a wide audience. For the show *Ben Casey*, a physician was consulted on the scripts and the creator would go through medical journals and speak to physicians about storylines (Turow 2010:85). *Ben Casey* was a gritty show that may have “foreshadowed later series like ER” (Grimes 1996). On *Dr. Kildare*, the first technical advisor was hired, “George Andros, the intern
who had been…a model for Dr. Kildare” in the research for the show, and also the AMA was still involved with both shows (Turow 2010:87). Dr. Kildare was connected to previous radio narratives, novels, and movies and was a popular show, considered to be soapier than Ben Casey (Turow 2010). It became a trend to have physicians available by phone or occasionally on set to make sure the medicine was being presented accurately. By M*A*S*H in the 1970s, the show was more focused on the aspect of being set during a war but it also maintained the heavy medical focus. There was more room for creativity in the medicine because the staff studied war footage and looked to the lack of supplies and challenges of practicing medicine in those circumstances. “M*A*S*H might be credited with being the forerunner of the ‘dramedy,’ its unique blend of comedy and grimness” (Thompson 1996:57). The war setting gave way for the dark humor of death and this was highlighted by their research into transcripts from physicians who had been in the war, according to writers on the show. M*A*S*H “centered on the impact (usually negative) of the patients and the environment of the physicians” because of the dark comedic nature of the war setting and the types of cases handled (Turow 2010:267). M*A*S*H was an incredibly popular show and the medicine was an imperative to add tension to that was brought also by the war. It addressed issues of soldiers trying to get out of the war with the character of Maxwell Klinger, who cross-dressed constantly as a joke on the show. M*A*S*H also showed the difficulty of being a female nurse in wartime among a staff of mainly male doctors and male soldiers. The character of nurse “Hot Lips” Houlihan was the butt of derogatory comments and provided a space for the audience to have an uncomfortable laugh at the way women were treated in the military.
Also, during the 1970s “producers also tried to gain audiences by confronting hot-button issues such as abortion, homosexuality, drug addiction, venereal disease, and rape” (Turow and Gans-Boriskin 2007:271). The shows started to push at these boundaries of ‘decency’ and they added to the kinds of medical conversations people could have publicly by discussing these topics on television. *M*A*S*H* was not the only medical show during the 1970s, it was just the most popular. “Twenty-seven doctor series aired during the 1970s…[and] eighteen did not last more than a year” (Turow and Gans-Boriskin 2007:270, 272). This demonstrates not only the occasional success of the medical show, but also a willingness to repeat the model to see which versions will consistently draw an audience.

In the 1980s, medical shows took two different styles. In one, “*St. Elsewhere* deviated from the traditional doctor show because most of its creative staff didn’t know much about the formula in the first place” (Thompson 1996:78). *St. Elsewhere* created a specific formula for medical shows where storylines were detailed in patterns to match tone and character development, and this structure is still used today in most shows. *St. Elsewhere* had a physician available to them by phone, but did not have a dedicated medical staff. The writer’s room has been described as a “frat house of smarty pants” where everyone was bringing in their own outside medical research to have the newest or coolest cases for episodes. “An important way *St. Elsewhere* differed from most previous hospital series was in its tendency to deal with chronic illness that did not necessarily have a sure-fire cure” (Turow 2010:312). There was not a feeling on *St. Elsewhere* that medicine had to have a happy ending, which was a departure from some earlier shows.
St. Elsewhere’s “doctors struggled with an assortment of complex personal problems, and their patients were as likely as not to leave the hospital with a sheet pulled over their faces” (Thompson 1996:78). It was this reality that not everyone survives and doctors cannot fix everything that ails a patient that made the show compelling for the audience. ER later followed in this tradition in many ways. St. Elsewhere was different than its predecessors because “the doctors were good but patients still died, sometimes as the result of physician errors” and the show was “set in a seedy inner-city hospital rather than in a state-of-the-art facility” (Vandekieft 2004:226). Coming out of the 1970s where more medical topics became acceptable to present on television, St. Elsewhere became a landmark for a couple of big breakthroughs in medical procedures.

“Many of the ailments and medical procedures on St. Elsewhere were aggressively made-not-for-TV, and their presence was yet another proclamation that the show was groundbreaking and daring. Various patients suffered from prostate cancer, hemorrhoids, hernias, infertility, impotence, premature ejaculation, an inability to urinate, and an inability to defecate. Doctors performed mastectomies, hysterectomies, vasectomies, sex change operations, colostomies, foreskin reconstructions, and once they even had to treat a colleague whose penis was stuck in his zipper” (Thompson 1996:81-2).

These innovative storylines triggered concerns over decency standards for studios, but audiences loved the new, more edgy stories. One of the big moves by St. Elsewhere was a storyline that ER again would also carry to new ground. “St. Elsewhere presented the first prime-time series story about AIDS” (Thompson 1996:15). This kind of new and interesting medicine made the show popular with audiences but it was also a show with hidden quirks that drew in audiences. St. Elsewhere famously was a smart show with many pop culture references, but it also contained many ‘in-jokes’ that referenced previous medical television shows like “doctors named Kiley (Marcus Welby M.D.),
Gannon (Medical Center), Steiner (Medic), and B. J. Hunnicut (M*A*S*H); [and] a nurse named Consuelo Lopez (Marcus Welby M.D.)” (Thompson 1996:85). Shows with references like this also create a sort of game with the audience to find the references and ‘in-jokes.’ The medicine pushed boundaries and the show was well written, and this gave St. Elsewhere an honesty about, as one writer told me, “how screwed up people are, doctors and patients.” St. Elsewhere communicated to audiences that doctors were who they are as people in a hospital, not automatically heroes and worked to complicate the character of the physician for the first real time on television. It is no accident that this moment in history coordinates with the lack of intervention from overseeing medical bodies like the American Medical Association, where writers had more freedom from monitoring.

In the second model for 1980s medical shows, where after M*A*S*H ended and St. Elsewhere was running it’s course, there was a trend with physicians as major characters but with almost no medicine. The best examples of these prominent physician shows in the 1980s are Doogie Howser of Doogie Howser M.D. and Dr. Cliff Huxtable, of The Cosby Show. They were “all characters in prototypical sitcoms; their identity as a physician was of peripheral importance” (Vandekieft 2004:228). Doogie Howser M.D. “presented a sixteen year old genius whose adolescent interests interlaced with his mature work as a hospital surgical resident” but in the pilot another physician called him a “snotnose genius” and that set the tone for the character (Turow 2010:333). It was more about the character and his development as a boy genius than it was about Doogie’s patients most of the time. A director of several episodes of Doogie Howser M.D.
described the show as being about a “genius kid [that happened to be] set in a hospital.”

For *The Cosby Show*, Cliff Huxtable practiced medicine out of his basement. The audience saw him meeting with patients for his Obstetrics and Gynecology practice in an office setting, never in an examination, which would have required a nurse to be hanging around in the basement as well, and then occasionally he would leave in the middle of the night to deliver a baby. These were peripheral moments compared to the family aspect of the show where the main plots revolved around his five children upstairs and lawyer wife, Claire. These two ‘medical’ shows, although they did not feature much authentic medicine, did feature the distinctly neoliberal, biomedical characteristic of the telling of stories. By showing stories of medical and personal success, like those of a child genius saving lives and a successful doctor delivering babies and raising a beautiful family, Doogie Howser and Cliff Huxtable are both meeting the biomedical ideal and showing the audience how to behave and be successful themselves.

The 1990s brought a new wave of medical dramas like *Chicago Hope* and *ER* to our living rooms. David E. Kelley who created *Chicago Hope* also co-created the show *Doogie Howser M.D.* (Thompson 1996:187). *Chicago Hope* stood in contrast to *St. Elsewhere*, as a clean, shiny, technology driven, well-funded hospital. Because *Chicago Hope* was a David E. Kelley show, who himself is a lawyer and known for legal shows as well as medical shows, this show, like all of his shows was a little wacky and unconventional. “*Chicago Hope* mixes comedy and drama, explores complex ethical and religious issues, and specializes in quirky characters and unexpected situations” (Thompson 1996:187). Rival networks pitted *Chicago Hope* and *ER* against each other
on Thursday nights. The two shows could not have been more different. As stated previously, *ER* followed *St. Elsewhere*’s style with cutting edge, raw medicine that pushed boundaries and storylines that were controversial, set in an inner city, county hospital. “*ER* quite shamelessly ripped off story ideas, details, and situations that *St. Elsewhere* had done years ago, and much of the grim, ‘depressing’ feel for which people had blamed *St. Elsewhere*’s low ratings was present in many episodes of *ER*” (Thompson 1996:188). After some time passed, it turned out audiences were much more accepting of the gritty setting and more graphic medicine in *ER* than they were initially with *St. Elsewhere*. *ER* showed “that it was possible to build series around the personal travails of doctors operating in high-intensity situations within a hospital setting” (Turow and Gans-Boriskin 2007:276). The show really thrived on intensity for the audience. The pacing was fast and the camera shots unique. In an Emmy Award winning episode of *ER* in the first season, titled “Love’s Labor Lost” a pregnant woman is featured having complications in the emergency room and an ER doc having to perform a caesarian section in haste. Of course chaos ensues and it is a very graphic, fast episode that was based on a real experience of a physician friend of one of the writers.

Because *Chicago Hope* and *ER* ran together and aired against each other, there were many comparisons drawn between the two shows. In Makoul and Peer’s study of *ER* and *Chicago Hope*, they found that “providing medical care—and living the life of a medical care provider—is presented as interesting and exciting, intense and emotional” (2004:256). Two physicians that worked on *ER* said that applications for medical school went up during *ER*’s highest ratings years, as did the selection of emergency medicine as
a specialty, anecdotally one heard a rate of over 300%. People at home wanted to do what the doctors on *ER* did. “For their most obvious stabs at realism the creators of both *ER* and *Chicago Hope* turned to the kind of gore and frankness about illnesses that a few years before several people in Hollywood confidently stated that the audience wouldn’t accept” (Turow 2010:339). The ‘gore’ or medically graphic presentation of bodies, diseased bodies, was a social phenomenon. For having been set during a war, looking at old episodes of *M*A*S*H* there is a shocking lack of blood or gore as compared to these two shows. The level of gore or graphic realism and the changes over time towards more graphic presentation is exemplary of Clarke’s visual imagery realized as “things medical,” whereby audiences began to be interested about what the inside of bodies look like and what physicians really see when patients have been shot or stabbed and come into an emergency room (2010:108).

Modern medical shows from the mid-1990s showcase “physicians [who] personify every quality a patient could want: brilliant diagnostic abilities, an unlimited fund of knowledge in all medical subspecialties, and Hollywood good looks” (Cohen and Shafer 2004:211). This is more referential of Dr. Welby than many of the more recent shows, but with more technology and information at hand. The ‘sexy’ doctor has always been in our television imaginary (remember James Brolin played Dr. Kiley on *Marcus Welby M.D.*). George Clooney’s pediatrician character on *ER*, Dr. Doug Ross, had patients’ mother swooning over him and people at home thinking, ‘my kid’s pediatrician does not look like that, but I wish he did.’ But one of the most important criticisms of *ER* and several other medical shows was the lack of medical accuracy with respect to interns
and residents, but that the methodology used for teaching medicine is true. “[ER] has
paid lip service to med ed’s ‘see one, do one, teach one’ method… [but] naysayers point
out [that in real life] a third-year would never be dispatched to do half the procedures that
Carter [on ER] gets to do on his own” (Durso 1995:22). The writers admit to playing with
those details but only to add to the drama of the show. Physician writers fully discussed
having committed those medical errors, but for the sake of the storyline. It adds urgency
and fear if someone who seems inexperienced is left with the responsibility of saving a
life and then when they save someone there is a higher pay off for the audience and the
character. These issues of authenticity and accuracy were raised with my informants
often, but they struggle with the fact that these errors of omission might be important for
the audience. They believe that these are negligible and necessary for the drama of the
eyisodes.

Also of great importance was the new presentation of diversity on screen in ER
but not Chicago Hope. “In ER, the panorama of character types was broader…[and] the
show followed the travails of more African-American physicians—male and female—as
well as South Asian Indian, Chinese, and Croatian doctors…[as well as a physician
revealed] to be a lesbian” (Turow 2010:341). This diversity set the stage for medical
shows in the 2000s and represented better the diversity of physicians in real life.
Diversity for the writers, producers and actors, those who have the most visibility or
power over the television shows has risen dramatically in the last twenty years, but before
that was very lacking. St. Elsewhere in the 1980s did not have any females on the writing
staff until their last season and then it was only one woman. For shows like Grey’s
**Anatomy**, the heterogeneity of physicians and actors in general on the show followed the trend set by *ER*, with lesbians, African Americans, and other ethnic and sexual diverse characters. “*Grey’s Anatomy*…depicts a class of bright, sexually desperate residents flummoxed by the pressures of the hospital environment” (Turow and Gans-Boriskin 2007:278). While, the entire cast of Grey’s Anatomy is diverse, the interns of *Grey’s Anatomy* have four white actors and one Korean. The diversity of actors on medical television is slowly growing over time.

The interns on *Grey’s Anatomy* were set up from the first season in a cohort for the audience to follow, in contrast to primarily following Dr. John Carter as an intern on *ER*, surrounded by his superiors. On *Grey’s Anatomy*, “as the doctors struggle to understand and treat a patient’s condition, they are forced to grapple with lessons in their personal lives” (Strauman and Crandall Goodier 2008:129). *Grey’s Anatomy* more closely follows the peer cohorts that medical students, interns, and residents agree occurs within real hospitals. The writers of *ER* went to Los Angeles emergency rooms to do observations on physician behaviors, interactions with colleagues, and other general information got story ideas just from these observations based on real life events they witnessed. These observations supplemented the many physicians who worked on *ER* in the on-set advisory role and in the writing room. Observations of real activities in hospitals makes the accuracy and authenticity heightened in language, medical stories, but largely the dramatic elements override the idea of complete accuracy. There is a lot discussion internally about the term ‘soap opera’ in reference to shows like *ER* or *Grey’s Anatomy*. *ER* set the tone for the ‘new’ medical show by focusing so heavily on the
medicine and, as some say, only following the personal lives of physicians enough to keep you invested in the characters. This perspective is part of the *ER* effect, whereby audiences had a new bar set for them about what medicine looked like on screen and what kind of operating terminology they could interpret for themselves after exposure to *ER*. *Grey’s Anatomy* is often characterized, even by their own staff, as soapy or a soap opera because of the greater focus on the doctor’s personal lives. In discussions with writers from both shows, I argue that both shows are soapy. The difference between the two is in how the information appears to the audience. *ER*, when looking at a single episode, gives the impression as being a serious medical show. When looking at the longer personal narratives and thinking about an angry physician who could not get along with anyone, he gets his arm cut off by a helicopter blade, he has his dead arm sewn back on at his demand, he lights it on fire once accidentally, he tries to practice surgery with one arm, and then finally dies by being crushed by a crashing helicopter, as it is for Dr. Robert Romano on *ER*, it begins to sound possibly a little more soapier than previously thought. And it should be said that even on *ER*, doctors and nurses have a good amount of sex with each other, as *Grey’s Anatomy* is known for kissing in the elevator/stairs/on call rooms/supply rooms. What characteristics determine a show to be soapy were certainly not agreed upon by my range of informants, from directors to actors to producers. Some said it was “heightened drama” or “an interest in the characters and character development” over the episodic drama. Nevertheless, *ER* raised the bar for dramatic medicine and graphic depictions of life in a trauma hospital.
Scrubs is an often overlooked 2000s medical show because it was a half-hour comedy. “To the layman, the half-hour sitcom may hardly seem like a paragon of factual accuracy” (Weiss 2009). Scrubs was often completely overlooked as well by my informants when speaking about their competition or other shows that might be relevant for this project. Not a single informant mentioned it in any way, even when speaking derogatorily about others who did not do something as well as they did on their show. It just was not even on their radar, which is intriguing considering it ran for nine seasons from 2001 to 2010. “If you look past the cartoonishness [of Scrubs], you find a series that's quite in tune with the real lives of doctors—and unlike your typical medical drama, one that's not required to end each episode with a climactic surgical procedure or whiz-bang diagnosis” (Weiss 2009). A writer for the show described their process for medical ideas for stories, where the writers would speak to at least five physicians between seasons. They struggled to get doctors to move past their “bar stories” of “something someone got stuck in their ass” which is apparently the go-to stories of many emergency room physicians when you tell them you are writing a medical comedy. Scrubs had one medical consultant who was the physician friend of creator Bill Lawrence who inspired the show and also the main character of J.D. played by Zach Braff. The writer said that the physician spent a third of his time “throwing up his hands and saying ‘this isn’t real medicine’” but the show looked at story ideas first and “then medicine.” The medicine was “MacGyver factual accuracy” and not what is expected from most major medical shows. On Scrubs, “nearly every medical scenario on the show has originated with a real-life situation, tweaked a little bit for drama and the constraints of half-hour comedy”
(Weiss 2009). The writer I spoke with described “stealing stories outright and/or cannibalizing” them when he interviewed physicians, spent the night in a real ER and saw someone die, and when in knee surgery, he gained information from his physician that they used in the script.

*Scrubs*’ major contribution to accuracy, while not really in the medicine, is in the emotional core of the show, the relationships between the interns, as the main characters begin in the hospital, and also their relationship with their mentors and bosses, the residents and attending physicians. J.D. is searching for a mentor and father figure in Dr. Cox, and until he realizes he is “capable of doing it himself” he will continue to let “Dr. Cox pull the football away.” As my informant told me, doctors loved the show. “*Scrubs*… is mostly about what happens at hospitals between crises—the way doctors and nurses handle ordinary cases” (Weiss 2009). The show provides the “crazy fantasy [that] runs through your head [and] we all have it” but it plays out in a cartoonish way for broad comedy laughs. The relationship between co-workers becomes its own form of authenticity of medical jobs. “Doctors say what makes *Scrubs* resonate isn’t the specific scenarios so much as the broader themes” (Weiss 2009). I think that the show *Scrubs* really gave physicians a way to think about the more philosophical nature of their profession, the long hours, the friendships, the rivalries, the love and hate for people in such close quarters, the romantic hook ups, and ways to deal with the life and death situations confronted every day. Specifically on *Scrubs*, J.D. and Turk have a taxidermied dog named Rowdy, whose presence suggests the inability to care for something with the schedule of an intern and the “different attitude towards death” that doctors have. J.D.
and Turk act like Rowdy is real, he moves around in the apartment so that the audience actually thinks that he might be real, and there was even a fantasy episode where Rowdy really was real. This more humorous nature and philosophical view of the medical profession contribute to a different kind of authenticity than seen in most other medical shows.

Also in the 2000s, House M.D. showed a very different kind of protagonist physician, at once neurotic, drug-addicted, and brilliant. The show was a constant diagnostic game with the smart Dr. House discovering unusual illnesses and ailments. The medicine was especially different from most other medical shows because of the predominance of ‘zebra’ diseases. One of the physician consultants said in an interview, “We paid a lot of attention to accuracy. But rather than creating an onscreen textbook of medicine, the writers constructed and inhabited a modified universe in which probabilities and time were severely stretched but not broken” (Sotos 2012). One of the great lessons of House M.D. is that “a great doctor is smart and observant, has encyclopedic knowledge, has sound judgment and works relentlessly on the patient’s behalf” (Sotos 2012). House M.D. is an interesting case because House as a character alone is unlikeable. He has a drug habit and is cranky, but he has some extremely redeeming qualities that the audience liked. He was the doctor the audience wanted if they were very sick, as he would always come through for the patient in the end. After House M.D.’s run ended in 2012, there were several shows like Mob Doctor, Do No Harm, and Monday Mornings that showcased physicians as antagonists, not always working in the best interest of their patient, or having similarly dramatic personal
failings. All of these shows were cancelled in 2012-2013 season because they failed to recognize that the audience needs to see a doctor have some sort of redeeming quality that the audience can believe in. We know that “doctors [on TV] often take risks and break the rules—[and] defying authority is a recurrent theme” (Makoul and Peer 2004:244). It is important to understand that the most meaningful times this happens is when it is in the patients’ best interest, not just to show a character flaw. These are the kinds of mistakes that can bring down a medical show. Audiences want to see doctors who fight for their patients and that is one of the single most recurring themes through all of medical television. Though I am studying specifically the history of the medical show, it should be recognized that almost all television shows have medical storylines at some point. Someone will have a baby, end up in an emergency room, get shot, or wind up murdered. The physicians and nurses who work on these specifically medical shows will also work on single episode television when it has a medical component and this has been normal practice since the 1990s. This is because writers and television shows are concerned with issues that they may have no background with and will choose to bring in specialists and consultants to make sure everything is done correctly.

**The ER Effect**

I met with many physicians and nurses who work on television sets, trying to inform non-medical writers and crew about their world. They give them options for diseases patients could have, they write in medical terminology, they position actors in an emergency room set, they demonstrate putting in intubation tubes, and they often dress in scrubs and surgical wear to appear in the scene as background actors. In all of this, I often
had to convince them or rather correct them that people actually care about the medicine. These writers and advisors know about the online blogs that point out giant medical mistakes and told me about the emails and letters they get from overzealous medical students pointing out the impossibility of a disease presentation. Most of them did not really believe what they did was really all that important to the people at home, but generally all of them hoped that it was. One informant said that she will not compromise on the kinds of medical points that people at home could put to use, like CPR. “Someone at home could save Grandma with this information” she said. They work hard to ensure a balance between the drama of the story and the medical possibilities being stretched to accomplish both an entertaining show and a fairly accurate portrayal of medicine. I had one physician who had consulted on a show because of the specific nature of their specialty tell me that if potential physicians are “getting a sense of how to behave [as a doctor] from TV, they should not be in medicine.” But another physician who consulted on House M.D. stated, “if the ‘House’ stories steered just one capable young person away from a career in investment banking and towards a career in medicine then the show was a success” (Sotos 2012). Most often to the physician writer I spoke with, the line between reality and television was so far away that it is creating an unrealistic sense of medicine and that doctors like House are “such a bad example for other doctors as to how to behave.” A different physician in a discussion about the idea of accuracy said, “everyone thinks ‘you should depict my life, my experience’ but that isn’t gonna happen. It can’t be universal. Is accurate then average? It happens to most people?” Many of the physician writers expressed this difficulty in feeling like accuracy was something everyone thought
they should be chasing but no one seemed to be able to define what that exactly means. If accuracy is medically accurate then most of medical television counts because the storylines have the potential or the possibility to happen to someone. Most often people had difficulty with the idea that if the storyline depicts a 1% case or an unusual presentation of symptoms then somehow it was not accurate and those expectations were unrealistic according to physicians because then there would be an extreme limit on the diseases they could discuss and it would begin to get very repetitive. A nurse that I interviewed told me that when she called a specific well-known physician for a question about a surgery only he performs, that this physician thanked her for trying to be accurate on this medical show. The physician cited Dr. Oz as one of the primary media sources that lead patients to being misinformed and he was happy that knowing diligent medical staffs are working on these shows behind the scenes.

It has long been established that audiences pick up information from television, from both fictional and non-fictional programs. There have been many studies done on this at various levels, some on the CSI effect and other legal concepts like Miranda rights. The foundational, often cited medical study about television is based on CPR rates and HIV transmission, both viewed as potential sites for misinformation that would concern public health. In a study in the New England Journal of Medicine, researchers looked at television episodes with a keen interest in CPR or cardiopulmonary resuscitation and survival rates. “Patients learn about CPR from many sources, including physicians, family and friends, personal experience, and CPR courses, [but] in a number of studies…”
patients report that they obtain much of their information from the media” (Diem, Lantos, and Tulsky 1996:1578). With this basis, researchers found that,

“Survival rates for CPR on these television programs were significantly higher than the highest rates reported in the literature [for real patients]. For short-term survival, the rate of success on television was 75 percent, as compared with 40 percent in the literature (P<0.001), and for long-term survival (assuming that the patients on ER about whom no explicit information was given survived to discharge), the rate of success was 67 percent (40 patients survived) as compared with 30 percent (P<0.001)” (Diem, Lantos, and Tulsky 1996:1580).

The differential survival rate on television and in real life is numerically dramatic, but what does it mean for people in real life. One of the physicians I interviewed who writes for television said that as a practicing Emergency Room physician in Los Angeles, he runs a code (where the patient is crashing and CPR is administered) so that “patients’ families know everything has been done.” He believes that patients’ families need to see doctors doing the work but being unable to save their loved one. They are told on television that CPR is a life saving treatment, one that often works to bring their family member back to life.

“The portrayal of CPR and death on three popular television programs is misleading in a number of ways. First, these three television programs give a misleading impression about the kind of people most commonly given CPR. On television, children, teenagers, and young adults accounted for 65 percent of the patients given CPR. Of the total number of deaths on the programs, 83 percent were of nonelderly patients. In fact, cardiac arrest is much more common in the elderly than in children or young adults. Second, cardiac arrest on television was often due to acute injury, the result of gunshot wounds, motor vehicle accidents, or near-drowning; only 28 percent of the patients had primary cardiac arrests. In real life, 75 to 95 percent of arrests result from underlying cardiac disease. Third, CPR succeeded more frequently on television than in the real world as reflected in the medical literature. On all three shows combined, 75 percent of the patients were alive immediately after their cardiac arrests, and 67 percent appeared to survive in the long term. On Rescue 911, which focuses on the successes of emergency services, the survival rate after CPR was 100 percent. Of the patients on ER, 65 percent survived the initial arrest; three of these patients died before
discharge from the hospital. On Chicago Hope, 64 percent of the patients given CPR initially survived cardiac arrest, and 36 percent survived to discharge.” (Diem, Lantos, and Tulsky 1996:1580-1).

Physicians who work in television repeated that the main misimpression that appears on screen is for the patient population given CPR. They agreed that most often it is not health, young people that are crashing in real life. It is often the very sick and the elderly and they will have a higher death rate. “Rates of long-term survival after cardiac arrest as reported in the medical literature vary from 2 percent to 30 percent for arrests outside a hospital, and from 6.5 percent to 15 percent for arrests that take place inside a hospital” (Diem, Lantos, and Tulsky 1996:1581). Most often the physicians I interviewed when asked about CPR portrayals on television talked about the fact that most people who code and then get CPR will be old and sick inside of a hospital and will often die, but that does not give you any real drama. A rebuttal in the NEJM stated that, “the problem in the television shows, then, is not so much inaccurate survival statistics as it is faulty representation of patients. The vast number of patients who undergo CPR every day in hospitals are not children and young adults, but chronically ill, elderly persons with limited life expectancies” (Markert and Saklayen 1996:1607). It is not generally problems with the demonstration of CPR techniques, but the patient problem of who is being featured for dramatic purposes.

Other medical demonstrations in a scene should always look as medically sound as possible, but ER set the standard for the most realistic portrayal of medicine. “The attraction of these programs [ER, Chicago Hope and Rescue 911] rests in their graphic ‘realism’” (Lederer and Rogers 2003:500). Because there is the expectation that the
medicine is real on these shows, the audience might pick up on information, tendencies, and terminology presented on these shows. The dramatically graphic and perceived realism on the show ER created a new medical imaginary for television and what I call the ER effect. Within that frame, ER gave audiences at home the feeling they were getting an inside “real” look at an actual emergency room. Medical shows have long had interest from the medical establishment in their accuracy but ER pushed the realism further than ever before. “Physicians assumed that many Americans would not be able to distinguish medical fact from the fictional presentation, and advised that physicians should both be aware of the images of CPR on television and be prepared to discuss these with their patients in order to promote well-informed decisions about resuscitation” (Lederer and Rogers 2003:500). Because of resuscitation rate differences in reality versus television, there is the “possibility that doctors may perform CPR, even when they realize the futility of such treatments, because families expect the procedure from watching medical television shows” (Friedman 2004:5). I spoke to an Emergency Room physician who agreed that patients’ expectations were set based on some of these media images but that his practice is to bring in a family member at the end of a code to let them see that what everyone in the room is doing and could possibly do is not working to save their family member. This helps with the finality of the situation for the family and also for warding off medical malpractice claims. In a rebuttal in the NEJM, Dr. Neal Baer, a writer and producer on ER wrote that, “two physicians are among the staff of six writers on ER and each script is reviewed by a physician trained in emergency medicine. The writers try to present stories based on real-life patients but sometimes dramatize the
events to garner high ratings” (1996:1604). Baer, in an interview said that this study “gave us pause” because “if we want people to feel it is real, people are going to believe what you are writing… and we have a responsibility.”

Additionally, in a Kaiser Family Foundation study of viewer responses and recall to an *ER* episode on emergency contraception they found that, “even before the *ER* episode aired, those who knew about emergency contraception were far more likely to say they had learned about the issue from the media than from doctors or clinics — 63% said they had learned about emergency contraception from TV, while just 11% had learned about it from their doctor or clinic” (1997). What was even more surprising was that “53% of regular viewers say they learn about important health care issues from *ER*” (Kaiser Family Foundation 1997). Importantly, Americans seem to enjoy programming that they see as both informational and entertaining, so that not only was *ER* seen as realistic in its portrayal of medicine, it showed something that captured people’s further interest beyond just that. “62% of those who say they learn about health issues from *ER* also say that’s one of the reasons they watch the show, including 25% who said it was a “major” reason they watched the show” (Kaiser Family Foundation 1997). *ER* was foundational for its storyline about a nurse infected with HIV, where many studies were done and academics looked at this to see what people at home understood and learned about this. Baer felt this storyline with the character of Jeanie Boulet was one of the most important they did on *ER* and “dispelled myths about HIV” for the audience. Not only did *ER* win awards based on this storyline’s presentation, but the writers were conscious about injecting social issues into the show, like this. “The issues raised by screening HIV
infected bodies [on ER] are located, then, not so much at the level of ‘positive’ or
‘negative’ representation (or interpretation), but at the level of organization, disruption,
and reinforcement of the processes of meaning production which take place as scientific
and popular realms make sense of the AIDS epidemic” (Nengeh Mensah 2000:149). As
academics wrote about the movement of bodies and the information about HIV/AIDS on
ER, there was a sense by the show that there might be a criticism of the portrayal and care
was taken by the show to make it a complex storyline, not one of black and white
information, which they accomplished by having it be a medical practitioner who carried
the virus.

A further example of the ER effect rests in a news story done by the Daily News
in 1997. Los Angeles’ Glendale Adventist Medical Center’s emergency department
director discussed the effect of medical shows on their practice and a surprising discovery
was made. They “didn’t use a heart medication called TPA as a treatment for stroke until
a patient who has seen it used for brain attacks on NBC’s ER asked about it” (Marder
1997:L3). It is now standard treatment at the hospital and medical professionals began to
understand that having an informed audience at home, meant having an informed patient
group when they became sick. One emergency department director interviewed was a
“believer that people should know far more than they do about medicine and that ER is an
excellent place for that information to be dispensed” (Marder 1997:L3). These studies on
the audience of ER are the beginning of what I call the ER effect, similar to the CSI
effect, whereby medical knowledge begins to become more important to audiences
because of the authenticity with which it is presented. In the example from a Glendale,
California hospital, lay knowledge was proven effective for the patient. Because the patient’s family watched \textit{ER}, a life was saved and a procedure was changed for the better. This lay knowledge movement is growing because of the enormous contributions these groups have provided for medicine and for patients. “Patient groups and health movements are...specific, concrete and locatable entities, well available for study” (Epstein 2008:501). Historically, medicine has not always known what to do with lay knowledge, how to classify it, or coordinate it with traditional knowledge, especially if the lay knowledge is coming from a television show that information could even be termed partial expert knowledge because of its source. “The term \textit{knowledge economy} usually refers to an economy based on highly developed technical knowledge” like that of traditional medical information (Sismondo 2010:189 italics in original). It is the newly categorized lay knowledge that must then gain some sort of authority to be placed alongside this medical, technical knowledge as just as valid a form. It is a completely new movement to have traditional medical knowledge coming from a lay actor who received it from an unusual source like television. When both types of knowledge are equally valid, both lay and traditional, then the movement will have succeeded and there will be a space for someone to use traditional knowledge through this kind of mechanism. When patients go into their doctor’s office quoting someone like Dr. Oz or \textit{ER}, it is not always treated as expert knowledge because of the processes of translation through the television to the lay actor. Somehow this takes away from the knowledge, but this is becoming more and more common, as the \textit{ER} effect has grown alongside the \textit{CSI} effect.
This kind of real, traditional knowledge presented in fictional programming is usually based on the idea of edu-tainment or info-tainment, the process of both entertaining and informing people at the same time, maybe so well that they do not even know that they are learning. Brodie et al. surveyed viewers about an ER storyline on HIV/AIDS between 1997-2000. More than half stated they watch for health information as well as entertainment (Brodie et al. 2001). There is something appealing to Americans where you can enjoy the knowledge being delivered to you in this programming. “About one in seven viewers said that they contacted their doctor or health care provider about a health problem because of something they saw on ER” (Brodie et al. 2001:197). The knowledge being produced on television shows, in this case specifically ER, contributed to their body of information about their own health and also general health education. ER is where the ER effect really begins but it has continued on in many other long running medical shows, including House M.D. and Grey’s Anatomy and it now present in most major medical shows.

Further in regards to this demonstration of knowledge production and the previously mentioned CSI effect, information is constantly moving between reality and fiction on television. I was struck by some broadcast information during the Boston Marathon Bombings on the first day of the tragic events. News outlets as soon as the night of the bombing on Monday, April 15, 2013 (twelve hours after the event) were trying to explain to viewers why they had not solved the case yet. People wanted answers and perpetrators caught as quickly as they knew there was a crime. On Tuesday, the day
after the bombing, CNN contributor and former FBI assistant director, Tom Fuentes was quoted saying live on *Anderson Cooper 360°* that,

“And you know, everybody's exactly right as far as the expectation and speed. People think that this is like an episode of *CSI* that after five commercial [breaks] and within 60 minutes they ought to be solved. And the amount of data that has to be analyzed, the forensic data, the phone calls, other information is just -- it's just a mess, and even with all the investigators at their disposal, it's very, very difficult” (Doss and Moore 2013).

And on Thursday, four days after the bombings when law enforcement had publicly identified suspects, Mike Baker, a former CIA Covert Operating Officer spoke to Fox’s *Imus in the Morning Show* and said,

“The problem that I think we've got nowadays is there's this expectation of immediacy. So within 24 hours of the Boston attack, you know, people started complaining about the fact that we didn't have the perpetrators. We didn't have the suspects yet. And you think, this is not an episode of *CSI* or *24*. You know, we're not going to solve it inside of 60 minutes, including commercials” (McGuirk 2013).

These statements made during live broadcasts were meant to quell the audiences’ unrealistic expectations about the speed at which law enforcement was working, thought to be the result of the stated *CSI* effect. While law enforcement was working quickly on their end to solve this case, the audience had unrealistic expectations that these former law enforcement sources believed exist because of the medical-legal television shows, which admittedly speed up and compress time for the story. The writers on all of the medical or medical-legal shows that I spoke with usually gave “time” as the most unrealistic portion of the shows, where lab results are available immediately and time passes with a sense of urgency because it supports the storyline of an episode. This time compression is only one more similarity between the *CSI* effect and the *ER* effect.
One of the forensic consultants for medical-legal shows (both fictional and reality television) told me that in her opinion the CSI effect “is slightly overrated but definitely exists” and that “CSI is more technology driven than a lot of other shows” where character storylines draw away from such a technology heavy focus. When there is so much technology, and remember that “experts agree that much of the forensic science depicted on "C.S.I."--40%, according to forensic scientist Thomas Mauriello--does not even exist,” the audience is misled about what information law enforcement and forensic scientists can even gain from crime scenes (Cole and Dioso 2005). The consultant went on to say that the “technology is ridiculous” and “if all that worked, there would be no need for actual people.” Medical shows try to use real technology as often as possible. There are no holograms or somehow wildly accurate photo mapping, pixelating, or facial recognition computer programs that can be seen on medical-legal or legal-police procedural shows, but do not exist in real life. Almost all of the technology and medical procedures are real on medical shows, which made lead to more accuracy understandings by audience because of the ER effect.

The ER effect is a movement of medical information from television writers and consultants to audiences. This knowledge is produced by members of the medical community that have taken it upon themselves to self-regulate in order to ensure public health and safety messages are clear and authentic. The doctors and nurses who work on shows, especially since the era of ER, push for more realistic portrayals of patients, medicine, and disease. The shows depict what it looks like to be in a car accident or to have a heart attack. This effect from ER has had lasting effects in television. When a
viewer sees Dr. Oz holding up a lung, as he is want to do, it is probably not the first lung
they think they have ever seen. They probably saw a pig lung or a modeled silicone lung
on a fictional medical show long before Dr. Oz was making viewers put on gloves and
hold them. ER changed the medical landscape for television with all of the complicated
jargon, bloody gowns, and rushing around the emergency room. One of the
writer/producers of ER told me that they did not personally know what “bradying down”
meant, even though that had been written into hundreds of ER scripts. When this writers
was in the hospital with a sick family member and heard that phrase “the patient is
bradying down,” the writer called for help in the hallway because they only thing they
knew was “that was what I put in scripts when things weren’t going well with the patient,
so I only knew it was really bad.” Even the non-medical writers gained some medical
information from the ER effect of working on the show, and bradying down means that
the heart rate of the patient is dangerously slow. The process of knowledge production in
the case of ER and other modern medical shows has obtained biomedical approval by
having a staff of dedicated medical professionals and has been proven to save lives based
on the CPR and TPA examples. Further, a physician writer on ER told me a story about
how viewer contacted him after one episode of ER saved her life. She had chronic
headaches and was not getting answers from her physicians. In the episode of ER, Dr.
Greene’s brain tumor was shown to be coming back through having him sticking out his
tongue, and it deviated to one side. The woman at home went to the mirror and stuck out
her tongue. It lilted as well and she immediately went to the emergency room and was
diagnosed with a tumor behind her nose. Doctors said she would have died within a few
weeks if they had not caught it. She went through chemo and surgery and is still alive today. The woman contacted the physician writer and the writer flew her out to Los Angeles to tour the set of *ER* and meet everyone. She still calls this writer her “angel” and is alive today, 10 years later. This is the *ER* effect at its best.

**Accuracy and Authenticity**

Accuracy and authenticity are very important to the people who make medical television and they have become increasingly important to the audience at home. It needs to feel real to gain an audience. Bruner’s definitions of authenticity lead us believing that the bodies we see on medical television are “credible and convincing” and therefore authentic, but they are also a copy or imitation and therefore the authenticity is going through a process of mimicry (1994:399-400). Mimicry and mimesis show us that those are not real patients on the operating room table. You may not know at home how that exactly works (that the actors are on a ‘slant table’ where their head is exposed and their body is lying at an incline under the table with a fake torso on it) but you should believe and be connected to the actions whether it is a life or death outcome for the patient. There are so many slight of hand tricks that were described to me that the actors are taught or improvise for medical actions like intubation or injections or defibrillation, so that the audience perceives them as real. The show needs the audience to think of the scene as authentic or they will not cry when someone dies or cheer when someone lives. If there are no dramatic stakes, if someone is not actually saving a life (as they really are not) then there is nothing to be invested in with the characters. Authenticity is more than just medical authenticity often times, but that is easiest place for a show to lose an audience
member because of authenticity. When someone at home becomes distracted by a medical mistake often that is all it takes to remove some semblance of authenticity or credibility with the show.

