

Contents

<i>List of Figures</i>	vii
<i>Acknowledgements</i>	viii
<i>Notes on the Contributors</i>	ix
Introduction	1
<i>Martin King and Katherine Watson</i>	
PART I AUDIENCE RECEPTION STUDIES	
1 Public Medicine: the Reception of a Medical Drama	22
<i>Solange Davin</i>	
2 Health Promotion Campaigns for Ethnic Minority Groups: the Case of the Radio Campaign for Asian Populations in the UK	47
<i>Yumiko Doi</i>	
3 Performing Disability: Impairment, Disability and Soap Opera Viewing	66
<i>Alison Wilde</i>	
PART II DISCOURSES OF HEALTH AND ILLNESS IN THE PRINT MEDIA AND THE INTERNET	
4 Threatened Children: Media Representations of Childhood Cancer	94
<i>Clive Seale</i>	
5 Mad Cows and Mad Scientists: What Happened to Public Health in the Battle for the Hearts and Minds of the Great British Beef Consumer?	115
<i>Martin King and Clare Street</i>	
6 Writing Digital Selves: Narratives of Health and Illness on the Internet	133
<i>Michael Hardey</i>	

PART III UNRULY BODIES AND THE MEDIA

- 7 'Planting Landmines in their Sex Lives': Governmentality, Iconography of Sexual Disease, and the 'Duties' of the STD Clinic 156
Anthony Pryce
- 8 Slicing Through Healthy Bodies: Transsexuality and the Media Representation of Body Modification 184
Katherine Watson and Stephen Whittle
- 9 Representing 'Healthy' and 'Sexual' Bodies: the Media, 'Disability' and Consensual 'SM' 206
Andrea Beckmann

PART IV MORALITY AND HEALTH: DISCOURSES OF GOOD AND EVIL IN HEALTH TEXTS

- 10 Dope Fiends: the Myth and Menace of Drug Users in Film 234
Philip Guy
- 11 Disease, Decay and Dread: Literary Constructions of Illness 252
Angela Kershaw
- Glossary* 270
- Index* 275

Public Medicine: the Reception of a Medical Drama*

I

Solange Davin

Introduction

Medical dramas have been a staple of British networks since the early days of television. From *Dr Kildare*, *Emergency Ward 10* and *Dr Finlay's Casebook* through *Angels*, *Peak Practice* and *St Elsewhere* to *Cardiac Arrest*, *Chicago Hope* and *ER*, they have been enthusiastically received by the public, whose interest shows no sign of fading. *Casualty*, the flagship BBC1 medical drama, first aired in 1986, continues to draw over eleven million viewers, and its off-shoot, *Holby City*, also on BBC1, nine million, according to figures published in the television magazine *Radio Times*. *ER* attracted a record thirty-five million fans in its first season in the USA (Pourroy, 1996) and rapidly acquired a quasi-cult status in many countries, including Britain, where it has a following of over four million, a respectable rating for Channel 4. Yet scholars have paid scant attention to the genre and, apart from Buckingham's (1997) chapter on young *Casualty* spectators and an early telephone survey of American *ER* viewers (KFF, 1997), how these substantial audiences respond to medical dramas remains unexplored. This chapter begins to fill the void by reporting on a reception study of *ER*.¹

The study

Following Ang's (1991) methodology in her reception study of the American soap opera *Dallas*, an advertisement was circulated in television magazines.

* In this chapter, *italics* are verbatim quotes from informants.

Its wording was open² – simply asking viewers to explain why they watch *ER* – in order to allow respondents to express themselves in their own terms and to address issues of interest to them rather than topics pre-selected by the researcher. The aim was to generate rich respondent-focused data.

This chapter is based on almost two hundred letters received in answer to this message. Women and men³ aged between 12 and 84 and from very diverse backgrounds (unemployed, doctors, students, clerks, teachers etc.) replied. After repeated readings, the letters were submitted to an open coding procedure (Strauss and Corbin, 1990) which enabled the *post-hoc* emergence of thematic categories from the data. This initial classification was further analysed and divided into a number of sub-categories (and sub-sub-categories when and as appropriate) according to similarities, to differences, to contradictions etc. in the informants' statements (Deacon et al., 1999). The limitations of the study are acknowledged – the respondents were self-selected and more women than men took part in the study.

The findings demonstrate, first, that viewers use *ER*, a popular entertainment show, as a reliable source of knowledge, from which they gather information through emotional and/or ludic strategies. Secondly, viewers trust this information primarily because they perceive *ER* as realistic. But their concepts of realism go well beyond a simple television–reality comparison: they see the programme as a transparent representation of the world and yet as constructed; they disagree as to which elements decrease or increase realism, with some items described as doing both, depending on perspective; consensus about the realistic properties of a component may conceal underlying discrepancies; informants write of realism of details, or of blanket realism; the American origins of *ER* can reinforce or hinder realism or may be erased altogether; and television and reality overlap.

Thirdly, the intricacy of interpretations⁴ stems from the fragmentation of the postmodern individual into an array of dynamic identities, including health and illness, which, in spite of being fundamental identity segments, have been obscured by the academic preoccupation with factors like gender or socio-economic levels, and which need further examination.⁵ Finally, the study illustrates that real viewers are astute and insightful, which undermines perennial stereotypes of dumb audiences.

***ER* – a medical documentary?**

Conceived in the 1970s by Michael 'Jurassic Park' Crichton and based on his own training on casualty wards as a medical student, *ER* is a fast-paced drama

which follows the trials and tribulations of a group of health professionals in the emergency department of a Chicago hospital. Well-known actresses/actors (e.g. Julianna Margulies, George Clooney) and directors (e.g. Quentin Tarantino) have contributed to the serial.

Unsurprisingly, viewers see *ER* as outstanding entertainment. They like its broken rhythm where action and emotion, chaos and calm, happiness and sadness follow each other in quick succession. They look forward to their weekly rendezvous with their favourite characters, whose lives they compare to those of the actors who embody them (Figure 1.1). They enjoy guessing the content of the next episodes, rewriting the scenarios, imagining happy-ever-after endings.



Figure 1.1 Viewers look forward to their weekly rendezvous with the cast of *ER*

But many also describe *ER* as a trustworthy source of information, sometimes as, literally, a documentary:

If you remove the humour, it is like a documentary, things which happen round the clock and rather gloomy. [Michelle]

When I watch ER it is more like watching a documentary. [Jean]

What do informants report learning from the serial? First, they assimilate medical details about physiology, symptoms and syndromes, diagnoses, operations etc.:

It teaches you about diseases, like in one episode a woman had Alzheimer's disease. [Laurence]

It gives you the opportunity to learn more about medical knowledge and knowledge of your own body. [Lillian]

Secondly, *ER* is said to impart health promotion advice:

We learn all sorts of things, what damage a car crash can do, the consequences of taking drugs or drinking. [Christopher]

It does help with health promotion when it can. It warns about glue sniffing, drug abuse, smoking. [Gwen]

This echoes the findings of a 1997 US telephone survey (www.kff.org/content/archive/1358/ers.html) where just over half the subjects interviewed had improved their knowledge of health care by watching *ER* and 12 per cent recalled consulting a doctor after being worried by an episode. The date-rape narrative was estimated to have informed five million viewers about emergency contraception.