Bill D’Elia, the executive producer of *Monday Mornings*, spoke to me about the kind of creative control he had over the show. *Monday Mornings* ran for one season in 2013 and was based on a book by Dr. Sanjay Gupta, a prominent medical journalist for CNN and neurosurgeon, and featured mainly neurosurgeons and emergency room situations over their first ten episodes. The show had one physician on staff, Dr. Gupta, and several nurses consulting on set and writing episodes. Mr. D’Elia described for me the emphasis on mood and tone for the show through their use of color, by showing whites and blues prominently on set. The operating rooms were overlit so they appeared very bright and stark. By comparison the auditorium where the doctors convened for their morbidity and mortality meetings was very dark except for the overlit stage to emphasize the physician and case being discussed. There was a lack of red used on set so that “when someone bleeds, it means something” to the audience. These are the subtle ways that shows will shape the perception of the audience towards or away from something to give it meaning or purpose. Just with color and light gradations, there was an emphasis on people, patients, events that told the audience how to see things, how to feel. This is biopower, where the people who make television have the power to shape a perspective of biomedicine the way they want it to look and feel and the audience simply passively experiences their world, then possibly taking this information into their real medical lives. It is also worth mentioning that *Monday Mornings* focused on these morbidity and
mortality meetings (M&Ms) that physicians have in hospitals to look at mistakes that
doctors or staff have made and learn from them. The drama in the M&Ms was so high
and the meetings so often that the shows scored well with physicians and people who
work in the medical field, but failed to find a large audience among the general
population. Among other reasons, I believe that people at home do not want to see
doctors constantly making mistakes and hurting patients, which was part of the message
incidentally of the show. The juxtaposition of what a general audience wants, who may at
some point have to visit a hospital and then see as scary, and what a physician targeted
audience sees as real drives the boundaries that have been created in medical television.
Show enough but not too much of the body, be graphic but not too graphic in the body,
and show doctors having personal failings but not too many professional failings because
no one wants to think they or someone they love is going to have to see that doctor who
is careless or reckless with them. The medical authenticity is what will keep everyone
interested in a medical show because like the CSI effect, audiences pick up on
information in the ER effect. With so much riding on the medicine, there are a lot of
people working together to ensure medical accuracy in the crew and outside as
consultants.

Medical accuracy and authenticity has long been a focus of medical television and
just as the AMA and LACMA were involved in the early days of medical television,
actual nurses and physicians worked together with the dramatic writers and other
television crew in the production of shows. “Known as ‘entertainment-education’ (also
called ‘enter-educate,’ ‘pro-social entertainment,’ or ‘edu-tainment’) the strategy has
been used throughout the world, often in concert with other kinds of public health information campaigns” (Brown and Walsh-Childers 2002:458). It has long been important to control for perception by audiences of medicine and medical professionals. This emphasis is representative of the need for control over public perception of “things medical” by the organizations that can contribute to the biolegitimacy of the television show. By giving a sort of stamp of approval, they create an authenticity but they also require control over the process, thereby previously making the process slower and more difficult. In 2001, out of a CDC panel’s recommendation in 1997, Hollywood, Health & Society was established at USC’s Annenberg Norman Lear Center with major funding by the CDC, National Cancer Institute, the Bill & Melinda Gates Foundation, and other major health non-profits to advise films and television about health storylines and provide a service of connecting shows to specialists and information (Hollywood, Health & Society 2013). Hollywood, Health & Society (HH&S) is primarily set up to be a gatekeeper between physicians and the entertainment industry like the AMA and LACMA before it. I did not speak to anyone at HH&S, after multiple requests, but I did ask my informants who work in television, and had all had some sort of interactions, about their experiences with them. Most often HH&S was considered somewhat useful, but often unusually controlling, mostly without any foreseeable reason. In one instance, for a show that had a storyline that required a neurologist specialist to consult, HH&S asked for a list of questions that they would then submit to a physician on behalf on the show. When HH&S was told that the show needed about 100 questions answered and probably, eventually for the physician to come to set and look at things firsthand, they
relented and put the show in contact with the physician directly. “US advocates have been working with the commercial media to embed subtle health messages into existing entertainment programming” (Brown and Walsh-Childers 2002:458). HH&S is one of these organizations that attempts to steer shows towards or away from stories or physicians. Everyone I spoke with had worked in some way with HH&S, and their opinions remained divided over its’ usefulness in their industry. HH&S is also on every call with the physician or specialist that they connect with show staff. There will preferably not be communication with the medical professional of their choosing without HH&S present, taking notes on the topics discussed. With so many working physicians and medical professionals, it seems a little redundant and many writers admit to using Hollywood Health & Society to do the legwork that they just do not want to do in some medical research.

Most often, the professionals at work on television shows and groups like the AMA, LACMA, and HH&S are working to establish fundamental medical accuracy and authenticity. They do this primarily by maintaining storylines that have factual accuracy and showing procedures in a way that might be recognizable to an audience. The medical staff are the ones making sure that all of the language, props, and actions are as real as possible. “As medical drama have evolved from fiction to near fact, professionals like [on set medical advisers and physician writers] have become the backbone of such popular shows as House and ER” (Fischer n.d.). They have become essential, indispensible parts of a television crew that even if not directly utilized on a given set will be present in case they are needed for advice or correction. There were many physicians who consulted on
television shows or wrote for shows who mentioned that if physicians or people who want to be physicians are taking a lesson from medical shows that this is what being a doctor is, then maybe they should not be a doctor, especially for characters like Dr. Gregory House. If people want to be doctors because they think they get to have lots of sex in on-call rooms, medically treat patients against their own will, always rush in and single handedly save the day, then maybe it is best of they avoid medicine for the public’s sake.

I mentioned to several of my physician informants that Joseph Turow, a professor of Communications created “a video essay, *Prime Time Doctors: Why Should You Care?* that…has been distributed for several years to first year medical students throughout the United States” and has video excerpts from medical television shows to be used in training real medical doctors (2010:15). Most were astounded that medical television would be used in physician training. In the beginning of the film, the caption on the screen tells the medical students, “to have a trusting relationship with your patients, it’s important to be aware of the images of TV fiction that may apply to doctors like you.” The film uses clips from shows like *Dr. Kildare* to *Gideon’s Crossing* to *ER* to demonstrate the changing role of the physician on television over time. In one segment on medical ethics, the series *House M.D.* is discussed and the caption states, “*House* highlights a complicated world of TV medicine where patients and physicians often mistrust each other.” In a segment featuring a clip from *Grey’s Anatomy*, the lesson is that doctors’ “personal issues pervade TV medicine.” As a comparison to the medical drama, Turow shows how forensic television programming may have given the audience one way to focus on seeing medical
perfection, where “the images drawn from shows like CSI and Crossing Jordan portray a process that is precise to the point of infallibility.” People do not often think of crime-forensic shows as medical shows but they do feature medicine in the form of pathology and the coroner’s office. The DNA evidence in these shows tell us “all crimes are solvable.” This sits in contrast to a point made soon after in the film that “TV’s continual message [is]: Doctors are quite fallible.” Both types of medicine sit in apposition to one another. Forensics are precise and perfect, medicine is personal and imperfect. This type of instructional film is rare to be interjected into medical training, but the message is interesting. It tells potential physicians that their patients will arrive influenced by the media they consume and to be aware of this in their practice and treatment.

When it comes to the generalized portrayal of physicians, the depictions change from show to show and almost season to season. “Physicians in prime-time fiction are still being portrayed positively on an objective scale, [but] these portrayals are less positive that they were in the past and less positive than physician images found on contemporary non-fictional programming” (Chory-Assad and Tamborini 2001:517). One of the most interesting shows for this kind of analysis is Grey’s Anatomy because there are so many main characters that are fully developed. “ABC’s Grey’s Anatomy continues in this tradition by showing both positive and negative characteristics of medical doctors” (Quick 2009:40). The physicians are not only diverse in terms of gender and ethnicity, so that they look more like the physicians that one might encounter in real world medicine, but they also do things both for themselves and for their patients. Quick hypothesizes that “portrayals presented…[in] Grey’s Anatomy will likely impact viewers’ perception
of real world doctors” (Quick 2009:43). In speaking with writers of Grey’s Anatomy, they are concerned with this idea but they assume viewers can decipher the difference between reality and drama within the storylines of the show. One example discussed in interviews is how interns were rarely featured once the main characters became residents, but they can pop up every now and then in an episode for story movement or the use of new characters. The writers assume the viewers know they are in the background of the hospital, just not featured most of the time.

There is generally always a complaint about the roles that these fictional physicians and nurses take on set. Many people in medicine, either as doctors or nurses, speak about the problems with interns doing resident tasks, doctors doing nurses tasks, and other changes in authority in the hospital. “One egregious misrepresentation on House, Grey’s Anatomy, and ER is showing the physicians performing critical nursing tasks, thus making them look more heroic and nurses look more incompetent and needless” (Bishop 2009:4). As well, “the interns on Grey’s Anatomy are filmed doing many jobs that nurses would normally do, as well as giving orders to nurses” (Bishop 2009:6). These actions and misrepresentations are often to give main characters more to do in a scene, to add to the action or the drama of the show. Writers assume that people are home will be able to understand that small misstep in representation, but it can be assumed that most people at home have no idea what an intern, resident, or attending physician’s jobs include and which rank of physician they are seeing when they visit a hospital. Quick’s analysis uncovers a link between “heavy viewers of Grey’s Anatomy [who] perceive the content to be realistic…[because of] the limited exposure most
patients have to these behind the scene looks at doctors at teaching hospitals” (2009:52). Without a lot of experience in a hospital, these portrayals can be confused for real life, and often the information and knowledge can be taken for granted and not looked at critically by the audience. The accuracy and authenticity is a struggle for those in the medical consulting and writing, but everyone I spoke with reminded me that they are making a drama or a comedy, not reality programming. They balance the two goals of the show as best they can while showcasing new technology and techniques for the audience in between the fictional love stories and friendships, both of which cultivate viewership together.

Beyond the medical information contributed by television shows, there are groups of people, some of them medical students, who will write about and point out any and all possible medical inaccuracies on television. There are web blogs and Internet articles about the medical mistakes made in television and movies. In one such article about Grey’s Anatomy, the author outlines storyline failings like “tampering with a clinical trial,” “practicing operations on one another,” and “cutting the LVAD wire” which was a primary plot point in season two (Clarendon 2011). The author also makes excuses for some of the mistakes because we love the characters. Izzie cuts the LVAD wire of the man she loves to move him up on the transplant list and “we can’t chide her too much, because it was all for naught and because our hearts broke when Denny done died” (Clarendon 2011). This demonstrates that the drama of the fictional show can be just as important to the audience as the medical mistake they are pointing out. This conflict is inherently at the heart of television and movies where there are medical storylines; how
to make a dramatic show that people want to watch without screwing up too much of the medicine. Neither should be at the expense of the other, because both contribute to the success of the other.

Several storylines from medical television shows featured medical conditions where the medical community welcomed the featured portrayal. In many cases, these episodes shed light or brought awareness to conditions that benefited from public exposure. In Season 5 of Grey’s Anatomy (air date November 20, 2008), an episode featured a hypochondriac woman who got rid of so much good intestinal bacteria that she eventually needed a “poop transplant” from her husband. There was a lot of interest in the story online in Grey’s Anatomy blogs after the episode aired. Real life imitated art when in 2012, CNN Health featured the story of Kaitlin Hunter’s “persistent infection [that] was beaten through a little-known technique involving the transplant of fecal matter from Hunter's mother, which put healthy bacteria back into her colon” (Hudson 2012 italics added). The technique should be no surprise to Grey’s fans and is still seen as a fairly new and little studied procedure that is generally only used when a Clostridium difficile infection (or C. diff) cannot be treated by other methods. The episode featured this procedure that is growing in popularity for antibiotic resistant C. diff patients in real life. In this case, public awareness may create an acceptance for something that seems distasteful and vaguely stomach turning because of the severity of the situation for patients with the infections. It may have helped public perception by making it humorous and tangible for the viewer, as well as making the knowledge resonate with audiences as established medicine, when it is not yet widely used.
In a similar way, in the next season of *Grey’s Anatomy* an episode (Season 6, air date: January 22, 2009) featured one of the doctors, Mark “McSteamy” Sloan suffering from a penile fracture after having sex with a young colleague, Lexie Grey. The episode “pushed ‘penile fracture’ to the top of the list of most-searched terms on Google, the likely result of men and their partners panicking at the thought of such a painful and embarrassing injury” (Friedman 2009). Blogs went crazy and many online news outlets called emergency room doctors and urologists to talk about the condition. The episode itself brought awareness for audiences but the ensuing media coverage of the storyline and the medicine behind it created even more information for viewers and web searchers. In one such article, the *NY Daily News* spoke to a pharmacologist and men’s sexual health expert, Dr. Salvatore Giorgianni who said, “they did a favor on the show by getting [penile fractures] out there, because it happens…so if we lose some of the stigma and you know you’re not a dork if it happens, then that can really be a positive thing” (Black 2009). One of the most important and stressed portion of the news coverage is that the condition is treatable but most men do not get treated for it, usually out of embarrassment (Black 2009, Friedman 2009). The idea is that, by having a handsome, sexy doctor on television suffer from something so stigmatized, it may help audience members associate the painful condition with being sexually experienced and exciting.

It can beneficial to have an embarrassing health issue shown on television in a fictional scenario for outreach to the public or inform small patient populations about treatment. “Fictional depictions could lead to viewers’ obtaining inaccurate information or taking away critical misperceptions about health topics” but often it is very well
researched and comes from medical writers (Brodie et al. 2001:198). Some groups complain about the lack of seriousness for the treatment of some medical issues on television, but most are incredibly happy to have exposure and information dissemination about their cause. One medical advisor told me that she would have shows hire real amputees, actual kids with cystic fibrosis, and real survivors of chemo as background actors when they were needed for hospital sets on various shows and then those shows would get fantastic feedback from those communities about their portrayal. There was one fairly odd anecdote I came across in the research for this project that I feel necessary to mention, but also acknowledge that no one who I spoke with that worked for Grey’s Anatomy had ever heard of, and did not condone this behavior. In an article by State.com about the medicine behind Grey’s Anatomy, there was a mention of an incident in real life where a patient “left the hospital emergency room before getting treated because he did not want to miss a Grey’s Anatomy episode. After he signed out against his doctors’ advice, he [the man] reminded us the medical shows are sometimes better than patient realities” (Katz and Wright 2005). Some people take their medical information more seriously than their own medical treatment.

One thing disclosed to me repeatedly by informants was the fact that the writers and producers were very careful to not address certain topics on television. The consensus was that it is difficult, if not impossible, to show teen suicide, anorexia, child obesity, some forms of overdosing on drugs, and certain medical murders. Shows do not want glamorize actions like suicide or overdosing, and child obesity is a difficult story to address tonally. Further, some medical murders that people can realistically commit and
get away with, are unilaterally agreed upon to be inappropriate for television, lest people take that information and harm someone. I had a television writer who spoke to a coroner about these types of concealable murders, the writer took the information and did not even take the research into the writers room because it was unnerving to her. There is power in the information distributed on television, and this may be an extreme example of the possible consequences of the *ER* effect that shows work to address ahead of any issue. If any of these issues or others like domestic violence were ever to be addressed on television, it must always be followed by hotline information and a public service warning advising audiences on steps to take about the issue for prevention or treatment. They do not want to be responsible for someone getting hurt, but they often do see themselves as educating the public.

Many writers and on set consultants talked about the opportunities their shows provided to highlight pet projects or issues close to their “TV family.” A writer said that he “didn’t view our primary role as to educate” but that social issues were compelling to the audience and the cast and crew. A writer for *ER* talked extensively about the awards given to the show for its’ coverage of HIV/AIDS storylines and tons of free publicity that resulted. Substance abuse for the Dr. House character on *House M.D.* was an example given by several writers for the show as their favorite storylines and their most important storyline. *Grey’s Anatomy* featured a story about woman who had a preventative double mastectomy and a writer for the show discussed how important that storyline was for the cast and crew. These stories are all good exposure for the shows and educational opportunities for the audience. Paired together, this is the *ER* effect at its’ height,
whereby the shows know they are giving the audience important information about a sensitive or popularly discussed health topic. A producer for *Grey’s Anatomy* told me about an instance where a popular actress was going to guest star on the show. She came in to talk to the writers and told them about something that had happened medically in her own life with her child. It was so compelling that her guest star role was of her reenacting a fictionalized account of her own medical encounter. Writers on medical shows get their ideas and information from so many places, that art imitating life is a frequent encounter, but audiences will never know how and when this happens. Noah Wyle, an actor on *ER*, spoke to me about his favorite storylines on the show. He met with overseas physician groups doing “international triage frontline medicine.” He felt a resonance with their personal stories and their charity medical work and had some of these storylines added to *ER*, where the show had his character Dr. John Carter, doing medical work in the Belgian Congo and Darfur, Sudan. The funny thing is that *ER* is supposed to be set in Chicago, but was mostly shot in Los Angeles, and these storylines were faked locations as well. The Belgian Congo scenes were shot in Hawaii and the Sudan in South Africa, and in our discussion the joke was that the desert area in South Africa that they used could have easily been the desert areas around Los Angeles (also frequently used as fake locations for many other television shows and films). They went so far around the world only to be in a scenery that felt entirely familiar. The reality of locations is generally faked or substituted for television to make it cheaper or safer. In this case, the show took on the personal storylines that Wyle felt would be compelling to an audience since it was compelling to him, and the authenticity of the storylines were based on real physicians
reporting their experiences. Television provides a medical imaginary of what can and should be for their bodies within biomedicine. While audiences might believe they can see the difference between real and fake or even admit that, of course some things are fake, but still believe they can tell the difference. There are often moments of real and unreal that cross boundaries on medical television, even adhering to the definition of authenticity, that if they knew when and where these happen, they would feel like it was fine, understandable. “The mass media… present a rich, ever-changing store of possible lives, some of which enter the lived imaginations of ordinary people more successfully than others” (Appadurai 1996:53). Medical narratives and stories are that of life and death, they are scary and uplifting, they make viewers cry and laugh, and these stories are written and set up by physicians and nurses who want it to be better and more real so that when the *ER* effect happens and people learn from television, they see something that will shape their biomedical perception in good and helpful ways.
Chapter Three: “I’m Not a Doctor but I Play One on TV”: How Patrick Dempsey Saved a Life in Real Life and Other Television Mimesis.

In April of 2012, life imitated art. Patrick Dempsey, who plays Dr. Derek Shepherd, also known as McDreamy, on TV’s Grey’s Anatomy, saved the life of a 17-year-old boy who crashed his car on Dempsey’s front lawn in Malibu, California (ABC News 2012). Everyone from TMZ to US Weekly to People Magazine covered the story and it made nightly news headlines and airtime on Los Angeles local news. “Derek Shepherd…is a glorified, sexy neurosurgeon who somehow always manages to do the impossible to save lives” (Bishop 2009:7). The idea that a television doctor would be in a position to save the life of a child in real life seems unrealistic because these actors are not actually doctors, but in this case a quick thinking bystander happened to play one on TV.

Television productions often show us what life should be like in a hospital. Doctors like Dr. Derek Shepherd fill viewers’ heads with the idea that physicians are not only gorgeous, but they risk everything to save patients’ lives, apparently even in real life. But television production, the making of television, is anything but glamorous. It is a much longer and more arduous process than many viewers will ever know. Television and films are based on a 12-15 hour day of shooting, and this does not include a one-hour lunch, so the workdays are long. Because of various union rules about working conditions, mainly the Screen Actors Guild, the day is usually 12 hours with a financial penalty if the day goes over this. It usually does. When looking weekly at shoots, most begin on a ‘Monday’, whether that is actually on a Monday is arbitrary, at around 6 am or 7 am. When each day is pushed to 13 or 14 hours days, the next days’ call time for cast
and crew will begin a little later each day of the week. By ‘Friday’ of that week, the day may start around noon because of these daily overages, and will shoot until the wee hours of the night. This can be different if it requires a night shoot outside and then there will be a delay to get everyone to nighttime hours. Shows have 8 days of shooting for each episode, and I was told that most often they will go past that into 9 to 11 days of shooting per episode. Any shoot will have what can seem like a massive amount of crew. There will be a director, assistant directors, production assistants, (all known as the production department), camera crew, set lighting, grips, production design or art department, set decoration, makeup, costume, special effects, props, a script supervisor, producers, consultants, location managers if not on a sound stage, construction, craft services (the people that provide the food) and many more. A lot of people are all on set together and they know their job very well, whether it is to move furniture, make props, or keep track of continuity from day to day. It can look like chaos, but it is very controlled chaos. The crew needs to be responsible because you never want to be the person holding up the show unnecessarily. It is a very well oiled machine and productions can be priced out to the minute spent doing this or that during shoots.

Being a medical adviser or consultant, a position established in medical television since the 1960s, can mean that you are a permanent part of the crew or that you come in for a few days when there are medical components to a storyline. If you are permanent, then there may be camaraderie with everyone else. If you are a day player, then you have to do your best to fit into the already established relationships everyone else already has, and this can either be the hardest kind of job or the easiest. All medical staff will attend
preparatory meetings and meet with directors of each episode that they will be involved in and also with each department head. Future work is created within these relationships with others on set. As you will see in the words of my informants, making friends is one of the biggest challenges of the job. Another is that this kind of work does not have its’ own union, and therefore no benefits or ways to organize together. One solution for medical consultants or advisers is to get a co-star role on the show if you appear in episodes and then get your Screen Actors Guild membership, or SAG card, or you might be named a producer, co-producer, or executive producer and then gain membership into the Producers Guild, or lastly as a writer on the show you would be a member of the Writers Guild. Guilds are unions and guarantee benefits, like health care and retirement plans. The on-set advisers often appear in episodes with background extras like as a nurse in a surgery and writers will work on the episode that they wrote by helping with casting or other duties if they are also producing it. Many of the nurses who work on set will have additional nurses that work as background extras so they have the medical knowledge to be able to pass the correct instruments to the key actors in a scene. ER had the same nurses that worked through the entire show’s run. Grey’s Anatomy has a set group of nurses in this capacity as well. The role of advisor is placed outside of the union system because there are few people who do this kind of work, there can be a transient nature to the population whereby they work only on one episode or only by phone or only on a single show, and the ways in which people can be incorporated into other guilds or unions based on their additional job duties of writing or acting.
There are differences in terminology used for these medical consultants or advisers in credits and by the individuals to identify themselves. As I have learned, there used to be more formality to the distinctions between an adviser and a consultant. An adviser used to be strictly for those who worked on set with the actors and consultant was just for those who worked in the writers’ room and on storyline issues. Now the terms, medical adviser, medical technical adviser, medical consultant, medical technical consultant, set technical consultant, and medical researcher can be used by anyone who thinks of themselves as that or whatever they prefer. Writers are often termed as advisers now and on set medical staff may be referred to as consultants. Those who do the work will give themselves their own title, and with the lack of a union, there is no overseeing body to have a standard for those roles or titles. This was part of the difficulty in locating informants and figuring out ahead of an interview which role was actually their job. This is also a point of frustration by the on-set medical staff where the writers will name themselves technical consultants which some might infer as on-set work, thereby somehow claiming to others that they have incorrectly done the work of the medical consultants on set. I am not sure how much of this irritation the medical writers are aware of, because those writers are often physicians and the on-set staff are often nurses and that relationship seems to be tinged by the typical hierarchy that would exist in traditional medical situations. Several nurses that I spoke with talked about their frustration with physicians thinking they knew everything about everything on set. ER was an exception among shows where the on set consultants were all physicians because of the technical nature required of the advising. The physicians have formed their own “biological
communities” whereby captive knowledge is maintained and access privileged to those chosen few who can guide the television set (Rose 2007:135).

I did find that most of the physicians working as writers are male, usually white males, and the nurse consultants on set are white females. Most of the physicians I interviewed who have worked consistently over the years were male, although there were a small number of female writers. There are several prominent female physicians working as pathologists or forensic consultants. All of the on set nurses I interviewed were female and I was told over the years there have been males who have done the job but most did not last very long or they were physicians who then may have either left the industry or many have shifted to writing jobs. I believe this gendered trend has to do with the nature of the differences in the two jobs and this was somewhat confirmed by one female physician informant. With the medical authority placed upon a physician through their education, there is usually no spoken belief about the ability of a female or male doctor doing the job of writing on a television, but because most of the physicians working today have been working in television for 10 or 20 years they tend to be males. An informant told me that it has historically been a bit of an “old boys club” and that is why there are still some very prominent men working consistently and very little space for new entrants into the field. They have the experience and longevity to stay in their positions, and any new physician writers come to the job through personal references or a referral. These jobs are almost never advertised publicly or are one that a doctor could apply somehow for, as it always based on personal connection with a fellow physician or a trusted colleague. For the on set nurses, there is a need for someone who can cajole,
prod, or gently work around difficult positions and this has been perceived as a female positive trait, hence the amount of females who have long had success in this arena. There is one female working as an on set advisor who is more loud, authoritative, and often described as “demanding,” all of these being more often stereotyped as masculine traits. This consultant has been in the business the longest and has more experience and control over her sets than most of the other nurse consultants. This is not to say that this is not changing. I think that over time perceptions about these jobs and the characteristics required are changing based on societal gendered beliefs and shows wanting to have the most expertise and knowledge brought to the set, just like the portrayal of female physicians as actors has paralleled the rise of women entering medicine. Marcus Welby M.D. only featured females as nurses or patients and Grey’s Anatomy has almost as many female leads as male leads in physician roles. Ethnic diversity is also changing, with more physician consultants (those available by phone or that come to set infrequently) that are Asian or African-American, but some of that is changing because physicians or nurses who work on shows full time will call colleagues or physicians they know to do this small amount of work and that does not seem to be skewed by ethnicity or gender, but by specialty or capability in discussing a very particular medical procedure.

Over the course of this research I began working with medical writers and researchers for television, and then sought out the on set advisors. Along the way I saw the need to interview several of the actors that these advisors named as especially interested in the medicine and medical authenticity. Through that quest for actors, I interviewed one actor from a medical show who has moved towards directing television
and had directed multiple episodes of medical television. In that interview, I recognized the essential information that directors could give me and I sought them out as well whenever possible. Directors of television play a very different role from actors, writers, and on set personnel because directors may only work on a single episode or multiple episodes scattered over a season of a show. When directing an episode of television, you come onto a set that is an engine already running with a very specific look and feel so that there is very little that can be changed or altered. You also work one week on preproduction getting ready for your episode, eight days of production of the episode, and about a week on postproduction or editing. While you are in preproduction for your episode, someone else’s episode is shooting, so that the machinery of television keeps going in a timely fashion. It would be almost impossible or at least incredibly difficult to have a single director for an entire season of television. The exception is the position of producing director, the producer who hires directors. They may also direct episodes and have more interaction with the crew because they are producing the show as well, being a constant presence and permanent part of the show’s crew.

Directors are somewhat interchangeable in television because of these constraints, but what that means is that with every show they work on, the machine has its’ own quirks, flaws, and fun to experience. It means being adaptable and doing what you can to gain control over the parts that are flexible and up for debate. Because the director is in control over blocking, or where people stand and move on set, they work very closely with the on set medical advisers to choreograph intensely medical scenes with the authenticity and dramatic intensity required. One director I spoke with said the first thing
he wanted to know was “where should each person be to motivate the camera moves.” He also wanted to make sure he spent the time in postproduction and editing to get his look and feel across in the episode. By making sure to spend the time with ‘your’ episode, they can control more of the episode. Another director spoke about the enormous authority given to the medical adviser on set because of the complications of their job. They are setting all of the medical props in the scene, they are teaching the actors how to do individual procedures, and it is important to remember that it needs to be “informative but also entertaining” and “medicine is only one part” of the show.

**Physician Writers: The people who put in the medicine.**

Medical writers and researchers work behind the scenes to create the storylines that make drama and comedy and also character development possible. They also are responsible for the oversight of medical information in the scripts. Often they are practicing physicians in their spare time, but some have left their medical practice behind for good. Several of the physician writers have graduate degrees in film production or screenwriting, in addition to their medical degrees. They often use examples from their own medical practice or physician colleagues’ stories from their practice as storylines, as well looking at medical journals and using online medical research. I was told that these physician writers use their own stories “but take all the boring parts out.” Some of these physician writers finished medical school, obtained their M.D., and then went to writing in Hollywood, forgoing their internship or residency years of training. Several of these writers figured out pretty quickly that they did not really want to be physicians but in the end having the medical degree allowed them to have this specialized knowledge that
created a space for them in Hollywood. Their captive, biolegitimate knowledge makes them authorized for this kind of task in writing or advising medical storylines.

*St. Elsewhere*’s staff included an operating room nurse and an internist “to add correct medical jargon to the script (which the writers would often denote by writing ‘medical bullshit here’)” (Turow 2010:312). When I interviewed a writer for *St. Elsewhere*, he stated that they had a physician on-call, as in you had to call her on the phone to get the medical information, and that most of the writers would do massive research of medical cases over hiatus. They would begin the season in a competition to see who had the better ideas and research and then set about the distribution of episodes to one another based on that. As I was told by other informants, this is often still a process utilized by writers on medical shows who do not have an medical knowledge and who will write “medical medical medical” in spaces in the script for the medical writers or physician writers to fill in later. Or on one show the writers would put in the statement “[Dr. Writer] fill this in” and then that person would be responsible for that medical jargon in the script. Dr. Neal Baer, a producer and writer on *ER*, described how the medical language on a show when written by doctors “feels real” and that without it “it feels like you are filing in medical here” for the audience.

In looking at the narrative storytelling aspect, there is a sense of telling and retelling that add importance to stories (Garro and Mattingly 2000) and this is true for medical television writers, many of whom said that the commonality of storylines among different shows running at the same time was at once frustrating but also understandable. The life and death tales in medicine come from a select amount of compelling disease
presentations. These can range from a birth storyline, which could be anything from a scary premature birth, to problems with a caesarian section, to an easy, breezy, happy delivery or also to things that most people, and even doctors, do not understand well like brain surgery or brain trauma. Cancer is a prominent life or death storyline, and both *ER* and *Grey’s Anatomy* had one of their main characters suffer from this on the show. In an interview with a writer from *Grey’s Anatomy*, I was told that they considered a specific medical/disease storyline but after looking into it discovered that both *House M.D.* and *Private Practice* had done it recently so they changed it and this it seems is quite common. Shows will cover the same medical ground, but they will put their own twist on the presentation or specifics of the patient or treatment to make it different and special from other shows. To demonstrate the toggle that happens between writers and production, a physician writer detailed to me how they were instructed to make a premature baby sick enough to be sick over three episodes, so the writers put in an appropriate illness. Then as the first of the three episodes was shooting, the producers/writers wanted the baby to be un-sick earlier than expected to free up an actor for a different storyline. The physician had to explain that with the conditions that had been given to the baby, that it was not so easy, to now ‘un-sick’ the baby character. This narrative storytelling requires patience on the part of the physicians attempting to dole out diseases that will match the theme of the episode, drama for the characters, and also remain clear on the medicine and the accuracy for the audience. Not only is there a balance between medical storytelling among all of the medical shows that are and have been on air, but there are complications within the stories of that show in particular. As a
further example of this difficulty, writers also make sure the medical problems of the patients match up the correct doctors involved in the storyline on the more broad medical shows. If someone comes into the emergency room in either ER or Grey’s Anatomy and the writers want specific doctors involved with that patient then the disease or condition needs to match their specialties. As I was told, a cardiologist is not going to consult with the orthopedic surgeon on a broken arm. But they might if there had been a car accident and there was some unknown amount of blunt force trauma to the torso, as well as a broken arm, so there are strategies for connecting physicians together on a team to treat a patient.

If there is a debate over medical accuracy from the physician writers’ point of view it revolves around issues of “cheating on time, where it happens, or who does it” rather than blatantly wrong medicine. By compressing time and not showing the normally long wait for lab results or scans, as they do only have 22 or 44 minutes of television to tell the story, then the rest of the case should follow along like it would in a hospital with medical accuracy. They do cheat where and who, by having an intern do a procedure they may not usually be allowed to do yet in their training or perform a procedure in the emergency room that would normally be done in another place in the hospital, usually an operating room. They do not see this as medically inaccurate, but as moving the drama or story along at the benefit to the tone and narrative in the episode. As one writer told me, in medicine “everything is plausible.” Another writer made the very specific comment about an episode showing a patient with Lupus, and that this was “not a PBS special on Lupus” but “a program for entertainment.” He went on to say that “writers take liberty for
[the show] to work” and that “compromise is inherent in the TV industry” partially because there are so many people who work on it and have a hand in making it. These writers feel very strongly that the small shortcuts add to the audience’s experience and do not make that big of a difference to the truthfulness of the medicine in the episode.

Biomedicine asks people to tell their own stories and within the healthscapes, these are accepted as fact and narratives that push the neoliberal goal of personal responsibility. Authenticity, in whatever form it takes, “credible and convincing” by the audiences’ standards or “authorized, certified, or legally valid” by the medical staff who write the show, is acceptable as self-regulation within the industry (Bruner 1994:399-400). These stories of biomedicine told on television are compelling not only because of the characters, the drama, and especially the medicine that moves both characters and drama throughout the episode. Healthscapes are the movement of images and representations of the reality of biomedicine, and because of these “things medical” that Americans are viewing on television, there is an institutional control over these images (Clarke 2010:108). The television industry is working towards a balance of authenticity and accuracy, that is achieved in such a way as to not be completely, factually accurate but still maintaining a semblance of authenticity because of the flexibility given in how it is defined and understood. Further, physician writers are not alone in their quest for medical authenticity, as they are joined by nurses, who guide the movements, styling, equipment, and props on set. These two groups work in tandem together in the act of ensuring medical authenticity.
Nurse Advisors: The People who Guide the Set

Nurse advisors are a rare breed and an even smaller community. One woman is attributed by current medical advisors as having started this field of work on shows like M*A*S*H and Trapper John M.D. and she started the medical prop house industry, of which there are very few in Los Angeles, because studios and individual prop masters have their own stock of equipment additionally contributing medical equipment. She is responsible for teaching two of the handful of women working in the industry today and is now retired. Nurses were essential in the early days for advising actors and for being shown in the scenes doing most of the technical medical work like in television surgeries. “Early in [House M.D.’s] run, if you saw a close-up shot of hands performing surgery on House, they were likely” the medical technical adviser (Porter 2012). This was true from the beginning, where actual medical professionals’ hands would be shown in the close up shots and actors faces would also be shown in close up and the shots would be married together in editing to make it seem like the same person. I heard from multiple informants that actors have the hardest time putting on gloves. This was repeatedly the number one problem medical advisors had with trying to make actors look like doctors. One director even said that with several actors he had to marry a shot of grabbing the gloves and the beginning of putting them on, with a follow up shot of them already on, because of the difficulty in that small detail. A medical adviser told me that she spends hours in the start of a show helping actors with these kinds of small details and that when it comes to learning how to put on gloves, they go through a lot of them. Michael Crichton created the show ER, and as a former physician, he wanted medical accuracy. He essentially
invented the trend of having many physician writers on staff and they worked hard to have actors doing most of the medical procedures themselves. Medical technical advisors “teach actors how to hold a scalpel, insert (fake) intubation tubes, perform CPR, choreograph operations, make incisions into lifelike (prosthetic) chests and brains, and speak and think like doctors” (Fischer n.d.). They are the ones who work primarily with actors to make sure everything looks as accurate as possible when ‘faking’ a procedure and that the equipment and technology looks seamless and as much like a real hospital as possible. Noah Wyle of ER described a few “fakes” they used on the show for these actions, like hiding a tube up their sleeve for intubation and pushing with their legs on a gurney to make CPR look like they were really pushing down on an actor’s chest. Many of these “fakes” developed on ER are still in use on medical shows today because of the constant concern for accuracy on the show. Medical advisors on set are the embodiment of medical accuracy and the medical imaginary, as they are last line of defense in making sure everything looks like the real thing.

While working with these nurse on-set advisors, I realized their jobs require quite a bit of maneuvering and special attention to the people and things going on around you. They are responsible for the setting and resetting of all medical props, creating choreography for the actors, often like a “football playbook” and making sure the “fakes” look real for what would be invasive medical procedures on camera. To do their job well, there are a couple of key rules all of these nurses must live by. The nurses I worked with on this research helped me create this list of rules for how they do their jobs.
Rules for Medical Technical Advisors

1. Always remember it is a compromise.

Never say “no” to a director or a producer too much. Your job is not to say “no.” You are to be accommodating to their needs and find places where concessions can be made that will ensure the most authenticity. Be creative about solutions. If a medical adviser says “no” too much, that can be the end of working on television. You cannot say “no” without offering possible solutions or ideas to work around the problem. Often because there are so many departments of people involved in the creation of television, there are ways to work around problems. A medical writer told me that there was constantly conflicting information coming in from doctors about their real life ways of handling medical situations, and this is part of the problem for medical television. Medicine has a lot of improvising and often multiple successful ways to do procedures and actions. The audience is generally uninformed about these possibilities of actions, but they pick up on the ones that are shown on screen. Medical advisors take great care with the biopower they are imbued with to create an honest and true portrayal of the medical situations depicted.

I spoke to a technical advisor who was fired from a television show. This person spoke too much about the lack of logic in the show, the presence of technology that did not exist, and the removal of reality too often to be believable, in her eyes. She said “no” too much. The show does not need someone who just squashes all of the drama, creativity, and imagination on the shows, but rather, they need someone who can go along with the show’s ideas and interests but can steer them back towards authenticity.
where easily done. There is a little more freedom in medical television (as compared to legal or crime shows) with solutions. Because within medicine there are often multiple ways to do a single procedure or technique, this can often be the best part of their job as there are options and the experience of the physicians or nurses from real life gets put directly to use in this way. In practice, medicine can be flexible and physicians may do procedures differently from one another, giving television shows options in how to portray everything from surgeries to techniques. The more options and creative solutions the better it is for this kind of creative work.

2. Everyone is a critic.

As shown in the previous chapter, the Internet will light up with medical students explaining all the failings of medical advisors. Even on a set, there will be critics, either from the physicians writing the episodes or anyone on the crew who may have had a similar experience (as in “my wife had a baby and that wasn’t what happened”). One medical adviser told me about making a compromise with the director where a nurse was not wearing gloves to hang a bag of IV fluids. The rationale was that the following scene dictated that she not be wearing any gloves and it was a closed bag of fluid, with nothing to really contaminate. This compromise was made based on both the dramatic necessity and the fact that this much glove usage is a recent standard of practice in nursing. Later that day, another crew person came up to the medical advisor and said that a craft services person (they provide food on set and are basically a catering company) told her that the medical advisor must not be very good because the nurse would be wearing gloves for that. Often crew members on set will weigh in privately with one another on
the handling of more popular and publicly known medical practices, like hygiene, CPR, coding patients and other things that may not be as technical.

3. Make friends, with everyone!

Medical advisors are a small community but there is no union, no organization, and they are independent contractors on a set. They get jobs almost exclusively through recommendations, either through a medical prop house or through crewmembers that have worked with someone before on another job. When I was on set with a medical advisor, everyone from the primary prop guy to the key make up artist to the producers had worked with her before on other shows. Being friendly and listening to others is a big key to getting a job and getting referred to the next one. Most television has a medical storyline at some point, so there will be a need for possibly a single episode or a 2 or 3 episode storyline arch when a character gets shot, has a baby, or gets into a car accident.

Medical advisers will work side-by-side with every single major department that works on a movie or television set. They need to be close to make up and wardrobe for any wounds, injuries, or surgical cuts that actors’ characters may sustain in the scene. They work with props and set decorators to get the crash site, operating room, or hospital room exactly set up for the needs of the actors and with as much authenticity as possible. They must be able to capture the feeling the director or network wants/requires for the scene (less blood or more blood, very gory or not gory at all, more skin or less skin shown). The simple question, “How can I help you?” goes a long way on set to facilitate other departments feeling like you are a team player and will do what you can for them, especially when you are working on a set for one episode or one day.
One really good example of how departments work together is when there is blood present on set. Here is how the department coordination works together. If the blood is on the actor’s face or hands, then it is controlled by the make-up department. If the blood is on the clothing of the actor, then it is controlled by the wardrobe department. If the blood is on a prop, like a knife or pipe, then it is controlled by the props department. If the blood is on the furniture in the scene, like a couch or bed, then it is controlled by the set decorators. If the blood is on the floor, then special effects handles it. All of this blood is supervised by the medical technical advisors and used at the specific instruction of the director. When a single actor is standing bloodied in a room holding a knife, that means at least four departments have been involved with and coordinated that specific look for a character.

Also, when there are multiple medical consultants or advisors working on a single medical show, they may not be friends but will have heard about each other. Rates are usually never discussed amongst each other but often people have an idea what the other is earning. Undercutting of rates is one way to steal jobs (often accidentally), and making friends will help prevent that because you may then have a better idea of what others are also charging for their services. Only a couple of the medical advisors I spoke with had any real idea what the other charged, and then they all said they were flexible depending on the job and budget of the project. Friendships were not that common within this small community and many had some critical words about others who worked in and around them in the industry. There is a biosociality of and between these women, whereby they are a community, and they know each other or at least of each other (Rose 1992:234).
They recognize the strengths and weaknesses of each other and admire specific things about one another. Because they may work together on sets, or recommend someone if they are unavailable there are some relationships of some kind created amongst each other as a community.

4. Gain the trust of the actors.

As it was told to me, these medical advisors only get one chance to make an actor feel really secure that you are giving them all the tools to play a doctor, nurse, or patient successfully. They need to believe you and trust your directions about a procedure or symptom. This also means working well with directors, who also are giving instructions to the actor. You do not want to contradict the director or confuse the actor, so this relationship is important in both directions, towards the director and the actor. Another way that medical advisors make actors more comfortable is by hiring actual nurses for background actors in surgical or emergency room scenes. The actors know that the real life nurse will hand them the right tool or instrument and help them portray the scene accurately.

Some actors do not handle very well doing multiple actions in the scene that they are unfamiliar with, so the medical advisors gauge who can and cannot do multiple medical actions even with rehearsal time. One example of this was a complicated scene of multiple patients coming into an emergency room, where one actor was very good at taking direction as to her necessary jobs to take care of the patients and another was not so receptive. The scene allowed for the actor who could handle the direction to do most of the active work and the other to sit back more and do a couple of key, critical actions.
that made it more manageable for him to focus on his dialogue. Almost every physician writer and on-set consultant told me that some actors get really interested in the medicine and those are the ones who want to do the most technical parts of a scene. Others never really feel comfortable and then they will be less involved with the technical or longer sequences.

Some medical advisers will teach everyone playing a doctor to do a couple of basic things like intubation, CPR, drawing medication, aspiration and basic suturing, often called a medical boot camp on set. Another medical advisor stated that she only taught those when needed or called for in the script. This variation often depends on how much medicine they will be practicing, their ability to learn these techniques and remember them over time, and their interest in the medicine behind their actions. Often actors are not that interested in what they are doing or why, but sometimes the actors are very concerned (sometimes called method acting) and they are eager students of the medical advisors. I interviewed Noah Wyle after a physician writer for the show described him as one of the actors most interested in the medicine behind the episodes. Wyle told me that early in the run of ER that his friends would come over to his house and find “franken-chickens” in his freezer that he would use to practice suturing. He along with other cast members did ‘ride alongs’ where they would shadow real emergency room physicians, he read medical textbooks, anatomy and physiology texts, and diaries of medical students to familiarize himself with what life would really be like as an intern. Wyle also admitted that he was ambitious, hungry and “grew to love the seal of approval from the medical community” conferred upon ER. Another actress on a
medical show described for me the comfort she experienced after watching several neurosurgeries in a real operating room and going on rounds with residents at a local hospital. She said it gave her an idea of the “day to day concerns” of residents and also “their relationships with other doctors.” The more interested the actors are in the medicine, often the easier the medical advisors’ job becomes. Actors do research into their characters on their own behalf so they are prepared, but often the executive producers ask the medical advisors to locate opportunities for the actors to do these observations through their real medical work. For the case of ER, both writers and actors spent time in a Los Angeles emergency room to get the feel of the “entire behavioral world of the ER” and “for the actors it was more specific and doc-centric.” On Grey’s Anatomy, actors are given the opportunity to shadow physicians in a hospital if they would like, but some have chosen not to do this. This could be because they may have sensitive stomachs and did not want to see any of the real blood and gore, or simply that this is just a job, they are only actors, and it seemed like overkill in preparation.

5. Watch the background actors.

On a medical television show or on a medical set of a regular show, you will have background actors or “extras” on-set milling around in the scene. Sometimes they will be in gowns or masks and not very noticeable. Often they can be seen and can be a potential problem. Extras are known for causing problems on sets. They are mostly starving actors and can be found trying to stand out in a background, when they should be trying to blend in with the scene and not be noticeable at all. For a medical scene in particular, they need to be instructed on what exactly they should be doing with their petri dishes or
blood bags or medical equipment. One medical advisor told me that she would quickly assess who the smartest background person was and then give them the more technical training. The last resort is just for the medical advisor to put on a gown and mask and do the work herself. Most of the medical advisers working now will be listed as cast occasionally and several of them on long term shows like Grey’s Anatomy and House M.D. will have Twitter followers who find them in episodes like a game of Where’s Waldo. Usually the nurse advisors have a group of working nurses who come and work as background actors for the shows that they work for, as to make the actors more comfortable. All three of the actors I spoke with said this made a huge difference for them and Noah Wyle even said that he can remember all of background nurses’ names and when he watches an old episode of ER he can point each of them out even though they are masked and gowned.

6. Be on set or be by the monitors.

Never disappear. On a television set there are many lighting guys, several make up people, but there is usually only one of you. Television moves quickly from one set-up to the next and you cannot be the person wasting everyone’s time and especially money. Plus, most of the initial medical rehearsals with actors are private because actors never want to look silly or like they do not know what they are doing in front of other people. This gives them a space to ask a lot of questions and participate with the medical advisor without the rest of the crew being as involved. If medical advisors do have to leave set for a meeting of some kind, they often have assistants who are also nurses watch the set for them and they are available by walkie-talkie if needed.
One of the most interesting things about this that I saw on set and also heard from multiple people is not to ask a question or make a suggestion twice when you have been told the answer. If they really should have more blood for that injury and you have made that point to someone and been told that is not the way they want it to look, then asking the questions again or pointing it out once more only annoys the crew. This section goes back to the point in #3, Make Friends. You should always be aware that people know each other from past gigs and jobs and rolling your eyes might seem cathartic but it is risky. You endanger future jobs by not understanding that your role is to facilitate the production of a television show, not to make the most accurate set possible.

Authenticity was a concern for several of the medical advisers I spoke with and they seemed pleased that audiences pay attention to their hard work. Often it was the physicians who work more in writing the episodes who seemed skeptical that anyone actually pays attention to all of that. In looking toward authenticity, producers and show creators often want the highest levels of authenticity on their sets and they use product placement as a way to go beyond simple set dressing to get a better picture of what a real hospital might look like for their show. All of the medical advisors I met with discussed that they do their own research and work with writers. They want to “make sure what we are doing is accurate.” They will attend a concept meeting where the basic storyline ideas are discussed. Then a production meeting when the script is out, to discuss special effects, props, wardrobe, how much blood (network versus cable shows have different standards). Next there will be a meeting with the episode’s director about the how medical the episode will be, how graphic they want the effects, and how violent the scene
will be. Lastly, there is a meeting with the actors close to the shooting of the episode to rehearse the scene and talk about medicine. For each episode there is a week of prep, sometimes 10 days, where everyone is racing “to get all of this stuff taken care of while the current episode is shooting.” A big part of maintaining authenticity is making sure the props department can get all the equipment they need and the set decorators can obtain all of the medical devices. Sometimes medical advisors will work with companies on their own to get the equipment for free, with product placement, or with medical prop houses that store equipment for rental.

**Product Placement**

Product placement on television started with the show *CSI* and their need for more equipment, medical and laboratory, than most prop houses carry. They also wanted new and expensive technology, which they could get for free when a company donated to the set with promises to show the company logo or name of the product would be displayed on screen or said in the episode. This product placement has gone so far that there are now $1 million dollar sets that were free to the production and requests for things like mass spectrometers and MRI machines that may not even be available to hospitals yet. The newest technologies and medications are very expensive and “Americans invest in the medical imaginary—the many possibility enterprise—culturally and emotionally as well as financially” (Good 2007:364). This medical imaginary is a part of the hope that patients have about biomedicine and their physician, that they will be successfully cured or treated for any diseases. Neoliberalism stresses that purchasing health is a patient’s right and also responsibility and it can be accomplished by getting
pharmaceutical products from their doctors and seeing the highest level of technology used for their medical benefit. By seeing the newest and most expensive machinery and technology on screen, viewers get a chance to see inside the medical imaginary and understand the ways in which physicians and scientists utilize it for the good of medicine.

How these products and technology come to be in the set of medical and medical/legal shows is complicated. Some productions will use machines that have been at trade shows for the company to sell their newest machines because there will be little risk of radiation or heat problems from the safe demo models that have been around the public and have had their key machinery removed already. Companies, especially medical technology companies, love product placement because consumers may not remember exactly what it was called but they do tend to recall the shape or look of the equipment, which may be brand specific. Hospitals and clinics will recognize the equipment and may be driven to purchase that for their patients to see. “Modern technology, featured prominently on realistic sets, allows viewers to identify elements from their own experiences with hospitals” (Cohen and Shafer 2004:213). This recall is very useful for companies and one product placement specialist I spoke to had placed two mass spectrometers on a show (where the logo and machine were prominently featured) and after the episode aired, they reported back they had three orders in a single day for the half a million dollar machine.

Having real machinery and medical technology on set helps with the authenticity of the set, but it is also a status item for productions whereby the medical imaginary is realized. They can secure the most extravagant, new, expensive technology all for free
from companies that fits the look of the show. “Producers insist on surgeons holding scalpels correctly in an up-to-date operating room even if the operation they are portraying is an extremely rare procedure carried out by a doctor who hasn’t been trained in it, that ends, improbably, quite happily (Turow 2010:11). The fiction of medical television is that a lot of situations that should not end happily, do so on television. One of the ironies described to me about this process and the use of product placement was fairly worrying. A product placement expert described setting up a lot of expensive new equipment she had secured for a revamped medical set. They started from scratch and got everything as high technology as possible. Then a physician who was consulting on that specific episode, but was not a usual consultant, walked to the set, looked around, and was quite upset. He said something like, “This is amazing, but I’m going back to a hospital that treats real people, sick people, and we have none of this equipment.” This is the idea of the fantasy hospital, the medical imaginary that is often created through product placement on television.

Producers and writers have the luxury of looking at all the new FDA approved equipment or the updated machinery as window-shopping. *Grey’s Anatomy* featured a Heart in a Box device, which was brand new at the time, because a medical researcher for the show heard about it and put the actual device in a storyline. They made one call and got the real device to use on the show. Shows will be approached by companies who will ask them to feature their product or device. Most shows do not do this or allow companies to contact the writers or researchers directly. It is most often initiated by the writing staff in approaching a company to ask for a device to feature in the storyline.
When this happens, it is paired with letting the company look at the script and not having a negative outcome for the patient using the product. I was told one story about a vent hood that was featured in the background of a laboratory scene where the lighting called for a green light to shine down from the hood to make it look creepy. The day after the episode aired, the company received multiple calls from hospitals that had the vent hood asking why their hood did not have a green light, did they need the green light, were they missing something in their hood. Then the company had to explain that the show had taken license in lighting the vent hood and it was not a problem for their machinery. Then there are cases where people have shamelessly self-promoted their own work through television. “In 1985 Dr. Robert Jarvik inserted himself into the writing of a script for Trapper John M.D. with the aim of promoting his artificial-heart company” (Turow 2010:7). Jarvik incidentally also appeared in cholesterol drug ads for Pfizer’s Lipitor, which were controversial, but this kind of product placement is now more popular than ever.

**Making Organs “Real”**

When considering the entire process of authenticity, the props and body parts being utilized by television and films are incredibly important. “Well-articulated terminology and appropriate descriptions of illnesses, preventions, and cures joined accurate suturing and graphic body depictions as cues to viewers… [and] filled the same storytelling role that the authentic-looking hospital set, uniforms, and surgical hand movements filled in earlier decades” (Turow 2010:367). The changes over time in medical shows often have to do with the graphic nature of the surgical field being shown.
on camera or the explicit quality of the bodily functions and processes featured. I was
told that in the old days, before the early 2000s primarily, the “bodies” on a surgical table
were made up of pig parts, bought at a local slaughter house and that the prop guys would
be below the table making parts move or blood shoot out through syringes. Now it is a
mixture of pig parts and silicone and plastic robotics in these bodies in a surgery,
depending on the needs of the surgery being shown. Noah Wyle, who played Dr. John
Carter on ER described the days on set when a large amount of pig parts were used by
“the smell” from the lights and heat on set. There are obviously benefits to using silicone
and plastic robotics, not to mention the fact that a prop person does not have to be under a
table for hours crouched only to shoot blood out at the actors on cue. Shows work to have
the most graphic and realistic presentation, and now by mixing and matching the choices
for bodies they can achieve this. This graphic realism is the symbol for the medical
imaginary. True accuracy is never realized, as there will never be real bodies open on the
table, but the crew really focus on making it look real, feel real, seem real for the
audience.

I visited a special effects studio that crafts organs, body cavities, and other
human-like body parts for film and television. This studio focuses on “photo realism”
according to the owners and they are known primarily for this work. The studio, started
by a special effects artist and a medical illustrator, also employs others who have long
worked in this industry. They use everything from anatomy textbooks, anatomy
illustration books, YouTube videos of surgeries, and pathology DVDs as reference for
their authenticity. They use silicone primarily because it “feels like skin” and has a
“coolness and softness” that mimics real organs and biological processes. They can do everything from robotics to entire body cavities for on set surgeries. For sutures, silicone “will tear” so they use a “stretch fabric” so that when the actor or technical advisor “sews it will grab the thread.” Everything is dyed the color of flesh and then hand painted with both spray guns and brushes. Hair is hand placed and “punched” into place. The hairs for eyebrows and eyelashes are either from skunks, badgers or muskrats so that the hairs will have a natural taper to them and look more realistic. The mold shown in Figure 3.1 is for a brain and it was formed off of a cadaver brain model, purchased from a medical educational company, to be as realistic as possible. Silicone would be poured into the mold, then let dry. Once removed from the mold, the two halves are bonded together with liquid silicone and then hand painted to reveal all of the detail like the vessels.

Figure 3.1 Silicone Mold of Human Brain

Photo Courtesy of Burman Studios.

These studios can make casts of a real actor to make a fake body or prosthetics that will be added to an actor’s face and even full bodysuits that an actor will wear. The process to make a body or body section for surgery on television is entirely thought
through backwards. They begin with what will be seen inside, like a brain or internal organs, and make that portion first. Then they make the surroundings like a face/head or torso. The best studios will cast the actors in the position they body will be shot in, either laying down, sitting up, or on their side, so that the skin and features will be natural with tautness and slack skin and muscles laying correctly. This also then requires that the show know exactly how the scene will be shot as the process to make a large scale model or prosthetic will take about a week. Each prosthetic will generally only be able to used once, so if it involves cutting into a body, the show will use a blood knife for the first takes so as not to ruin the body. Prosthetics that go on the face or body of an actor, like with a burn effect, are made in multiples because each prosthetic is only good for one day or use. These are very delicate pieces because they are made of silicone, which is a very delicate material and then a specific special effects make up artist will apply the piece.

The head shown in Figure 3.2 was made for Grey’s Anatomy by Burman Studios for Season 10 in 2013. When I encountered the head, it had not been used by the show yet, but there is a realistic brain and skull inside the head of the prosthetic. The head was in the process of being finished, so he does not yet have all his hair, eyebrows, and facial hair. This head and bust will be attached to padding to replicate a body and then covered in medical drapes for shooting. In contrast, Figure 3.3 is of the brain, skull, and head of an actor on the 8th and last season of Dexter. This photo shows you what the head for Grey’s Anatomy would look like inside once cut into. The head for Dexter was used to show both the front of the model which is a realistic casting and silicone model of the
actor’s face, and also the open brain and back of the model for when a serial killer murders him, cuts open his skull, and takes a scoop out of the brain in the episode.

Figure 3.2 Prosthetic Head for Grey’s Anatomy.

Photos Courtesy of Burman Studios.

Figure 3.3 Brain in Prosthetic Body on Dexter

Photo Courtesy of Vincent Van Dyke Effects.

The lifelike depiction of the actors and assorted bodies that will be used on shows are very disposable. Silicone does not last very long or wear very well, so once things like this are used on set, they are generally disposed of. The medical imaginary of prosthetics
allows medical television to cut into an actor, take out a tumor and the audience, while knowing that is not the actor really on the table, still finds the surgery to be believable. This is medical authenticity, whereby people with medical models are making fake organs to be cut open on television and they are so incredibly lifelike that they are “credible and convincing” (Bruner 1994:399). These prosthetic models are so credible and convincing that a law enforcement organization bought two complete “dead” male bodies to train officers if they encountered bodies that had been left for days or had committed suicide. This level of authenticity when combining product placement and silicone bodies and organs, uses the medical imaginary to trick the eyes into believing the stories and the medicine on screen.

It is important to remember that the television has become background noise in a lot of households, but some television shows infiltrate the public culture. “Television strongly impacts public perceptions of physicians, despite individuals’ direct experience with physicians” (Strauman and Crandall Goodier 2008:128). Shows like ER, House M.D. and Grey’s Anatomy have changed the viewership of medical television, partially through the presence of additional methods of communication with the shows. Grey’s Anatomy had a very popular website where writers and researchers would update blogs about the characters and the episodes. The ability to feel a connection with the show and to communicate with the people who play your favorite characters or write the show can be both a secondary method for knowledge production and a source of blending between the real world and this fictional world. This interconnection of television and online communication is the technoscience that Clarke describes in her healthscapes, whereby
“the Internet itself… frames knowledge profoundly” and technology enables these connections in faster and more personal ways (Clarke 2010:137). By having alternative methods for forming bonds with the characters and medicine on television, there is even more of a specificity that the audience is learning from and making deep connections to the people and content. “[These shows] provide a map for understanding the unfamiliar world of medicine for audiences” (Strauman and Crandall Goodier 2008:130-1). People like to think that these high-tech, expensive hospitals are accessible and filled with doctors struggling to do what is right for their patients.

In explaining the popularity of medical television shows, Strauman and Crandall Goodier write that there are a variety of factors at play.

“First, the drama inherent in the often life and death struggle of medicine offers a prime device to move along plots and examine relationships. Second, television physicians with the expertise and charisma, represent attractive characters to audiences. Last, the medical drama offers audiences a glimpse into the backstage of a word that is simultaneously engaging and exciting as well as frightening and overwhelming” (2008:130).

Medical shows work on so many levels to bring in an audience that it is this mixture of drama with medical information that creates magic for the audience. There is tension, there is fast-paced action, and it is exciting. One medical consultant told me a story about her friends’ son being rushed by helicopter to a hospital after an accident and when they landed on top of the building no one was waiting for them. The helicopter pilots unloaded them and tried to navigate an unfamiliar hospital to find the emergency room. The friend later told the medical consultant that all she wondered was “where are all the people?” On ER, and on every other medical show, there are people waiting for you, doctors waiting for you up there. There was no one in real life to help them until they found their
own way to the emergency room. She thought that it was a completely weird expectation of her friend, but there are so many iconic moments in medical television where doctors at standing at the heli-pad, wind whipping their hair, ducking down and trying to listen to the paramedics reeling off the list of patient history and stats, and the reality is no one was there for them in real life.

There will never be agreement in the negotiation that occurs on set. Some will always be disappointed by the concessions that advisers make so that the shows looks and feels like what the director is aiming for in the end. “Medical shows may never be as realistic as some physicians might have them be.” (Edwards 1984:781). Other times, there is great joy in the fact that often it is more right than wrong and there is appreciation for the effort that medical advisers expend on these shows for authenticity. “Medical shows usually go to great lengths to get the superficial details right” (Durso 1995:21). The truth is somewhere in the middle. One story told to me by a medical advisor is very apropos here. She said that she could take footage from a real surgery filmed in the operating room, cut the footage in editing, give it characters, shape the story or narrative of the surgery to make it seem fictional. In the viewing of the footage there would be people who found things ‘wrong’ with the way the surgeons were doing their procedure. This simple fact that is probably true, demonstrates the concept of healthscapes, which include “whatever is imaged or imagined as things medical” (Clarke 2010:108).

Healthscapes encompass all that is medical in our imaginary, real or not, to be part of the process of knowledge production and understanding of our own bodies and health. For the on set consultants specifically, it is often a no win situation because of this duality. If
they push too hard, they are not doing their job, but if they let too much go, they are also not doing their job. This idea of a ‘negotiation’ is so perfect for their positioning when they are backbone of the sense of authenticity and accuracy for the medicine.

Medical television, while a trusted source of information for the audience, is fiction at its core. The stories may be drawn from real life, modeled after a physicians’ real experience, and centered in medical truths, but some element will be fiction. They will need to cut for time, the drama, the story, the whatever. They will fake things and change things because of these points of negotiation have to happen. It will sound strange to some that it takes eight days to shoot a single episode of television, sometimes more. People may think that seems excessive but there is so much that goes into making a television show, including all of the time and attention the “medical medical medical” gets from the script to the set. A director and producer told me “We’re not making a show for a few thousand [surgeons]” so there has to be both a balance of authenticity and drama for a show to find an audience and stick around for Season 2. Narrative and character development help a show stay on the air, but too many flaws and the audience no longer believes it as well. The line physicians and nurses walk makes the drama and medicine come together in new and different ways for audiences, but it always part of the larger engine of television production which has its own limitations and focus.
Chapter Four: “Doctor. I need the little blue pill. Wait. Or was it the purple one?”: Direct-To-Consumer Advertisements, Why We Love Them and Why No One Else Has Them

“The cultural environment in which we live becomes the byproduct of marketing” (Gerbner 1998:176).

“In so many ways pharmaceuticals have become integral to daily life in America” (Dumit 2012:181).

Pharmaceutical advertisements have long existed directed at physicians, but the trend of advertising towards consumers began heavily in 1997, and exists primarily in the United States. Only New Zealand also has these Direct-to-Consumer Advertisements or DTCA and they regulate them differently than the US (Weber 2006:158). Canada and Mexico have some DTCA by having US cable feeds broadcast in these countries without changes made to the advertisements that run in between programs. “Just turn on the television. There are constant advertisements from pharmaceutical, weight loss, and supplement industries barraging you with images of happy, healthy, smiling people enjoying their products” (Besser 2013:3). The advertisements have traditionally featured ‘normal’ or ‘well’ people while discussing often frightening, complicated or distressing illnesses like rheumatoid arthritis or atrial fibrillation to contrast the present or past alongside the possibilities for the future. “In DTC campaigns nominally healthy persons, or prospects, become secretly sick persons, or patients-in-waiting, who are oriented toward becoming healthy again” (Dumit 2012:72). DTCA can promote conditions or thresholds for disease like with cholesterol number awareness or the threat of post-menopausal osteoporosis.
The idea behind DTCA was originally to present consumers with a way to democratize medicine, giving the people at home options, information, and control over their own health. “Direct-to-Consumer advertisements [have] been simultaneously called both educational and beneficial, and misleading and costly” (Atherly and Rubin 2009:640). There has been and continues to be controversy about the benefits for the public with this kind of large, often ambiguous information. The ‘expert patient’ should take in this information and bring it to their physician for confirmation or explanation from the medical authority. “The assumption behind the idea of education as patient cultivation is that the public, doctors, and medical institutions are ignorant” (Dumit 2012:63). Part of the argument for the necessity of the creation of these ‘expert patients’ is that medical providers do not or cannot spend the time with patients to essentially treat the patient as they would like to, because of things like insurance reimbursements, the lack of family doctors in practice today, and the new and ever-changing information that makes it difficult for physicians to stay abreast of everything changing in medicine. “Websites of multinational drug companies now refer to advertising as part of their responsibility to ‘empower the consumer’ through information” (Oldani 2004:329). When the pharmaceutical companies work to ‘educate’ patients, they are simply informing them about products or diseases for which they offer treatment. “Consumer education on diseases and on available medications can only be done well when separated from the conflicting goals and interests of advertising” (Weber 2006:163). The processes of both marketing and education are inherently in conflict, as the goal of
marketing products is to push specific purchasing behaviors, not to simply educate the public about generalities.

**The FDA and Pharmaceutical Advertising**

The primary force regulating the messages put out in the world by pharmaceutical and food companies is the Food and Drug Administration or FDA. They control the wording and messages used by companies in their ads with regards to health and food products. The FDA plays a role in everyone’s lives, whether we know it or not; they are in charge of protecting people through the regulation of food, pharmaceuticals, and animal products. Their ability to protect people can be helped or hindered by those on the inside of all of these industries, including lobbyists, the companies themselves, consumer groups, advocacy groups, and experts within these fields. The FDA falls under the Department of Health and Human Services or DHHS, and is charged with protecting people from harmful products and regulating the safety of consumable goods. They have become the intermediary between consumers and companies and with new legislation in 1997, the FDA created guidelines that made television advertisements or Direct-to-Consumer Advertisements (DTCA) more manageable for companies and broadened the advertisements’ previous restrictions.

“The Federal Drug Administration Modernization Act of 1997 made several changes that…loosened the restrictions placed on the kind of information that pharmaceutical companies could share with physicians regarding ‘off-label’ uses of their drugs, and subsequently, the information that must be included in direct-to-consumer advertisements” (Conrad and Leiter 2004:160).

The FDA has four requirements for television ads: list the 1-800 number, give the website for the drug, direct the consumer to your print advertisement often in a magazine,
and tell them to seek more information from doctors (FDA Guidelines 2009). The pharmaceutical companies, although not explicitly, are framing their advertisements in a way that understands that their audience of consumers should and will have access to the Internet, more medical background information, and a medical glossary because with our increasing access to technology that is often assumed to be the case; we have information and research skills at the ready. Because DTC Advertisements are no longer required to give a full listing of side effects, which are supposed to be available online, in the package insert, through your doctor, or the company’s toll free phone line, the ads can be delivered in thirty seconds or less.

“The brief summary and fair balance requirements [previous to the 1997 FDA change in regulation] effectively eliminated broadcast advertisements from pharmaceutical companies’ consideration and lessened print advertisements’ promotional appeal since their effectiveness message might be negated in the viewer’s mind by the contraindications and side effect warnings that would follow” (Lyles 2002:77).

These changes have prompted a dramatic increase in television advertising by companies, many of which run multiple ads on multiple channels throughout the day targeting specific groups through programming choices. “Broadcast advertisements are only required to include the most important product risks, making this, alone, an incomplete source of information for viewers” (Lyles 2002:83). Further, “almost half of the people who see a DTCA do not pursue the sources required by adequate provision for additional information” (Lyles 2002:81). This means that consumers do not utilize these secondary sources of information about the product and many will rely on the advertisement as a sole source of information.
Not every drug available is advertised to the general public. Pharmaceutical products like antibiotics have not and will not be advertised because their usage is determined often by a laboratory bacteria culture done by a medical professional. Consumers have no part in this kind of medical decision. “DTCA tends to be concentrated into a small number of products” and these are often the types of drugs that have more discretion in their usage (Lyles 2002:80). Brands need to be cultivated to promote drug usage, whereby consumers might compare who you know that is on which drugs, like with Viagra, Levitra or Cialis all for the treatment of erectile dysfunction. “The problem today is that the industry has perhaps become too successful at launching new products (i.e., crafting blockbuster markets)” (Oldani 2004:337). By cultivating a brand, the drugs have become ‘name brand’ and have a cache for people who use them and what they can do. The launching of these products often connects to things consumers can remember like colors in “the purple pill” for Nexium or “the little blue pill” for Viagra or memorable imagery like Abraham Lincoln and a beaver hanging out for Rozerem or the pastel butterfly fluttering to soothing music for Lunesta. These advertising tools allow consumers to connect something easy to remember with the drug being advertised. “The restriction of content necessitated by [television] time limitations creates an inevitable inequality between these ads and print ads” (Boden and Diamond 2008:2197). Most believe that the print DTCA are more informative, simply because they are hard copy, a consumer can go back to them, and they have far more fine print with more tangible, reinforcing information in them. “It is disturbing that television ads promoting drugs inevitably fail to fully disclose the benefits and risks that must be
included in print advertising, whether in medical journals or lay publications” (Boden and Diamond 2008:2197). These advertisements are legally disclosing all of the major risks and benefits according to regulation set out by the FDA, but it is the ways in which television ads give major side effects, the tone (gentle and soft) and speed (accelerated and hastily), that create a passive interaction with the audience. “The FDA requirements covering advertising to the public…constitute only the legal minimum” (Weber 2006:150). Companies follow the requirements down to the detail, and often go no further to do much more in actual education unless it involved educating the public about a condition or disease for which they have a specific treatment available.

The FDA allows three types of Direct-To-Consumer Advertisements (DTCA) of prescription drugs: “Product claim ads: These name a drug and the condition it treats, and talk about both its benefits and risks. Reminder ads: They give the drug's name, but not the drug's uses. Help-seeking ads: These describe a disease or condition, but don't recommend or suggest specific drugs” (FDA Direct To Consumer Ads 2013). Help-seeking ads tend to have a website for more information listed on or within the ad, this often with enough searching or click-throughs leads to the pharmaceutical company’s website for the drug that matches the condition. Help seeking ads are interesting because often they suggest the consumer seek out more information about a disease. Especially for conditions like cholesterol where “knowing your number becomes having to know all of your numbers” and that means finding out your own bodily information as well as options for treatment (Dumit 2012:125). One of the things to keep in mind is that the “the FDA does not require that all new medications be compared to other medications,
only that they be effective in treating a condition (compared with a placebo) and that they be safe…[which] means sufficiently safe to be allowed on the market and used under the supervisions of a physician” (Weber 2006:149). This specific definition of ‘safe’ and the process by which drugs are approved is often unknown to the consumer who may believe that if a new drug is approved, then it must be better than what is on the market already. This is not true and often a common misconception by consumers. Further, the FDA can and does approve drugs that “offer trivial or no advantage over drugs already available, and may be even worse” (Angell 2005:241). The drug only has to beat a placebo, and then it may in fact not be as good as others things currently on the market.

There are few requirements for pharmaceutical companies with regards to print advertisements; one is that they must contain more information than television advertisements about the risks and benefits of the drug, but there is nothing to require that the language used be easy to read.

“The [FDA] encourages product sponsors to provide consumers with non-promotional, consumer-friendly information consistent with product labeling, along with the information required by the act and the regulations…[and] in the case of print advertisements, FDA encourages sponsors to write their product brief summaries in consumer-friendly language” (FDA Guidelines 2009, italics added).

When something like “consumer friendly language” is a suggestion rather than a requirement, companies have most often opted to keep their official, regulatory language. Additionally, the FDA has given companies the leeway to use larger words for several smaller words when describing the side effects or symptoms of a medication for the sake of condensing the message in advertisements. This means that for the drug Abilify that ‘Neuroleptic Malignant Syndrome’ can be substituted for the more manageable “very
high fever, rigid muscles, shaking, confusion, sweating, or increased heart rate and blood pressure;” it may not all fit in the verbal dialogue time limits for a 30 second ad, but it is only common sense that people would be able to understand the latter rather than the former (Abilify, November 2009, 570US09AB31809).

**DTCA Consumer Understanding**

In testing the effects of DTCA, the FDA does periodic inquiries with the general public, sometimes through relationships with health magazines. In one such FDA survey of patients, it “revealed a nearly universal awareness of DTC advertising, with 81 percent reporting exposure to broadcast or print promotion in 2002” (Aikin et al. 2002:3). Of patients asking about a prescription’s availability, “39 percent asked about a specific brand” (Aikin et al. 2002:4). In a startling case of product advertising, the survey respondents reported that “a little more than half (58%) believed the ads make the product seem better than they really are…and forty-two percent felt the advertisements make it seem like the drug will work for everyone” (Aikin et al. 2002:5). The reasoning for the creation of DTCA was originally to educate consumers about public health messages, to make ‘expert patients.’ So that when “17 percent reported that the advertisements cause anxiety about their health” these advertisements become unproductive for a rather large population of consumers (Aikin et al. 2002:5). Further, “18 percent [of physicians surveyed] reported that the exposure [to DTC] led to problems…and included the time needed to correct misconceptions, requests for unnecessary drugs, and requests for one prescription treatment when another treatment
was effective” (Aikin et al. 2002:6). This may represent only one way that DTCA has been viewed, and it is a rather dated survey at this point.

In a study conducted by Bell et al. the researchers found that “this study suggests that the typical consumer [of DTC] is decidedly neutral…[and] those individuals who said they like DTC advertisements tended to have falsely confident views about the extent to which these appeals are regulated” (Bell et al. 1999:656). These falsely confident views are reflected in the following passage from their study, where

“approximately 50% thought that DTC advertisements had to be submitted to the government for prior approval, 43% thought that only ‘completely safe’ prescription drugs could be advertised directly to the consumer, 21% believed that only ‘extremely effective’ drugs could be so marketed, and 22% believed that the advertising of prescription drugs with serious side effects had already been banned” (Bell et al. 1999:655).

None of these statements are true about drugs that have DTC Advertisements. None of them. So if any consumers believe that all drugs advertised are safe, then that is a problem. “Regulatory oversight is critical since many consumers believe television advertising implies drug safety” (Lyles 2002:81). This is one of the major sticking points with critics of DTCA. The implied safety, simply because it has television advertising is in itself misleading from the outset and not much has been done through any information campaigns to correct this view. Additionally in a study conducted by Weissman et al., “four out of five doctors believed that DTCA did not provide information in a balanced manner, and a similar number felt that it encouraged patients to seek treatments they did not need” (2004). Weissman et al. asked the physicians in their survey what conditions and drug advertisements brought their patients into the office in the past week for a consultation and,
“the ten most common conditions [were] impotence (10.9 percent of all DTCA visits), arthritis (10.5 percent), allergies (9.6 percent), high cholesterol (8.7 percent), heartburn (8.4 percent), depression (5.8 percent), anxiety (5.6 percent), pain (3.8 percent), diabetes (3.6 percent), and menopausal symptoms (3.3 percent)” (Weissman et al. 2004).

This list of conditions matches the list of drugs that have the most advertisements in DTCA. “Companies use a DTC marketing approach for drugs to treat conditions that consumers understand and may be used to self-treating. Thus, drugs to treat allergies, pain, arthritis, GI upset and ulcers, asthma, diabetes, high cholesterol, and depression have been widely promoted” (Findlay 2002). Impotence and menopausal symptoms are the only ones that do not match from Weissman et al., keeping mind that the first list is of ten conditions, and the second list is only of eight ones. All others match up entirely.

“Beyond raising basic awareness regarding prescription drugs, the educational potential of DTCA appears to be failing” (Lyles 2002:83). Traditionally, education means that people have learned something from the advertisement. But these advertisements are marketing, intended to induce purchases, and this has been shown to confuse the consumer on the facts presented in DTC Advertisements when “41 percent of all physicians indicated that their patient was confused about the effectiveness of the drug because of the DTC advertisement” (Aikin et al. 2002:6-7). Often these DTCA are seen as misleading and confusing for patients who do not always look closely at advertisements or follow up with outside information or additional research. The only other standards for the industry are their own, and pharmaceutical companies follow the guidance of PhRMA, their lobbying and industry representative. “PhRMA’s guidelines are voluntary and do little to address…issues [in DTC Advertising]” (Mitka 2007:940).
Because the FDA guidelines are just that, guidelines, there is often little that they can do besides regulate false advertising. Unlike the television industry which has elected to do some form of self regulation, the pharmaceutical industry only follows the minimum regulations set out by the FDA.

With public perception and education ideals in question, DTCA have become ubiquitous in our lives and in our media. They tell us stories about what life was like before the drug and then after, selling us on this narrative of health. These advertisements are “constructing medications as unseen helpers” (Metzel 2004:31). These helpers will solve your problems, get you back to health, and they will lower your numbers or your risk factors. “Pharmaceuticals are biopolitical artifacts” (Lakoff 2008:742). They exist in our world as artifacts of image, usage, and material possession. Viewers are able to control their own health destiny, and are told over and over that they alone can “help their doctor’ and this is becomes an imperative of neoliberal personal responsibility. “Today’s patients are vocal partners in decisions about their own care” (Basch 2003:867). The differential preference of traditional, medical knowledge versus lay knowledge is seen in the statement of fact that “patients are not qualified to act as their own physicians” (Weber 2006:148). ‘Expert patients’ know enough to make some of the decisions with physicians, not enough to act as a physician.

In a presentation by Kathryn Aikin, a spokesperson for the FDA’s Division of Drug Marketing, Advertising, and Communications, she reported information found in an FDA survey of physicians on DTCA. The FDA found that “DTC [was] not [a] primary driver of visits to doctor” and that “DTC plays a role in generating questions for doctor”
and both of these are seen as positive responses to DTCA (Aikin 2005). Because it is not
driving doctor visits, it is not seen as pushing people for prescriptions and if it is creating
substantial conversation with a physician then it is engaging the patient in their own
health concerns and patients will be more likely to be compliant. Even further the
physicians surveyed were “evenly divided in opinions about the overall impact of DTC
ads on patients and practice- 1/3 positive, 1/3 no effect, 1/3 negative” (Aikin 2005).