Such responses are not limited to *ER*. According to Kingsley (1995), millions of viewers have acquired medically-related information from *Casualty*, and some fans have used the data given in the show to make a self-diagnosis. My own (Davin, 1999) reception study of the serial confirmed that its followers learned about diseases, about high technology, about emergency procedures, and, as Buckingham (1997) found in his work with adolescents, that the show helps viewers to prepare themselves for a possible involvement in a real emergency.⁶

Nor is it only medical dramas which provide useful medical data. Other entertainment broadcasts, such as soap operas, have proved to be a valuable resource.⁷ A spectator gave *All my Children*, where she heard about ovulation prediction kits, credit for her getting pregnant (Rogers, 1995) and some fans of *The Young and the Restless* lost weight alongside the main character (Cassata, 1985). Viewers learnt about amniocentesis from *Dallas* (Rapp, 1988) and about mental illness from *Brookside* (Philo, 1996). Melodramatic serials have also been an efficient device for the dissemination of health promotion material in developing countries (Singhal and Rogers, 1999).

That continuous serials act as a pool of knowledge should not be surprising since some of their producers have regarded their remit at least in part as one of information-provider.⁸ The *Casualty* team try to include helpful medical and first-aid advice in their storylines, and their scenarios are overseen by medical experts whose motto is to 'educate as well as entertain' (Kingsley, 1995, p. 86). The producer of the British soap opera *Crossroads*, Jack Barton, was committed to 'using the soap-opera form for bringing to the notice of the audience the problems of the disabled, the need for kidney donors, and many more issues of social concern' (Hobson, 1982, p. 47). Likewise, the BBC soap *EastEnders* was intended to help raise awareness of social problems and has featured many, from racism to rape, including a range of health topics – vaccination, cot death, drugs, alcoholism, infertility, cancer, HIV/AIDS, spina-bifida, mental illness (depression, schizophrenia) etc. – often championed by 'teacherly' characters such as the local nurse or GP (Buckingham, 1987, p. 84); the creator of *Brookside* had similar ambitions (see Gottlieb, 1993, p. 40). Even science-fiction can have pedagogic objectives (see Cull, 2001, on *Dr Who*).

On the other hand, although the *ER* production team was keen to ensure 'that the finalized script interprets the medicine correctly and that, once shot, it remains authentic', it refused to 'pander to viewers medically' (Pourroy, 1996, pp. 18–24). Nevertheless, *ER* possesses many attributes commonly associated with documentaries: the medical storylines are based on real emergency cases sent by health professionals from all over America, medical consultants supervise the script-writing and filming stages, some of the actors are acquainted with real hospital procedures, the technological equipment is authentic, the Steadycam cameras are indicative of factuality (Pourroy, 1996).

ER – a socio-political drama?

While many viewers are fascinated by the medical angle of *ER*, some are also attentive to its social aspects. First, they gather socio-medical information about the organisation of health care. They compare the welfare state structures

with which they are familiar with the American privatised health market, where, apart from a few underfunded and overcrowded hospitals, public provision for those without private insurance is almost non-existent. These respondents conclude that the public-service egalitarian ethos is far superior to the no-payment-no-treatment consumerist model, which they condemn as a harmful manifestation of an overarching for-profit culture.

Secondly, because *ER* takes place in one of these rare state hospitals, it also serves as a refuge to many homeless and/or unemployed people in time of sickness or accident, and it is therefore ideally situated to reveal the flip-side of the American dream – a utopian land where all aspirations can be achieved through hard work and resilience – portrayed in some Hollywood-style serials. Some viewers praise this *non-PC approach* [Lisa], which exposes the climate of violence, of poverty, of exclusion, with which the less privileged are confronted:

We keep seeing patients who need social workers, who cannot afford care, children with bodies full of gunshots, abused children etc. It seems to me that ER is a rich and realistic portrait of American society. [Sylvia]

These viewers find such depictions of a country in chronic crisis shocking and alarming, and the underlying *laissez-faire*, profiteering and consequent lack of compassion and of support for those most in need unacceptable. These political comments reflect those made in other studies: both the Russian interviewees in Liebes and Katz's (1993) cross-cultural research on *Dallas* and the young fans of *EastEnders* (Buckingham, 1987) interpreted the shows in an ideological framework even where it was not made explicit within the programme itself.

How do ER viewers learn?

Two approaches to learning, one ludic and one emotional, are prevalent in this study. The first is the transformation of *ER* into a quiz, a detective story, whereby spectators join in the investigations and try to predict which diagnosis, test(s) and treatment(s) will be given to each patient, if possible before the screen medics:

We record it so we can stop the tape and guess the diagnosis once we know the symptoms. Some of our friends even play games to guess which tests they are going to carry out for each patient. [Elizabeth]

The second strategy is identification. *ER* fans identify particularly with medical students because of the affinity of a (perceived) common position of novice:

The student is the beginner prototype, to whom everything happens, who is ignored or patronised, but who evolves. I really like him. He resembles the spectator. [Jean-Paul]

We see the ward through the student's eyes. [Laurent]

Viewers empathise with the ups and downs of students' training, sharing their joy when they succeed and their sadness when they fail or make mistakes. These future medics become the 'open sesame' which unlocks the doors of the strange hospital universe to viewers, which enables them to discover the intricacies of the casualty department and to engage in a virtual course in emergency medicine. This corroborates previous evidence that 'emotional' tactics foster learning (e.g. Brown and Basil, 1995; Poole-Hayward, 1997).

Thus informants re-generate an entertainment programme as a quasi-factual broadcast from which they extract information through sentimental or playful tactics. Being in apparently incompatible viewing modes – cognitive/emotional, distant/close, critical/involved – echoes both the 'edutainment' trend and the 'travelling' or 'growing' theories of learning which juxtapose 'desk' and 'couch' metaphors (involved concentrated viewers and relaxed easy-going viewers) (MacMahon, 1997, pp. 88–91), and where the objectives of the broadcast are to entice viewers into exploring a topic (Meyer, 1997). *ER* certainly is inspiring:

ER makes me feel like finding out more. I'd like a doctor to comment on the gestures and the words. [Carol]

My daughter has just started studying medicine partly because of the series and she is not the only one [Eileen].

While 'top-down' transfer of knowledge (intentional or otherwise) does occur in *ER*, its audiences are by no means the proverbial blank slates waiting to be injected with information, but media-literate, analytical spectators evaluating programmes in the light of their considerable pre-existing knowledge and experiences. This resonates with health promotion campaigns using melodramatic serials in developing countries, whose efficacy was largely due to the acknowledgement not that viewers are sponges ready to unthinkingly absorb all television images, but that they are simultaneously serious and playful, sentimental and critical, detached and involved, educating and enjoying themselves. It is by enabling individuals to empathise with characters, to assess the pros and cons of various solutions, to discuss the questions raised in the narratives with friends and families, that advice seems to be best disseminated (see Davin, 2000), rather

than through information-processing approaches where direct influence is inferred between message and behaviour (e.g., being made aware that their actions are potentially dangerous should lead rational receptors to modify their conduct).