Mirroring this belief by the FDA, Pat Kelly, a Vice President of Pfizer, authored an
article touting the benefits of DTC and playing down the risks, stating “we believe that
any health information for consumers that is accessible, accurate, and motivating is
beneficial if it leads to more, and more productive physician/patient encounters” (2004).
This is basically a benign statement that most would agree with in principle, things that
help patients become smarter about their own health is a positive. DTCA is still
controversial enough that is restricted to only two nations, as everyone else agrees that it
is not how their system should function. Even still, pharmaceutical companies spend a
lot of time and money trying to continually change their minds here and abroad.

Physician Matthew F. Hollon believes that “DTCA is probably harmful, suggesting that
such marketing is one of the least valuable contributions of the pharmaceutical industry
to the public’s health” (2005:2032). The other side argues that people need DTCA and
have come to expect it as something we are entitled to. “Millions of Americans are now
being treated for conditions that might have gone undiagnosed if not for DTC
advertisement” (Kelly 2004). While advocates and critics cannot agree on the

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4 Pharmaceutical companies have spent a lot of time and energy trying to break into UK and European markets
through repeated regulatory lobbying without much success. This continues to be a source of frustration for them,
spoken about in regulatory conferences for pharmaceuticals and in their own annual corporate reports.
productivity of advertisements for consumers, it is conclusive that it is generating income for pharmaceutical companies and has been successful for increasing consumernesship.

“Research [the National Institute for Health Care Management has] conducted over the past three years has led us to conclude that DTC ads are one element—and probably an increasingly important one—in the recent sharp rise in the demand for, expanded use of, and increased spending on prescription drugs” (Findlay 2002). All of these advertisements drive purchases, as they are intended to do. “From 2000 to 2008, 416 brand-name drug products—different drug strengths and dosage forms of the same drug brands—had extraordinary price increases” (US GAO 2009:i). Further in this Government Accounting Office report, they found that “a number of these drugs had more than one extraordinary price increase… [either multiple price increases total or] more than one extraordinary price increase in the same year” (US GAO 2009:10). Of the drugs named in this GAO study, 44 of the drugs and dosages were within the scope of the advertising I collected, supporting the idea that expensive drugs are often the most marketed by drug companies.

One of the biggest criticisms of DTC Advertising is the changing role of the physician with regard to their monopoly on traditional knowledge. Patients, now being asked to be the ‘smart patient’ or Patient 2.0, are increasingly asking their physician for pharmaceutical products or at least inquiring about them. “Drug advertising may encourage overuse of higher-cost drugs among patients who have little to gain” (Weissman et al. 2004). Patients may not understand their own drug formulary or their insurance differential in cost savings on drugs, but it is generally safe to assume that if a
drug is advertised, it is on patent and therefore very expensive. “Research indicated the ads [DTCA] not only were increasing consumers’ awareness of drug brands but also were influencing their decisions about medication” (Brown and Walsh-Childers 2002:465). Because they are advertised on television, there is a perceived legitimacy for these medications. The increases in advertising and revenue “both transforms doctor-patient relationships and increases the power and profit of the pharmaceutical industry, furthering biomedicalization” (Clarke et al. 2003:178). Physicians now encounter a new problem of patients possibly unwilling to take a drug that they have never heard of before, because brand recognition weighs heavily in the minds of consumers.

Pharmaceutical companies also still advertise to physicians and educate them about drugs in case patients begin to ask about a prescription. In this process is also the delivery of samples and product swag, like pencils, pads of paper, and other small worthless trinkets. “With physicians acting as intermediaries, patients are asking for drugs they see advertised and they are receiving samples of most of those drugs in their doctor’s office, along with a prescription” (Findlay 2002 italics in original). They start from the physician with a free trial and leave with a prescription to fill later. Proponents of DTCA argue that “while DTC advertising alone cannot provide all of the information necessary to justify a particular treatment, it motivates consumers to consult their doctors and other resources, and to learn more about the benefits and risks of treatment alternatives” (Kelly 2004). It is this visit to the physician that is at the heart of the “ask your doctor about X drug” in every advertisement you will see (part of the FDA requirements) that concerns critics because “any resistance on the doctor’s part is seen as
a lack of knowledge, of interest, or of time” (Dumit 2012:77). Physicians are placed in an often, difficult position. If a patient is not a candidate for, say, erectile dysfunction drugs because of a history of heart disease, then the physician has to make a choice. They can either have a long conversation to talk them out of the drug because of their medical history, write the prescription and monitor them if they are adamant about it, or have them leave and not discuss their medical history with a new doctor to get the drug. This positioning places the physician in a strange new place with the ‘expert patient,’ one where they are not the final authority they used to be for patients. “Direct-to-consumer advertising has increased consumers’ role in the prescribing equation” (Conrad and Leiter 2004:170). There is now a legitimate space in the physician’s office for patients to speak up and make requests, sometimes educated and well-researched ones. “Nearly two-thirds of all patient visits result in the doctor handing over a prescription, and more than half of all adults take two or more medications a day” (Roizen and Oz 2006:142). We are increasingly medicated, in a way never seen before and the money spent on DTCA is paying off for pharmaceutical companies.

One of the most interesting sources of opinions on the issue of DTCA and the physician’s role in prescribing came from George Evans and Arnold Friede in a Letter to the Editor in the Journal of American Medical Association. They “believe that DTCA empowers patients with information to help them engage in a meaningful dialogue with their physicians about the benefits and risks of prescription drug therapy” (2003:2646). They were both employees of Pfizer at the time and neither are doctors. The conversation about DTCA has become open to influence like these statements by pharmaceutical
company employees in one of the most prominent general medical journals. While the
FDA recognizes that “general practitioners report feeling more pressured to prescribe”
(Braman and Aikin 2003) and that “sixty-one percent of physicians felt some pressure to
prescribe a drug when they were asked about a specific brand name drug” there is no sign
that DTCA will be going away anytime soon (Aikin 2003:5). Further, my interviews
with physicians suggest a growing annoyance with the overeducated patient. They take
more time to placate in the office to explain why they cannot take certain medications
because of their medical histories. Doctors overall are not against the DTCA because
they feel that people have become more aware of diseases, disorders, and their own
health. In an interview with Dr. Michael Roizen, Dr. Memhet Oz’s (Oprah’s doctor,
often called America’s Doctor) writing partner and medical advisor for his weekday
medical talk show and practicing anesthesiologist, Roizen stated that DTCA even if
deceptive were productive because often the visuals in the ad reference healthy behaviors
like walking, dancing, and bicycling and this might contribute to healthy behavioral
modifications by the patient. Whether this is true or not has yet to be proven. DTCA do
show increased consumership of those drugs heavily marketed and increasing brand
familiarity by the general public.

Pharmaceutical Response to Criticism

I began my research by contacting pharmaceutical companies for comment,
especially in regards to product specific ads from their company. Not only did I often not
get a response, either through their online web forms or contacting their public relations
departments directly, but I also obtained no response from their lobbying group PhRMA
either. It should be noted that “by 2002, there were six pharma lobbyists for every sitting U.S. senator” (Critser 2005:225). I was referred in a single email response from one company to their annual reports (what a company discloses to shareholders about their corporate information) but they refused to comment on any specifics that I presented to them. So I went to their annual reports and this is the kind of information that the pharmaceutical companies state in an annual report: costs spent on advertising, advertising policies, company statements about specific product advertising, and statements about their changes in advertising because of FDA requests. In Pfizer’s annual report, they discuss past costs to their shareholders. “Advertising expenses relating to production costs [include] the costs of radio time, television time and space in publications... Advertising expenses totaled approximately $3.9 billion in 2011, $4.0 billion in 2010 and $2.9 billion in 2009.” (Pfizer Annual Report 2011). That is quite a bit of money but these advertising costs include not only DTCA but also marketing to physicians. A common topic was the importance of DTCA and also the changing procedures they have adopted. Below are GlaxoSmithKline’s statements about their advertising and the role that it plays in educating patients and their choices for drugs and the removal of some advertisements.

“We believe that responsible pharmaceutical advertising is a useful source of health information for patients. It helps to increase knowledge of conditions and educates patients about treatment options. All our DTC advertising in the USA is reviewed by legal, regulatory or medical specialists and new DTC television advertisements are submitted to the US Food and Drug Administration for review and comment prior to broadcast. In 2011 we took the decision to stop television advertising in the USA for erectile dysfunction medicines. Although such advertising was legal, we made the decision to no longer advertise these medicines on television out of respect for viewers.” (GlaxoSmithKline Corporate Responsibility Report 2011).
In this statement by GSK, the erectile drug they are discussing is Levitra, which was already losing out in brand recognition to Viagra and Cialis, both of which have television ads currently on air. Many times the companies have these kinds of statements about the care and attention they place in making sure drug advertisements are adequately reviewed. These reviews are conducted either by in-house legal staff or former FDA officials who now work in consulting, as many choose to do when they leave the FDA and are only submitted to the FDA prior to broadcast if they are entirely new advertising campaigns as required by regulation. Merck stated that “in 2008, we strengthened our policy on DTC advertising, including adopting a minimum six-month time period following the approval of a new product before launching DTC broadcast advertising in the United States.” (Merck Sales and Marketing Website 2012). For Pfizer, the emphasis was on a new campaign they were running to be more helpful to consumers. The methods they mention below in their strategy are all required FDA items like risks and benefits, so these should not be something new to their ads, if they have been doing them correctly all this time.

“A year after announcing that we would improve direct-to-consumer advertising of prescription pharmaceuticals, we have delivered on that promise with television and print ads that include better communication about risks and alternative treatment approaches, dedicated advertising for Pfizer Helpful Answers®, more disease-focused ad campaigns, and product ads that always include the product indication, benefits and risks.” (Pfizer Sales and Marketing Website 2012).

These statements should be considered misleading, as they are all company rhetoric, by promoting that they are proud of following the rules.
I do not estimate that annual reports are often widely read, given that most are over 200 pages. AstraZeneca’s annual report specifically focused on a single drug, Nexium, as an example of what they are doing right for stockholders. Nexium is an interesting case for AstraZeneca because “Prilosec and Nexium are members of a class of drugs known as proton pump inhibitors (PPIs). Nexium (esomeprazole) is the newer formulation of the original Prilosec (omeprazole) product” (FDA News and Events 2007). This means that Nexium replaced Prilosec when it went off patent and could be made by other companies in generic form. “Before the patent on omeprazole [Prilosec] expired in 2002, its parent company AstraZeneca, simply introduced Nexium (esomeprazole), an isomer of Prilosec” (Healy 2012:33). These processes to create similar but patent-able drugs are called “mirror image, or left and right hand (isomer) forms” (Healy 2012:33). AstraZeneca described their huge success with Nexium in their annual report, stating:

“Nexium was the fifth most prescribed branded pharmaceutical in the US. In the face of continuing generic, OTC and pricing pressures, Nexium sales declined 11% to $2,397 million (2010: $2,695 million). Nexium remains the branded market leader retaining significant market share and volume within the proton pump inhibitor class.” (AstraZeneca Annual Report 2011).

There are now so many proton-pump inhibitors available on the over-the-counter market because many went off patent within the span of a couple of years that the market has become competitive for Nexium, their little purple pill. They are still very proud of their market share for a mirror image drug, but is much more expensive for consumers and healthcare insurance companies than the over the counter Prilosec. These pharmaceutical companies report some useful information on their websites and in their annual reports
but I would have much rather engaged in a conversation with the companies and their spokespeople. They chose not to be participatory in this project, after repeated requests, so we are left to study the advertisements themselves and study the biopolitical artifacts, the documents they leave behind for further information.

The Collection

For clarification on the issue of Direct-to-Consumer Advertisements, I began a collection to be able to view the progression over time for as many drugs as possible. This collection includes both magazine and television advertisements, with magazines ads collected over an eleven-year period (2002-2013) and television ads collected over a five-year period (2009-2013). I maintain a hard copy of every print advertisement in the collection and television ads were transcribed live when they aired. Most are still available online, although that was not a source for this project because of the difficulty in knowing the dates when they aired. I chose to collect advertisements from magazines (and newspapers where found) and television because these are the most widely viewed sites of DTCA. There are other places that these advertisements occur like in medical journals, but those are aimed at physicians not a general audience, or bus shelters, where I saw one Januvia advertisement, but these are much less common and harder to track.

I collected a total of 762 prints ads, from 77 companies and for 150 different drugs. I collected a total of 86 television ads, from 23 companies, and 50 drugs. The most advertised conditions are listed below in Table 4.1, for the number of different, single, advertisements and different drugs. Cholesterol was the highest reported magazine condition by advertisement number and by drug. When looking back to the studies and
reports by Weissman et al. and Findlay, these results match theirs in terms of conditions most often advertised in DTCA (Weissman et al. 2004, Findlay 2002). Allergies, arthritis, asthma, high cholesterol, impotence, and depression were all in both of their top list of conditions for DTCA, and it lines up perfectly with these conditions (Weissman et al. 2004, Findlay 2002). I did draw, as indicated by the asterisk (*) the largest definition of each condition, so the cholesterol category includes ads for triglycerides and cholesterol/high blood pressure combination medications. When a drug, like Cymbalta, is advertised for depression, chronic osteoarthritis pain, and fibromyalgia, each advertisement was counted separately for each indicated use category.

Table 4.1: Most advertised conditions in DTCA database.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Magazine</th>
<th>Television</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ads</td>
<td>Drugs</td>
</tr>
<tr>
<td>Cholesterol*</td>
<td>91</td>
<td>14</td>
</tr>
<tr>
<td>Arthritis/Rheumatoid Arthritis*</td>
<td>58</td>
<td>6</td>
</tr>
<tr>
<td>Depression*</td>
<td>55</td>
<td>9</td>
</tr>
<tr>
<td>Allergies</td>
<td>52</td>
<td>10</td>
</tr>
<tr>
<td>Asthma</td>
<td>42</td>
<td>6</td>
</tr>
<tr>
<td>Erectile Dysfunction</td>
<td>34</td>
<td>3</td>
</tr>
</tbody>
</table>

* indicates that the condition is drawn by the largest definition possible.

When looking at the DTCA by company, Pfizer had the most number of ads by far than any other company, as seen in Table 4.2, in both the magazine and television collection. Often drugs would have changes over time in the company that owned them because of
company mergers or sales and those changes were reflected in each advertisement as it was recorded. That information should not affect Table 4.2 as most drug company changes happened when one of the larger companies (like the ones below) bought a smaller pharmaceutical company.

Table 4.2: Companies with the most DTCA in database.

<table>
<thead>
<tr>
<th>Company</th>
<th>Magazine Ads</th>
<th>Magazine Drugs</th>
<th>Television Ads</th>
<th>Television Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pfizer</td>
<td>134</td>
<td>17</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>GlaxoSmithKline</td>
<td>83</td>
<td>19</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Merck</td>
<td>65</td>
<td>9</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>AstraZeneca</td>
<td>60</td>
<td>7</td>
<td>8</td>
<td>4</td>
</tr>
</tbody>
</table>

These databases were as inclusive as possible to record all of the information necessary to understand the marketing pitch or tag lines of the advertisements over time, but also the use of coupons, prescription payment assistance, the coding numbers (numbers to keep track of each advertisement version and over time), and the presence of a celebrity endorsement or actual physician (actor portrayals of doctors were not recorded). The individual advertisements are cited by their date of issue or publishing (some have only date of issue) and their coded number to identify each advertisement the same way pharmaceutical companies and the FDA also keep track of them.

To really understand the particulars of these advertisements, I want to discuss several specific pharmaceutical products and their advertisements. I want to make clear that I am not attempting to undertake a study of the semiotics of pharmaceutical advertising, that is the linguistic language utilized by the pharmaceutical companies, although one could undertake such a study with ease because of the overwhelming amount of repetitive pharmaceutical language. I simply want to show the ways that the
everyday statements and language used in advertisements contribute to possible misunderstandings by consumers, as it relates to the idea of a ‘smart patient’s’ understanding of information circulating within the healthscape. These regulated processes of knowledge production can still be misleading for consumers and accuracy should be more of a concern. As has been shown by many (Dumit 2012, Aikin 2003, Healy 2012), the consumer often has no realistic knowledge of the threshold a pharmaceutical product must possess to be approved by the FDA, but further the regulatory language used in ads can mislead the public about drugs, drug safety, and the potential relative benefit compared to current medications on the market or even sold over the counter. As seen in all of the statistics given above, the consumer is often starting from a place of misconception about what a drug can do, has done, and will do for them.

As a reminder, the FDA allows three types of Direct-To-Consumer Advertisements (DTCA) of prescription drugs: “Product claim ads: These name a drug and the condition it treats, and talk about both its benefits and risks. Reminder ads: They give the drug's name, but not the drug's uses. Help-seeking ads: These describe a disease or condition, but don't recommend or suggest specific drugs” (FDA Direct To Consumer Ads 2013). All of the advertisements listed above for the database are ‘Product Claim Ads’ and ‘Reminder ads,’ although ‘Help-seeking Ads’ were also collected separately.
CASE STUDIES:

Ambien and Lunesta

Sleep medications have become big business for pharmaceutical companies, with two prominent drugs on the market, Ambien and Lunesta. Pharmaceutical companies decided that “insomnia was an undertreated condition, with only 40 percent of all sufferers getting help” (Critser 2005:155). With this unmet need, there was a substantial market for these sleep aids for consumers. These companies “then initiated a huge DTC sleep awareness campaign, focusing on the long-term dangers of not getting enough quality rest” (Critser 2005:155). The tag line for Ambien ads have focused on living a full life with the help of the sleep aid. “A full day starts here. Ambien helps you get the sleep you need” (August 2002, 57-041133-A). Also, on the benefits of sleep medications for getting a whole night’s sleep uninterrupted. “Ambien has 1 layer to help you fall asleep. Ambien CR has 2 layers to help you fall asleep and stay asleep” (July 2006, US.ACR.06.07.037). The warnings of such sleep drugs may not have registered with audiences, but an Ambien ad on television stated, “Until you know how Ambien CR will affect you, you shouldn't drive or operate machinery. Plan to devote 7-8 hours to sleep before being active. Sleepwalking, eating and driving while not fully awake with amnesia for the event have been reported” (Ambien, 4/13/2009, 12:00PM, CBS). These can be severe side effects and have even spurred online postings of people taking Ambien and videotaping their shenanigans during the evening. “A brief google search reveals hundreds of nightmare stories resulting from Ambien, from people jumping out of windows, to violently assaulting spouses, and, most commonly, to highly dangerous sleep
driving” (Leibig 2010). There is even a rash of criminal activities that have occurred while people were under the use of Ambien, often alongside other medications or illegal drugs and alcohol. In one case, “a woman from Texas took Ambien one night and woke up on a cement jail floor the next day only to discover she was arrested for driving her car in a zombie like state and crashing into other parked vehicles” (Leibig 2010). These kinds of cases are growing in number as Ambien is affecting people’s chemistry differently or its use is mixed with other substances.

These sleep medications have been prominently discussed in medical literature and by the FDA because of their use of coupons in advertisements. They are not, by any means, the only pharmaceutical products that have offered free trials or inducements to purchase. “DTCA for some products extends to inducements such as coupons for discounts or a free period of supply, such as a month” (Lyles 2002:86). One example of this kind of encouragement occurred in a Lunesta ad. “Take the Lunesta 7 night challenge” and offered 7 free tablets of Lunesta through the company, Sepracor (2005, no ad number). The sleep market is competitive and in these kinds of pharmaceutical competitive atmospheres, coupons and free trials are seen as easy ways to have consumers select your drug over your competition. “Some specific advertising strategies—such as offering coupons for an initial supply of prescriptions drugs—reinforce the message that drugs are just like non-medical products” (Weber 2006:265). By feeling that an inducement to purchase, like a coupon, can make the difference in gaining a consumer over your competitor it creates the perception that these drugs are interchangeable or no different from one another, that price is the only difference for
consumers. In contrasting the statements about ‘help your doctor help you’ and ‘ask your
doctor about X medication’ statements, there is the belief that creating coupons and free
trials can be seen changing the conversation between patients and physicians for one
specific product over another. “The use of free offer incentives may well be sending an
implicit alternative message, however: ‘tell your doctor that this is what you want’”
(Weber 2006:172 italics added). The choice then is up to the consumer about which of
these two non-differentiated drugs and the price then becomes a dominant factor in the
selection.

Figure 4.1 Product Reminder Advertisement for Ambien CR (2005).

The advertisement pictured in Figure 4.1 struck me as I looked through the collection of
advertisements because of the complete lack of information (it never says what condition
Ambien treats) and total focus on symbolically representing itself as an ad on a telephone
pole or college flyer, with tear-away strips. The message in the ad is clear “FREE
AMBIECR.” It is a singular statement that follows through the entire advertisement. I spoke to my lone contact at the FDA about this ad in particular, and while they do not comment on specific ads, I was directed to a study that is being run currently by the FDA on drug promotion and coupons, inspired by this specific ad and a few others like it.

“This study will examine types of promotional offers (for example, free trial offer; money off cost; money back guarantee; buy one, get one free; and no offer) in three types of drug advertisements (prescription drug full product, over-the-counter (OTC), and prescription drug reminder). The fictitious test product will treat insomnia and will be modeled on an actual drug used to treat this condition. Participants will be consumers who have insomnia or who self-identify as having met the diagnostic criteria for insomnia” (FDA Notices 2011: 58011-58018).

This study will determine if these inducements are important factors for purchasers of pharmaceutical products. With the large amount of advertisements that include some form of inducement to purchase, the pharmaceutical companies seem confident that there is an influence on consumer purchasing with these particular tactics.

Lunesta has been running a very prominent ‘Reminder ad’ campaign in magazines and on television. The ad features a black screen and a pastel colored butterfly flying with the tag lines “followthewings.com” or “Join us at ProjectLuna.com” or “On the wings of Lunesta.” These are very simple advertisements with again a complete lack of information about the product, risks or benefits, or conditions being treated.

“The advertising regulations exempted some types of advertisements from the requirements. “Reminder advertisements,” which were designed for medical journals, contained only the name of the drug, and made “no claims for the therapeutic safety or effectiveness of the drug,” were specifically exempted from the FDA’s requirements regarding the brief summary and fair balance of risks and benefits. Ads lacking a proprietary drug name also were exempted from the regulations. In the early 1990s, in order to circumvent the brief summary requirement, pharmaceutical manufacturers ran reminder ads and help-seeking ads that mentioned a disease or the name of a drug, but not both” (Donohue 2006:671)
Reminder ads were allowed by the FDA before DTC Advertising was opened up to consumers, and the regulation did not change or modify when consumers became part of the larger audience of ads. “Reminder ads, which were originally designed for physicians and medical journals, led to some confusion among consumers who did not know what condition the drug was supposed to treat” (Donohue 2006:684). This advertisement for Lunesta, shown in Figure 4.2, is simply a butterfly on a black background. Lunesta has also run a television advertising campaign with the similar graphic and offers only a website or a tag line.

Figure 4.2 Image of Reminder Advertisement for Lunesta (2011)

These advertisements rely on product name recognition, whereby the audience recognizes the drug name and what conditions it treats, or advertising campaign recognition, whereby the audience recognizes the butterfly imagery and recalls the print or television advertisements when seeing the other types of ads. These advertisements have the
potential to confuse consumers as they are not specifically being told about the drug, risks or benefits, or conditions being treated. It is expected that the ‘expert patient’ will be following these signals or information on their own.

**Advair 250/50**

There are two versions of Advair, that reflect differences in dosage, where Advair 100/50 is for Asthma, and Advair 250/50 is for COPD (chronic obstructive pulmonary disease). The different dosages reflect varying levels of two drugs that make up in combination the single drug Advair. The two dosages have different and distinct advertisements but they have very similar wordings because they both treat breathing problems and have similar side effects. Advair is not the only pharmaceutical product that contains two separate drugs within one product, but it is the only one where I noticed a distinct difference in what was said in the television advertisement and what was printed at the bottom of the screen. In the television ad for Advair 250/50 the voice says, “While nothing can reverse COPD, Advair is different from most other medications because it contains both an anti-inflammatory and a long acting bronchodilator working together to help you breathe better” but the text at the bottom of the screen states, “it is not known how anti-inflammatories work in COPD” (March 1, 2010, 5:48 PM, Lifetime). For a pharmaceutical product that contains two drugs in a single delivery, it is surprising that the company does not know (or cannot directly say) how one of them will work in the condition being advertised as treating. Additionally, it is disconcerting that one version is said aloud, the other is in print, so that requires a consumer to both listen and watch the advertisement, not always a common behavior with television audiences.
COPD, like other often self-diagnosed conditions, has become a popular condition to have ‘Help-seeking ads’ asking people to answer questions of to ‘Fill in the Blanks.’ Thereby creating a way for consumers to make themselves aware of their risks or risk factors for COPD and therefore eligible for treatment. The ‘Help-seeking ad’ shown below in Figure 4.3 is for COPD, by GlaxoSmithKline, the makers of Advair 250/50.

Figure 4.3 Help-seeking Advertisement for COPD by GlaxoSmithKline (2012)
In Figure 4.4, the companion ‘Product ad’ for Advair 250/50 asks the same questions as the ‘Help-seeking ad’ in condensed form. Both ask about medical history, progression of symptoms, and previous medications. These checklists are “encouraging patients to complete self-assessments and ask their doctor” about medications (Healy 2012:37).

“The paradox of checklists is that while they appear to be a form of self-help they take the questions of diagnosis, Am I sick? out of the subject’s hands” (Dumit 2012:72).

Checklists are considered productive by pharmaceutical companies because it allows consumers to be proactive and complete the self-assessments, which would then necessitate a visit to a physician. These kinds of help-seeking ads with checklists are quite common for conditions specifically found in my collection for migraines (AstraZeneca for Seroquel XR) and depression (GlaxoSmithKline for Imitrex). ‘Expert
patients’ are targeted with these kinds of advertisements because they are expected to take up the call for personal responsibility and engage with their physician in a proactive, healthy way.

**Trilipix**

Tripilix is a cholesterol-lowering drug that was aimed at triglyceride levels, a little known component in the HDL and LDL trifecta of cholesterol health. Abbott Laboratories undertook a ‘Help-seeking ad’ campaign to create awareness of triglyceride numbers as an essential number for ‘smart patients’ to monitor. Notice in Figure 3.6 that the Help-Seeking Advertisement for triglyceride awareness was issued in July 2008, almost one year ahead of the Product Claim Advertisement for Trilipix. The website featured in the ‘Help-seeking ad’ for triglycerides, www.forheartrisk.com, is not online any longer, but previous thread posts in an online forum show that it was created by Abbott Laboratories, the same company who sells and markets Trilipix and operates www.trilipix.com today. This phenomenon is common for drug launches, whereby a company releases a Help-Seeking Advertisement ahead of the final drug approval if the drug may be for a symptom or condition not widely known by the public. This raises the public awareness of the disease etiology the coming drug will treat. The Product Claim Advertisements will then often utilize the same diagrams, fonts, colors, and other markers to push audience memory of the previous advertisements while now providing drug and product information, like in the case of Trilipix shown below. By stating in the Trilipix ad, “I didn’t realize there was more to the picture than just bad cholesterol” the ad is referencing the picture of the triangle graphic, which is repeated in both the ads (June
These graphics and advertisements are meant to signal repetition of information to consumers in subtle ways, thereby encouraging information retention and possible future purchasing behaviors.

Other cholesterol drugs, some of them the popular statin drugs, have chosen to link their drugs to other ways of creating more drama. A new “Lipitor campaign debuted during the hit TV show ER in February 1998, only months after FDA approval” (Critser 2005:108).

By having Lipitor premier at the same time as a highly rated medical show, they are trying to show a link between their drug and the treatment of medical conditions on the show, while capturing a medically informed audience. Another Lipitor ad linked their drug with physicians as way to address authenticity and legitimacy. “Lipitor is the #1 choice of physicians to treat high cholesterol (especially when it comes to lowering their own” (June 2005, LP268415-A). If physicians are not only prescribing the drug, but also taking it themselves, then there must be a benefit to taking this pharmaceutical product
over another statin. In another ad, Lipitor looks to the adage of diet and exercise, as wise but possibly not enough ‘treatment’ for cholesterol levels. “Are you kidding yourself? A lot of people think exercise and healthy diet are enough to lower cholesterol. For 2 out of 3, it may not be” (June 2009, LPP03587OB). This ad gets to the heart of the notion that people may need to be so involved in their health that even changing their daily activities towards health behaviors may still be deficient, so the ‘expert patient’ should know what else they can do for their health.

**Enbrel and Humira**

There is an explicit effort from pharmaceutical companies to find ways to advertise their products with as little real information for consumers as possible about the negative side of their medications. A pharmaceutical researcher told me that drugs that suppress immune responses (like those to treat Rheumatoid arthritis or Psoriasis, namely Enbrel and Humira) may result in some patients dying of cancers that flourished without the needed, bodily immune response, but if one person who was suffering was helped then it was a win. Jain has showed that this is common thinking with regards to clinical trials for cancer patients and I would argue that it is generally prevalent thought process for how pharmaceutical companies see their consumers (2010). Look at the wording of the transcribed television advertisements, especially the marked bolded sections.

“**Enbrel suppresses your immune system it may lower your ability to fight infections. Serious, sometimes fatal events including infections and tuberculosis, lymphoma, other cancers and nervous systems and blood disorders have occurred.** Before starting Enbrel your doctor should test you for tuberculosis and discuss whether you've been to a region where other fungal infections are common. Don't start Enbrel if you have an infection like the flu. Tell your doctor if you are prone to infections, have cuts or sores, have had Hepatitis B, or have been treated for heart failure, or if while on Enbrel you
experience persistent fever, bruising, bleeding or paleness” (Enbrel, 10/31/2011, 7:21 PM, ABC).

“It was a weekend to relax with friends and family but even here there was no escaping it. It's called moderate to severe chronic plaque psoriasis. Once again I had to deal with these embarrassing, flaky, painful red patches. It was time for a serious talk with my dermatologist. This time he prescribed Humira. It fights my moderate to severe plaque psoriasis. It works inside my body to help clear the surface of skin. In fact in clinical trials most adults saw 75% skin clearance. And the majority of people were clear or almost clear in just 4 months. And the makers of Humira offer financial assistance to patients who qualify. **Humira can lower your ability to fight infections including tuberculosis. Serious sometimes fatal events can occur such as infections, lymphoma, or other types of cancer, blood, liver, and nervous system problems, serious allergic reactions and new or worsening heart failure.** Before starting Humira your doctor should test you for TB. Ask your doctor if you live or have been to a region where certain fungal infections are common. Tell your doctor if you have had TB, Hepatitis B, are prone to infections or have symptoms like fever, fatigue, cough, or sores. You should not start Humira if you have any kind of infection” (Humira, 3/27/12, 12:22 AM, BRAVO).

The tag lines for both drugs echo similar sentiments. For Enbrel, the focus has often been on the celebrity endorsement of Phil Mickelson, a golfer and someone prominently featured in their print and television advertisements, See Figure 4.6 for a print ad with Mickelson. One magazine print ad stated, “Enbrel helps stop joint pain at work and at home. Just ask pro golfer Phil Mickelson” (August 2012, 60733-R1-V2). Another one of Enbrel’s ads that stated, “I have Rheumatoid Arthritis. I also have a life” (November 2009, MC41435-E-1). Emphasizing the presence of the disease but also the willingness to continue everyday activities and keep up with life. Humira’s advertisement concurred with the statement: “Doing dishes could be a splash...and is just one of the daily activities you may be able to do with less pain and stiffness” (August 2009, 64X-270712). Glamorizing the dishes may seem odd, but rheumatoid arthritis pain prevents people from doing small, daily tasks, and by glamorizing something so small, it may
appeal to those who would like to get back to a normal life. Humira’s advertisement “Hate psoriasis. Love clearer skin” appeals to those who are fed up with their situation (April 2010, 64Y-371525). All of these ads are a call to action and a push to take steps to get back to real life, which is possible with these drugs, as promised in these advertisements.

Figure 4.6 Enbrel Advertisement featuring Phil Mickelson (2011).

Viagra

Viagra advertisements were popular within my collection of DTC Advertisements, where I recorded 23 magazine ads and 3 television ads over 11 and 5 years respectively. Their tag lines varied from, “Deal with it. That's what men do” (Jan 2010, VGU00761) to “Viva Viagra. The three reasons I'm singing the praises of Viagra” (October 2007, VGU00200A), and “Get back to mischief. Compliments of Viagra”
(September 2002, VG216216A). One of my favorite early tag lines was, “What happens if you don't talk to your doctor about Viagra? Nothing” indicating a purposefulness of action needed to take control of erectile dysfunction (September 2001, HC144A01B). A television advertisement for Viagra stresses action stating,

“You've reached the age where you've learned a thing or two. This is the age of knowing what needs to be done. So, why would you let something like erectile dysfunction get in your way? Isn't it time you talked to your doctor about Viagra. 20 million men already have. With age comes responsibility” (Viagra 10/25/11, 11:49 PM, ABC).

It is this responsibility, that places the consumer in control of their own destiny. Nothing happens, nothing gets fixed if you do not act. In an analysis of Viagra’s historical advertising campaigns, Baglia points out that “Pfizer demonstrates how to successfully market a product for a condition that—historically—most men would not admit to” (2005:88). Erectile dysfunction or ED as an advertising concept “medically legitimizes this previously embarrassing condition” (Baglia 2005:88). It also becomes a campaign of harnessing the power of you, what you can do in situations, and as well one of taking back what you may have lost, by getting back to a good, ‘healthy’ sex life no matter your age.

Looking at another usage of checklists and self-examinations, “male visitors to Viagra.com are encouraged to take a ‘sexual health quiz for men’ and to print out the results for their doctors” (Weber 2006:176). This sexual health quiz is set up so that many men might fall into the ‘ED’ category and “it is an interesting understanding of disease or dysfunction if sexual health means that men, presumably of any age, are always able to have satisfactory sex” (Weber 2006:177 italics in original). Viagra became
a very lucrative product for Pfizer, but its advertising campaigns also became well known for their successful marketing to men about something they were resistant to hearing or discussing.

**Smart Patient Ads**

There were a few advertisements in my collection that really stuck out with their presentation of the ‘smart patient,’ even offering instruction or guidance into how to be the ‘expert patient.’ The advertisements below were the most compelling or direct presentation of the themes in the larger collection.

**Figures 4.7 Pradaxa (2011) and Restasis (2012) Product Claim Ads**

In this Pradaxa ad, it states, “With AFib, I’m glad my daughter had me talk to my doctor again about reducing my stroke risk” with an image of a girl looking over her father’s shoulder at a computer, which probably means they are on the Internet that is providing
important information to them both. This is just one way that pharmaceutical ads are reinforcing the imagery of ‘smart patients.’ There is also the inference that it is important to listen to your family and to have them involved in your health decisions, and that they do research as well.

“I’m not shy about speaking my mind” is the tag line for this Restasis ad for chronic dry eyes, giving the impression that she had to speak up to her doctor about wanting treatment, wanting this treatment, or wanting to be more participatory in some way in her healthcare. This is again, the Patient 2.0 model of being active in your own health, the search for help with your conditions and taking responsibility for yourself. For something like chronic dry eyes, which needs to be diagnosed by a physician, this ensures the patient is proactive in making sure their symptoms are not dismissed as simply something that may not be a big deal. If it is a troubling or important thing to you, then speak to your doctor and do not be “shy about speaking” your mind.

These smart patient ads are encouraging a biomedical solution for medical complaints in areas where people might be dismissed by physicians, like dry eyes, or for when there are several medications available, like with atrial fibrillation. There is an emphasis on choice, empowerment, and decisions, all of which are familiar themes in the neoliberal world of Patient 2.0. Also, with the Pradaxa ad, the man is telling his story, his narrative, which is heavily encouraged in biomedicine, and revealed as an example for others to model their behavior after.
This advertisement for Niaspan shows a photo of a loving father and daughter along with a sticky note, assumedly, from this daughter to her father about being proactive about his health. The note says that he need to be concerned about plaque in his arteries, and specifically mentions the website for niaspan.com. This would not be normal teenage knowledge or conversation, so it is safe to assume that she is involved in his medical appointments and general health conditions because she cares about him or for him. In this care, she is showing him the way to good health, a possible prescription of Niaspan.

In this Viagra ad, which differs greatly from most Viagra ads, as previously stated above, the advertisement directs the customer to not only to go get a prescription, but to then return to Pfizer to fill the prescription with “Viagra Home Delivery.” This program is changing the way customers interact with these advertisements, because now the
consumer sees this ad, goes to the doctor and gets a prescription for Viagra and returns (or boomerangs) back to the drug company. Pfizer is becoming their own distribution source as well as a source of information. Pfizer, in a press release about the program, states that “to meet the needs of consumers who are increasingly going online to purchase prescription medications, Pfizer today launched Viagra® home delivery, a new prescription-fulfillment website for Viagra® (sildenafil citrate) tablets, Pfizer’s most counterfeited medicine” (Pfizer News and Media 2013). “The site, which is powered by CVS/pharmacy and accessible through Viagra.com, offers men with erectile dysfunction (ED) an opportunity to purchase Viagra online (with a valid prescription) from a trusted source” (Pfizer News and Media 2013). This will change the current structure of pharmaceutical product advertising and communication with the patients if they have direct access to patients who have bought their products. “Pfizer's bold move blows up the drug industry's distribution model. Drugmakers don't sell medicines directly to patients. Instead, they sell in bulk to wholesalers, who then distribute the drugs to pharmacies, hospitals and doctors' offices” (New York Daily News 2013). Other drug companies will be watching to see the promise this new model might hold for Pfizer, and this could revolutionize the business model for pharmaceutical companies, pulling them even further into consumer’s lives.

Analysis

Pharmaceutical advertisements breed confusion amongst consumers. As statistics have shown, consumers believe these advertisements to be trusted sources of information for drugs and treatments. These DTC Ads are coming from a very few number of
companies, mainly Pfizer, GlaxoSmithKline, Merck, and AstraZeneca, and the FDA is not as involved in the process as consumers are lead to believe. Foucault describes biohistory as “the effect of medical intervention at the biological level, the imprint of human history, one may assume, by the strong medical intervention” that occurs throughout biomedicine (Foucault 1994:319). The biohistory of these advertisements has been greatly influenced by the development of the FDA’s policies on the subject. While drug advertisements have existed for as long as there have been drugs, we have never been as inundated as we are now with this information and marketing knowledge because of changes in regulation in 1997. The modern, neoliberal subject that has long been influenced by the notion of personal responsibility and a need to be the ‘smart patient’ is doing what Foucault calls the care of the self.