The transformation of *ER* into a reservoir of medical information is of particular importance since it is known, first, that medical subjects top the public's list of interests (Wellcome Trust, 2000), and secondly, that television has long been a prime source of medical information (e.g. Karpf, 1988; Kitzinger, 1998). By their very content, medical dramas are therefore likely to play a key role in this search for knowledge; all the more so since, when consulted, viewers have repeatedly articulated their preference for hybrid broadcasts which amuse them while addressing their problems (e.g. Elkamel, 1995). When the radio soap *The Archers* was created in 1950 to disseminate agricultural advice, the format was chosen by the farming community (Kingsley, 1988). More recently, adolescents have requested that safe-sex issues be included in soap operas (BAC, 1999). Furthermore, in a study on the reception of parallel illness storylines in fictional and factual programmes, interviewees, in a somewhat counter-intuitive fashion, expressed scepticism about documentaries, which they criticised for being selective, incomplete and artificial, and contended that continuous serials are a better support for the communication of (medical) data because they have massive followings, their multiple plots render distressing narratives less upsetting, they promote identification and they allow repetition (Davin, 2003).

Realism(s)

Viewers give a number of reasons for trusting the data imparted by *ER*. Some have read (p)reviews in magazines and newspapers praising its authenticity or have heard about it from friends or acquaintances involved in health care. But the most widespread argument is the realistic quality ascribed to the *ER* images and storylines, which is mentioned in almost all letters. Informants make 'referential statements' (in Liebes and Katz's (1993) terms): they connect fictional situations and/or characters to real life:

I have been to casualty and it reminds me of the atmosphere and the gestures so typical of this ward. [Jane]

In Benton's lack of realism about his mother and his verbal violence I can see my own father and my grandmother. [Sue]

But respondents' conceptions of realism go well beyond basic dichotomies whereby television mirrors reality (with varying degrees of accuracy). Just as

Hagen's (1992) informants described news bulletins as a transparent reflection of the world and yet as fabricated, and in spite of their repeated affirmations that *ER* does *show what really happens in casualty*, viewers are, like Pasquier's (1999) adolescents, well acquainted with the 'manufactured' aspect of television and cite many factors likely to raise or to detract from the impression of realism. The Steadycam cameras, which have long been associated with *cinéma-vérité*, enhance realism because *they move around a lot as if the viewer IS the camera looking all over the place. It makes it look very real* [Didier]. Conversely, actors' outside commitments may hinder realism. As one person asks:

In episode one, Susan meets a psychiatrist who vanishes. Did the actor have a contract somewhere else? [Janine]

Financial constraints and the quest for ratings may also compromise realism. The first can lead to the numerous romances between characters being mostly confined to the group of medics (*this way, they have fewer actors to pay* [Monica]). The second compels producers to maximise audiences, even if realism suffers in the process:

The medicine is fairly real but not to the point of putting people off. [Liz]

Most of the cast are good-looking, which is not the case in hospitals. But I know that they have to do this so that more people will watch. [Anna]

This viewer is not alone in perceiving the characters as better looking than average:

Most characters are attractive and slim, not as in a normal hospital. [Dorothy]

But when informants write about this subject, antagonistic criteria begin to appear as some perceive the characters as 'deglamourised':

The actors are not all cute with lots of make up, they are just everyday people. [Justin]

They are not all good-looking as in some other American series. [Didier]

This is in line with the remit of casting officers and make-up artists to have plain, tired, sickly-looking characters to match the hospital setting:

ER takes place in Chicago, which is filled with people who have come from all over the world, who are too tall and too short, too fat and too thin – and who look like hell because they are sick. Or feel like hell because somebody they care about is sick. None of us are at our stylish best when we're in *ER*. That's not the story we are after. (Casting director John Levey, quoted in Pourroy, 1996, p. 42)

Equally controversial is the question of the speed at which the patients are brought in, assessed and treated, which is taken, on the one hand, as evidence of realism:

Everything is done at breakneck speed just as in my everyday work. Everything happens so fast. [Janet, nurse]

and, on the other, as a mark of unrealism:

In the hospital I know there is no such speed. [Camilla]

Speed is a fundamental and recurrent feature of *ER* and essential to its sense of urgency and excitement, as is the endless cortège of seriously injured patients arriving on the ward, and respondents are very aware of these implausibilities. Yet they discount them and persist in asserting that *ER* is very realistic, because they are fully *au courant* that such excesses are neither accidental nor due to mistakes, sloppiness or deception, but deliberately included in the scenario to heighten the tension that a quality drama requires:

A series needs drama hence everything happens in the same place. [Maria]

Although it is rare for a casualty to have so many disasters, the fiction requires it! [Andrew]

Gibbs (a physician) and Ross (1996), in their book on *ER* and its medicine, concur that most of the unrealistic details which they spotted in the episodes – students never going to the library, residents being on call on the ward rather than at home, etc. – are explainable by the imperatives of dramatic stimulation. The *ER* script-writers do not deny that realism occasionally has to be sacrificed to the demands of drama: 'From the beginning we decided to take liberties when necessary. We knew there would be times when scenes would not depict exactly the way emergency medicine is practised. But *ER* is a dramatic show . . .' (medical consultant Dr Gentile, quoted in Pourroy, 1996, p. 26).⁹

Moreover, *ER* is not exempt from minor medical errors, and manifestations of this ‘approximate realism’, often expressed in ‘it’s realistic but...’ formulas, are most frequent in the replies of physicians, who are in a good position to detect them:

The medical terms ring true, and it shows the problems of being an intern, but there are too many intubations and reanimations which work. It shows electric shocks as miraculous, which is far from being true. [Catherine, gynaecologist]

There is a good medical realism except that the reanimation scenes are shortened too much, and the doctor who goes out of the reanimation room, removes his gown and simply gets on with something else is not very realistic. [Jerry, GP]

Other informants, however, are not concerned with technical or medical minutiae and concentrate instead on blanket links to reality:

It is real, the decoration, the people waiting, running all over the place, worrying. It is real in its facts, that is, the person arrives, she has a problem; this follows real life. Outside too, things are real, like they take the tube. [Tony]

That evaluation of realism happens at various levels and is exemplified by the following quotes about the episode ‘Love’s Labour Lost’, with its string of mistakes and difficulties leading to the death of a young patient. At the micro-level, the intern *would not have made such basic errors of judgement, having delivered a couple of hundred babies* [Charlotte]. But, in a more general way, ‘Love’s Labour Lost’ *put things back in place, things are not always great* [Lucy].

Not only can viewers disagree on whether a particular item reinforces or decreases realism, as seen above, but when they do agree, this consensus sometimes conceals underlying discrepancies. Thus there is no doubt in many respondents’ minds that the medical jargon which peppers *ER* is realistic. For some, failing to understand this vernacular is a guarantee of realism:

The universe of the hospital is well represented with its language which is incomprehensible to outsiders. [Lisa]

The medical jargon makes the situations more real. I mean, how many times have you been to the doctor’s or to the hospital and not known what on earth they are talking about! [Helen]

This is what the *ER* executive producer hoped to achieve. He claims that unlike other dramas, where

you hear characters saying a lot of ridiculous things like ‘it’s time to do the laparotomy! Joe get that tube so we can see if there’s blood in his stomach!’ when, clearly, everybody in the scene would know what a laparotomy was . . . [w]e allowed the audience to feel as if they’d stepped into a real hospital. (John Wells, quoted in Pourroy, 1996, p. 18)

But, again, their efforts are not entirely successful and some viewers (outside health professionals) do understand the medical expressions and take this as a proof of realism:

The doctors talk in such a way that the patients understand, so we can understand as well.
[Michelle]

I think that what makes it realistic is the expressions, the use of medical terms. It gives an impression of competence. And some of them we already know so we know they are real.
[Robert]

The complexities of respondents’ notions of realism are perhaps best illustrated by their constant to-and-fro oscillations when they write about the American-ness of *ER*. The origins of the show are sometimes foregrounded when, as above, the US and UK health care systems are contrasted. For example, some informants point out that many non-urgent patients would not be in casualty in the UK because they would have attended their local GP surgery instead. In this sense, *ER* is ‘their’ reality, that is, *it is reality made in the US, it is different from here* [Jonathan]. Nevertheless, for some, *ER* may be a worrying preview of the future as ‘their’ reality threatens to become ‘ours’, and the serial thus has a potentially realist dimension: they fear that a US-style two-tier medical system may be implemented in their own country and that the social problems which plague America may soon reach their shores. Likewise, some young viewers of news bulletins read images of violence in the United States as a warning of what may happen in Britain, and voice their unease about the growth of crime through comparisons with the US: ‘“We are just going to be like New York” [or] “I feel lucky that I don’t live in America”’ (Buckingham, 1997, p. 195).

On the other hand, *ER*’s made-in-America label contributes to its realism, first, because medical experts supervise the making of the show while, as a number of viewers complain, *many of our programmes lack medical advisers*, and secondly, because American broadcasts are believed to be less censored than European ones

and to have more latitude to handle issues which may be avoided or inadequately covered on their side of the Atlantic:¹⁰

I never know why British audiences have to be protected from all unpleasantness, it makes the programmes so bland. . . . Why is UK entertainment sanitized to the extent that they [sic] fail to grasp the imagination? [Moira]

The American-ness of *ER*, then, manifests itself in idiosyncrasies, which lower realism but which give rise to a potentially closer realism, and an added veracity and openness which enhance it. At other times the foreign roots of the serial disappear altogether behind the (perceived) universality of biomedicine, of emergency procedures and of high technology. The casualty department, which in the previous discourse was typically American, remote, different, now becomes one of many identical casualty wards, a global, familiar, realistic location:

Everything seems true, it is universal. We are in America and the equipment is new but it is in all the ERs in the world. [Gwen]

We saw how viewers sometimes establish parallels between *ER* and their lives. But they also assess realism by contrasting the elements of different broadcasts:

The pace of Casualty is so slow and unreal compared to ER. [Julia].

Moreover, fictional programmes may be a reference point to which factual ones are compared. Thus *ER* can be taken as the blueprint for the documentary *The Real ER*, filmed at County Cook Hospital in Chicago and believed to be the model for *ER*:

The Real ER is the same hospital as ER. The real doctors resemble the ER doctors. [Jean]

If I did not know that The Real ER is a documentary I would think that it is another ER. The characters look like ER characters. At the beginning, it's Dr Greene, and the nurse could be Carol. [Avril]

The juxtaposition of programmes can be so ambiguous that the inside and the outside, critical distance and suspension of disbelief, reality and television are inextricable:

In Chicago Hope, I did not get the impression that they were concerned. They were in a film, while in ER you feel that they are real doctors, because they are on call, they get woken up, they are constantly in this milieu, facing all sorts of problems, and we feel that we are in a hospital when it is a series. [Carol]

Such overlaps and reversals are only to be expected since much of our *savoir*, our knowledge, is, has always been, in some way, mediated, derived not from direct acquaintance with facts or with events but from hearsay, from friends, from books, from magazines, from newspapers, from the radio, from films, from television, from CDs, from the internet (or, in days gone by, from posters or from the town crier), particularly when the subject matter is outside the daily routine of most people, as Gerbner and Gross (1976, p. 179) underline:

How many of us have ever been in an operating room (awake), a criminal courtroom, a police station, jail, penthouse, corporate boardroom, movie studio, or other staples of television locales? Yet how much do we ‘know’ about such places, about what goes on in them, about the people who live and work in them? How much, indeed, of our images of the real world has been learned from fictional worlds?

We live in a ‘pseudo-environment’, as Lippman wrote as early as 1921, and we learn about real life from fiction:

In my family everybody watches. They are delighted to have an insight into what I do. [Jude, nurse]

Thanks to fiction, we can go in the parts of the hospital which are prohibited to the public and to families, operating theatres and others. [Brian]

Thus reality can be interpreted through the media: patients’ expectations of (and disappointments about) their therapy were partly based on media representations (O’Keefe, 1999) and one of Seiter’s (1994, p. 390) interviewees described his malaise by recollecting a favourite drama: ‘I was rushed to hospital in an emergency. So then all the General Hospital things that went on, that I had seen, sort of become real to me. I could not believe that I was in hospital playing the part of a very sick man.’

Sometimes the media can be more potent, more compelling – more real – than experience, and it is on the screen that events are ‘real-ised’ (see Fiske, 1995): some of Philo’s (1996) informants trusted media information on mental illness over their own experience. In *The Cosby Show*, Clare Huxtable as a lawyer and the Cosby family as ‘middle-class’ were deemed more representative than those met by

viewers in real life (Press, 1991, pp. 110–11). For Woolley (1993, p. 195), who was at the site of the Clapham rail accident, it was nevertheless on the screen that ‘the event happened’; his own experience had a ‘lower meaning’. Along similar lines, a police officer changed his testimony in the ‘Rodney King trial’ after seeing a videotape to which he too attributed a ‘higher truth’ than he accorded to his experience (Fiske, 1995, p. 130). And some spectators seem puzzled when reality fails to match fiction, as one informant ponders:

People say to my wife [a nurse]: Why don't you wear a green jacket? Why is your husband an engineer and not a doctor as on television? [Timothy]

Television, then, is not the legendary window on the world. In our intertextual postmodern world, the line which separates television from reality is no longer clear-cut. The two endlessly deconstruct, construct, reconstruct themselves and each other. Viewers compare television to reality, programme to programme, reality to television. Attempting to disentangle them is a thankless (and pointless) task because

The media do not impart a slice of reality. . . . Reality consists of that which has been mediated both by the media and by other things, and is constantly constructed anew. The content of television radiates out into the rest of reality, which therefore cannot be separated from it. (Bausinger, 1984, p. 350)

It is ‘the dissolution of TV into life, of life into TV . . . a sort of fantastic telescoping, of collapsing of one into the other of two traditional poles . . . implosion’ (Baudrillard, 1981, pp. 54–5).

Attempting to evaluate programmes unambiguously as un/realistic is therefore over-simplistic. In informants’ letters, form and content interact, contradictions and ambiguities abound, television and life are intertwined, and *ER* remains realistic regardless of errors, of implausibilities, of excesses, of artificiality, of American hallmarks:

We really feel as if we were in the hospital with its disorder, its fauna. In short, we believe it.
[Carol]

This suggests that it may be fruitful to replace the reel/real dichotomy by a continuum which can accommodate degrees and levels of realism, overlaps, incongruities, approximations, antagonisms, ambivalence, conflicting perceptions and criteria, etc. Understanding audiences’ notions of realism is important not solely for media studies but also for health promotion because realism is a crucial

requirement for people's willingness to accept advice and to take it on board (Elkamel, 1995).