One of the primary forms of subjectivity in medicine is what Foucault calls the cultivation or care of the self, an idea that begins in ancient Greece and holds firm as a way to connect the soul and the body through bodily practices (1986:43). Foucault demonstrates that the care of the self is first an attitude, then a “mode of behavior” and “evolved into procedures, practices and formulas” (1986:45). Care of the self begins with the idea of Cartesian duality in that both the body and mind need to be educated and trained in the interest of health. “The care of the self is in close correlation with medical thought and practice” because “educating oneself and taking care of oneself are interconnected activities” (Foucault 1986:54-55). This is focused on the individual bodies of the neoliberal call to personal responsibility and this is what pharmaceutical
advertising depends on, a consumer who will see the DTCA and then do something with this information.

Furthermore, “the increased medical involvement in the cultivation of the self appears to have been expressed through a particular and intense form of attention to the body” (Foucault 1986:56). The body as a site of domination and surveillance makes people increasingly susceptible to the powers of the state in influencing behaviors and the localized interpretation of these kinds of knowledge. “There is an inducement to acknowledge oneself as being ill or threatened by illness” as self-knowledge becomes important in the care of the self (Foucault 1986:57-8). DTCA are designed, especially through these check lists and help-seeking ads to create a sense of being ill or possibly ill by the consumer. The production of knowledge on the cultivation of the self comes from the state through the avenues of the medical institutions, like that from the FDA to the pharmaceutical companies. “The development of neoliberal approaches to health that promote new modes of governing bodies and populations” (Epstein 2008:502). Medicine was expected to propose standards of conduct for individuals and “it was necessary to equip oneself with a medical knowledge that one could always use…to ensure self-reliance” (Foucault 1986:100). This self-reliance is an important parallel to personal responsibility and the rights of the modern subject; “one of the basic principles of the practice of the self: be equipped with, have ready to hand, a ‘helpful discourse,’ which one has learned very early, rehearses often, and reflects on regularly. The medical logos was one such discourse, dictating at every moment the correct regimen of life” (Foucault 1986:101). The medical discourse is driving behavioral responses of the population in
ways that are state-sponsored and encouraged through the production of knowledge about the subject in medicine. Pharmaceutical advertising is a direct call to action to the consumer. This information, directed at the television or print audience of lay people, arms them with health information, preparing them to look this up online or ask their doctor about it.

The prescription pad is a powerful symbol of the knowledge and power the doctor has to render aid to the sick patient. It is through the biomedical system that physicians are imbued with the authenticity and power to maintain their hierarchical position in relation to the patient. “Both the roles of the ‘doctor’ and ‘patient’ are constituted by the discourses and practices of medicine, which rest on the doctor remaining in the position of the expert” (Lupton 1994:116). Patients go to their doctor with information they have obtained from the media and the Internet, but the only expert with any authority is the doctor. “Patients rely on their faith and trust in doctors to cope with illness, preferring to hand over their responsibility for the management of the illness to the doctor” (Lupton 1994:106). Ultimately though patients are seeking a prescription overwhelming from physicians and this has been driven by the medicalization of the media and the production of knowledge by the pharmaceutical companies. “The consumption of commodities has become central to how people define themselves” (Lupton 1994:36). Even in health, the ability to be able to purchase health is central to the economic and moral imperative based in neoliberal practices. “The extraordinary developments in medical sciences and medical technology in the last two decades were paralleled by the rise of broad public consciousness about their impact on medical care” (Maretzki 1985:27). Even as Maretzki
is writing in the 1980s, technological advancements were gaining ground in the public consciousness and this process has sped up more than ever with the Internet and Direct-to-Consumer Advertisements (DTCA), whereby people know explicit information about products available for purchase to enhance their health. “Direct-to-consumer (DTC) advertising of prescription drugs and procedures has produced the major visual cultural change vis-à-vis things medical in the biomedicalization healthscape, dramatically widening distribution of medical knowledge” (Clarke 2010:136). The healthscape was broadened with advertising and the presentation of information to the broad audience at home.

Physicians are increasingly speaking out through their publications on the subject of DTCA. Dr. Marcia Angell is the former Editor-in-Chief of The New England Journal of Medicine, and she believes that the pharmaceutical companies, in conjunction with regulatory agencies, have given too much power to the industry by being able to produce knowledge for consumers about their products. She writes that for pharmaceutical companies, “the major method of obfuscation is to pretend marketing is really education” (Angell 2004:118). “Health has little to do with [direct-to-consumer advertising], except that it…has created what is probably the greatest marketing opportunity of all time” (Abramson 2004:150). The profit being made by pharmaceutical and health promotion companies often overshadows the best interests of consumers. Abramson’s main point is that “we [patients and doctors] need to become critical consumers of medical knowledge itself” (2004:150). Even though physicians have spoken out against DTCA, it continues to be a major source of knowledge for consumers about medications and treatments.
There was a “pharmaceuticalization of public health” in the late 1990s as pharmaceutical advertising was allowed to flourish by the FDA (Biehl 2007:1085-6). The responsibility of the pharmaceutical companies was to inform the public about their possibilities for treatment in order to have a more compliant biomedicalized, healthier American public. “Advocates of neoliberal reforms of the 1990s encouraged the participation of the private sector in resolving social problems” (Biehl 2007:1099). When sick people should be seeking treatment or being more compliant with their physicians’ orders, the DTCA stepped in with the aim of being pharmaceuticalization to the larger social body and the more individual body of the consumer. “The body remains a site, which (collectively) through the consumption of prescriptions generates billions of dollars annually for the industry” (Oldani 2004:338). The body of the patient is the site of both consumption and information, which if marketing is done well, will coincide together with the patient having the knowledge to request the pharmaceutical product to heal their bodily ailments. In this conflict, “DTCA supporters view it as an appropriate extension of patient empowerment, opponents reject it as inappropriate and misleading for its intended audience” (Lyles 2002:73). The argument is between intention, what is the actual intention of this kind of marketing for both the companies and the audience.

DTCA is big business for pharmaceutical companies. They spend a lot of money on these advertisements and they also select the drugs they believe will be good contenders for public consumption. “Combined, the top 10 advertised drugs represented nearly one third of the total DTCA spending” (Atherly and Rubin 2009:643). With so few drugs being advertised, out of the multitude that exist in entirety for patient
treatment, they tend to be ‘on patent’ and focused on diseases or conditions that easily understood and defined for the consumer. “Determining what counts as a condition that requires pharmaceutical treatment [is the issue for] direct-to-consumer advertisements” (Lakoff 2008:743). The areas of medicine that are primary for Direct-to-Consumer Advertisements are conditions like cholesterol, osteoporosis, acid reflux disease, asthma, and others which may be easy to diagnose or medicalize. “DTCA critics argue that physicians can be pressured by patients into providing inappropriate drugs” (Atherly and Rubin 2009:641). By having a system where the consumer is informed about both the disease or condition and the drug or treatment options, the power lies in the consumers’ hands. They have become an ‘expert’ on their own health and they may usurp power from the physician. One concern for consumers who may see many different doctors or specialists is that the consumer has captive information, their own medical record, that may not be available to their physicians. By doctor shopping or changing physicians over time, the patient has the potential to be precariously taking medications that could be in conflict with one another or to have a condition like heart disease that could prevent them from being a candidate for erectile dysfunction drugs. “If [your physicians] are not able to communicate with one another, you are at great risk of being overmedicated” (Caputo 2009:15). This idea of overmedication means that drug interactions or drug overdosing could occur because the ‘expert’ patient has some power to exert over their physicians, but that is inherently worrisome for physicians. The real problem in this system is that the DTCA creates new meanings and understandings about health, what it means to be healthy, and the medicalization of our bodies. “Health now means different things to
different people; it can mean a state of well-being, an absence of disease, a lowered risk profile” (Critser 2005:133). All of these convoluted, contrasting definitions of health lead to consumer purchasing, but also a changing nature of the physician-patient relationship.

There is a controversy about these forms of information that are disseminated from the pharmaceutical companies. “Beneath the controversies, discussions, and attempts to make sense of the current promotion and use of medicines must be the understanding that medicines have become one of the most consistently profitable commodities in history” (Paluzzi 2009:274). Processes of medicalization have driven people to be open to the advertising claims made by pharmaceutical companies. “Ads create new forms of discontent that can only vanish or be cured by new products” (Meijer 1998:237). Further, “advertising manipulates people into being consumers and instills false values” (Meijer 1998:238). Moynihan and Cassels point to the idea of “met un-need” to show how pharmaceutical corporations are using medicalization to feed drugs to consumer who may not yet have a physiological disease (2005:31). The larger issues of medicalization have opened a space for the medicalization of non-medical problems and as individuals seek help for these ailments, they are becoming a participant in the process by using the information that was created to drive consumership. “In the face of pervasive pharmaceutical marketing enmeshed with patient mobilization [like that of the Smart Patient], regulatory incoherence thrives” (Biehl 2007:1108). The problems with DTCA can be seen directly in the problems with advertising retractions and bad faith claims made in advertisements.
Ad Retractions and the Bad Ad Program

The FDA, while allowing DTCA with some requirements after 1997, is understaffed for overseeing the creation, modification, and resulting issues with the ads. One of the major problems is that “the number of staff members [at the FDA] who are dedicated to reviewing advertisements has remained relatively stable, whereas the use of such advertising has grown substantially” (Donohue et al. 2007:677). These people are working much harder than ever before, looking at thousands of print, television, and internet advertisements before they are posted and this could possibly lead to a misstep or the overlook of a critical problem. The FDA only had “thirty reviewers to cull through the 34,000 DTC ads submitted to it in 2001” (Angell 2005:124). So that if there are problems with ads, there is a time lapse in response because the reviewers must prepare and send letters to companies in violation of the regulatory system. Since 2002, the Department of Health and Human Services stated that it takes the FDA an average of four months to respond to violations, up from two weeks in the period of 1997-2001 (FDA Testimony 2003). Moreover, the FDA from 1997 until 2002 sent a total of 45 “Notice[s] of Violation” and three “Warning Letters on broadcast ads” both of which are serious indications of issues with DTCA (FDA Testimony). In an effort to help this lapse in oversight, the FDA’s Office of Prescription Drug Promotion or OPDP (what was the Division of Drug Marketing, Advertising, and Communication or DDMAC until an overhaul in 2011), created the new Division of Advertising and Promotion and Review or DAPR I and II, which oversee the new Bad Ad Program. Thomas Abrams, the Director of OPDP, described the Bad Ad Program as an “FDA-sponsored outreach program
designed to increase awareness of healthcare professionals (HCPs) about the role they can play in helping [the] FDA ensure that prescription drug advertising and promotion is truthful and not misleading” (2012). There are possible problems with the new program, as the “FDA is asking doctors to be government snitches” by reporting any misleading activity they may see in their office from drug reps or in advertisements (Minsk 2011). The FDA reports that “most of the violations cited were because the ad overstated or guaranteed the product’s efficacy, expanded the indication or the patient population approved for treatment, or minimized the risks of the product, through either inadequate presentation or omission of information” (FDA Testimony 2003). These are important because they are not something that can be determined by the untrained eye even by the ‘smart patient,’ meaning that the average consumer has no idea if the company is overstating efficacy or broadening their approved target market or even omitting information unless they are highly trained within the medical or pharmaceutical field.

The Bad Ad Program identifies four common violations for DTCA: “omitting or downplaying of risk, overstating the effectiveness, promoting off-label, or unapproved, uses, and misleading drug comparisons” (FDA Bad Ad Program 2013). One of the frequently asked questions of the program is “Will OPDP be able to stop the misleading promotion?” and the answer is quite awkward, “in many cases, yes, especially if evidence is provided” (FDA Bad Ad Program 2013). They provide only a 1-888 number and a website for physicians to make reports. The Bad Ad Program releases a year-end report and only 2010-2011 and 2011-2012 were available at this time, as the program is still new to the OPDP. The highlights of the first year of the program, 2010-2011, include
creating a brochure, writing a letter to 33,000 doctors, a webinar, and an informational video (FDA Bad Ad Program 2013). They cite that they received 328 reports of bad ads, 188 from physicians and 116 from consumers, many of which were then investigated (FDA Bad Ad Program). In the second year of the program, 2011-2012, a continuing education program was created for physicians, a journal advertisement was created to get more attention for the program from physicians, and case studies were created as teaching tools (FDA Bad Ad Program 2013). Now, the FDA just states that the “OPDP received hundreds of reports” and it has gotten better at prioritizing these by importance (FDA Bad Ad Program 2013).

Prior to the OPDP’s Bad Ad Program, notices of violation were issued to stop the current promotion and warning letters were issued. This is exactly what happened to Bayer Schering Pharm, who owns Yaz, in 2009 when they were required to create “a remedial campaign be conducted by the company to correct the misimpressions left by the ad” (FDA Testimony). In this case, Yaz is a prescription birth control pill, FDA approved for the treatment of PMDD (Premenstrual Dysphoric Disorder) and moderate acne, Bayer Schering Pharm was forced to recant their previous advertisement and run new ads only on television, dictated by the FDA to clarify what was misleading in the original ad and clearly state the updated information about the drug.

“You may have seen some YAZ commercials recently that were not clear. The FDA wants us to correct a few points in those ads. Yaz is approved for pregnancy prevention. If you choose the pill for contraception, you should know that Yaz is for the treatment of Premenstrual Dysphoric Disorder or PMDD and moderate acne. Not for the treatment of PMS or mild acne” (Yaz, 4/14/2009, 10:07 PM, TBS).
The process for correcting ads before the Bad Ad program involved a large lag time, as the FDA employees were tasked with reacting to problems in existing ads and then completed a long procedural letter exchange that went back and forth between the FDA and the company. What should be more disconcerting for consumers in America is the fact that in Europe, PMDD is not a legitimate illness to treat with medication. “A panel from the European Agency for the Evaluation of Medicinal Products noted that ‘PMDD is not a well-established disease entity across Europe. It is not listed in the International Classification of Diseases and remains only a researcher diagnosis’” and that the clinical trials for Sarafem [Prozac repackaged], the first treatment for PMDD, had “major deficiencies” and could not be sold for PMDD in Europe (Moynihan and Cassels 2005:115-6). Should consumers be aware of the lack of support for this illness as a medically treated disease almost everywhere in the world but America? Examples like this are what Conrad discusses in his argument about medicalization (2005, 2007). We are increasingly medicalizing conditions like PMDD, if it even is a condition, and treating it with medication and these misleading advertisements.

The FDA correction for Epi-Pen in 2012 was based on “a record 33 complaints on a single advertisement” and “as a result of the volume of complaints and the egregiousness of the violation, OPDP was able to contact the company and have the television advertisement pulled within three days of receiving the Bad Ad complaints” (FDA Bad Ad Program). Epi-Pen made statements about their efficacy that had to be retracted and clarified. This is the new, updated ad that aired following the original ads being pulled.
“You may have seen an Epi-Pen commercial that created the impression that a child who has peanut allergies can eat cake with unknown ingredients and be worry free from the risk of anaphylaxis if prepared with Epi-Pen. **The FDA said this was misleading and asked us to clarify.** Epi-Pen cannot prevent an allergic reaction. The most important step is to avoid your allergen all together. If a reaction happens, use Epi-Pen right away and immediately seek emergency treatment. Epi-Pen auto injectors are for the emergency treatment of life threatening allergic reactions, anaphylaxis, and for people who are at an increased risk for these allergic reactions. They are intended as supportive therapy and are not a substitute for immediate medical treatment” (Epi-Pen, 12/24/2012, 10:06 AM, NBC).

Epi-Pen made restatement ads in both print and television formats. “Sometimes the [FDA] acts so late that a commercial it finds misleading is already off the air” (USA Today 2008:10A). The Bad Ad Program is meant to speed up the response to these kinds of misleading advertisements.

There is also a debate among physicians about consumers’ basic understandings of the benefits and risks that are given in DTCA. Even the FDA’s newsletter shows that “about 75% of physicians believed that DTC ads cause patients to think the drug worked better than it did” (Aikin 2003:5). There is also a problem with the fine print that the DTCAs refer consumers to for more information. The FDA is aware that there is an “ineffectiveness of the brief summary in DTC print advertising in informing consumers about the indications, contraindications, and risks of prescription medications” and agreement that the “brief summary is somewhat hard or very hard to read and understand” (Braman and Aikin 2003). In addition, the Journal of the American Medical Association has been having a lively discussion within editorials between doctors and pharmaceutical companies about the risks, benefits, and issues with DTCA and print ads. One such article shows that physicians are concerned about the “multiple-page long lists
of risks required for printed advertisements—which may be ignored by 33% of patients—are optimal” (Henney 2000:2242). This is full well known to the FDA and pharmaceutical companies and has not been addressed fully to rectify the situation.

In all of these examples, the pharmaceutical companies are making attempts to speak to the consumers in a language they are not fluent nor should they be. Medicalized rhetoric found in DTCA is above the average consumer and often times somewhat deceiving about the general conditions under which people would be taking the drug. Doctors are the first line of defense against patients taking drugs that will not be beneficial to them but this is mitigated by evidence the FDA themselves know and cite about doctors feeling pressure to write prescriptions on brand name drugs that are requested by patients; this information the patients have comes from advertisements whether they be from television or print in magazines. In the above information, I have not even alluded to the ever-present issues of celebrity spokespeople, actors posing as doctors in ads, television news programs on medical ‘discoveries’ and the books and articles in major newspapers and magazines that highlight pharmaceutical products and health information. These work additionally in the world of marketing and advertising of pharmaceutical drugs and in conjunction with DTCA and will be discussed in Chapter Six.

In 2000, Pharmaceutical Executive Magazine, Edgewood Consulting Group, and CBS News held the second annual “Recognizing Excellence Awards for DTC Marketers” banquet where awards were given for specific advertisements and campaigns (Koberstein 2000:156). The goal of the event was to “establish the first award ceremony dedicated
exclusively to highlighting the best examples of pharmaceutical DTC marketing” and the judging criteria included both “creativity… in marketing” and “bottom line results in… growing sales” neither of which are concerned with helping sick people get better (Koberstein 2000:156). The celebration of themselves and their sales, is not unexpected in biomedicine, but selling drugs to people who do not need them is institutionalized into the system of marketing, regardless of the fact that this pertains to consumers who may be taking the drugs for an “met un-need.” By creating a world full of ‘expert patients,’ there is still difficulty recognizing when consumers are confident in their own knowledge base or needing to know more about the accuracy of such advertising. “Drug advertising also may have unintended and negative consequences if it encourages individuals to buy and use medications they may not actually need or that are less effective and/or more costly than other drugs or treatments for the same health problem” (Brown and Walsh-Childers 2002:463). If there are doubts about doctors being supportive of patient medical choices or selections, for example when we would prefer one drug over another, there is a problem in the system. As shown in the statistics on consumer beliefs about DTCA, most people are confused about whether drugs that all treat the same conditions, believing drugs like statins or allergy drugs, are interchangeable and they often are not. Some of them might have different side effects, work in new and different ways, or affect our bodies more so because of pre-existing medical conditions. This is when traditional medical knowledge needs to be prioritized over the lay medical knowledge. One physician I spoke with described the necessity of the clinical encounter to bring this lay and expert knowledge together. He said, “patient may find something I have never heard
of before online and I will integrate that into my treatment for other patients.” Further, he said “I encourage them to email me, snail mail, or call me with information so that I can look it over or possibly steer them towards more credible sources if needed.” Chemistry and pharmacology are not generally areas of expertise among the public, but this is an area of captured knowledge by physicians. In the process of educating America through advertising, the audience does not know what they have not said, what they have left out of the advertisement, not always understanding what the language of the advertisements say or what can be expected when taking these drugs. In this advertising, “one has gained not just a fact about oneself but also a vocabulary, rationale, and moral judgment about the unfinished process” (Dumit 2012:72). We have been lead to believe that this edutainment or marketing information is enough. A consumer can look things up online and research will tell if the advertising or our doctors do not, but there is an implicit trust in the system by consumers. Because of the neoliberal rhetoric of personal responsibility and the biomedicine machine, of which pharmaceutical advertising is key, Americans have been created to be smart patients. We can and will do for ourselves, especially when pushed to do so. Researching health information on the Internet is often even more convoluted, confusing, and disconcerting. The FDA has been drafting guidelines for pharmaceutical companies’ use of the Internet and social media, in advance of their mandatory guidelines required by the Summer of 2014. These guidelines that exist now are only advice on how to handle new and different ways that pharmaceutical companies may interact with their customers or prospective customers online.

“The Internet has revolutionized communication, information-sharing, information exchange among systems, and collaboration, enabling consumers to
become more proactive about their health and safety. Consequently, the Internet has become a widely used medium for manufacturers and distributors of FDA-regulated medical products to disseminate information. The Internet has also spawned a variety of social media tools that host online content primarily created and published by users other than the intellectual property owner or product manufacturer. In some cases, this online content may not be accurate” (FDA Social Media Draft Guidance, 2011).

The guidelines press further that these are only suggestions based on the FDA’s current view their accountability for online communication and information exchange and clarifications. These temporary guidelines and the presence of a deadline for the FDA’s formal draft are possibilities for future study, but not something undertaken in this analysis. The world of online health searching is becoming a popular access point for information, but there is not always the clarity needed to understand exactly what information is being disseminated and by whom.
Chapter Five: “Oh God! I think I have cancer. Wait. Nevermind”: Cyberchondria and Other Tales of Web Searching.

“Health information seems to achieve maximum kinetic energy when circulating over the Internet” (Briggs and Hallin 2007:58).

“The Internet is a potentially bottomless source of information on health. It is truly a game changer in terms of expanding your knowledge about your well-being” (Besser 2013:222).

The technology revolution of the last twenty years has brought more information directly to people’s hands in smart phones and to their homes with computers. The presence of the Internet is central to Americans’ lives and neoliberal practices encourage people to be active for their own best interest, utilizing the Internet to search for information and answers. “The Internet gives patients equal, universal, and unlimited access to clinical information; comparative quality and cost data on providers; information on treatment alternatives; and each other” (Kleinke 2000:64). The Internet is a vast resource and it can answer many questions for people about diseases, symptoms, physicians, hospitals, medications, supplements, and many other processes of the body and health practices. We are seeing “the information revolution, in which both parties (patients and health care providers) have potentially unlimited access to health information” online create these ‘smart patients’ (Sinha 2000:293). One example is the process of cupping, where the Eastern medical practice of taking hot glass cups and suctioning them onto the upper back became popular after celebrities like Jennifer Aniston were photographed with the marks on her body. A multitude of Internet searches began after the photographs circulated with people searching online for “marks on Jennifer Aniston’s back” and led to sites that promote cupping and articles on celebrities
who also engage in it and where the best places are to get cupping performed. There would be no other easy way to find out what those marks are unless there were covered in a newspaper or magazine article or possibly asking friends and family without the presence of the Internet.

The Internet is also very user-friendly because there is a sense of anonymity while searching for things, especially if they are about embarrassing or strange bodily functions. If no one knows who posted a question online in a forum about something like excessive sweating or some sort of bodily odor, there may be more of an incentive to ask a question that a person might not even ask your doctor for fears of embarrassment. The Internet can have promise for people to “overcome patient isolation while preserving a measure of patient autonomy” (Sinha 2000:299). Those suffering from chronic diseases or housebound by illness may be able to reach out to a community online for support or encouragement. Also, patient autonomy allows searchers to feel a sense of freedom in doing research on things that may be of interest for themselves or others they know.

“Patients with chronic diseases have always had a vested interest in researching their conditions and various treatment options; the Internet greatly accelerates and simplifies this process” (Kleinke 2000:64-5). The Internet can be both helpful and hurtful when searching without a lot of information or guidance. The sheer abundance of information online and a lack of skill for discernment can easily lead people astray in web searches. Physicians or friends and family often tell their loved ones to “stay off the Internet” when sick and waiting for a diagnosis, the idea being that patients may scare themselves with worst case scenarios before knowing their medical outcomes (or a range of possibilities)
from physicians or medical test results. I heard this from many people when discussing my research in informal conversations, including someone with a very sick child whose pediatrician specifically told him to stay off the web.

**Patients Online**

The movement of patients towards more information and away from a reliance on traditional medical information sources like doctors has lead to the ‘empowered patient,’ the ‘expert patient,’ or ‘Patient 2.0.’ These ‘smart patients’ are becoming more common and processes of neoliberalism have spurred this movement. As people gain more medical knowledge and become better at distinguishing what are trustworthy websites and which are more anecdotal or lack credibility, they approach this ‘smart patient’ status. A *Time Magazine* article identified “Patient 2.0 Pioneers” who created websites that drove “medicine’s power-to-the-people movement” and these websites include: Patientslikeme.com, ACOR.org, and Armyofwomen.org (Rochman 2010:48). Patient 2.0 or the ‘smart patient’ is an idealized subject within the biomedical, neoliberal healthscape that asks consumers to be productive biological citizens. This article is one way that people learn about websites that they feel they can trust, as they have been imbued with a sort of authenticity because of the prominence or authority of *Time Magazine*. These identifiable pioneers of web-based patient movements are becoming more common in the public discourse. People can now create a website very easily and this has lead to two very clear directions online, one with websites that pull people together with commonalities, creating biosocial support or information hubs, and another where anyone with a computer can create a website that may be misleading or harmful. There is always
the risk online that the websites visited could be harmful, but often people find relief and comfort from these online support groups and informational sites. Cline and Haynes provide a more complete picture of both the positives and negatives for consumers searching online for health information, as both coexist together (2001). “These lay people are banding together and starting websites to help figure out which practitioners to see and which hospitals to avoid, which clinical trials show promise and which experimental treatments are bunk” (Rochman 2010:47-8). These websites usually revolve around a specific disease, condition, or cancer that has its own specific patient group, treatments, providers, and can even be gender or age specific. This Patient 2.0 movement online can now clearly be viewed as an integral part of the new Embodied Health Movement evolving out of the AIDS and breast cancer movements, as discussed in Chapter One (Jain 2007, Epstein 1996, Zavetowski et al 2004, and Sismondo 2010).

Patient 2.0 looks different than before and has tools available to them in ways never before seen. We know that “knowing you are at an increased risk for certain diseases may help motivate [the patient] to focus on changing certain behaviors to minimize those risks, and it will definitely help your doctor guide your health decisions” (Besser 2013:6). By giving someone more traditional knowledge, the hope is that the patient or receptive audience with then move into action to better themselves, in the process gaining both lay and traditional knowledge. “The expert patient is an expert at being a patient, at living the lifestyle of the good patient… [he or she] knows all of his or her numbers, watches them, and will help others do the same” (Dumit 2012:183). Americans are being asked to know more and more about their bodies to be able to
inform biomedicine with this biomedical information. Keeping track of medical information, and knowing what they can mean for your health, is a large part of the Patient 2.0 or empowered patient movement. “Simply understanding a few key numbers can lead you to better health” (Colino 2010:151). For Colino these include: blood pressure, cholesterol count, thyroid levels, body mass index, c-reactive protein, and height, all of which may be intuitive or counterintuitive for patients to keep track themselves (2010:151-8). “We can think of the expert patient as a consumer who adopts a public health attitude toward himself or herself and is always on the lookout for better information” (Dumit 2012:184). These are the important aspects for biomedicalized control over the body, attitudes are changed first, which gives the patient the ability to see that their actions have meaning. They are also part of the larger project of public health whereby health individual bodies make a healthy larger social body.

One example of this kind of site, highlighted by Time Magazine, is Patientslikeme.com where people report their symptoms, medication reactions, and treatment outcomes in order to help others also suffering from the same condition. Patientslikeme.com is “free to patients [but] the for-profit venture sells pharmaceutical companies the blinded data it compiles from its members about drug safety and efficacy” (Rochman 2010:48). There are many websites that work within this model, both for profit and not-for-profit. BestPillsWorstPills, found at worstpills.com, compiles adverse medication reactions and is supported by subscriptions to a newsletter and database and also its lobbying and advocacy arm, Public Citizen. These are not often well known to consumers and they may have more knowledge of the adverse reaction reporting system.
than the FDA’s program Medwatch, now listed on every DTC Advertisement with the statement “You are encouraged to report severe negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088” (FDA Medwatch). This is the official program for reporting by both patients and physicians if they discover adverse drug reactions, most of which are usually not compiled or coordinated and reported, but it can be empowering for a patient to know about and be participatory in this system. Medwatch is the official reporting system for the FDA and Patientslikeme.com and BestPillsWorstPills are entirely informal and outside of the FDA.

The presence of so many websites and technological advances in health information and health management has been supported by the greater usage of these sites by consumers. It remains a capitalist market, where applications and websites remain successful only as long as they have relevance for consumers and are useful to people. “The process of consumer empowerment will be encouraged by those with the strongest commercial interest, ranging from the dozens of commercial consumer health care Web sites to the drug companies that provide most of the advertising and other sponsorship revenues for such sites” (Kleinke 2000:65). The top Internet sites and apps are consumer determined, such that even if someone declares their website to be better or more fitting, the market will decide if that claim is true. Advertisers look at web traffic and sites, closely monitoring that traffic and how the users find them, whether it is a search engine or click-through or direct find.

One of the real problems for consumers will always be in the accuracy and authenticity of the information contained on or in the site or app. “It is often difficult to
know whether the seemingly ‘objective’ information located in the Internet is produced by medical experts holding professional credentials and/or what kinds of financial and/or scientific stakes they might have in presenting information in a particular way” (Clarke et al. 2003:177). There is very little information about investors in technology companies, some of which get their financing from diverse sources, which may be pharmaceutical companies or healthcare companies with a vested interest in sending your business in a particular direction. “Anyone with a computer can set up a website and post information. Having so much health content from uncredited and noncredentialed sources allows incomplete, misleading, and even totally incorrect information to be presented as fact” (Besser 2013:223). On the other hand, “research shows that the Internet can empower you, which can enrich your relationship with your physician” (Besser 2013:222). This dynamic makes it difficult to know whom to trust. Even further, “one study showed that the focus of 80 percent of Internet sites that address back pain is advertising, and only 12 percent of the sites were rated as ‘high quality’” (Abramson 2004:79). With those kind of statistics, it seems very little of online content can be trusted and even then, will patients do the research to find out which is trustworthy and which is not?

One of the types of websites that patients can encounter may be fake grassroots organizations or a practice called astroturfing. Pharmaceutical companies or healthcare companies set up these websites to push or direct consumers to their marketing information, but they are disguised as patient support forums or sources of information. Consumers often have no idea they are on these sites because the information contained within the site does not look like it has ties to any singular group. “The Internet is the
DTC movement in overdrive. Web-based DTC advertising allows drug companies to target specific patients with specific diseases” (Kleinke 2000:66). Astroturfing sites give pharmaceutical companies a way to encourage a specific group of consumers to gather in one particular site and then take aim at them, often very subtly. A ‘user’ may suggest a medication to another user and this ‘user’ will work for the company that supports the site and makes the recommended drug. In another way, there are often virtual support groups, disease-focused websites that patient groups have created, or disease awareness non-profits that have started to draw in patient populations for information exchange. “In comparison to television…the Internet offers greater interactivity and better tailoring of information to individual needs” (National Research Council 2000:59). Television also leads viewers to the Internet by having websites and information available in messages at the end of a program, like after a character threatens suicide or a breast cancer storyline. People can often easily find somewhere online, sometimes too many sites, that are in support of their illness, disease, or medication that may aid them in resolving problems or finding anecdotal answers to their issues. “Online support groups are associated with feeling better informed about disease, finding ways of living with it, feeling more in control, and limiting inhibitions experienced in face-to-face encounters, especially with physicians” (Lemire, Sicotte, and Paré 2008:136). The odds are that a patient may not be in physical proximity to someone who directly understands what they are going through, but online there is no requirement for location or proximity. “People communicating with one another via the Internet are frequently total strangers at computer terminals scattered all over the world—people who have never seen one another, who are not likely
to meet, and who many not even know one another’s names” (Goldstein 2004:126). One of the best parts about the online support group is the presence of others who match what you need at that very moment and often with total anonymity. No one has to know who you are in real life. In that moment you are just another person with something to ask or share. This may be especially true for those who have just begun on their medical journey. “People newly diagnosed with a medical condition made up about 5% of online health consumers, and they typically expended considerable amounts of time searching online for information about their condition, often with the help of family and friends, within the first few weeks after the diagnosis.” (Brown and Walsh-Childers 2002:455).

The presence of others who are already experiencing medications, side effects, specialists, treatment centers, and other experiential information, coupled with advice on what sites to trust and others to stay away from, these sites can provide a real service to those newly diagnosed.

One of the major trends with Patient 2.0 or the ‘expert patient’ is the tendency to look things up and come to a medical appointment ‘ready.’ What that can mean is different for everyone, but usually it will include Internet research, either on a Direct-to-Consumer Advertisement or a suspected medical condition. This online research should always be accompanied by medical advice from a physician. “Feeling discouraged and disconnected, you may try to self-diagnose and end up spending even more money on expensive supplements or treatments that don’t work” (Besser 2013:1). Also, physicians can advise on the reliability of such information and medications, and their advice is one of the best clearinghouses for getting a better understanding of the source and reliability.
Murray, et al. found that “85% of all [physicians surveyed] had experienced an occasion when a patient brought information from the Internet to a visit” but also reported that “84% of respondents rated their patients as only fair or poor…at appraising the quality of information on a website” (2003). Online information that is not legitimate can easily still appear legitimate because of the ease of creating a quality website. A family practice doctor in Toronto said that patients bring in information from online and things that “you read on the Internet, although it appears to be scientific, most of the time it’s not” (Landry 2006:D1). Physicians worry about all of the effort spent online trying to drive promises and claims that will never and could never be fulfilled. “There is no study that would tell us how often people fall victim to online ‘snake oil’ cures that may damage their health” (Brown and Walsh-Childers 2002:457). So many times if it sounds too good to be true, your doctor will confirm that for you, saving you time, money, and wasted hope. Patients, however, are not the only targets of marketing and information campaigns online. “In cyberspace, for example, federally sponsored websites target not only researchers and health-care providers, but also Internet savvy health-care consumers” (Clarke et al. 2003:177). When a multiplicity of groupings can be located and addressed, marketers will go out to everyone they can with their information. A good amount of physicians are using the Internet for their own medical research, as they cannot be expected to know *everything* off the top of their heads, after all. “An increasing number of clinicians use web search engines to assist them in solving difficult medical cases, for instance when confronted with rare (or orphan) diseases” (Dragusin et al. 2013). These kinds of cases are the rare and irregular diseases and conditions that may be as yet
undiagnosed and the Internet creates an ease for this kind of searching even for physicians.

With the abundance of results that come from a single Google search, the consumer, be it a patient or a physician, is faced with a multitude of options. “The increasing number of sites and variety of information available mean more choice for health consumers” (Sillence et.al. 2007:397). But the problem is in the vast quantity of information and possibilities available, coupled with the inattention of search engines to formulate exactly what you may be searching. “Using the Internet as a source of health information may therefore increase the likelihood that users will be exposed to conflicting or confusing information or to unreliable, inaccurate or outdated information” (Muse et.al. 2012:190). It is this push-pull of possibly too much information and a lack of discernment that can lead people down the rabbit hole online. It should be acknowledged that just because there is an abundance of information found, does not mean that everyone will have problems figuring out what to do with it. There are increasingly more savvy consumers of health information, hence the informed patient groups. “It's important to acknowledge that there is a lot of high-quality health content on the Internet that has helped a lot of people, both on respected, vetted Web sites… and also within the myriad online support groups for particular illnesses, where people can seek information, encouragement or a shoulder to cry on” (Butler 2009). So, while tracking the difficulty for consumers of health information, there are reliable sites and well known health companies or organizations that people trust, and are able to locate online. Consumers are using the Internet and the relationship between this technology and the consumers of it is
a new and ever-changing phenomenon, brought even closer by the proximity of the health application. As a personal example, I know someone who has a complex and long lasting medical condition and sought out specialists for over 10 years for treatment. This person tried many different medications and treatments (some of them pretty horrible), and finally got a useful solution from an online forum. They started taking the over-the-counter recommendation and were immediately helped more so by this treatment than anything else ever taken. Their physician, once consulted, just shrugged his shoulders without a lot of thought and said, “Yeah. I guess that would work in the way you want it to.” This person has an anonymous stranger across the world somewhere to thank for that advice, not their physician specialist. The physician was displaced by the source in an online forum (especially because they did not need a prescription) and took biopower into their own hands as a ‘smart patient.’ Granted the physician was given 10 years to trial and error medical solutions, but in this case, advice from a fellow sufferer was most helpful in the end.

Health Apps

One of the easiest ways to access Internet information is through health apps or health applications on a device like a tablet or smart phone. Apps of all kinds have become incredibly popular for Internet and technology companies to release after gathering some amount of users for their online sites. Apps provide a more mobile and often accessible version of their web content and create a second way to get users accessing their technology. Analysts predict that by 2017, more than 1.7 billion consumers will have downloaded mobile health apps creating a revenue stream of $26
billion dollars (Comstock 2013). This is a growing and profitable trend that is enticing for consumers and health information sites alike. As consumers of health information increase, health applications have increased as well. The information on the sites are not always reliable and the makers of each app sometimes questionable. How are consumers to know whether to trust the site? One way is popularity; those with the most buzz or hype for the sites often gain notability and fame amongst Internet users, which becomes a way to verify them. Another way is by being tied to a reliable or verified medical institution, like the Centers for Disease Control or the Mayo Clinic, but medical authorities may be hesitant to attach their names to any applications they do not control. News sites or outlets also may periodically review applications for their ease of usage or content, but this is still relatively uncommon.

As government research on health websites has been evaluated, the common refrain is that “consumer health Web sites do not demand exceptional reliability because they are unlikely to be used for applications in which lives are at stake” (National Research Council 2000:61). This is an odd finding because of the repetitive reporting by doctors that patients are doing their own research and finding information that is increasingly scary or worrisome when left on their own. The safety valve on this trend of consumer health information searches is the placement of the research between the patient and the doctor. There is no official capacity regulating the Internet or apps of any kind, and that leaves consumers almost on their own. If someone decides based on the research discovered online that they must have cancer or some other serious illness, then only a doctor stands between them and the automatic dispensing of what may be a
harmful and unnecessary dose of chemotherapy. The National Research Council decided that what consumers need more than a control on website content is a tool “to help consumers find information of interest and evaluate its quality” because of the “sheer volume of health information available on the Internet” (2000:61). While admirable, it would take longer to have a rating system for websites than to just have a reliable list of primary sites to visit initially that have academic and verifiable medical data.

Many different sources will rate the consumers’ ability to trust in the app or application, favorability, ease of use, and graphics. Some of the sites are technology sites promoting apps, and others are various health online platforms (sometimes an online magazine or personal website for a trainer or health counselor/lifestyle guru). The Surgeon General’s office has rated and reviewed many health apps for people to be able to find trusted applications (2012). Most of the apps are for ‘healthy living,’ so they focus mainly on diet, exercise, and children’s health (Surgeon General 2012). Chicago Magazine rated the 11 best health apps and among them were a diabetes manager, blood alcohol calculator, weight loss application, and blood pressure manager (Springen 2012). These apps create tracking, monitoring, and game based products that allow consumers and companies to track their habits, a form of governmentality. In these apps, consumers will input their regular insulin levels, blow their blood alcohol numbers periodically, or input numbers after visiting their physician. These apps follow a model that aligns itself with the duties and rhetoric of public health that feed off of neoliberalism. “Risk may be understood as a governmental strategy of regulatory power by which populations and individuals are monitored and managed through the goals of neo-liberalism” (Lupton
1999a:87). Going back to Foucault, Lupton writes that “discourses on risk are directed at the regulation of the body…and thus are part of the panoply of ‘practices’ or ‘technologies of the self’” (1999a:88). It is these technologies of the self that Foucault identifies as sites of control by the government and institutions, allowing institutions to manipulate the individual, like in the use of surveillance techniques in prisons or schools. Health apps, tools of the ‘smart patient’ are both helpful to the biomedical body of the individual and society through the surveillance and monitoring they provide. By having patients keep track of their number on electronic devices, the applications are also large scale tracking these numbers and sometimes selling the data to healthcare companies.

Two health apps in specific, WebMD and iTriage, are both general health managers and generally acknowledged to be among the top general web health applications for reliability and accessibility (Springen 2012). WebMD is often mentioned by name on television shows for the web-based platform (webmd.com) and with its entry into applications, it is more accessible than ever. iTriage is a relatively new application that is very similar in it’s design to WebMD. When iTriage was introduced, it had problems without any name recognition, so it did a lot of advertising online in games and other apps. I came across six different ads for iTriage in 2011 on my iPad and took photos of the ads, and they are shown below in Figure 5.1. I did not come across any other advertisements for other health apps in this research, so these are remarkable for their repetitive nature and constant appearance, as well as the fact that Healthagen, the owner of iTriage was bought in December 2011 by health insurance company Aetna (Munro 2013). The implications in this purchase are great, as bipower resonates from the
ability Aetna will have now to monitor consumer behaviors, health concerns, and direct them towards their own healthcare solutions.

The language of the advertisements is really interesting. Slogans included “put a doctor in your pocket” and it is “like having a doctor in your pocket” which suggests that the apps is just as good as visiting your doctor. “iTriage gives you the answers you need instantly” gives the impression that everything anyone would need to know is located within this single application. “Before you get sick, download this quick” pushes the observer into action to get the app on their smart phone or other device. All of these advertisements stress the ability of the application to do what a healthcare provider could also do. It is offering a virtual replacement for physicians. But the problem lies in the ability of the user to often access the correct information on their own, without a physician’s direction.

Figure 5.1 iTriage Health Application Advertisements
The menus for the apps iTriage and WebMD are very similar, and both work to manage health information for the consumer as well as to inform them about symptoms, medications, and providers. They offer databases of medical information that the consumer can access if selected from the menu. You much search selectively or have some basic information to begin on the right track or face an endless search of knowledge without direction. See Figures 5.2 and 5.3 for images from iTriage and WebMD’s menus. The menu for iTriage offers information about symptoms, physicians, facilities, medications, and other areas. iTriage is especially good for the storage of your medical information and ‘keeping track of your numbers’ something Patient 2.0 is asked in particular to do in the My iTriage section. A patient can enter all of their lab work or blood pressure from each visit and keep tabs of their own trends. What this app then does with this information on their own is still questionable. Every time you open iTriage the consumer is asked to set up a profile or log in to get the best use of the app.

The medication section of iTriage focuses on name brand drugs, many of which will have had Direct-to-Consumer Advertisements and people may have some previous awareness of them. The medications listed on WebMD use both brand and generic names, are more extensive in their list and also give descriptions of the differences in
medication usages, like oral versus inhaled. WebMD also has a ‘Pill ID’ section where you can find what a rogue pill might be based on shape, imprint, or color. This may be one of the most useful sections for the consumer about whether to save old medication, lost or questionable medication separated from its packaging, or when identifying medications that may have been accidentally consumed.

WebMD, as shown in Figure 5.3 has a warning screen that comes up only on the first loading of the program. The warning says, “This app provides useful information but is not a substitute for professional medical advice, diagnosis, or treatment. If you think you may have a medical emergency, immediately call your doctor or dial 911. Before acting on any of the information in WebMD, consult your doctor to make sure that it is right for you.” It never says this again after you click the OK button on the first opening of the program. iTriage does not have such a warning screen as of 2013. This legal formality acts to remove responsibility from the app for unsafe use of the medical information contained on the site.

WebMD has a section where you tap on the part of the body that hurts (or is having a problem) and then are linked to all possible conditions that one could be suffering. My favorite section is based on tapping the head of the ‘patient’ on the screen, looking for headaches, and then going through a 9 page questionnaire that spits out specific conditions based on the answers. One of the possibilities is then usually a brain aneurysm, where the last page lists these major sections of information: symptoms, an overview on brain aneurysms, an emergency warning in red alerting people to call 911, what the expect if you have an aneurysm, a ‘made worse by’ section, treatment, self care
strategies, when to see your doctor, questions to ask your doctor, diagnosed by, how common, and risk factors. The self care section is especially ironic because someone at home cannot treat a brain aneurysm successfully and it follows the section on the necessity of calling 911 if you think this may be the case for your current situation. Other symptoms listed under the section of ‘head’ are everything from frightening dreams to itching or burning to punching or kicking in sleep to visible deformity, all of which link to diseases or conditions.

Figure 5.2 iTriage Interactive Menu Screenshots

iTriage Main Menu. Source: Screen capture. April 25, 2013
Medications Section on iTriage. Source: Screen Capture. April 25, 2013.

Figure 5.3 WebMD Interactive Menu Screenshots

Information contained within these apps differs from company to company. In exploring these applications, I began to see how there is at once a multitude of options for what you may be searching or a very narrow window of conditions for what you may be searching. Both of these scenarios can be disconcerting to the patient. If you select headache and take the nine part quiz, you end up with many different options, but if you put in WebMD that this is the “headache (worst ever)” then the choices are limited and they all sound pretty scary. The way these applications are created, the user chooses their own adventure. A user can browse, peruse, wander the site and discover or can seek direct, specific, and narrow information and discover that as well. The versatility for the consumer can empower them or disempower them based on their response to this availability of information. Biomedicalization wants consumers to have medical information ready at hand, but it can be problematic when knowledge is available in such
abundance. Lupton maintains that there is a necessity to maintain control because people are inherently engaged in risky behaviors that the government and political powers deem unacceptable. “For the ‘governmentality’ perspective, risk discourses contribute to the constitution of a particular type of subject: the autonomous, self-regulating moral agent who voluntarily takes up governmental imperatives” (Lupton 1999a:104). The ‘smart patient’ will take up the biomedical call to make themselves healthy. The individuals affected most by the governmentality approach are those who modify their behaviors in accordance to the prerogative of the state, or those who have successfully understood the knowledge of these risks and have taken action to change their position in relation to them. Health apps bring the ‘smart patient’ into biomedicine and give consumers access to this once privileged health information. “Foucault…emphasizes the role of expert knowledges in the constitution of the late modern subject” that will create a dutiful and responsive population adhering to the knowledge that has been produced for their consumption (Lupton 1999a:86). The inherent contradictions set in place between the respect for physicians’ expert knowledge and the patients’ imperative to take responsibility and become knowledgeable as well remains unaddressed. There is also risk placed for the individual in knowing too much or too little within neoliberalism. Health apps make the subject informed, monitors their information, and controls their access to expert knowledge.

**Cyberchondria**

Access to technology is one of the great equalizers in information inequalities that have existed for generations between physicians and patients. The discussion of lay
knowledge versus expert knowledge changes when lay knowledge can be amplified with medical, technical knowledge gained independent from established medical authority, like that of biolegitimacy. Although most who look up medical information online do so through traditional channels. “Popular general-purpose Web search engines such as those provided by Google, Yahoo!, and Microsoft are more frequently used by consumers to access online medical information” (White and Horvitz 2009). It is the verification process that needs updating and accessing, when it comes to web pages. In research done between 2000 and 2005, researchers found that “the majority of people found sites using general search engines and thus were exposed to material from a large range of sources” (Sillence et.al. 2007:402). These websites are often not the best sites to use for genre specific searches like for health, as they can lead to trustworthy and untrustworthy sites alike, and there is often no way for the general consumer to tell the difference. “Web search engines may retrieve pages that contain alarming content that can alert consumers to the possibility of serious illnesses without providing information about their likelihoods versus benign explanations” (White and Horvitz 2009). It is this alarm that has been of interest to a team of researchers at Microsoft for a while. They have been watching search engine usage, time spent of pages, and click-through to other pages based on content. One of their biggest concerns is that “information drawn from the Web can influence how people reflect and make decisions about their health and wellbeing, including the attention they seek from healthcare professionals, and behaviors with regard to diet, exercise, and preventative, proactive health activities” (White and Horvitz 2008).
Within this frame, began their foundational study of a phenomenon called hypochondria online or ‘cyberchondria.’

Hypochondria is “characterized by a persistent pre-occupation with the fear that one has or will develop a serious disease” (Muse et al. 2012:189). Hypochondria has a foundation in medical anthropological literature. Foucault writes about the problem of hypochondria in “eighteenth century medicine, and [how] to make hypochondria and hysteria diseases of the “nervous type”; that is idio-pathic diseases of the general agency of all the sympathies” definable for clinicians (1988:151). For Foucault the challenge became one of the “disease of the nerves” and in these “hysterias” for physicians, as to creating a sick patient or a well patient with a psychiatric condition. Anthropologist and physician, Arthur Kleinman defines hypochondria as “a chronic condition in which the patient persists in his nosophobia (fear of disease) in spite of medical evidence to the contrary” (1988:194). For Kleinman writing in the 1980s, “the patient fears he has a disease, but the physician finds no evidence of a pathological process” and in modernity, the patient may not even be a patient because they may fear disease but not visit a doctor (1988:194). The problems for clinicians often occur in a realm of pain and suffering that is not visible to the eye.

With the rise in technological availability and medical information that circulates, some patients will be consumers of information that instills fear about pathology from symptoms they experience. The name for the more technologically advanced hypochondria is cyberchondria, which develops when hypochondria is detected in online searches. The panic may be the same, but many people can calm themselves down about
the panic that comes from health based web searches. “This kind of Web-enabled hypochondria, dubbed “cyberchondria,” is becoming increasingly common as more people visit the Internet instead of the doctor’s office” (Peterson 2012). Hypochondria in the pre-Internet days, is generally fondly remembered as a disease of worry and the hysteria that Foucault described. Now, hypochondria tends anecdotally to revolve around people who convince themselves they must have a type of cancer, certainly something more serious than a cold or flu. ‘Expert patients’ know too much now to let an eye twitch or sneeze go by without a thought to something greater. Some would hark back to the discussion of medicalization and might argue that we have become ‘soft’ or easily persuaded into making every facet of life a medical condition that needs treating (Conrad 2005, 2007). The point-in-fact is that medicalization is a pervasive mindset, but the Internet has given us all access to information and that information may be making us a little crazy. “The Web is fertile ground for those with hypochondria to conduct detailed investigations into their perceived conditions” (White and Horvitz 2008). I interviewed Dr. Eric Horvitz, who is a PhD and MD, and also a co-author of the foundational academic paper on cyberchondria, currently serving as Co-Director of research at Microsoft. He stated that while he was in medical school, he saw himself and those around him becoming sick with something affectionately called “second year med student syndrome.” This is the phase of medical school where students know a lot about symptoms, but not enough about how to put that information into practice, thereby making something out of every twitch or sore muscle, sneeze or ache. “References to medical school syndrome, also called medical students’ disease or medicalstudentitis,
date back nearly a century” (Collier 2008: 820). This medical student syndrome is an excellent frame for comparison because with our abundance of accessible information, we have essentially become second year medical students, lost of information, without adequate frames of reference. I also heard from several medical television writers and producers that they suffer from hypochondria on set, saying “we know just enough to be dangerous.” They become “arm chair doctors” because of all of the medical information circulating on these medically specific sets. I had one on set medical consultant who described an episode of a medical show where the disease they gave one of the “patients” seemed silly to everyone on the crew, and one of the writers in particular hated the episode. It involved a form of repetitive, uncontrollable arm movements, but a little while after the episode shot, in a huge coincidence, a member of the crew’s wife began to have the same problem and he diagnosed the issue because of this exposure to the condition and got her the correct medical attention. So the lesson may be that they know just enough to be dangerous or to be helpful.

Cyberchondria is still relatively new and has really come of age recently. “The term cyberchondria -- a digital age-play on hypochondria -- has been tossed around since the early-to-mid 2000s, when searching symptoms online became commonplace” (Goldberg 2011). Americans now think that they can just look up everything online, even on our phones, but that search to assuage our nerves often becomes scarier than anyone ever thought it would be. “The more common the symptom, the more likely it is that a misdiagnosis will occur. For example, something as broad as a cough could be anything from a benign cold to lung cancer” (Goldberg 2011). When a consumer
searches for sneezing, cough, and throat ache, everything from cough, cold, flu, and throat cancer come up in a general search engine. Microsoft has been doing research into what they call “page rhetoric” which is the location of information on a webpage, whereby the placement or prominence of less severe and more severe outcomes lead to more or less scary searches, often causing cyberchondria. “Cyberchondria occurs when people jump right to the worst-case scenario” (Goldberg 2011). Page rhetoric and information overload can equally cause concern from web searchers. It is this escalation that is of most concern because technology can do quite a bit of good or evil for people in need of medical answers online.

In 2008, “The Harris Poll [found] only 150 million [people] who claim to have gone online to obtain healthcare information…[this] includes 66 percent of all adults and 81 percent of those who are online” (Harris Interactive 2008). This is a lot of web searching about health, and overtime the numbers have risen dramatically. The number of adults going online in 1998 was “54 million” rising to “110 million in 2002” (Harris Interactive 2008). All of these people are looking for some type of medical information, whether it is about symptoms and diagnostics or medication and conditions. In the study done by White and Horvitz, in answer to the question “Have you ever been concerned about having a serious medical condition based on your own observation of symptoms when no condition was present?” 39.4% of respondents answered yes (2008). This all leads to a predictable outcome when people search the web and they can often come to a spurious conclusion on their own. “70% of individuals who initially search for common, innocuous symptoms progress to searching for information on rarer, more serious
conditions” (Muse et al. 2012:190, White and Horvitz 2008). Part of this could be the validity of the sites that may come up in a general web search. Many websites can be unverified, contain old or outdated information or lack crucial information for a corroborated conclusion. “Although 80% of American adults have searched for healthcare information online, 75% refrain from verifying key quality indicators such as source validity and source creation date” (White and Horvitz 2009). Consumers are not always good at discerning whether the site or source of the information is medically approved, part of some kind of marketing campaign, authentic, trusted, or in any other way validated by the multitude of ways to find authenticity (Bruner 1994:399-400).

We also know that we are trending toward the hypochondriac. Many people I discussed my project with, whether they be friends or acquaintances, suggested that they had at least once, often just for a moment, let themselves worry that maybe the cold was not just a cold but something bigger, even if they never sought medical advice to discount such an outcome.

“Approximately 4% of subjects were self-reported hypochondriacs and around 5% had been “called a hypochondriac” by friends, family, or medical professionals. Subjects who self-identified as hypochondriacs performed over five times the average number of health-related searches. Three quarters of subjects reported searching for symptoms and two thirds reported searching for professionally-undiagnosed conditions at least once per month” (White and Horvitz 2009).

At least some of respondents seem to be introspective enough to realize that they may be overreacting to web searches or that others have seen this in themselves. “Two in five people report that interactions with the Web increases medical anxiety and approximately half of people report that it reduces anxiety” (White and Horvitz 2009). Often this
information overload can either make people incredibly nervous or extremely relieved about their health prognosis, and this may have a lot to do with the fact that some will begin their web search preparing for the worst and find more likely solutions that actually calm them. The most important lesson for the researchers at Microsoft seemed to be the necessity for the intervention of medical personnel. “Our survey and analyses underscore the value of the Web in helping people to better understand medical conditions in tandem with professional advice” (White and Horvitz 2009 italics in original). It is this essential, indispensible medical authority that can calm the worry that people may have after a web search. For all of the power the ‘smart patient’ is given, biomedicine will always ask the patient to come back to the medical authority for final guidance. The problem then becomes are these people working with their physicians to assuage their nervousness from their web search? That is difficult to assess and often people will calm themselves in time or push the worry into the background of everyday life and more pressing problems.

When left on their own, patients can do a lot of good for themselves using the Internet. Cyberchondria can lead to more doctors’ visits, contact with physicians, and help treating any illnesses that may actually exist. “The Internet could become an increasingly important platform for self-empowerment in health” (Lemire, Sicotte, and Paré 2008:131). This ability to walk into a doctor’s office with information can benefit the patient and allow them to feel more in control over their own medical experience. This is often in contrast to medicine of the twentieth-century where the doctor was the sole provider of information and treatment. With this ‘expert patient’ status, “the
individual will become actively involved in learning about their health conditions and the prescribed behaviours or solutions,” often to their benefit (Lemire, Sicotte, and Paré 2008:131). Public health programs have long looked to see how to get at-risk patient groups into doctors’ offices and how to change behaviors toward things like healthy eating and exercise. “The Internet is a central vector [for the]…structural changes in the process of diffusion and appropriation of health knowledge” (Lemire, Sicotte, and Paré 2008:136). The patient becomes more active and engaged in their biological citizenship and both the patient and society win when technology helps people with their basic health activities and orientation.

One of the most worrisome problems with healthy biological citizenship will always be the potential for anxiety caused by too much information. Muse et.al. found in their research on anxiety and online research that “whilst the Internet is used as a source of health information by individuals across the spectrum of health anxiety, those with higher levels of health anxiety are more likely to search for health information online more frequently, and for longer” (2012:193). The longer people stay online, the more information comes across their computers and phones, responding to fear faster than a physician ever will. Also, in the information age, the technology savvy population most expected to act on the necessity for a web search should be those growing up in a world where this has been fact for their whole lives. Gray et. al. found that “many students [across the US and UK in their study] reported that the internet was their primary general information source” (2005:1467). For these students, and youth in general, they have never not known a world where all of this existed. They do not understand paper maps,
printed phonebooks, and encyclopedias, all obsolete for their childhood. For them this is the way things are done, online. Because of this kind of generational trend, the presence of online health information’s importance is only predicted to grow in the future.

Cyberchondria can be seen affecting people’s everyday lives by looking at real life implications. Canadian doctors have seen “an increase in unwanted side effects health information overload, health worries inflamed by alarming or confusing information (dubbed cyberchondria), difficulty separating credible from non-credible information, and even more seriously, the casualties from self-diagnosis” (Landry 2006:D1). Further, one gynecologist that Landry spoke to said that “about half of his patients [arrive] with a confirmed diagnosis at their follow up appointments primed with printouts from the Internet… and more arrive at his office having researched themselves into a tizzy” (2006:D1). This kind of anecdotal response from physicians in a newspaper article backs up the statistical responses that White and Horvitz were seeing large scale in their research at Microsoft. There is not a whole lot written by people to show evidence of such a phenomenon, so while perusing Twitter I searched to see what people were saying, if at all, about cyberchondria. It turns out the tweets held a wealth of information and can be illustrative of the circulation process of this kind of medical information. The first four tweets shown describe people’s interactions with cyberchondria as a process and interacting with others on the topic. Most often they involve personal experience with cyberchondria or the sense of how online our lives have become and where that has led.

@courtneylala
@Zak_Bagans my mom is an ER nurse and says a lot of her patients come in because WebMD convinced them they're going to die. #cyberchondria
@frhnsmlek
having the internet as my main companion all day merely encourage my cyberchondria.

@99centimos
"Will probably diagnose drowsiness as chronic fatigue, anal itch as bowel cancer and a headache as a tumour" http://en.wikipedia.org/wiki/Cyberchondria …

@honorharger
The permanent, ambient, unspeakable dread that many of us feel has an actual name: http://is.gd/cyberchondria (cc @juhavantzelfde)

Just like researchers have found, people are getting their information from untrustworthy websites like Wikipedia, that are user generated and constantly changing. Also, there are personal experiences being described, as in @courtneylala’s tweet about her mother’s experience with patients or @honorharger’s confession that many people feel this way, creating community with others online through real world experience.

Many tweets are informational, either news outlets like @CBSNews highlighting their own coverage of cyberchondria or health and wellness professionals or companies like @PureWellness alerting people to further information online at their own websites.

@daingneintinne
Do you have #cyberchondria? How the dangers of self-diagnosing online can potentially hurt you. #infographic
http://www.healthcarecommunication.com/Main/Articles/10692.aspx …

@PureWellness
If you're sick, please see a doctor! INFOGRAPHIC: dangers of self-diagnosis & #cyberchondria | http://tinyurl.com/cg8myfd

@CBSNews
Do you have cyberchondria? Excessively searching medical info on the web might be making you sick via @CBSThisMorning http://cbsn.ws/14h9oRR
@aza
Word of the day: Cyberchondria. The act of thinking you have a medical condition based on reading the Internet.
http://en.wikipedia.org/wiki/Cyberchondria ...

Many tweets online come from physicians or are connected to medical professionals. @MegsMcCann was retweeting a post from a health news site about a physician’s experiences with cyberchondria and @EricTopol is a physician and technology expert becoming more widely known online for his tech-medical devices. His first encounter with a cyberchondriac patient was important enough or relevant enough to tweet about to his followers.

@MegsMcCann
Guilty! RT @NMHnews Do you research symptoms and self-diagnose? Dr. Khare says Cyberchondria is becoming more common http://trib.in/vNBPVt

@EricTopol
TMI for 1: Saw my 1st patient with true diagnosis of cyberchondria, induced by self-monitoring all vital signs for 24 hrs #mHealth + and -

Tweets reveal a public communication about often private feelings or subjects. Tweets are widely read and easily searchable online, but the names or handles can often be private and there may be no way of knowing the identities of users.

@amelapay
Bad chills all morning. Worried this is not just sinuses. Good thing there are only 1045 causes: http://j.mp/f1Mw0i #cyberchondria

@westr
Im sure i have most of these. #cyberchondriac RT @drwalker_rph: Top 10 Odd Diseases With No Known Cause -- http://ht.ly/30Dfs

An increasing number of tweets are like the last two from @amelapay and @westr where people are confiding in Twitter that they are concerned about their symptoms or sickness and easily swayed to see the possibilities that it may be the opposite of the old medical
adage, “When you hear hoof beats, think horses not zebras.” This adage is often used to describe to doctors at the beginning of their training to look for the most likely diagnosis and to let tests reveal later if you need to look for the rare or specialized diseases, which are hardly ever the case. For physicians with hypochondriac, or now cyberchondriac patients, the patient may arrive convinced they have a ‘zebra’ and need some talking down to convince them they only have a ‘horse.’ This type of clinical encounter is very different from several decades ago when patient compliance was a larger issue, not patient over-enthusiasm. Even more pertinent may be a comparison that can be made from 18th Century medicine and the present day understanding of hypochondria, where as Foucault writes that medicine “tended increasingly to identify hysteria and hypochondria as two forms of one and the same disease” (1988:137). It is easy to see cyberchondria as a tendency to lean towards a small case of hysteria over web findings, but one that may not transform into a clinical case of hypochondria.

**Rare Diseases: FindZebra & CrowdMed**

On the other hand, if a patient comes in with ‘hoof beats’ and no ‘horse’ can be found, it can be quite difficult to decide what ‘zebra’ a patient may in fact have. Rare diseases are often the hardest to catch and diagnosis, for patients with a direct interest or equally for clinicians. One physician television writer told me that often in medical school you have the ‘zebra’ beaten out of you, so you really learn only about ‘horses’ because you see them so much more often in a medical practice. When a physician does come across a ‘zebra’ it may be very difficult to know which ‘zebra’ it might be because of the rarity that they see them. When it comes to ‘zebras,’ a rare disorder is “any disease
affecting fewer than 200,000 Americans... There are nearly 7,000 such diseases affecting nearly 30 million Americans” (NORD About 2013). If your clinicians cannot diagnose you and a multitude of testing has yet to reveal any answers, many will try to turn to the National Institutes of Health’s Undiagnosed Disease Program.

“In May 2008, the NIH launched the Undiagnosed Diseases Program, a clinical research program that aims to provide answers to patients with mysterious conditions that have long eluded diagnosis. This trans-NIH initiative focuses on the most puzzling medical cases referred to the NIH Clinical Center in Bethesda, Maryland, by physicians across the nation” (Office of Rare Diseases Research, Resources 2013).

Most who apply for the UDP program will not be selected, as there is simply not enough time or money in the program to help everyone. As well there is also the concern of hypochondriacs who might take up the resources of someone who is actually sick, which explains the necessity for a physician referral and a case review before selection to the program. The Office of Rare Diseases Research or ORDR also gives the names of two advocacy groups to people seeking help without a diagnosis who may also be helpful for patients in need of support, either medically, emotionally, or possible financially. “In Need of Diagnosis (INOD) provides help and support to individuals with undiagnosed conditions. Syndromes Without A Name (SWAN) is a supportive organization for families of children who have undiagnosed, unnamed conditions, or who are still looking for a diagnosis” (ORDR, Resources 2013). These resources are often more limited than anyone would like to think and are not able to serve as many sick people as are out there.

Recently there have been two new websites that were created to help solve this problem without the need for all of this government intervention. One, FindZebra, works as a database of rare and orphan diseases and the other, CrowdMed is a way for patients
to crowdsource possible diagnoses from the general public. Both approach the problem of diagnosing rare diseases, but from very different and often contrary points of view. The simple fact that the technology industry is so invested in health shows the kind of biopower and financial gain to be made in this sector. With so much money from user fees and advertising revenue to be made, companies are vying for consumer attention. Like with the preponderance health apps, these two websites are looking to a smaller section of the market to capture the focus of very sick people with rare, undiagnosed diseases who remain unhelped by biomedicine, yet are eager for participation in their own health care solutions. These ‘smart patients’ are borne of the structural assemblage of health literacy but questions remain about the accuracy and authenticity of their motives and biopolitics.

FindZebra.com, based on the adage of hoof beats and zebras, works as an online database for clinicians who are attempting to diagnose a patient. “We therefore made FindZebra, a search engine specifically designed to retrieve rare disease information for clinicians” (Dragusin et.al. 2013). In an interviews with Radu Dragusin, the lead author and main creator, he said that “FindZebra is a specialized search engine that targets medical professionals who, when confronted with difficult medical cases, currently often resort to searching Google which is in no way optimized for the clinical setting.” The problem for clinicians is often digging through the massive amount of information that a general search engine can spit out. “FindZebra searches for rare disease information from a repository of ‘clean,’ specialized resources, unlike web search engines that search the whole web and are hence likely to return spurious, commercial and less relevant results”
When they say ‘rare’ they mean rare. “For a disease to be defined as rare in the U.S., it has to affect fewer than 200,000 Americans” and this includes about 7,000 diseases currently (Gesenhues 2013). Further, FindZebra is special because it only returns search results from the 7,000 rare diseases, leaving behind the horses or more common diseases, which can be helpful for physicians unfamiliar with the zebras. “While the [FindZebra] homepage includes a notification stating that the site is a research project and should only be used by medical professionals, the developers boast that it delivers significantly better results than Google when searching for rare disease content” (Gesenhues 2013).

FindZebra is a Masters thesis and will be continually tinkered with as new diseases are added and as better search technology and input from physicians drives the site’s productivity. The researchers realized that “clinicians could use a helping hand in tackling the vast amounts of information” that they currently get when looking up possible diagnoses online in normal search engines. “Google, for example, considers pages important if they are linked to by other important pages, the basis of its famous
PageRank algorithm. However, rare diseases by definition are unlikely to have a high profile on the web” (MIT Technology Review 2013). The nature of a ‘zebra’ is that it hides in plain sight, waiting for the right clinician to discover it for the patient in the diagnostic process.

FindZebra is meant to assist physicians only with finding a diagnosis, but Patient 2.0 wants to look things up for themselves. “The informed public are increasingly visiting their doctors armed with detailed information downloaded from the internet. Any move to improve the quality of this information must surely be of significant value” (MIT Technology Review 2013). With that review by the MIT Technology Review, the implications of this kind of website for tech-savvy patients are heavy. In this information available, fast-paced life, patients do not want to sit around. I heard from people within this research who suggested a condition or disease to their doctor that their doctor then had to look up because they did not know what it was off the top of their heads. Physicians usually then had a discussion with their patients about how or why they did not meet the criteria for that condition or disease, the implication being that they had enough information at their fingertips to drum up some ideas, but not enough information to know medically why that was not a possibility, similar to the afore mentioned medstudentitis. The creators of FindZebra stated that “it has taken us two years and required setting up a multi-disciplinary team with a physician, information and computer scientists and in particular information retrieval and machine learning experts to make a tool which combines ease of use with the relevant information” (Rare Disease Report 2013). FindZebra works for physicians because they were involved in the process and it
sources physician approved medical databases, but it does still use questionable websites like Wikipedia for some information.

FindZebra’s genius is in the details whereby medical professionals can input symptoms and get very specific search results that may lead them to ideas and avenues they had not yet thought to search for the patient. “The search engine is not designed to diagnose a patient but rather to provide clinicians with another tool to help them decide what further diagnostics tests they should consider” (Rare Disease Report 2013). Radu Dragusin, one of the primary creators of FindZebra stated that, “we realized that laypersons might stumble across the website, hence our warning that FindZebra is to be used by medical professionals only.” Because they wanted greater accessibility and exposure, it is an open website and people can use FindZebra with no medical expertise, possibly furthering a case of cyberchondria. “The search engine is designed for clinicians. Persons without a clinical background are strongly advised to not use it” (Rare Disease Report 2013). The problem is that only rare diseases will come up in a search on FindZebra. It does not work like WebMD or other popular medical symptom search engines. Dragusin went on to say, “we got more media attention than we could imagine, but virtually all mentions in press state that clinicians are the target audience and that FindZebra is only returning rare diseases as results, regardless of input, “which is not say that that might negate people’s worries if they hear about it and start a cyberchondriac panic. “FindZebra could obviously be a hypochondriac’s charter. On the other hand, that’s true of any medical dictionary” (MIT Technology Review 2013). Anyone searching any of the wealth of apps discussed above could stumble onto a rare disease
they might talk themselves into thinking they have. The odds grow exponentially when
the only answers available are rare diseases and not the more minor, more common
ailments.

The benefit of FindZebra is that most people who are suffering from rare or
orphan diseases can possibly find answers for their own diagnosis. FindZebra “lets users
search an index of rare disease databases looked after by a team of researchers” (Nuwer
2013). There are inherent benefits and drawbacks for patients and clinicians using
FindZebra. Mostly, as it says in the name, it only returns zebras in the web search. This
may add clarity or give new direction to a quest for a diagnosis or it might lead someone
down the wrong path. As a personal anecdote, I looked on FindZebra for search results
with several common symptoms, “headache abdominal pain sneezing.” The results for
this search included, “perineural cyst, irritable bowel syndrome, Chiari Malformation
Type 1, cluster headache, gastric sneezing, Fitz-Hugh-Curtis syndrome, and cyclic
vomiting syndrome.” Contrast that with the Symptom Checker on WebMD where the
results for the same search terms were, “indoor allergens, allergic reaction, tension
headache, constipation, and then the more serious lupus and thalassemia.” The
biomedical production of knowledge on a site like this might be incredible accurate for
the given parameters, but what is more likely for a patient at home, allergens or a Chiari
Malformation? The power and biopower in this search creates a situation that may be
accurate but is it authentic, necessary, or helpful knowledge for the ‘expert patient?’
Time might be wasted, as well as money, looking down a dead end, but physicians can
always use new tools in their diagnosis process. The patient is empowered with their
ability to participate on the same intellectual, expert knowledge level with their physician in the world of biomedicine, leading to a biosociality and a smarter patient.

As a counter point to FindZebra, CrowdMed is a website that recently launched and seeks to help people with undiagnosed illnesses through traditional means get help from crowdsourcing, the use of many people to find answers online. CrowdMed’s website has been through a testing phase and then “CrowdMed, [which] launched on 16 April at the TedMed conference in Washington DC, uses crowds to solve tough medical cases” (Nuwer 2013). They have gotten some buzz online for their unique methodology in diagnostics, mostly now still a physician driven field. A physician will still formally diagnose most patients and this is still true for the patients who use Crowdmed. “CrowdMed hopes to use the wisdom of the crowds to speed up and lower the cost of diagnosing rare medical conditions” but diagnoses will still be ultimately pronounced by traditional biomedicine (Lawler 2013). Even if CrowdMed pronounces a single diagnosis, a physician will still have to confirm it and then treat it.

CrowdMed is a personal mission for one of the founders, Jared Heyman, whose sister was very ill and undiagnosed. For three years, she went from general practitioners to specialists and finally ended up at the National Institute for Health’s Undiagnosed Disease Program (UDP). The UDP is very selective about cases they take and their process is simple. A number of clinicians run every test they can think of over the course of a couple of days and many doctors are assigned to you specifically. “It takes 8-12 weeks for the UDP to evaluate an application, and the waiting list for admission is 2-6 months” so the program can be very difficult to get into even if they recognize that the
person is ill (National Institutes of Health 2013). It ended up that Heyman’s sister was able to get a diagnosis from NIH’s UDP, and her case was the first run through CrowdMed as a test. The belief is that suggestions can come from anywhere and “more often than not, the suggestion comes from a peer” not a physician as Heyman told me.

CrowdMed works by having patients who are sick, but do not have a formal diagnosis, and are usually out of options or running out of options, post their medical information and case file to the site. “The cost to post a case onto CrowdMed is $199, and comes with a money back guarantee if a user doesn’t feel satisfied with the results” (Crowdsourcing.org 2013). So far, the results are good and in CrowdMed’s “20 initial test cases, around 700 participants identified each of the mystery diseases as one of their top three suggestions” (Nuwer 2013). In this trial, many of the participants who solve cases, called ‘medical detectives’ or ‘MDs’ by CrowdMed, looked at case data for the patients and then bet points that are doled out by the site to wager more on their more likely outcome. MDs are allotted 5000 points to begin with, and bet 1000 points per case. You can divide up your points however you see fit across multiple or singular diagnoses, but selections are from options that others have suggested or you can add to the list of possible diseases for the patient. Medical detectives get points back by being correct in their wager on a diagnosis. The hope is that the MDs that are not so good at diagnosing will run out of points, leaving the better diagnosticians to play with their more rapidly accumulating points. “Participants are given points that they can then use to bet on the correct diagnosis from lists of suggestions. This creates a prediction market, with diagnoses falling and rising in value based on their popularity, like stocks in a stock
market” (Nuwer 2013). As Heyman described, the points give them several advantages, it creates an atmosphere of competition among MDs, it is performance based which should “lead to better answers,” it creates a leader board of the best MDs, and it gives the technology a way to weight answers in the mathematic formula used to calculate most likely diagnoses for patients. CrowdMed is in discussions with medical schools to use their students as medical detectives, which would lead to better answers and also train medical students in the diagnostic framework with less time than a clinical rotation and the ability to be wrong with little repercussion.

There are many potential benefits for patients who are suffering. “While the platform isn’t designed to serve as a replacement for highly trained medical professionals, CrowdMed is there to provide help in the case of rare illnesses that are easily missed or to provide a “second opinion” for patients who aren’t sure of a doctor’s diagnosis” (Lawler 2013). When many doctors have the ‘zebra’ run out of them in medical school and they learn the most about ‘horse’ diseases, this can be a solution for patients to find answers. This website can expose medical students to those ‘zebra’ diseases and patients who may only be learning about these diseases in theory, not in practice. “Opening up such an important decision to a crowd of laymen is bound to draw detractors. Critics are likely to argue that identifying the correct diagnosis should be left up to the professionals, and not to a group of amateurs, no matter how large that crowd is” (Crowdsourcing.org 2013). And this is a possibility. The crowd’s decisions and wagers may not work for the patients, but mostly that will be seen in the long run as CrowdMed serves more patients and has more interaction with medical detectives.
The slogan, “You don’t need a medical degree to help save a life” is fairly ‘empowered patient’ type of slogan. It relies on the idea that by having the knowledge gained from everyday life, experiences with others around you, and by being a human being, a person can contribute meaningfully in this biomedical situation, a diagnosis. I spoke to Heyman about the feelings of doctors about their clients (the patients) using this service, and about their possible replacement by a herd of Internet participants who may not have any formal medical training. He said the input from a couple of physicians they consulted with ranged from “fantastic” idea to this “requires an expert” to do well. Mostly Heyman’s concern is for patients and he does not worry about the doctor getting his feelings hurt or being traditionally displaced. His goal is to “arm the patient to talk to their physician seriously” and they will in the end from CrowdMed go to their doctor.
with a top three list of crowdsourced, possible diagnoses. This is the arming of the patient with expert knowledge in order to interact more adequately or seriously with the physicians’ expert knowledge. This site may enable patients to take more of a seat at the table of their own diagnosis. “Because doctors can’t always track the thousands of rare diseases that are out there, patients may find themselves going to dozens of physicians and specialists and still not know what is wrong with them” (Lawler 2013). UDP can not take everyone who is struggling with a long term, undiagnosed illness, so this may be a viable option to help doctors narrow down a list of possibilities.

Heyman and his team are looking to attract not only medical students, but also retired physicians and amateur medical sleuths. They may be people with some medical training or they may have a chronic condition of their own. MDs can be anyone with some medical knowledge that has the will and the want to help someone who is sick. The basic premise is that a crowd of non-experts can be helpful and that this is something to help make patients feel like they are being proactive for their own benefit. Being sick and outside of the loop of traditional medicine, patients often feel disempowered, and this may be a way to regain some power. I imagine walking into a doctors’ office with a list of three diseases that have been whittled down by a large crowd of people who were all working for you must feel pretty good, as long as the physician responds well to the list. This is the new Patient 2.0, still sick but, now empowered.

One of my central concerns when speaking with Heyman was the possible presence of hypochondriacs or cyberchondriacs in their ‘patients.’ At CrowdMed, they are concerned about these kinds of cases, mainly because they are patients that will never
get a diagnosis and their case will not get solved, because there is nothing actually wrong with the patient. This would hurt their success rate, in a statistical frame, but also it could be frustrating for the medical detectives who have invested in the case and bet their points. “There is a danger, of course, that CrowdMed will attract the many people already Googling lists of symptoms in order to horrify themselves with stories of bizarre and terminal illnesses” (Clark 2013). Heyman points out that he “doesn’t know how to screen for those people” and traditional medicine has a hard time dealing with them as well. He believes that they will “catch more people who are legitimately sick” and that this is only a small concern for CrowdMed.