Health and illness identities

Audiences who are capable of reading television in such an intricate and fluctuating fashion cannot be divided *a priori* into pre-set groups, cannot be expected to produce bounded, distinctive interpretations according to the category to which they have been ascribed, a not uncommon approach in media studies (and in other social sciences disciplines). In his seminal Nationwide Study, for example, Morley (1980) endeavoured to establish links between subjects' socio-economic levels and interpretations. Instead he found that 'social position in no way directly correlates with decodings' (Morley, 1980, p. 137)¹¹ and he later suggested that we should

try and reinstate the notion of persons actively engaged in cultural practice. To put the point another way, one cannot conclude from a person's class, race, gender, sexual orientation and so on, how she or he will read a given text... [because] the same man may be simultaneously a productive worker, a trade union member, a supporter of the social Democratic Party, a consumer, a racist, a home owner, a wife beater and a Christian. (Morley, 1991, p. 43)

While Morley's stance befits the multiple subjectivities of the postmodern 'screenager',¹² a conspicuously missing component in his list is health and illness identities. Health and illness are fundamental identity segments (Crawford, 1994), and, although they are usually taken for granted and have therefore remained invisible (partly because they have been obscured by the academic focus on some of the sociological variables mentioned by Morley, such as gender, class, ethnicity), they are likely to contribute to the shaping of interpretations, especially when programmes include medical themes.

Health and sickness, however, are not a straightforward matter of biology, whereby each disorder can be explained by a particular underlying pathology, but fluid concepts created at the interface of the material and social/cultural realms. Accordingly, they have a range of meanings. Health, for instance, has been equated to an absence of illness, to a reserve of health, to self-care, to vitality, to equilibrium, to mental well-being, to the ability to carry out everyday tasks. Moreover, the line between health and sickness is hazy: countless people are suspended in a limbo state, in between health and ill health, by recurring but benign aches and pains; some ailments are 'normal', healthy even (children's diseases, colds), and even a serious condition need not prevent patients from describing themselves as being in good health (e.g. Robinson, 1971). Likewise, illness has a variety of

meanings, from destructive to liberating; recovery can be of minimal concern or it can monopolise patients' time and efforts and develop into a new way of life.¹³

Any alteration of health status can engender anxiety and an erratic sense of identity. Sickness, especially if it is life-threatening, chronic or disabling, profoundly affects our self-consciousness and our world-view, as Duff (1994, pp. 9–11), who has Chronic Fatigue Syndrome, vividly describes:

I find it difficult to reconcile the contrary visions of health and illness, or even hold them in my mind at the same time. They slip away from each other, like oil and water. . . . There is, perhaps rightly so, an invisible rope that separates the sick from the well, so that each is repelled by the other, like magnets reversed. The well venture forth to accomplish great deeds in the world, while the sick turn back onto themselves and commune with the dead; neither can face the other very comfortably, without intrusions of envy, resentment, fear or horror. Frankly, from the viewpoint of illness, healthy people seem ridiculous, even a touch dangerous, in their blinded busyness, marching like soldiers to the drumbeat of duty and desire.

The removal of this invisible rope was one of the objectives of some early medical documentaries, whose producers hoped that their programmes might help lower the 'barrier which too often isolate healthy people . . . from the sick' (Barrère, Desgraupes and Lalou, 1976, pp. 94).

A particular disease, however, need not give rise to a unique, immutable identity segment. Any disorder can create a number of identities in sufferers (and in non-sufferers, see below), as shown, in the case of asthma, by Adams, Pill and Jones (1997),¹⁴ who uncovered different relations to the illness: 'accepters' acknowledge asthma as part of their lives, 'deniers' develop strategies to hide it, and a few redefine their asthma as acute rather than chronic. To all these patients several sickness subjectivities are available, and these may guide interpretations of (medical) narratives in varied ways: an asthmatic viewer may not interpret an episode – especially if it features asthma – as would non-asthmatics, but an 'accepter' may produce different readings from those of a 'denier'. Furthermore, conceptions of asthma fluctuate across time and place (Gabbay, 1982) (as is the case for many diseases, whose changing constructions are well documented in the medical humanities), and illness identities would fluctuate accordingly. It is also important to note that such identities have no necessary link to biology or to diagnosis, and are not the prerogative of patients. In the previously mentioned study of fictional and factual sickness narratives, it emerged that a number of healthy respondents had incorporated an illness segment in their otherwise healthy identities after prolonged contact with seriously ill relatives or friends, and that many of their

responses differed markedly from those of viewers who had had little or no contact with disease.

Incidental findings show that sickness identities can affect interpretations and viewing practices. For example, the respondents in Cumberbatch and Negrine's study (1992) read media texts according to their illness experience. A woman who had had breast reduction read the *Roseanne* episode dealing with the subject in a more critical way than did others (Crowther, 1998). Tulloch's (1990) older informants watched the Australian 'medical soap opera' *A Country Practice* because they found its medical items relevant and were eager to find out more. Experience of ill health can also make viewers hesitate before watching:

I watch sometimes, but with moderation. The reason is simple: after a few 'minor life accidents' (car crash, beginning of cancer), I ended up in hospital several times. I know hospitals well enough and it is not a pleasure I enjoy when I want to escape in front of the screen. [Eric]

Such memories can have a lasting impact: a couple disapprove of the use of ill health for entertainment because of their daughter's lengthy stay in hospital over twenty years previously. However, the impact can be mitigated by other identities, as suggested by this college pupil, who explains how the same accident led to different responses to *ER*:

My friend had an operation for her foot and since that she has stopped watching. She said that it was so horrible that she does not feel like watching anymore. I too had surgery on my foot but it made no difference! I too broke my foot at Christmas, but maybe I still like ER because I want to work in a hospital setting and she does not. [Nadia]

Furthermore, curiosity can overcome caution:

The medical milieu is not really 'my thing' because it reminds me of bad childhood memories. But I said to myself: 'don't stay ignorant, watch' and I watch. [Sue]

And *ER* can have 'medicinal' qualities which counterbalance disturbing recollections:

I was myself admitted to A&E several times. Before ER I could never watch medical programmes where you are shown operations (blood, flesh...). This series helps me not to feel concerned by the physicians' aggressive gestures. [Jill]

Health and illness identities, then, are flexible and dynamic. They intersect and interact with other identities¹⁵ and colour interpretations in multiple ways. Reciprocally, they may be shaped by television representations.¹⁶ These processes need further scholarly attention.

Conclusion

The skills and intelligence of television viewers have too often been underestimated in media studies. Time and time again research agendas have assumed, more or less explicitly, a one-way linear model of communication which reduces reception to the regurgitation of fixed narratives transmitted by an omnipotent media to a naive, gullible public with little agency (e.g. the viewer-in-the-text, information-processing etc.) – a mere referendum, complains Barthes (1970, p. 10). But there exists no necessary correspondence between sent and received messages. Meaning is not inscribed ‘in the text’ but generated in the encounter between contingent texts and nomadic viewers. Recent qualitative reception studies (Baudin, 2001; Buckingham, 1997; Hill, 1999; Pasquier, 1999; Turnock, 2000) illustrate that real audiences are media-literate, insightful, astute, that they read, reread, modify, extend, analyse, assess, play with, learn from, and variously use broadcasts in unexpected, sometimes idiosyncratic, possibly contradictory ways according to their frames of reference, to their moods, to their situation, to their dominant identities, at a given moment.

The sophistication of viewers is manifest in this study, where they re-gendre a popular entertainment show as a reliable (medical, social, political) pedagogic broadcast – a documentary – and collect data from the episodes through sentimental or recreational tactics of identification or game-playing. They trust this information largely because they consider *ER* to be realistic – despite conflicting viewpoints, despite dissent on which elements heighten or reduce this sense of reality and why, despite unconvincing excesses and implausible details, despite its American roots, which may be highlighted or disregarded. Their evaluations rest not merely on their own *vécu*, their lived experience, but on their substantial knowledge of production practices, on friends’ opinions, on the written press and on other programmes, as the media and real life increasingly overlap and merge into a transtextual, global hyper-reality. In spite of its limitations, this research demonstrates that viewers are neither cultural dopes nor witless dupes, that they do not resemble traditional caricatures of innocent simpletons, that their multiple subjectivities – including health and illness identities – promote complex contextual readings. More attention needs to be given to the reception of (medical) broadcasts, with or without pedagogic ambitions, if the elaborate information-gathering and meaning-making processes viewers engage in are to be fully

comprehended. This calls for more qualitative audience research and for theories grounded in their findings.

NOTES

1. The project began as a cross-cultural study of British and French viewers. The rationale was less national differences *per se* than the disparity in the number of, and enthusiasm for, medical dramas between the two countries. However, no cross-cultural difference emerged at analysis (see my article at <http://wjfms.ncl.ac.uk/ER.htm>). For full details of the study, see Davin (forthcoming, 2004).
2. This openness can be seen in the fact that six detractors of *ER* replied.
3. Almost a third of the respondents were men, who answered mostly by email. Some stated that it was the technology which had enticed them to do so. This indicates that men do watch broadcasts with an allegedly 'feminine' content – romance, health, illness – and that they may come forward given appropriate means and incentives.
4. 'Interpretation' is used here in its largest sense – as including denotation, connotation and evaluation (see Palmer, 1995, chapter 3).
5. Another reason for the diversity of interpretations is that texts have many blanks (without which television would be impossible), which viewers who are knowledgeable about media grammar, routinely fill in (for instance, unless this is part of the plot, characters are not usually shown going from one place to the next, yet the public know that some travel has occurred) (see Iser, 1995).
6. It would, however, be hasty to conclude that all medical dramas are equal: one informant trusts *Peak Practice* more than *Casualty*, another is more confident if a helpline number is given at the end of the broadcast (Davin, 1999). In terms of health promotion, such questions have to be attended to at the formative research stage.
7. Soap operas have an ambivalent status. They started on American radio in the 1930s, sponsored by domestic cleaning products manufacturers eager to target housewives (hence their name). Replete with sentimental and familial storylines, they earned a reputation of being 'women's programmes', of triviality. In Britain soaps were part of the public service ethos and as such had a duty to inform and educate as well as to entertain (see Anger, 1999; Buckman, 1999). Nevertheless, the stigma endures: *I despise Casualty because it is a soap and not a medical drama* [Helen].

8. Two meanings of 'information' need to be distinguished: 'pedagogic' ('learning that') and 'instrumental' ('learning how to'). Whether television is an adequate medium through which to 'learn how to' do first-aid, for example, is a moot point (anecdotal reports of deaths following attempts at resuscitation 'as shown on television' have appeared in newspapers).
9. This jars with the previously mentioned concern for medical authenticity. The *ER* production team constantly oscillated between the requirements of 'authenticity' and of 'drama' (Pourroy, 1996), although the medicine *per se* seems to have remained, on the whole, accurate (notwithstanding minor details).
10. Most UK medical dramas employ medical advisers, and early ones were overseen by medical associations (Karpf, 1988). Some topics are heavily censored on American networks (see Kingsley, 1990).
11. For other examples of pre-set groups collapsing at analysis, see Schlesinger et al. (1992), Dahlgren (1986), Corner, Richardson and Fenton (1990).
12. Machin and Carrithers (1996) and Liebes (1997), amongst others, show how different identity segments come into play according to the situation and contribute to different interpretations.
13. A large and fascinating body of work on the meanings of health and illness is available in the anthropology and sociology of medicine (see, for example, Calnan, 1987; Blaxter, 1990; Herzlich, 1973).
14. For other examples, see Smith, Flowers and Osborn (1997) on arthritis, Cain (1991) on alcoholism, BSC (1997) on disability.
15. Other identities are known to play a role in (interpretations of) health and illness: e.g. gender (Cornwell, 1984; Saltonstall, 1993), age (Quadrel et al., 1993), class (d'Houtaud and Field, 1984).
16. On the role of television in identity construction, see Buckingham (2000), Fisherkeller (1999), and Steele and Brown (1995).

REFERENCES

- Adams, S., Pill, R. and Jones, A., 'Medication, Chronic Illness and Identity', *Social Science and Medicine*, 45:2 (1997), pp. 189–201.
- Ang, I., *Watching Dallas* (London: Routledge, 1991).
- Anger, D., *Other Worlds* (Toronto: Broadview, 1999).
- BAC (Brooks Advisory Centre), 'When you meet someone you really like, you don't think of AIDS...' (London: BAC, 1999).

- Barrère, I., Desgraupes, P. and Lalou, E., *En direct de la médecine* (Paris: Stock, 1976).
- Barthes, R., *S/Z* (Paris: Éditions du Seuil, 1970).
- Baudin, R., 'Le Phénomène de la série culte en contexte soviétique et post-soviétique', *Cahiers du monde russe*, 42:1 (2001), pp. 49–70.
- Baudrillard, J., *Simulacres et simulation* (Paris: Gallimard, 1981).
- Bausinger, H., 'Media Technology and Daily Life', *Media, Culture and Society*, 6 (1984), pp. 343–51.
- Blaxter, M., *Health and Lifestyles* (London: Tavistock, 1990).
- Brown, W. J. and Basil, M. D., 'Media Celebrities and Public Health', *Health Communication*, 7:4 (1995), pp. 345–70.
- BSC (Broadcasting Standards Council), 'The Disabled Audience: a Television Survey', in A. Pointon and C. Davies (eds), *Framed – Interrogating Disability in the Media* (London: British Film Institute, 1997).
- Buckingham, D., *Public Secrets* (London: British Film Institute, 1987).
- Buckingham, D., *Moving Images* (Manchester: Manchester University Press, 1997).
- Buckingham, D., *After the Death of Childhood* (Manchester: Manchester University Press, 2000).
- Buckman, P., *All for Love* (London: Secker & Warburg, 1984).
- Cain, C., 'Personal Stories: Identity Acquisition and Self-Understanding in Alcoholics Anonymous', *Ethos*, 19 (1991), pp. 210–50.
- Calnan, M., *Health and Illness: The Lay Perspective* (London: Tavistock, 1987).
- Cassata, M. B., 'The Soap Opera', in B. G. Rose (ed.), *Television Genres* (London: Greenwood Press, 1985).
- Corner, J., Richardson, K. and Fenton, N., *Nuclear Reactions* (London: John Libbey, 1990).
- Cornwell, J., *Hard-Earned Lives* (London: Tavistock, 1984).
- Crawford, R., 'The Boundaries of the Self and the Unhealthy Other', *Social Science and Medicine*, 38:10 (1994), pp. 1347–65.
- Crowther, B., 'Comedy, the Breast and the Knife', in N. Moody and J. Hallam (eds), *Medical Fictions* (Liverpool: John Moores University Press, 1998).
- Cull, N. J., 'Bigger on the Inside...: Dr Who as British Cultural History', in G. Roberts and P. M. Taylor (eds), *The Historian, Television and Television History* (Luton: University of Luton Press, 2001).
- Cumberbatch, G. and Negrine, R., *Images of Disability on Television* (London: Routledge, 1992).
- Dahlgren, P., 'The Modes of Reception', in P. Drummond and R. Paterson (eds), *Television in Transition* (London: British Film Institute, 1986).