As of September 1, 2013, CrowdMed has 93 cases, 61 solved with 4,800 medical detectives. I logged into the site to try my hand. I feel like a fairly well-educated medical detective and even I felt overwhelmed with lab results in the case files that I could barely read, and symptoms that came and went over time. The information provided in the file came from the patient, so it did not look like a typical medical file and the information was sometimes spotty and less clinical in nature. I felt a lot of sympathy for the patient whose case I obviously did not solve. I did bet on two disease options, even adding an option to the possible bets made by others, but I am pretty sure I was not at all helpful. If I am an ‘expert patient’ created by biomedicine, then I failed at being an MD for CrowdMed. It will be interesting to see how CrowdMed fares in the long run and who the population of medical detectives will end up centering around. They hope to partner with insurance companies, so the company pays the fee and not the patient. They are currently operating a web-based version and would like to move to a mobile version or application.
once they are more established. In the summer of 2013, CrowdMed sent me an email announcing they had hired a Chief Medical Officer, a woman who had just completed medical school in June in the Bay Area. By fall when I checked back in with Heyman, she was no longer with the company. Their intention with that hire was to have someone with medical training working on “marketing and providing some in-house medical knowledge” because otherwise the staff are all tech people. Somehow this physician would have given them credibility or authenticity, just by being a doctor that they otherwise did not have and they expressed that they still may hire someone in this capacity in the future.

While our technological and information consuming generation prides itself on greater access, access may not always benefit the patient or the provider. All of this available and circulating information can lead to worry and feeling overwhelmed, and even then the person may not see a doctor about it. Consumers just scare themselves. Cyberchondria is a growing movement whereby patients are seeking knowledge online about their symptoms or a possible medical condition and their web search escalates out of control with fear. “If used correctly, the Internet and TV can make you a more educated and empowered patient -- and maybe even save your life” (Goldberg 2011). That will of course depend on if you are actually sick, or actually really sick with what could be a ‘zebra.’ Our access to information and feelings of empowerment situate us often in the second year med student syndrome problem, one of too much information and not enough experience or practice to know what to do with it all. The ‘expert patient’ is being told to help themselves, but the paths to health can take them off track like with
FindZebra if used incorrectly. The Internet is only one way that patients source information. Studies have tracked the new trend of information gathering from television, even fictional shows. We watch the celebrities, the celebrity doctors, and the programming for the entertainment value, but there are often assumptions from the audience that the medical information contained within these sources are also good information and of value to the ‘expert patient.’
Chapter Six: “But Dr. Oz Said…”: Why We Trust TV Doctors and Celebrities About Our Health

In the Spring of 2009, Dr. Sanjay Gupta, a top medical correspondent for CNN and often called America’s Doctor, was publicly considered by the Obama Administration for the job of Surgeon General. The reverberation of the phenomenon where CNN’s America’s Doctor might actually be “America’s Doctor” by being the Surgeon General struck a chord. Dr. Gupta eventually turned down the job (Dorning 2009:A20). “CNN reported that Gupta, a neurosurgeon, decided to withdraw [from consideration] so that he could continue to practice medicine, work as a journalist and spend more time with his family” (Dorning 2009:A20). There were some mixed feelings from the public about his possible appointment and it might have been the first time that the public at large knew the name of the Surgeon General, a mostly low-profile position within the federal government.

“America’s Doctor” is a title that many public doctors have placed on themselves. Oprah christened Dr. Mehmet Oz as America’s Doctor and CNN has called Gupta the same as well. There are many who look to Dr. Drew Pinsky for health decisions and information. This rise of the public doctor, those physicians who speak about medical issues based in news, popular culture, and research updates, have a place in America’s consciousness, whereby their word can be that of God for some viewers. The New Yorker wrote an extensive profile of Dr. Oz where they state that, “Certainly, no American physician has greater influence over a larger number of people” (Specter 2013). These three physicians have New York Times Best Selling books, their own television programs, appearances on multiple networks and media outlets (both radio and television), write
magazine articles or appear on the covers of magazines, create podcasts, and appear in newspaper articles and Internet content. They are across all media platforms but we become the most familiar with them when they all appear on television. They are appealing figures offering advice and often comfort that the viewer is not alone. They focus on answering embarrassing health questions that some will never discuss with their doctors but will share with the world, as when Dr. Oz has a “Your Most Embarrassing Questions” episode and with Dr. Drew’s Loveline radio call in show that answers sex, sexual health, addiction, and alcohol and drug use questions.

As evidence of how appealing these doctors are to the American public, in a Health Magazine poll, entitled “Who would you pick if you could spend a day with one of these stars?” Readers overwhelmingly selected Dr. Mehmet Oz with 49% of the vote versus Giada De Laurentis (TV chef with 17%), Jillian Michaels (TV fitness trainer with 25%) and Jennifer Hudson (American Idol runner up, Broadway star, Academy Award winner and Weight Watchers spokesperson with 9%) (2011). America loves these guys. They become friends, accessible celebrities, and trusted confidants. Through the biomedical push to share narratives, when people call into Dr. Drew’s radio show or are in the audience for Dr. Oz’s show, they are part of the entire assemblage of the healthscape. It is worth noting that while there are popular female physicians that work for CNN and other news outlets, not one has risen in popularity to even broach that of the top three men listed here.

Even further with background information for these physicians, we have learned to love them over multiple years and several outlets of exposure, and they do not do this
by themselves. Doctors like Sanjay Gupta, Memhet Oz, Drew Pinsky, and others work on staff for media outlets as consultants and also have their own shows. They become reliable sources of medical information, as well as household names for giving out all kinds of medical information, especially outside their medical specialty. Anyone in the ‘40 years old and under’ age group will generally know Dr. Drew either from his long time stint on Loveline, a radio love/sex call in show, or his many appearances on shows like Teen Mom, Nancy Grace, HLN, Celebrity Rehab, Sober House, and many others. Dr. Oz was launched by Oprah and now has his own show, as well Time Magazine columns, magazine covers, best selling books, and regular press coverage by major newspapers. Dr. Sanjay Gupta has been a correspondent for CNN with his own hour-long health specials, as well as a New York Times best selling author and the creator/medical consultant for his own fictional medical television show based on his book, Monday Mornings. In addition to these most popular physicians, there are many more who work for news outlets and are trusted to report on interesting findings from medical journals or the latest medical study. Media outlets have “a stable of faculty experts who reply rapidly to media requests for pity quotations and sound bites on a given topic, an available gaggle of pundits for print and television journalists to interview and quote” (Friedman 2004:4). Dr. Richard Besser, one of these popular physicians, writes in his book that “as the Chief Medical Editor at ABC News, I have the responsibility to clearly state my opinion on the critical health challenges of our time to millions of Americans… one day eggs are good for you, the next day they aren’t, and then they are again” (2013:3). Besser in a press appearance on May 8, 2013 for his book on The Colbert
Report with Stephen Colbert had this conversation (this followed a discussion on FDA labeling of vitamins/supplements with an asterisk to denote that they are not FDA approved and therefore possibly dangerous):

Stephen Colbert: “Let’s talk about doctors on TV, if you will pardon the expression. You’re a doctor on TV.
Richard Besser, M.D.: I am.
SC: If they’re on TV I should trust them, right?
RB: Not exactly. Not exactly.
SC: So the FDA does not have to approve a doctor being on TV either?
RB: No.
SC: Is there an asterisks on you?
RB: I think there should be an asterisks on me. Yeah.
SC: Okay.
RB: And then when you hear something from a doctor on television you want to, you want to, try to understand why are they saying that. Is there an ulterior motive? Is there…
SC: Why are they saying that?
RB: Well, sometimes they are trying to sell you something.
SC: Uh, huh.
RB: Sometimes they are trying to explain something, but when…
SC: If they are trying to sell me something should I trust them?
RB: I’d be very careful. I’d be very careful.
SC: Ok, so then I assume you are giving this book away.
(everyone laughs)
RB: For you, I will give you a copy.
SC: (laughs) For me? So I should trust you, but nobody else”
(Colbert 2013).

Stephen Colbert is known as a satirist and for his trademark sarcasm, and this illuminated a lot of concerns for this process of knowledge production and communication that have been discussed in this research. Physicians on television have a motive, and often it can be a public health motivation, wanting to help people, but sometimes it is towards their own fame and fortune, celebrity status and public adoration. By being a household name, something that is intentionally cultivated, these physicians are becoming larger than life.
personalities with a strong hold on people’s attention and this motivation should be of interest to us, as consumers think about issues of authenticity and accuracy.

The Doctors

I intended to interview Drs. Gupta, Pinsky and Oz for this section of my research to be able to give readers better insight into why they do the work that they do. What actually happened in trying to obtain these interviews is probably more telling than what they would have said. I was able to get to someone who could personally get me 15 minutes with Dr. Sanjay Gupta, but then the next week the Boston Marathon bombing happened and he was a permanent fixture on CNN, discussing amputations (remember he is a very well respected neurosurgeon). Then the explosion in West, Texas happened. Then it was the missing girls found held hostage in Cleveland and then the tornados in Oklahoma, well you get the idea. When someone is constantly on call for breaking news there is always something happening somewhere to delay an interview. Around the same time in 2013, I finally got into contact with Dr. Drew’s PR person and finally started getting responses from her only to be told that the Jodi Arias murder trial had released a verdict and he would be otherwise occupied reporting on that for HLN (remember he is an addiction medicine specialist). Dr. Oz’s PR person was very responsive to email while his show was shooting in New York, but he was shooting and would not have time, but I did submit questions and I had them approved by his people. Once the show finished shooting and he would actually have time, he began a press tour to promote his cover of Women’s Day Magazine and other PR events and I stopped getting email responses from his PR people (remember he is a cardiothoracic surgeon). Most of the time these
physicians are reporting on cases outside their area of medical expertise but because they are all considered as “America’s Doctors” they are not held to speaking in their specialty.

Americans trust these physicians who treat and practice on television. They have medical authority and they inform the public’s general information about health. Further, many of the smaller public medical figures will report almost daily on developments in medicine that may be pertinent to our lives or at least may be of interest to us in media spaces like the local or national nightly news. “Millions of people who would never read [medical technical] journals or possess the sophisticated knowledge necessary to understand their studies watch researchers discuss their work in prepublication interviews with national news outlets” (Friedman 2004:2). News outlets have more and more been working to bring audiences the latest health information and speak to the researchers themselves, often shooting in their laboratories, showing scientists at work. It is these images of medicine and science that are broadcast that often give partial information or changing ideas to the general public about technology, treatments, or clinical trials. They may speak to nutrition, supplements like vitamins, or new medications or diseases. “A perusal of newspaper articles from the 1980s and 1990s reveals a seemingly endless list of topics in which each new study seemingly conflicted with the previous one” (Lerner 2006:276). These news reports may be in contrast to one another over time, with caffeine being good for you one day and not the next, harkening back to the earlier comment by Dr. Richard Besser on eggs.

In addition to such reports, there are also articles in popular magazines, not just health-based magazines, that ensure that people get such new medical information and
direct them to seek appropriate treatment for their ailments, and by diagnosing themselves, get well. In one such article on health in *Harpers Bazaar* entitled "Take Charge, Live Longer," women are asked to “take a proactive approach” and “to go into the doctors office knowing what tests you need” (Botton 2008:179). They advocate that this method of treatment makes it so that “you help your doctor help you” (Botton 2008:179). Not only does the author of that article cite the well-known Dr. Mehmet Oz, but also staff at the Centers for Disease Control and Prevention, people from places that most of the audience would be familiar with and believe. This type of article reinforces the belief that your doctor needs guidance from the ‘smart patient’ and that biomedicine now requires the sick to do research on their own into their symptoms and prepare to become their own advocate if needed. Even with this sense that everyone is affected by all of this information circulating around them, it must be remember that not everyone will be paying attention or tuned into these shows all the time. “Broadcasting health information into America’s homes does not guarantee that it will reach occupants even if they are watching TV” (Cooper and Roter 2000:332). But it is known that “news producers increase the volume and prominence of health news during sweeps, the four periods each year in which audience size determines the price of commercial advertising” (Cooper and Roter 2000:332). They are trying to gain their audience when it matters most for their bottom line, and television news outlets know that people pay attention to health information when they deliver it. With regards to all of this information, it should be noted that not all of the information is damaging or potentially damaging, or helpful or potentially helpful. “Their producers cannot determine in advance the precise nature of
the public, how information will reach it, how the discourse will continue to circulate (if it indeed does), and the multiple ways that it will be received” (Briggs 2003:291). At the core, the simple fact that knowledge is circulating for possible consumption drives this research. I want to underscore the fact that consumers will pick up and understand some of the information directed at them and the importance of being able to judge the accuracy and authenticity of this information.

**Health News Programming**

Dr. Oz is a specific case of compelling daytime television. “*The Dr. Oz Show* has since won two Emmys and averages nearly four million daily viewers” (Specter 2013). His audience is so great that whenever I discussed this project with anyone his name would generally come up, sometimes in reference to some sort of advice he gave them. As an example, I had a friend who described taking a vitamin because of Dr. Oz’s recommendation and an acquaintance who described watching his show religiously for advice on her struggles with diet and exercise. I even use a piece of advice from Dr. Oz in my teaching about the size of a healthy waistline, because it was backed up by medical studies I researched further. “Much of the advice Oz offers is sensible, and is rooted solidly in scientific literature. That is why the rest of what he does is so hard to understand. Oz is an experienced surgeon, yet almost daily he employs words that serious scientists shun, like “startling,” “breakthrough,” “radical,” “revolutionary,” and “miracle.” (Specter 2013). Dr. Oz and his show are often criticized for their constant hunger for more edgy medicine and information. Because this is a daily show, there needs to always be new information, relevant topics, and something to talk about that will
compel the audience to tune back in tomorrow. The idea that he is giving people multiple sides to a medical issue is interesting, in that he is regarding the consumer as a ‘smart patient,’ or at least smart enough to be able sift through the arguments being presented. “Oz often says that he is just trying to present people with all their options, because they are sophisticated enough to make decisions for themselves” (Specter 2013). Television segments are not very long, 44 minutes for an hour-long show, to have an in depth and balanced discussion of complicated issues; neglecting that most often his shows present more than one single topic in an episode. These ‘smart patients’ will somewhat be expected to fend for themselves after the show has ended. They will need Internet access and the interest to continue doing their own research to sort out and unpack the topic for themselves. “The era of paternalistic medicine, where the doctor knew best and the patient felt lucky to have him, has ended. We don’t worship authority figures anymore. As Oz likes to say, Marcus Welby—the kindly, accessible, but straight-talking television doctor—is dead” (Specter 2013). What Dr. Oz’s self-analysis is missing is that he wants to be, and often has become the authority figure being worshipped. “Oz, however, functions essentially as Welby 2.0, presenting the ideal of a caring physician who has all the time in the world to discuss what ails you” (Specter 2013). The bodies of his viewers trust Dr. Oz primarily because of the knowledge they believe they are receiving from his established medical education and authority. “The doctor gives himself the insignia of knowledge” and “the doctor’s words appear with a greater power than those of anyone else” (Foucault 2006:185, 187). It is of primary importance that the doctor, who has been imbued with the power to ‘make live or let die,’ be completely trusted by the patient to
handle the diagnosis and treatment of the disease (Foucault 1973:35). When viewers trust Dr. Oz, they are assuming his medical authority supersedes their own lay knowledge and they are being both informed and entertained by him. What Dr. Oz really provides is 44 minutes right now and then look for more time with him on another channel, on your bookshelf, or tomorrow at the same time, same place. “Physicians featured on a talk show, another form of non-fictional programming that blends drama, humor, and information, may be depicted differently than doctors on purely fictional programs or strictly news-oriented programs” (Chory-Assad and Tamborini 2001:504). These daytime medical shows have a specific audience and message to consumers than most other formats, although there are similarities between these mediums.

One of the most fascinating aspects of The Dr. Oz Show is his use of human organs as visual aids and computer graphics for assistance in explaining health questions. Dr. Oz can often be found on the show holding up a smoker’s lung and a healthy lung, both from deceased patients (never mind what the healthy guy died of) and demonstrating in all ‘reality’ what people need to see for themselves. It is this focus on reality as a concept that drives the visual presentation, as is his way of doing, people should see what he sees as a physician. “The template for “The Dr. Oz Show”: powerful graphics driven by a compelling narrative” (Specter 2013). The graphic images are usually medically graphic. He must have some kind of deal with organ procurement companies, because it is rare to watch an episode and not see him forcing an audience member to put on purple nitrate gloves and hold some sort of human body part. The show is appealing to consumers of daytime television, graphic imagery and all, because now they too can see
what doctors see inside of the human body. In considering *The Dr. Oz Show* as a case example of the kinds of health informational shows that are particularly interesting to audiences, it is important to remember that he is a product of Oprah, with her support, both in production company and in name, and he spawned a revolution in terms of daytime health programming. *The Doctors* is also a show that features a panel of physicians daily in daytime programming, but has much lower ratings. It is interesting to note that one of the physicians on *The Doctors* is a former *Bachelor* contestant who went looking for love on reality television. These types of shows lead into nightly news health coverage that has now become a staple of their time allotted programming. Reality health programming “is biomedicalization writ large, offered in presentational formats that work effectively as informercials and consults” (Clarke 2010:132). These shows are a large part of the modern, American healthscape for our visual medical imaginary.

Dr. Oz and other public physicians are the face of this medical imaginary. They are handsome, well trained, good feeling, physicians. They seem kind and caring. In biomedicine, these physicians command authority and “for capitalist society, it was biopolitics, the biological, the somatic, the corporeal, that mattered more than anything else. The body is a biopolitical reality; medicine is a biopolitical strategy” (Foucault 1994:321). The intersection of the celebrity physician and Americans’ media consumption provides a space for real implications on knowledge production processes. Traditionally, the medical process “involve[s] the doctor identifying a reality of the illness in the patient’s body, and the use of his own hands, of his own body, to nullify the disease” (Foucault 2006:188). It is “the doctor’s physical corporeal power” that enables
him to have a physical presence and a considerable power that comes from biomedical training established through his connection to the institution of medicine (Foucault 2006:235). Now, these celebrity physicians have that kind of somatic, corporeal body without any actual clinical encounter, personalized attention, or true confirmation of accuracy and authenticity of the information being dispersed. Viewers are shown technology, flashy graphics and visual images of “things medical” and convinced to be the ‘smart patient’ and do what they say, also a form of biomedical discipline.

“Discipline was never more important or more valorized than at the moment when it became important to manage a population” (Foucault 1994:243). Public health and medicine utilize these forms of discipline under neoliberalism to push audiences to take responsibility for their own health. Dr. Oz is giving YOU the tools, just like in his self directed YOU: The Smart Patient book series. This puts the responsibility solely on the audience and consumers. This is a pattern with the healthscape and of biomedicine, which offers information at the cost of pushing people to do something with the information.

When there is, what is considered to be an important health announcement for the public (possibly something like a new indicator for autism or reported flu cases in the area or across the nation), that will inevitable be standard ‘news’ on every channel that you could possibly select for your local or national news. You will see topics repeated throughout the day if you watch enough of this programming, like the morning news shows getting up, noon news while eating lunch, daytime health programming at your afternoon break, and nightly news at the early evening and late evening news before bed.
“Biomedicine could not achieve such productivity without fusing with an important segment of the culture industries—the news media” (Briggs and Hallin 2007:44). With biomedicine rewarding the sharing of narratives and stories, the news media then covers stories that will fulfill this agenda. Often it will be a science report about new discoveries, new technology, new correlations, new medications, and the like. “Newsworthy events have included the latest health and dietary information, the discovery of gene mutations related to susceptibility to cancer, new treatments for wrinkles or baldness, and the health effects of silicone breast implants” (Nelkin 1996:1600). These are all things that affect a good amount of the public in the viewing audience and are not necessarily taboo topics for discussion. Viewers are expected to keep up with all of this information that can be contradictory or inflammatory from day to day, because they are now ‘expert patients.’

There has been a “transfer of the burden for keeping one’s self healthy onto individuals” unlike we have ever seen because of neoliberal practices (Briggs and Hallin 2007:44). It is within this “media-ted world” that the general population is guided through this process of how to be healthy (Nelkin 1996:1600). They are being told both by the volume of the medical health information stories and the content of these that the world is scary and we are not always okay; it is a message that very much fits the local or national violence being reported on with crime reports. “Despite clear evidence showing that Americans today have a comparative advantage in terms of diseases, accidents, nutrition, medical care, and life expectancy, they perceive themselves to be at great risk and express specific fears about this” (Altheide 1997:649). When the world is viewed as incredibly risky, we approach things in very cautious ways but we also become excited
by the prospects of new inventions, new discoveries, and new medications or treatments.

“We live in the era of ‘governmentality’” which focuses on several key places within society where people’s behaviors and beliefs can be changed according to perceived risks and societal concerns, especially when it regards health decisions (Foucault 1994:245).

The problem with this approach to knowledge production is that in news reports “research findings are tentative, undigested, preliminary,—and therefore not yet newsworthy—until they are certified by peers to fit into the existing framework of knowledge.” (Nelkin 1996:1600). When they are discussed on the nightly news, the audience might be exposed to information subject to change after its exposure, not guaranteeing that they will ever see the retraction or rebuttal days or months later, if at all. There is a lack of regulation in medical journalism and reporting except for the vague, largely unquantifiable journalistic integrity in both television and print media. One study in The New England Journal of Medicine shows that “news-media stories about medications may include inadequate or incomplete information about the benefits, risks, and costs of the drugs as well as the financial ties between study groups or experts and pharmaceutical manufacturers” (Moynihan et al. 2000:1645). This further complicated the process of knowledge creation and landscape of the healthscape, whereby biomedical and economic processes are incomplete for consumers and lack the full report, details, and information for consumers to make the most informed choices for themselves as ‘smart patients.’

Many news stations will have medical or science based reporters, who exclusively cover this topic for the audience, becoming trusted sources of information. “Journalists
are positioned as advisers to patient-consumers, helping them manage” (Briggs and Hallin 2007:55). The same person comes into your home and gives you advice on a nightly, weekly, or breaking news basis, become an authority, regardless of whether they have any medical training or not. Sometimes these journalists are physicians, sometimes not. Viewers of news programs, in a study done by Cooper and Roter, responded better to news items they classified as “reporting new information, being about something unusual, and being entertaining” (2000:336). The focus of news stations and networks is on attracting and maintaining an audience, as well as bringing in good news and information to their audience. “For journalists, by contrast, established ideas may be ‘old news’, and of far less interest than fresh or dramatic, though possibly tentative research” (Nelkin 1996:1600). They have to keep you coming back with something that makes them special in comparison to other stations. “Many news reports are produced through a process that reflects entertainment considerations and formats” (Altheide 1997:650). This entertaining prerequisite is an important imperative because it must be considered that the audience is not being told everything that happened in health news that day, but only what someone else considered the most interesting or relevant for their specific audience or sponsors. “News coverage of health is heavily dependent on pharmaceutical company advertisers interested in reaching its aging audience, and it is therefore not an ideal choice to represent health coverage more generally” (Briggs and Hallin 2007:47). Several good examples of this are programs like 60 Minutes or Nightline that skew older in audience and have significant pharmaceutical advertising in their commercial breaks, even tying into direct sponsorship in the throw to commercial. Briggs and Hallin studied the
“metropolitan daily newspaper” because in the same way with television news, “coverage of health issues is indeed structured around a particular conception of the neoliberal subject, the patient-consumer who actively and responsibly seeks health information” (2007:44). This is a crucial aspect of the sponsored programming issue because pharmaceutical companies’ sponsorship links them to choices in programming and would benefit from a program or story looking at something medically scary and then shows pharmaceutical solutions for this at the commercial break or nearby advertisement.

The repercussions of these pictures of medicine and health in news programming can be great. “Reporters increase public panic, impede medical responses by rushing to the scene of emergencies, and politicize health issues” (Briggs 2003:289). These pictures of on-the-scene reporting of medical emergencies like a possible pandemic (remember the H1N1 scare) on the news always frustrate public health officials who see an increase in emergency room squatters, simply afraid for the possibility of what they have seen on their television. The panic of the public is only one consequence possible in a world of incomplete information and often inaccurate breaking news. Another problem is that coverage can influence opportunities a company or individual might have based on the publicity. “Media coverage may also influence research funding and, therefore, research priorities” (Nelkin 1996:1603). Even further, media showcases of technology or medications can be problematic after they have been shown to have serious repercussions, like the weight loss drug Fen-Phen or the arthritis drug Vioxx’s public demises, which come back to haunt their own publicity. “Especially newsworthy are scandals” (Nelkin 1996:1600). These medical scandals, like all good scandals, are
fascinating to viewers and draw in an audience to these news programs. The audience
typically is not thoughtful about the factors that news stations and networks take into
consideration when creating the programming line up each night. “Media constraints of
time, brevity, and simplicity preclude the careful documentation, nuanced positions, and
precautionary qualifications that scientists feel are necessary to present their work”
(Nelkin 1996:1601). This can possibly lead to misunderstandings by consumers of the
information in exactly what the knowledge means or can possibly do for them. A good
eample is the recent back and forth argument in the media over the screening age and
regularity for mammograms in 2013. The news reported several stories on the changing
viewpoints by multiple parties and depending on which stories were seen by consumers,
they might understand that it is in discussion or they may have only seen one story and
assume that what they saw is the new guideline. Similarly to The Dr. Oz Show, the
format and timing does not allow for the complex discussion required when looking at
most health issues. “Accusations of inaccuracy [in the media] can be traced back to
reporters’ efforts to present complex material in a readable and appealing way” (Nelkin
1996:1602). When considering the amount of misinformation that can and does occur by
audience members, the physician’s role as the formal gatekeeper to medical access
becomes again a meaningful role because most consumers cannot act of this
misinformation without the approval of their physician. “The upshot for consumers [is
that] medical wisdom that has stood the test of time—and large, randomized, controlled
trials—is more likely to be right than the latest news flash about a single food or drug”
(Begley 2011:9). The physician will inevitably come back into the picture, hopefully
averting any misuse of knowledge produced in this format before the consumer suffers, reinforcing the importance of the physician. Viewers’ “new knowledge’ and information is always connected to a stock of knowledge and symbolic interpretation” and will become combined with their physicians’ traditional and established medical knowledge (Altheide 1997:650).

Medical reality programming is a separate kind of non-fictional health programming, not commonly thought to be linked to news reporting of health information. Both types of programming are informative to consumers, both are showing new technology, medical research, and new diagnoses, and both are featuring a specific bent on the issues presented to the audience. “To create a human-interest angle, journalists look for personal stories and individual cases” (Nelkin 1996:1602). In this way, there is a similarity in these types of narrative storytelling. There has been a shift in medical reality storylines post-ER, where the doctor and patient work together to solve a medical mystery in medical television. “The technological progress of medicine has shifted the dramatic focus from the doctor to the patient, who is the new hero” (Hudson Jones 1981:193). Most reality shows are focused on patient empowerment, whereby the patient rescues their own bodily health. “In keeping with the dramatic impetus of the documentary [format], patients are heroic pioneers” (Hight and Coleborne 2006:241). This is contrasted with the more traditional view in medical shows of all kinds of physicians as the medical hero. Medical discourses in non-fictional portrayals show “medical practitioners…presented as ‘enlightened’ in more than one sense—possessing superior knowledge, but also caring and able to incorporate a growing variety of medical
repertoires” (Hight and Coleborne 2006:243). With the increase of consumer knowledge, compliant patients, and ‘smart patients’ there is an imperative to portray that struggle within medicine. The neoliberal subject reaching actively for their own health may be problematic as “his or her relation with biomedical authorities often appears as an antagonistic rather than a harmonious and entirely natural relation” (Briggs and Hallin 2007:45). Two shows on Discovery Health, “Mystery ER and Untold Stories of the ER, clearly aimed to get a ratings bounce from” ER and other popular, fictional medical shows (Turow 2010:351). “Two others, Dr. G and Mystery Diagnosis, clearly were exploiting the popularity of CSI-like dramas” and what are often called medical-legal shows (Turow 2010:351). The rise of real medical programming has driven viewership and active biological citizenship within this realm of programming.

All of these shows have online web chat rooms with these active and ‘expert patients’ telling their own stories, and this kind of engagement is not uncommon because of the format of the shows, which show actual patients’ real life struggles. This move to have multi-platform engagement with viewers mimics the similar rise in fictional medical shows as well, like the web interactions previously mentioned from Grey’s Anatomy fans. “The distinction between factual and fictional presentation of medicine becomes even more problematic with the rise of…medical documentary programs” (Lederer and Rogers 2003:500). The medical documentary is full of interviews of real people recounting their health crisis and their path to health. One physician I spoke to who consulted on a medical fictional show and is a diagnostic specialist told me that you can never trust a patient to recount their health crisis after it has been solved because they now know
where the break in the case came from, which test or procedure was the key and their story will forever be changed by that realization. Shows like *Mystery Diagnosis* and *Untold Stories of the ER* are based on dramatic reenactments and interviews with the key players, both patients and physicians about the patient’s medical condition being explored in that particular episode. When most of these reality television shows rely on first person recounting of experience, it is inevitably clouded by this knowledge and experience gained in the process, and additionally the crux to most of these cases is the diagnosis being granted to them or upon them. “A key concern in research on contested, uncertain illnesses is the intense interplay between diagnosis and legitimacy: without a diagnosis and other forms of acceptance into the medical system, sufferers are at risk of being denied social recognition of their very suffering and accused of simply faking it” (Dumit 2006:578). Diagnoses lend legitimacy to patients, especially suffering from rare or orphan illnesses, and their cases are good television because of the prolonged struggle with medicine and being understood, trusted, or even heard by biomedicine. “The neoliberal subject often appears in media discourse as hybridized with passive subjects who need to be infused with authoritative knowledge or are frustrated or overwhelmed” (Briggs and Hallin 2007:45). These programs showcase these specific narratives and bring to life a reality that some will inevitably relate with and follow. “To see reality television as merely trivial entertainment is to avoid recognizing the degree to which the genre is preoccupied with the government of the self, and how, in that capacity, it demarcates a zone for the production of everyday discourses of citizenship” (McCarthy 2007:17). These programs present a ‘way of being’ in biomedicine that gives viewers not
only a language or discourse, but a perspective on how one must act in that situation should they find themselves there. Because “the most [reality health programs]—seven—appeared on the Learning Channel and Discovery Health, both niche cable channels owned Discovery Networks” the preponderance of programming is coming from one single perspective (Turow 2010:350). These shows are all very familiar and similar to one another, even if they are premised on different ideas or places in medicine. This places a focus on the need for a critical eye on the creation and control over these programs and channels. The use of dramatic recreations and first person interviews skews the perspective of the viewer in a way they may not even know because the story is being told after the outcome has been decided and through the use of memories and patient charts. In this, “the distinction between news” or information “and entertainment content is increasingly problematic” with viewers not necessarily able to recognize the difference in their programming (Makoul and Peer 2004:246). They are being entertained but also informed in the same process by a specific group of individuals who control the content.

Public persons and television + medicine

Along the same lines, the medical news reports about celebrities when they are sick, and we, Americans, talk about it, just like we do when celebrities publicly screw up or have a new project to discuss. From television programs to celebrity magazines, Americans follow the culture of celebrity including their health crises as well as their relationships, pregnancies and weight loss. “Scrutiny of celebrities extended beyond their romances or divorces to include their illnesses and deaths. At one level, interest in
famous people’s health crises merely continued a venerable tradition of curiosity about sufferings of exemplary individuals” (Tomes 2007:39). When a famous person goes public (or is forced to go public) with some sort of secret, like a medical condition, America wants to know. Some of the most popular cases are when celebrities like Michael J. Fox tell the world that he has Parkinson’s Disease or Christina Applegate shares that she had breast cancer. These scary but now relatable narratives create awareness, funding for research, opportunities to promote early detection, and possible available treatments. When Magic Johnson went public with his HIV diagnosis and Angelina Jolie spoke about her genetic predisposition to breast cancer and preventative double mastectomy, the public discussed their situations and began a discourse on these issues as related to public health and our own bodies. “Diagnostic centers can anticipate a spike in screening requests for diseases after a well-known person (or their spouse) discloses that they suffer from it” (Tomes 2007:59). The use of their celebrity, public persona has become a legitimate platform for opening up discussions about illness and treatments in the public arena.

In the same way that the celebrity spokesperson for pharmaceutical drugs is influential because of their admission that they too have X disease, they are also lending their name to a treatment solution and bringing awareness. “Americans’—indeed everyone’s—tendency [is] to observe what the famous do and then conclude we should do the same” (Kruger and Park 2013:30). Celebrities are often spokespeople for companies hoping their brand along with the celebrity endorsement will change consumer purchasing like in the case of Nike supporting golfer Tiger Woods. Also,
events like the Sundance Film Festival often feature an enormous number of retailers at gifting suites giving away products to “talent” in the hope of having them photographed with their headphones, boots, or clothes from companies like Skullcandy or Timberland. Further, when celebrities use their platform to discuss personal details, like Katie Couric speaking about her spouse’s death from colon cancer, they can motivate action from the public. “When Katie Couric underwent a televised colonoscopy in 2000, demand for the procedure jumped—a phenomenon that was promptly dubbed ‘the Couric Effect’” (Kruger and Park 2013:30). With Ms. Couric going so far as to have “an on-air colonoscopy” after her husband died of the disease, she was bringing awareness to a procedure that was often thought of as scary or intimidating and uncomfortable (Tomes 2009:59). She showed on air, that the procedure was painless and easy to have done. “Gastroenterologists reported a twenty-one percent increase in colonoscopies after Today show co-host Katie Couric campaigned to promote early screening for colon cancer” (Tomes 2007:59). Couric did a good job promoting her awareness campaign because of the real life results whereby people in the audience saw this and acted on the information she was providing or promoting. Not every case of celebrity health pushes people to do the right thing for themselves. “Every patient is different, and the gravitational pull of a superstar role model has a way of distorting what needs to be a highly individualized decision” (Kluger and Park 2013:31). This was part of the public discussion when Angelina Jolie went public with her genetic breast cancer screening tests and then resulting double mastectomy. She had two close, female family members who died of breast or ovarian cancer and that warranted the very expensive screening tests. Physicians
spent the next few days after her announcement telling audiences that most people were not within the parameters to warrant this kind of screening, and to work with your physician to better understand if your health situation and family history put you in a position to be screened this way. The test is over $3000 without insurance and doctors worried that test might become some sort of status symbol to the public.

Actors who play physicians can have a particularly strange time in real life with the public perception about their level of medical knowledge or their actual medical authority. Maura Tierney, who played a doctor on ER for more than 10 years, had a public battle with breast cancer and when receiving her diagnosis described the incident to People Magazine when “in 2009… a radiologist put her mammogram on the wall, he assumed she could read it too” and diagnose herself (Wihlborg and Messer 2012:72). Even doctors assume that television doctors are part of their tribe. When interviewing Noah Wyle about his time on ER, he said there was a time on an airplane when the flight attendant came on the loud speaker to ask if there was a doctor on the plane because someone on the flight was having chest pain. He said he panicked and thought, “please let there be a doctor on the flight,” because people kind of looked his direction. The people on the plane were correlating his time on the show to some kind of established medical knowledge that he recognized he did not have in real life. Wyle did ask the physician attending to his daughter after she split open her forehead about the stitches he was using. Wyle’s request was unusual but he was well versed in sutures from his time on the show, showing he gained some level of genuine medical knowledge in his training to play a physician on television, much the same way as Patrick Dempsey did in saving
the child’s life on his lawn. This kind of biomedical repetition of narrative and perceived authenticity creates a mimesis and toggling between reality and fiction, showing the lines are much more blurry than normally thought to be.

There is also “the tendency for people to engage with fictional television characters as if they were real human companions” (Gardner and Knowles 2008:157). An example of this is a story from someone who worked on *Grey’s Anatomy* and told me that when fans go on set tours past the room where a character, Denny, died in Season 2, that fans will often cry when seeing that room, remembering the storyline and how Denny tragically died in the hospital. Also, someone who worked on *Chicago Hope* told me how the day after episodes aired they would get calls to their production offices from fans wanting to talk about the episode. One such fan got into a routine where she called every week and became friendly with the production office staff while discussing the episodes. The writers at *Chicago Hope* named a character after this woman on the show because of this relationship and she called after it aired, very happy and excited about being used on the show. As well, a consultant from numerous reality forensic shows and one fictional, medical-legal show gets emails from high school students saying that they want to be forensic anthropologists or forensic scientists, and asking for advice on how to go about this with education and training. This consultant then has to inform them that it is in reality not a very glamorous job, quite low paying, and there are actually very few jobs to be had. The prominence of the positioning of these celebrities, characters, and storylines, creates an understanding about health and often their medical ability which is somewhere between fiction and reality.
One of my favorite public medical storylines involves chef, author and now former Food Network host Paula Deen, who in 2012, went public about her \textit{three-year} knowledge of a diagnosis with diabetes, but “as a paid spokeswoman for the manufacturer of a diabetes drug” (Ozersky 2012:56). Deen’s style of Southern cooking involved extensive frying and lots of butter, so when she came forward with the news she described the medication she was taking and her diet modifications which included only that “she has ‘cut back’ on sweet tea” (Ozersky 2012:56). In a spoof about the announcement, \textit{Saturday Night Live} aired a sketch on March 10, 2012 with Kristen Wiig playing Deen, who described her diabetes diagnosis as “getting hit with what my Mama calls ‘the sugars!’” and hit the tenor amongst the public about her handling of this just right. People were confused about her public statements. She has Type 2 Diabetes from her diet and lack of exercise, but she was not making any real changes except for her medication. She was seen as a non-compliant patient, but also as in denial about what her own cooking had done to her health and others through her cooking shows and cookbooks. She later changed her tune and publicized her periodic weight loss and gave swaps to be made in her recipes for healthier options. In June 2013, after a public fall from grace over controversial racist remarks, I found this image on Facebook (Figure 5.1), posted by a friend who is a pharmaceutical sales rep, for her friend who reps Victoza the diabetes drug Deen publicly reps, asking if they were planning to keep her as a sponsor. Novo Nordisk, the maker of Victoza did drop Deen in late June 2013, as did most of her other sponsors.
In an interview with Eric Horvitz of Microsoft’s Research department, I was told that Microsoft tracked an increase of web searches related to head trauma after the publicity surrounding Natasha Richardson’s death. Ms. Richardson was the wife of actor Liam Neeson and from a well-known Hollywood family. She died after a skiing accident where she suffered a minor fall and bump to the head, which then escalated quickly and she died soon after. People were very interested in this kind of fall, which looked minor to those around her and the web traffic increased around this issue. This specific example was given to me from the executive at Microsoft as one way that they track consumer health web searches. Tracking like this is example what Foucault was describing in the idea of governmentality where surveillance creates disciplined bodies. Americans watch celebrities because they are interested in their lives, but also because they become enamored with their health and health scares as the narratives may relate to their own bodies and health.
Celebrity Rx

Throughout my pharmaceutical advertising collection, I saw a reoccurring theme of the use of celebrities to sell their products. Most often it was famous athletes and Hollywood stars like Claire Danes and Brooke Shields pitching Latisse or Phil Michelson for Enbrel. But there were so many others like Sally Field for Boniva and Blythe Danner for Prolia, both osteoporosis drugs, or a former football star, Mike Ditka for the erectile dysfunction drug Levitra or John Elway for the acid reflux drug Prevacid. For pharmaceutical companies to be the most successful, they must find celebrities that have the conditions their drug treats, as to be able to say that this celebrity takes this drug. “In America, there is scarcely any disorder, no matter how lowly, that has not had its image enhanced thanks to a celebrity spokesman” (Kuczynski 2002:1). There is a real opportunity for drug companies to make a great pitch to the American public by having a recognizable face for their product. “The public does not always understand that many of these celebrity champions are paid players in the marketing strategies of pharmaceutical companies, who pull the strings to make them dance before the public and news media” (Kuczynski 2002:1). This may sound exaggerated, but paid spokespeople like these celebrities, do what the companies ask, by being in the advertisements, but also appearing at events for the product, just like when working for a car company or any other product. “Some companies, such as Celebrity Connection, even [exist] to match up Hollywood stars with pharmaceutical companies” (Lerner 2006:273). When you need to find a celebrity that has a specific condition and will not only use your product but also sell it on television and in magazines and at events, there is such a specific target being sought
that of course a company exists to set up these connections. Celebrity Connection’s spokespeople maintain that, “any celebrity, no matter how famous, is available to endorse a drug for almost any disease, no matter how unpleasant for a price” (Kuczynski 2002:1). The prime examples are for erectile dysfunction drugs, where there might be a stigma for the celebrity for coming out in support of an embarrassing condition. When “Bob Dole was enlisted as Pfizer’s first spokesman for Viagra in 1998, he was seventy-five years old” (Fishman 2010:303). He became a bit of a public target for people making fun of this endorsement, but they were seeking public awareness among older Americans from a trusted source. It worked. “In the first five years of its availability on the market, Viagra netted approximately $7.4 billion in total sales” (Fishman 2010:302). Viagra now uses ordinary men in their commercials, and most often they have lowered their target age to the middle-aged male, someone who may just be beginning to become a customer for erectile problems.