- Davin, S., *Casualty: Reception Study of a Medical Drama* (London: Le Drac, 1999).
- Davin, S., 'Medical Dramas as Health Promotion Resource – an Exploratory Study', *International Journal of Health Promotion and Education*, 38:3 (2000), pp. 109–12.
- Davin, S., 'Healthy Viewing: the Reception of Three Medical Narratives', in C. Seale (ed.), *Media and Health: Ninth Monograph of the Sociology of Health and Illness Journal* (Oxford: Blackwell, 2003).
- Davin, S., *Urgences: Les Spectateurs* (Paris: L'Harmattan, 2004).
- Deacon, D., Pickering, M., Golding, P. and Murdock, G., *Researching Communications* (London: Edward Arnold, 1999).
- d'Houtaud, A. and Field, M. G., 'The Image of Health', *Sociology of Health and Illness*, 6 (1984), pp. 30–53.
- Duff, K., *The Alchemy of Illness* (London: Virago, 1994).
- Elkamel, F., 'The Use of Television Series in Health Education', *Health Education Research*, 10:2 (1995), pp. 225–32.
- FisherKeller, J., 'Learning about Power and Success: Young Urban Adolescents Interpret Television Culture', *The Communication Review*, 3:3 (1999), pp. 187–212.
- Fiske, J., *Media Matters* (Minneapolis: University of Minneapolis Press, 1995).
- Gabbay, J., 'Asthma Attacked?' in P. Wright and A. Treacher (eds), *The Problem of Medical Knowledge* (Edinburgh: Edinburgh University Press, 1982).
- Gerbner, G. and Gross, L., 'Living with Television: the Violence Profile', *Journal of Communication*, 26:2 (1976), pp. 173–99.
- Gibbs, H. and Ross, A. D., *The Medicine of ER* (London: HarperCollins, 1996).
- Gottlieb, V., 'Brookside', in G. W. Brandt (ed.), *British Television Drama in the 1980s* (Cambridge: Cambridge University Press, 1993).
- Hagen, I., *News Viewing Ideals and Everyday Practices* (Bergen: University of Bergen, 1992).
- Herzlich, C., *Health and Illness* (London: Academic Press, 1973).
- Hill, A., *Shocking Entertainment* (Luton: University of Luton Press, 1999).
- Hobson, D., *Crossroads* (London: Methuen, 1982).
- Iser, W., 'Interaction between Text and Reader', in A. Bennett (ed.), *Readers and Reading* (London: Longman, 1995).
- Karpf, A., *Doctoring the Media* (London: Routledge, 1988).
- KFF (Kaiser Family Foundation), 'Documenting the Power of Television – a Survey of Regular ER Viewers', at www.kff.org/content/archive/1358/ers.html (1997).
- Kingsley, H., *Soap Box* (London: Macmillan, 1988).
- Kingsley, H., *Prisoner Cell Block H* (London: Boxtree, 1990).
- Kingsley, H., *Casualty* (London: BBC/Penguin, 1995).

- Kitzinger, J., 'Resisting the Message', in D. Miller, J. Kitzinger, K. Williams and P. Beharell (eds), *The Circuit of Mass Communication* (London: Sage, 1998).
- Liebes, T., *Reporting the Arab-Israeli Conflict* (London: Routledge, 1997).
- Liebes, T. and Katz, E., *The Export of Meaning* (London: Polity, 1993).
- Lippman, W., *Public Opinion* (New York: Free Press, 1921-97).
- Machin, D. and Carrithers, M., 'From "interpretive communities" to "communities of improvisation"', *Media, Culture and Society*, 18 (1996), pp. 343-52.
- MacMahon, J., 'Imaginary Learners', in M. Meyer (ed.), *Educational Television* (Luton: John Libbey, 1997).
- Meyer, M., 'Introduction', in M. Meyer (ed.), *Educational Television* (Luton: John Libbey, 1997).
- Morley, D., *The Nationwide Audience* (London: British Film Institute, 1980).
- O'Keefe, I., "'It's not like Frasier": Service Users' Experiences of NHS Therapy', *Journal of Contemporary Health*, 8 (1999), pp. 49-54.
- Palmer, J., *Potboilers* (London: Routledge, 1995).
- Pasquier, D., *La Culture des sentiments* (Paris: Maison des Sciences de l'Homme, 1999).
- Philo, G., *Media and Mental Distress* (London: Routledge, 1996).
- Poole-Hayward, J., *Consuming Pleasures* (Lexington: University Press of Kentucky, 1997).
- Pourroy, J., *Behind the Scenes at ER* (London: Ebury Press, 1996).
- Press, A. L., 'Class, Gender and the Female Viewer', in M. E. Brown (ed.), *Television and Women's Culture* (London: Sage, 1991).
- Quadrel, M. J., Fischhoff, B. and Davies, W., 'Adolescent (In)vulnerability', *American Psychologist*, 48:2 (1993), pp. 102-16.
- Rapp, R., 'Chromosomes and Communication', *Medical Anthropology Quarterly*, 2:2 (1988), pp. 143-54.
- Robinson, D., *The Process of Becoming Ill* (London: Routledge, 1971).
- Rogers, D. D., 'Daze of Our Lives', in G. Dines and J. M. Hunez (eds), *Gender, Race and Class in the Media* (London: Sage, 1995).
- Saltonstall, R., 'Healthy Bodies, Social Bodies: Men's and Women's Concepts and Practices of Health in Everyday Life', *Social Science and Medicine*, 36:1 (1993), pp. 7-14.
- Schlesinger, P., Dobash, R. E., Dobash, R. P. and Weaver, C. K., *Women Viewing Violence* (London: British Film Institute, 1992).
- Seiter, E., 'Making Distinctions in Television Audience Research', in H. Newcomb (ed.), *Television: The Critical View* (Oxford: Oxford University Press, 1994).
- Singhal, A. and Rogers, E. M., *Entertainment-Education* (Mahwah, NJ: Erlbaum, 1999).

- Smith, J. A., Flowers, P. and Osborn, M., 'Interpretative Phenomenology Analysis and the Psychology of Health and Illness', in L. Yardley (ed.), *Material Discourses of Health and Illness* (London: Routledge, 1997).
- Steele, J. R. and Brown, J. D., 'Adolescent Room Culture', *Journal of Youth and Adolescence*, 24:5 (1995), pp. 551–76.
- Strauss, A. L. and Corbin, J., *Basics of Qualitative Research* (London: Sage, 1990).
- Tulloch, J., *Television Drama* (London: Routledge, 1990).
- Turnock, R., *Interpreting Diana* (London: British Film Institute, 2000).
- Wellcome Trust, 'A Review of Science Communication and Public Attitudes to Science in Britain', at www.wellcome.ac.uk/en/1/mismiscnepubpat.html (2000).
- Woolley, B., *Virtual Worlds* (Oxford: Blackwell, 1993).