Celebrity pharmaceutical spokespeople are increasingly commonplace and “this kind of below-the-radar media campaign, which blurs the line between drug advertising and public service efforts… and increasingly crucial to the success of these carefully orchestrated blitzes are celebrities willing—for a price—to pour their hearts out about how they or a close relative have struggled with a particular illness” (Goodman 2002:8). In one of the best public health campaigns/targeted drug advertisements, HIV awareness and public gossip came together with Magic Johnson, an NBA superstar, whose public announcement of his HIV status became a household topic of conversation. “In 2002…Earvin ‘Magic’ Johnson began appearing on billboards advertising Combivir, an
HIV medication made by pharmaceutical giant GlaxoSmithKline” (Lerner 2006:273). His work to raise awareness was seen not as selling a drug, but as publicizing an epidemic that he became a part of accidentally. His sexual activity and infidelities were opened up along with his status, but the major discussion became about how he was fighting the disease, through Combivir, a win-win for the drug company.

Many celebrities will make appearances and be in support of brand or condition awareness, in the same way that a ‘Reminder ad’ or ‘help-seeking ad’ puts select information out to the public. They may not discuss a drug openly but will discuss a condition and their appearance is paid for by X Drug Company. “For the most part, the celebrities don’t mention their sponsor its product by name, instead they urge people to go and see their doctors about the latest treatments, or, in [other cases, they] suggest that viewers or readers visit a specific website” (Goodman 2002:8). This is exactly the strategy of the ‘Help-seeking ad’ whereby information about a condition is disseminated at the expense of the drug company and all of the information leads be to that same company, who happens to have a treatment available. Celebrities then “insist they’re doing a public service” (Goodman 2002:8). And they may think that they are, because they are only involved in the public health portion of the campaign, raising awareness of the condition. It is not a coincidence that these appearances or informational sessions are paid for by a specific drug company, as this is still a business and celebrities are being used to create hype and financial rewards.

As a specific example, Latisse is a relatively new product that began advertising with first Brooke Shields, and then Claire Danes as it spokespeople. Both are well known
actresses and generally considered beautiful. Latisse treats hypotrichosis, which may sound serious but it is a lack of eyelashes and/or density or thickness of eyelashes (Latisse.com). The possible side effects of Latisse are related to the consumer usage of the product, as it is applied directly to the eyelid and can result in eye problems, swelling, etcetera, but it can also change the color of eye pigmentation. Hypotrichosis is a classic case of medicalization, whereby a lifestyle issue of not having beautiful enough eyelashes becomes medically treated. This is not a life saving drug, but a life enhancing one.

Figure 6.2 Latisse Advertisement with both Claire Danes and Brooke Shields (2010)

In this 2010 advertisement (Figure 6.2) featuring both Claire Danes and Brooke Shields, the tag line: “Grow longer, grow fuller, and darker lashes. Seeing is believing” becomes a prominent feature for their advertising campaign (APC09LO10). In a 2010 ad featuring Claire Danes the tag line was, “When your lashes grow, your lashes show!”
There is an emphasis on seeing results and seeing growth. This medication is being marketed here as a biomedicalized lifestyle product, where you should see the results of all of your hard work, from going to the doctor to get it, to applying it every night, to the patience of waiting for growth. It is all very consumer driven, whereby the consumer must take control of this problem and implement the solution on their own to be as beautiful as these celebrities.

One doctor I spoke with about Latisse said that the drug was and is still used primarily for cataract treatment, and displayed this unusual side effect during its traditional usage. She said she would not recommend it for patients because “misuse of the swabs can cause the medication to get into the eyes and be absorbed. And the side effects of that in people with healthy young eyes is not yet known over the long term.” I asked her if she would use it and her answer was “no” and that “I would not write a prescription for my sister who wanted to try it.”

Another great example of the confusing informational process is when Dr. Robert Jarvik appeared in DTC ads for Lipitor in December of 2005. “What Lipitor ads didn’t say is that although Jarvik graduated from medical school, he’s not licensed to practice medicine or write prescriptions. He doesn’t see patients. He was a consultant to Lipitor maker Pfizer, under contract for $1.35 million” (USA Today 2008:10A). These relationships, created by an intermediary company selling celebrities, are profitable for everyone involved. “Celebrity disease has become a potent marketing tool as pharmaceutical companies have recruited famous people to appear in the direct-to-consumer advertisements for prescription drugs” (Tomes 2007:59-60). These
advertisements, whether they be DTC Advertisements or awareness campaigns, create attention from the public towards either a drug directly or a company that sells the drug and therefore creates profit.

Celebrity culture is compounded when actors play physicians and are sometimes mistaken in real life for having medical knowledge. One actor on a medical show was described by someone on the show as having declared that he could perform surgery in real life, and as well several of the actors I spoke to were confident that there were at least a couple of procedures that they would be able to do in real life like suture, intubate, and often things like tracheotomies. They of course would never do these in real life, but they have practiced these procedures in such detail on set that it becomes real to them even if they were simply going through the motions, fake ones at that. Celebrity is a business, often selling just themselves, but additionally by extension products of some kind. The biomedical imperative to share ones’ story is evident throughout the confessional of the medical talk show, the nightly news health segment and the celebrity health scare or pharmaceutical solution. In the medical imaginary, the beautiful people in the advertisements stand against the graphic realism of organs presented to the public at home on shows like The Doctor Oz Show. If Dr. Oz is Welby 2.0, then all of America’s Doctors are contributing to this tangible, available, symbol of help and assistance for the public. The information and knowledge disseminated on television, in programming and advertising, are made more compelling because of the tools of narrative storytelling and the medical imagery.
Conclusion: Where We Go From Here.

“Culture can’t be wrong. That doesn’t mean it’s always ‘right,’ nor does it mean you always have to agree with it. But culture is never wrong. People can be wrong. Movements can be wrong. But culture—as a whole—cannot be wrong. Culture is just there” (Klosterman 2005:38).

This project focuses on the medical discourse that floats through the media: in magazine articles and advertisements, television advertisements, online medical databases and search engines, local and national television news health segments, and television health channels and fictional medical programming. These areas of media all exist in a larger healthscape of medical information and knowledge. This information also includes local shared knowledge that moves through friends and family, which is a common method for transmission of the media information they may have received from the sources above. Information circulates through formal and informal channels but most often the knowledge is created in very specific ways to induce more personal responsibility on the part of the audience. As this knowledge is produced for consumption, issues of accuracy and authenticity become increasingly important for consideration.

The many different ways that people gather their own information is vast and each one could be an entire project on their own. I focus here on four ways that the American public may collect medical knowledge through media sources. While the information circulates, what is also important is does it register with people, and when it registers does that information resonate directly or get muddled over time. Some things stick in our mind very clearly like when Dr. Mark Greene dies on ER or when someone recognizes their own chronic or elusive disease on Mystery Diagnosis or when a person
googles their symptoms and just for a second, they let themselves believe they might have throat cancer and then realize, nope, it is probably just the flu. The impact this information may have has real implications for people and the processes through which they operate are significant if we trace who created this information for us, why it looks a certain way, and ponder if there is any authenticity or honesty in the information. Moreover, the Pew Research Center “found that 39% of U.S. adults surveyed said they were caring for an adult or child with significant health challenges in 2012, compared with 30% who said the same in 2010” (Alpert 2013). This growing amount of people caring for themselves or sick family members will continue to be influenced by these kinds of technology, media, and knowledge produced directly for their consumption. “The numbers will continue to surge as the American population ages, putting added demands on workers and families” and this issue is one that could become extremely relevant as more and more people encounter the medical system, often as the ‘smart patient’ with their knowledge ready at hand (Alpert 2013). They will have gathered information, searched for information, and been exposed to information and the question becomes what kind, from who, and with what intention was all of it produced and disseminated. Our ‘expert patients’ are armed to do battle in defense of themselves or their loved ones because of these neoliberal imperatives that they should be empowered.

I began this project thinking that these four lines of evidence (pharmaceutical advertising, the Internet, media and celebrity, and fictional television) were connected in that we all experience some amount of exposure to these avenues of knowledge circulation. As I continued my ethnographic research, seeking out key players in these
worlds, I did not expect what I found. Many people were taking part in the systems of knowledge that overlap between these lines. People like Dr. Sanjay Gupta, who is the main medical commentator on CNN, also write health-based fictional and non-fictional New York Times bestsellers. While working on this project he took one such book, Monday Mornings and turned it into a medical television show on TNT. Dr. Lisa Sanders, a medical technical consultant for the show House M.D., also writes a popular New York Times column called ‘Diagnosis’ which lets readers attempt to diagnosis a person through the medical case file, similar to the aim of CrowdMed. Dr. Sanders also authored a book about diagnoses titled, “Every Patient Has a Story” about listening to patients’ narratives that I used in researching this project. Many of the medical technical consultants who I interviewed have worked not only on television shows and movies, but also all types of commercials, including pharmaceutical television DTC Advertisements. One of the physicians who consulted on a medical television show still had an active practice and also was paid by several pharmaceutical companies for research and consulting. One of the researchers for Microsoft that I spoke to has written about cyberchondria, and also done research on news media and its’ influence over our behavior. These people operate across these lines of evidence making the confluence of influence within knowledge production that much murkier. We often do not have any idea who is creating the knowledge that we consume and it seems like the pool of people is smaller than even I previously thought. Examining these people further and their future projects, as they move in new and different ways in their work, will be a continuing process out of this one.
Americans watch a lot of TV, “about six hours a day on average… [on] over 100 channels” (Turow 2010:5). This is a big part of our lives. Americans consult Facebook after a good episode of “Enter Favorite Show Here” and then discuss it, while anger ensues when people spoil it, and then crave news about our favorite actors. I live in Los Angeles and know a lot of people who work on television shows. This helped enormously when embarking on this project because I began with some level of access that most others would not have had, but I also love television and watch quite a lot of it. Television comes into your home and we often feel connected to the characters. Marshall McLuhan would probably say that is because it is ‘hot’ medium and engages us directly, but I think television resonates partly because we relax while watching it, we eat while watching it, it comes back every week to greet us, it is a long form of storytelling that draws viewers to some level of commitment to stick it out. When we fall in love with a show, we can be religious about it. Just ask Oprah. More and more, the younger generation is getting their media online, even through traditional television content that is viewed but not on a television. Hulu, Netflix, and iTunes all have content for purchase, subscription, or streaming and some like Netflix even have their own content strictly for their members. One off-shoot of this research would be to concentrate solely on medical television through the vast ways that people access it to look for saturation and knowledge absorption. If we consume the information in an on-the-go setting like our smart phone or tablet the question will be: does it resonate with the audience as much, or will the lack or lowered amount of advertisements create a space for more focus on programming?
I was unable to cover every aspect of medical media that is a part of the modern healthscape. Other sites of production are equally valid and interesting, but could not be included in the scope of this project. Many areas like radio and medical literature hold great potential to reveal more information about knowledge production and also consumer interaction with the information. In looking at future research areas, some that were considered possibly for this project, some would require more access, often were unobtainable for me personally or in the time frame, and also required more technical equipment and manpower than could be done, with regards to recording media on radio programs or trying to contact many more authors, medical researchers, or pharmaceutical personnel. Biosociality between media communities, like the interconnections in the greater pharmaceutical industry or as mentioned in the network of interconnections I discovered in my own research, as a process in itself would be a large task to research individually. There were so many more areas that can be explored coming out of this research.

One possible area for future research out of this project would be how physicians utilize the Internet, whether it be in research for their patients, like the creators of FindZebra hope, or by working with patients over email to avoid the spread of disease in waiting rooms or to answer a small but necessary question from a patient. “Only a small percentage of physicians report that they use [email] with patients” and this can be because email consultations are costly time-wise and not usually reimbursed time and also involves privacy concerns for patients (Pickert 2010:48). Email might be a tool that will grow in use over time with our health care system evolving because of new
healthcare legislation or with an understanding that not everything needs to involve an office visit. Some HMO companies like Kaiser Permanente utilize an email function between patients and physicians with some success. Some believe it could be the solution for cutting costs in our very expensive medical system. “Have you ever felt slightly under the weather, called your doctor for advice and been asked to drag yourself to her office—only to be told to rest up and drink lots of fluids? …Chances are these inconveniences could have been avoided if your doctor used a simple, ubiquitous tool: e-mail” (Pickert 2010:48). This area would make for some rich ethnographic work at the patient-provider level of study and interaction. Physicians report that they do not even always use the technology that we love so much. “Despite all the available technology, the tools doctors often rely on most are the most old-fashioned—a phone, a respected colleague, a mentor, or friend” (Sanders 2009:xvii). So, a study of physicians, possibly based on age generations, may be in order to address the possibility that the patients may be using technology more successfully than physicians.

Another avenue of future research would be to study things like self-help books, where a very specialized section of the population received medical knowledge. After all, the “help your doctor help you” mantra says you need to gather the information yourself and bring it to your doctor. This idea is central to why Dr. Mehmet Oz and Dr. Michael Roizen created a series of health books all about “You”: “You: The Owners Manual” (2008), “You: The Smart Patient” (2006), “You: On a Diet” (2009) and so on, because we now take ownership over ourselves and our bodies. As well, the language of these titles is interesting to note. It is akin to two doctors, one a household name, expressing
that we do not know our own bodies well enough and are not paying attention to the information we have literally at our own fingertips. This is only one example of the self-help book phenomenon that may be a much larger portion of the public than ever previously thought, with many of these personal insight books reaching status on the *New York Times* Bestsellers List. This area was problematic for this project, because self-help books get purchased, but are also not always read (partially or entirely) by the purchaser, nor enacted in practice. Self-help books may make you feel better, but how much behavioral change do they really create?

Radio would be another avenue to discover in this framework. I developed some small pieces of data from chance encounters with programs on NPR or Doctor Radio, but because radio is live streaming and often not captured anywhere, and this became difficult to continue pursuing. Just to demonstrate the information available in this arena, Doctor Radio, a channel on Sirius XM Satellite Radio created by and authored by doctors of NYU’s Langone Medical Center, published questions for use by listeners when going to doctors and specialists. These questions range from: “What is my vitamin D level?” for general practitioners to “Are you a parent?” for pediatricians to “Can my erections be improved?” for urologists (Doctor Radio 2010). These are meant to be helpful guides for general visits, something patients may not have considered or thought about. The questions are extensive and there are lists for 8 different types of doctors. This kind of information access combines both the radio and the Internet in new and different ways. As an example from National Public Radio, the programs are aired and often transcribed and posted online, another crossover between radio and the Internet. In one such three-
part program on NPR, they advised that “for most Americans, this is an incredibly difficult idea to accept, that more care isn’t necessarily better for you” and described a medical world where we get too many tests (NPR Doctor Decisions 2009). This is not often the narrative we hear in biomedicine, where the patient needs to get tested, be aware, seek out help, but they claim that “the behavior of patients in our health care system has changed dramatically over the last couple of decades. We’ve been transformed from passive patients into active and aggressive consumers” requesting too many tests and without the information to support it (NPR Patient Behavior 2009). This blurred line of Internet and radio would be an albeit small, but interesting new world to explore.

One possibility for future research could be on the spurious medical information that circulates within media. I have focused on information that pushes people to action and towards avenues that are productive in medicine. There is a lot of information that is created for consumers that is questionable in its’ purpose for consumers. A good example can be found in a Newsweek article on antidepressants and how they may not work, where the article featured a graphic about “The Placebo Effect” whereby “dummy pills can be almost as effective as real ones” (Begley 2010:40). A placebo is defined as “a pill which looked exactly like those… other patients took, but had no medicine in it at all; they took a inert pill” (Moerman2008:10). The Newsweek article lists diseases that have high responses to placebos, “Hypertension, Pain, Parkinson’s Disease, Psoriasis, Rheumatoid Arthritis, and Ulcers” and those that do not “Atherosclerosis, Cancer, Growth-Hormone Deficiency, High Cholesterol, Infertility, and Obsessive Compulsive
Disorder” (Begley 2010:40). This begs the question, what is the public supposed to take away from this? Should they ask their doctor for a placebo or dummy pills? This is information that has virtually no implication for the patient, as physicians never prescribe placebos and the only time you might encounter one would be a blind clinical trial where you will never know whether you were taking the medication or the placebo. This is information that goes nowhere in its usefulness for patient but could create a sense of resistance in the patients for one of the high response diseases in a clinical trial in order to avoid feeling like they are susceptible to the placebo effect. An interesting possible project for the future might be to revisit Moerman’s placebo effect and look further at how processes of hypochondria and cyberchondria may be affecting and influencing people’s reactions to medications and the effects they have on their bodies (2008). Because we are an informed generation, we think we know a lot about health but a lot of this information goes unquestioned.

The Internet and the biosocial groupings of people online in health-related sites have gained importance for those with chronic diseases searching out support and community. Ethnographies of these communities might prove fruitful for understanding the patient-based online research that is often undertaken and then passed along to others in the online group, similar to the communities in Second Life that Tom Boellstorff has written about (2010). These communities can be found connected to media, like those for medical shows like Mystery Diagnosis, Untold Stories of the ER, or even Grey’s Anatomy’s Grey Matter blog. Or many groupings can be located on patient forums around specific diseases or conditions, on pharmaceutical web pages, in question and
answer forums, or on personal web pages. “The Internet provides a means by which individuals suffering from unexplained symptoms, or recognized conditions, can reach out and become part of a virtual community of suffering, exchanging information on symptoms, diagnoses, illnesses experiences, treatments, and research with other individuals scattered around the globe” (Goldstein 2004:121). There are so many different ways to analyze or group these communities that this would be a labor intensive and often overwhelming amount of research. It is, however, worthwhile to study for anthropology because the individuals and groups online “create their own separate and distinct medical culture, a culture that gives primary importance to the role of subjective experience” (Goldstein 2004:127). Much like Boellstorff’s work online, these sites are full of online subjects with their own web-based identity that may be very different than their outwardly sick body positioned the keyboard (2010). “The Internet creates intimacy through anonymity” (Goldstein 2004:121). The variety of locations, personas, communities, and cultures makes for a multitude of choices if selecting these biosocial groups to research that could also prove very fruitful.

Another such possible line of inquiry could be into the pharmaceutical industry’s connections to university researchers and biotechnology research firms. There has been no significant work done on these interconnections, partly because of issues relating to access. It would be tremendously interesting to see inside of these companies to examine the financial and technological ties that bind them together in the marketplace and how they are linked to funding agencies like the National Institute of Health. Having spoken to one informant who worked in research with a pharmaceutical company, who spoke to
me under conditions of anonymity, it would be challenging to do this without doing covert ethnographic research and also would mean working in the field of pharmaceutical research to gain the needed access, both things being usually problematic for anthropologists. The potential information revealed by such research would give broad perspective on the financial and structural ties to the larger pharmaceutical industry.

While many anthropologists have studied pharmaceuticals and related advertising and knowledge production internationally, often at a local, cultural level, not much has been studied about the trend of medicalization through media around the globe. “Medicalization is prevalent in the United States, but it is increasingly an international phenomenon. This is partly the result of the expanding hegemony of western biomedicine” (Conrad 2005:11). By understanding how that knowledge circulates within American technology and media, there may be applications to study either the movement of American medical media in other cultures and geographies or to look at local, medical narratives in the media that may be moving in similar ways, parroted or mimicked after our own. Pharmaceutical companies have annual and regular industry meetings where they constantly discuss possibly ways to get into international advertising, especially in Europe. Their lobbying groups are pushing regulatory frameworks in attempts to open up DTCA in their markets worldwide.

For myself, I learned from my informants in television that there is a lot of crossover and similarity between medical television and medical-legal and legal procedural television shows. The same relationships exist for legal or police consultants on legal or medical-legal shows as do for medical consultants. Former police officers or
current/retired lawyers work consistently on these shows providing key information on police responses with numbers of cars, officers, agencies, and types of officers, and also verbal codes and jargon for crimes, crime scenes, car chases, and use of helicopters. My next project will expand on the role of television consultants as a whole as there are so many parallels, just as the CSI effect and the ER effect both show a contribution to knowledge through television accuracy. Especially many of my informants have moved back and forth between CSI and Law & Order franchises and other medical, medical-legal and legal shows because these two groups of shows are so ubiquitous in the television landscape, popular with audiences and a source of major jobs in the entertainment industry.

To conclude this project, I leave you with some of my favorite quotes from magazine and newspaper articles, and radio programs. Much of the advice is good, but also much of it is a little strange. One article tells you to “have a friend or family member act as an advocate for you…asking important questions that might have been overlooked” (Ulene 2010:E6). This is good advice and one that many people have heard by now about hospitals and doctors. Physicians may speak quickly, moving on to other patients, they may not address everything you need to know, or you may actually be too sick to remember what they are telling you and it is always better to have someone there who is healthy (and not on any pain meds) to be on your side. On another note, with all of the tests we are getting, we are bound to get nervous about them, but not to worry. “You are not alone. Going for medical tests fills the average person with dread…Follow [these] suggestions and you’ll sail through these exams with ease” (Hochwald 2009:89). The
suggestions are not important for this example (they were not that good to begin with) but the idea that a magazine can calm your nerves about blood tests, scans, and anything ending in –scopy, where they look inside your body, is laughable. While well meaning, medical tests are not usually something to be passed and failed. They are often indicators or early detectors and often should be seen as helpful. This article made medical tests sound scary in their attempt to calm patients.

In one of my absolute favorite articles, Dr. Elizabeth Cohen, a CNN contributor and writer of the ‘Empowered Patient’ column online, tell us that doctors do not always get it right. “No one knows the exact percentage of diagnoses that turn out to be wrong, but studies put it anywhere from 1 out of 10 to 1 out of 4. Chances are, at some point you’ll be on the receiving end of a misdiagnosis” (Cohen 2010:140-2). If that did not scare you yet, then not to worry, Dr. Cohen is putting you to work. “Luckily there are steps you can take to help your doctor make the right call” (Cohen 2010:142). She advises patients to follow several simple steps and double check for their doctors that everything they did made sense for you and that you do in fact have the correct diagnosis. If you do become concerned, “remember that you’re a smart person—if something doesn’t make sense to you, there’s a good chance it doesn’t make sense at all. The diagnosis might just be plain wrong” (Cohen 2010:142). Someone will figure it out with her plan, either you will as the ‘empowered patient’ or you will make enough ruckus that doctors will go back and double check everything.

After all the pushing to get you to become the ‘empowered patient’ there is a warning that because of the over-educated patient “doctors will order tests that you don’t
need, give you pills you probably shouldn’t take” to satisfy the patient’s concerns (NPR Patient Behavior 2009). Oh no! Now we are doing it too much. We are getting too many medications, having too many diagnostic tests, and doing too much of our own research. If you are confused, I’ll admit that I am too. The confusing message here runs the line of wanting you to be involved, but not too much. “By taking their case to patients instead of doctors, drug companies increase the amount of money that Americans spend on medicine” (NPR Marketing Sickness 2009). All of these questions we ask and all of the empowerment we have apparently leads to too much of everything which is a real moneymaker for many in healthcare. I have not addressed the financial end of any of this knowledge and that is another area that could be pursued in further research. Knowledge, often hopefully, produces action and when it comes to medicine that can be costly.

The multitudes of methods to study further areas coming out of this project are apparent and vast. This new field of medical media and knowledge production is open to study and I encourage others in anthropology to join me in investigating the world “above us” in medicine. Many people in this world of entertainment were lovely and open to participating once I got to them. They often wanted to discuss their work and their process and felt really good about being told that people at home are paying attention to their hard work on medical television. An actress I spoke to left me with a really profound thought about why she loved playing a doctor on television, “It allows me to live my life more fully to be telling stories about others or to cope with some huge problem…or to unlock something for someone else.” It seems the actors, as well as the audience, are looking for the same thing in these stories of human connections and
narratives of medical imaginaries. The care of the self that Foucault spoke of has come to fruition in the ‘smart patient’ and while they are getting information from all types of sources, the media and these portrayals are becoming increasingly more important to these patients, their families, and the companies that benefit from it. The love story continues between Americans and their medical media, and the knowledge learned from it only broadens our healthscape.
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Appendix A: Favorite TV Episodes

I asked all of my informants who worked on medical television what their favorite episode of medical television was (allowing them to comment on shows they may or may not have worked on, and also allowing them to often name multiple episodes). What follows is that list. All episodes have been compiled together and should be considered “recommended” by those in charge of the medicine, either for the fun, technical medicine they put together, or the medical storyline that was undertaken, or quite possibly because of the human-interest component in the medicine. All episode summaries have been taken from IMDB.com or TVGuide.com for more recent shows not yet available on IMDB.com. Enjoy!

Chicago Hope
Season 4. Episode 3 “Brain Salad Surgery”
Shutt suffers a brain aneurysm and hallucinates that Wilkes and Hancock are singing “Ain't That a Kick in the Head” in the ER.

ER
Season 1. Episode 10 “Blizzard”
The ER staff's slow snow day becomes chaotically hectic when the casualties of a 40 car traffic accident flood in.
Season 6. Episode 14 “All in the Family”
Carter and Lucy are discovered and the staff struggles to save them and go on with normal patient care.
Season 10. Episode 8 “Freefall”
On Thanksgiving Day, a helicopter crash outside the ER leaves several injured, and kills Dr. Romano. Alex tries to bring Sam and Luka together.

Grey’s Anatomy
Season 2. Episode 16 “It’s the End of the World”
The lives of everyone in the OR are threatened when a patient enters with a bomb inside of him... and a young paramedic with her arm inside the cavity is the only thing keeping it from going off.
Season 3. Episode 13 “Great Expectations”
George deals with his grief, Cristina and Burke's silence makes for an interesting dinner party, and the Chief makes a decision that sends all the attending doctors scrambling.

In his new role as Chief, Derek restores the hospital lecture series, and Richard, Bailey and Callie present to the group pivotal surgical cases from their pasts - Bailey reflects on her first days as a shy resident, Callie looks back on a polio case, and Richard recalls a case in which he and Ellis worked on a patient diagnosed with GRID, a virus later called HIV.

Season 6. Episode 24 “Death and All His Friends”
Shooter Gary Clark (Michael O'Neill) remains on the loose, presenting Cristina and Meredith with major surgical challenges. Meanwhile, Bailey and Mary (Mandy Moore) must find a way to get the injured Charles to an ER.

*House M.D.*
Season 1. “Pilot Episode”
Young kindergarten teacher Rebecca Adler collapses in her classroom after uncontrolled gibberish slips out of her mouth while she is about to teach students.

Season 3. Episode 2 “Cane and Able”
House is affected by the fact that he thinks he didn't solve the last case while a young boy, who believes aliens tortured him, is brought in.

Season 5. Episode 24 “Both Sides Now”
House and his team treat a patient who had his brain split in half, now it seems like one side of his brain is causing some health/behavioral issues. House plays games with Cuddy over the night he detoxed, and those events will cause major changes. Cameron and Chase come to a decision.

Season 6. Episode 1 “Broken”
House fights his doctors, the staff and his fellow patients when he's forced to stay in the psychiatric hospital under threat of permanently losing his medical license.

*The Mindy Project*
Season 1. “Pilot Episode”
Ob-gyn Mindy Lahiri struggles to clean up the mess that is her personal life in the premiere of this sitcom, which begins with an unforgettable toast at her ex-boyfriend's wedding that leads to an embarrassing brush with the law.

*Monday Mornings*
Season 1. Episode 9 “Wheels Within Wheels”
Ty and Hooten suspect that a Supreme Court aspirant has a brain tumor, but surgery reveals something more shocking. Meanwhile, a difficult case tests Michelle; Sung and Tina clash over how to treat a writer suffering from epilepsy.
Season 1, Episode 10 “Family Ties”
In the Season 1 finale, Hooten and Buck go to court over a grieving son's refusal to follow his mother's final wishes. Meanwhile, Sydney's relationship with Lieberman is further strained over the health of a morbidly obese teen; an outwardly harmless patient puts one of the staffers in peril.

*Nip/Tuck*
Season 2, Episode 7 “Rose and Raven Rosenberg”
The doctors go to New York to help in the separation of conjoined twins, but it's the practice of McNamara-Troy that may separate if Sean, still hurting from Julia's revelation, has his way. Real-life conjoined twins Lori and Reba Schappell guest star.

Season 6, Episode 8 “Lola Wlodkowski”
A medical consultation with one of Liz's friends, named Lola Wlodkowski, cause Christian to reconsider re-starting a possible romance with Kimber. Meanwhile, Sean begins to emotionally heal after an encounter with a pair of perfection seeking patients, named Tracy and Skip, who model themselves in the exact likeness of Barbie and Ken dolls.

*Off the Map*
Season 1, Episode 6 “It’s Good”
When a robbery deprives the clinic of all of their meds, the docs must scramble to keep treating patients. Tommy must save a frat brother whose hang-over turns out to be something much worse. Ryan must deal with a schoolgirl who's been bitten by an insect and gotten a serious problem that strikes too close to home. Meanwhile Otis must revisit his own demons in order to obtain some much needed pain relief for a man with burst appendix.

*Scrubs*
Season 1, Episode 4 “My Old Lady”
The whole crew learn their share about death when JD takes care of an old woman ready to die, Elliot and Carla watch over a woman who can't speak English, and Turk becomes too close with a patient.

Season 1, Episode 22 & 23 (two part-er) “My Occurrence,” “My Hero”
When Jordan's Brother, Ben, comes in for a medical exam, Dr. Cox reveals his more compassionate side and J.D. must reluctantly deliver the bad news about Ben's health. Ben's diagnosis sends shock waves throughout the staff at Sacred Heart. Surprisingly Cox is the man keeping everyone afloat.

Season 7, Episode 11 “My Princess”
Dr. Cox tells his son the story about a typical day at Sacred Heart in the form of a bedtime fairy tale.
**Three Rivers**

Season 1. Episode 3 “Good Intentions”

Andy goes out on a limb for a patient, who is a former drug user in convincing the UNOS (United Network for Organ Sharing) to allow the transplant, which takes a turn for the worse when the patient disappears from the hospital before the surgery. Meanwhile, Dr. Jordan treats a very dedicated lawyer who ends up threatening to sue her. Also, David and Ryan encounter a unique situation when they head to pick the donation.

Season 1. Episode 11 “Every Breath You Take”

Dr. Jordan, Miranda, David, Andy and the others deal with the captain of a firehouse who needs a lung transplant. One of his firefighters must make the tough decision of whether or not she wants to be a living donor. Meanwhile, Andy faces a personal and professional dilemma when his uncle comes to Three Rivers for treatment from a stab wound, but requests that Andy keep it to himself.
Appendix B: Fake Drug Advertisements

Saturday Night Live has been spoofing pharmaceutical DTC Advertisements since 2000. These ads can be found online in their entirety on websites like hulu.com or youtube.com for reference and hilarity. Most of them operate on premises about the outrageous side effects often heard in DTCA. Others work by making fun of social situations like cheating husbands or gay summer weddings. Most of them are honestly funny. SNL has been putting their finger to the cultural pulse of public opinion on many things, like in this case with fake advertisements.

<table>
<thead>
<tr>
<th>Saturday Night Live Product</th>
<th>Actual Pharma Product</th>
<th>Date Aired</th>
<th>Sample Dialogue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trilocaine</td>
<td>Scalp Itch Creme</td>
<td>February 19, 2000</td>
<td>“Trilocaine. Prescription medication for serious scalp itch. Possible side effects include dry mouth, or loss of appetite. Some users may experience dizziness or nausea. And 90% of users experience an instantaneous and horrifying sleep-paralysis containing a bleak vision of mortality”</td>
</tr>
<tr>
<td>Valtrex</td>
<td>Valtrex</td>
<td>November 11, 2006</td>
<td>“Husband: But then I read about a recent scientific study. It said some forms of genital herpes remain dormant in women for ten or fifteen years - but, oftentimes, the virus went undetected in tests. Wife: That would explain a lot. It made little sense to me that two married people without any history of genital herpes, could then suddenly be infected. Husband: But then I explained it, that that was the end of it, and there was no need to talk about it any more.”</td>
</tr>
<tr>
<td>Urigro</td>
<td>Frequent Urination Drugs</td>
<td>January 20, 2007</td>
<td>“Man: [ to the camera ] Well, I'm gonna hit the head. When I started using Urigro, my stream was thin and unpredictable. [ slow trickle sound effect from below camera view ] But, now -- [ powerful jet stream sound effect is heard from below camera view ] it's powerful and consistent, from beginning to end! [ stops urinating ] Couldn't hear me, could you? That's Urigro working!”</td>
</tr>
<tr>
<td>Brand Name</td>
<td>Generic Name</td>
<td>Date</td>
<td>Description</td>
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<tr>
<td>Annuale Seasonale</td>
<td>February 23, 2008</td>
<td>“Do not take if you are using MAOI inhibitors or if occupation requires you to operate heavy machinery. Do not take Annuale if you plan to ever become pregnant, as it may turn your baby into a firemonster. In the days around your period, you may develop a leathery tail. Annuale may cause you to develop a second vagina. Notify authorities in your town when your period is imminent as they may want to incarcerate you pre-emptively like a wolfman”</td>
<td></td>
</tr>
<tr>
<td>Preniva Boniva</td>
<td>May 15, 2010</td>
<td>“There doesn't have to be anything wrong with you to take Preniva. You just have to be scared, which you should be. Preniva makes sure you can do all your favorite, low impact every day activities. Like doing yoga, spritzing your plant, fanning out your magazines, and taking pills for other things your doctor scared you with, and having bangs”</td>
<td></td>
</tr>
<tr>
<td>Lil Poundcake Gardasil</td>
<td>October 1, 2011</td>
<td>“Little Girl: Would you like some more tea? [a surgical needle protrudes from Lil Poundcake's arm and administers a shot] Little Girl: Awesome! She got me! [the other little girls laugh] Announcer: Lil Poundcake is the first doll approved to administer the Human Papilloma Virus vaccination to girls under 10!”</td>
<td></td>
</tr>
<tr>
<td>Nuva Bling Nuva Ring</td>
<td>March 2, 2013</td>
<td>“Nuva Bling is a discreet yet diamond-encrusted ring and only 70% effective at preventing pregnancy, but it is 100% effective at getting’ dat swag on. You can customize Nuva Bling with charms, and instead of throwing Nuva Bling away each month, you can use it as jewelry. Did you get those earrings at Tiffany’s?” “Close, I got them from my vagina.</td>
<td></td>
</tr>
<tr>
<td>Xanax for Gay Summer Weddings Xanax</td>
<td>May 19, 2013</td>
<td>“Do you suffer from feelings of anxiety? Are you worried that you’ll never be good enough? That you’ll never measure up? Then this summer you must have been invited to a beautiful gay wedding.” “Usually at weddings, I’m the best dancer there. But at gay summer weddings, everyone knows a choreographed dance to a Beyoncé song that hasn’t even been released yet. I can’t stack up to that. That’s why I use Xanax for Gay Summer Weddings.”</td>
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Appendix C: BBC Shows and America’s Future

I was interviewing a physician television writer and he asked about my larger project. While I was discussing the role of non-fiction and dramatized television and he mentioned that he had just come back from a family trip to England and asked if I had seen the show *Embarrassing Bodies*. I had not seen this staple of BBC4 but upon more research I think it warrants a mention here because of the very fascinating way that English television often makes it across the pond to our own shows. This show has real potential to become an American reality sensation. We already get up on national television on shows like *The Dr. Oz Show* or *The Doctors* and spill our most embarrassing health questions (strangely the ones people are afraid to ask their doctor, but will ask on television without protecting our identity). This show takes that one big, gross step forward. *Embarrassing Bodies* is just that. People with embarrassing conditions, growths, or spot, bumps, itching, etcetera who apply for the show, with photos of said embarrassment, and then appear on television and show their grossness and get doctors to look at it and tell them what it is. The physicians will advise treatment or corrective surgery, sometimes that is even shown on the show.

There is something in the human psyche where we like to look; look at car crashes, look at people when they think we are not watching, look at gross things and scare ourselves. We apparently also like to confess our deepest secrets in one big, public spill. We stand up in front of other people, people we know, and undress (or confess) to show (or tell) something that did not even warrant a doctor’s visit until now. I do not claim to understand this phenomenon, but it happens enough now that I think it is a
‘thing.’ Go ahead and google the show *Embarrassing Bodies* to see the joy for yourself stateside. If you want to go really meta, with the British, there is even a show about people watching television called *Goggle Box* (also airing in American beginning in Fall of 2013 on BRAVO as *The People’s Couch*). *Goggle Box* follows families or couples while they watch television and eat dinner, including the show *Embarrassing Bodies*, so you can be grossed out by yourself to the growth on some woman’s thigh or you can watch someone else also be grossed out with you. This kind of reality health television might be coming our way. As a personal confession, I tried to watch an episode of *Embarrassing Bodies* but had to stop just before they showed something a woman called “her tail” and the doctor kept saying “oh, bless you, poor soul.” Maybe we are not ready for this, but it does exist in medical television as a potential influence or programming possibility. It will be interesting to see what our version of this might look like or to just be a viewer at home looking into English living rooms watching *Goggle Box* watch *Embarrassing Bodies*. 