Index

Page references in *italics* refer to figures and tables

- Abercrombie, N. and Longhurst, B., 76–7
active patient, 157–8, 162
Adam, B., 120, 128, 129
Adams, S. *et al.*, 38
ADHD, 111
Adorno, 17
AIDS *see* HIV/AIDS
aksësis, 160
All my Children, 26
Allan, A., 119–20
Ang, I., 23, 68, 70, 82
Annie Hall, 247
Anthony, E., *Tby Rod and Staff*, 215
apotemnophilia, 184, 186, 200, 201–2
Appleyard, Bryan, 214
Archers, The, 29
Armstrong, D., 158, 166
Ars Erotica, 157, 164, 179, 180
Arthur, 247
Asians, 58
Assassin of Youth, 234
asthma, 38
audience, 270
audience reception studies, 17–20
 disability and soap opera viewing, 66–85
 and effects model, 17–18
 and *ER see ER*
 health and illness identities, 37–40
 and Malaria Radio campaign, 47–62
 skills and intelligence of television viewers, 40
 and soap operas, 68–71
 uses and gratifications model, 18
Backpacker, 210
Barker, C., 78, 81
Barnes, C., 20, 66
Barthes, R., 7, 40
Barton, Jack, 26
Baudrillard, J., 4
Bayha, Betsy, 210
Beardsworth, A. and Keil, T., 120
beat writers, 270
Beauvais, Tina, 103
Beck, U., 128, 129
Berger, P. and Luckmann, T., 90
Bhopal, R. S. and Donaldson, L. J., 48
Biasin, Gian-Paolo, 256, 257
Big Jim McClain, 240
biomedicine, 152, 153
biopower, 152
Blair, Tony, 69
blame culture, 237
‘Bobo Doll Experiment’, 18
body(ies)
 contemporary representation of, 206–7, 219
 ideologies of, 208–9
 mapping of human, 152, 153
 modification of, 200–3; *see also* transsexuality/transsexuals
 promotion of normalising, 212–13
 relationship between soul and, 208
Body Dysmorphic Disorder, 184
Boller, D., 143
Bordo, S., 212
Bourdieu, P., 5–6
 and ‘economic censorship’, 4–5
 and high/low culture, 19, 272
Braidotti, R., 209
Brandt, A. M. and Rozin, P., 227
Branston, G. and Stafford, R., 6, 18
breast cancer, 95, 107, 109, 110
Brecht, Bertolt, 133
Broadcasting Standards Commission, 59
Brookside, 26, 73–4
Broomfield, Nick, 216

- BSE (bovine spongiform encephalopathy)
 crisis, 92, 115–20
 broadsheet and tabloid reporting
 compared, 121–2
 chronology of events, 118–19
 differing perspectives in reporting of,
 120–1
 health vs wealth debate, 120, 125–6, 129
 role of media in policy making agenda,
 124–5, 129
 use of science and ‘expert’ opinion,
 126–8, 129
- Buckingham, D., 22, 25
 Bulger, Jamie, 96, 98
 Bunton, R., 162
 Bunton, R. *et al.*, 228
 Burgan, Mary, 260, 263
 Burroughs, William, 245, 270
The Naked Lunch, 241
- Calman, Dr, 120
 Camus, Albert, *The Plague*, 254
- cancer
 breast, 95, 107, 109, 110
 and children *see* childhood cancer
- Cardinal, Marie, *The Words to Say It*, 257
 Castel, L., 162
 Castells, M., 137
Casualty, 22, 25, 26, 34
 category-bound activities (CBAs), 100
 censorship, 270
 Centre for Contemporary Cultural Studies
 (Birmingham), 11, 12, 18, 117
 chat shows, 19, 229
Chicago Hope, 35
 child abuse, 95, 96
 ‘Child B’ case, 95
 childhood, 94
 questioning of innocence of by
 media in Bulger case, 96
 reflecting contemporary ideals of by
 popular media, 94
 childhood cancer, 91, 94–111
 and ‘Child B’ case, 95
 connection between reporting of
 sports and, 103–4
 contrast between innocence and
 evil, 103
- denial of children to voice experiences
 on their own terms, 110
 enhancement of parental love and
 community support by, 105, 109
 entitlement of children to category-
 bound activities of childhood in
 news reports, 100–2, 106
 idealised subjectivity of reports,
 106–8, 109
 obstructive health care bureaucrats
 seen as villains, 104, 110–11
 restoring the category-bound entitlements
 of childhood, 105–6
 threatening of childhood, 102–5,
 106, 108–9
- children
 idealised and romanticised portrayals
 of ill and disabled, 97–8
 lack of careful regard for subjectivity
 in media’s image of, 96–7
 media stories on threats to, 95–6
 ‘Children in Need’, 213
 children’s hospitals, 95
 Chinese communities, 54
Chinese Opium Den, 234, 237–8
 chlamydia, 180
 cholera, 266, 267
 Chronic Fatigue Syndrome, 38
 Clapham rail accident, 36
 Cohen, S., *Folk Devils and Moral Panics*,
 121, 129
 commodification, 270
 computer mediated communication (CMC),
 135, 138
 Conan Doyle, Arthur, 238
 consumerism, 270–1
 content analysis, 271
 contraceptive pill, 121
 Cooper, Kayla, 106, 107, 108
Coronation Street
 disability storylines, 73, 79
 teenage pregnancy storyline, 75–6
 transsexuality storylines, 186, 188
Cosby Show, The, 35–6
Country Practice, A, 39
 Courtwright, D. T., 235, 238
 Crichton, Michael, 23
 critical discourse analysis (CDA), 190–1

- critical theory, 17
 Cronin, A. M., 213
Crossroads, 26
Crying Game, The, 186
 'cultural competence', 19
 cultural studies, 2–3, 11, 117, 231, 253
 and examination of public health issues, 128–9
 and newsprint analysis, 190
 use of to investigate health texts, 117
 Cumberbatch, G. and Negrine, R., 39, 213
Cure, The, 247
 cybernetic theory, 144
- Daily Mail*
 and BSE crisis, 121–2, 125
 transsexual articles, 190, 195–6, 197, 198
Daily Mirror, 124
Dallas, 26, 27, 68
 Dana International, 186, 187
 Darke, P., 78, 81–2
 Davenport-Hines, R., 153
 Davin, D. M., 260
 Dayan, D. and Katz, E., 5
 de Beauvoir, Simone, *Les Belles images*, 257
 De Quincey, T., 239, 245
 Devereux, E., 4
Devil's Assistant, The, 239
Devil's Needle, The, 239
 Dick, Kirby, 216
 disability/disabled, 20, 66–85, 110, 154, 206–23, 271
 media representations, 66–8, 206, 209–14
 'medical model' of, 66, 271
 negative images and notions of, 209–11, 213–14
 and Nike advertisement, 210–12, 213
 and sadomasochism, 207–8, 209, 214–17, 220
 and soap operas, 66–85
 and 'ethics of natural justice', 82
 gender division between ethical stances, 80–1
 meta-narrative level, 81, 82, 83
 micro- and macro-narrative level, 81, 83
 non-enjoyment of images of by non-disabled audience, 84
 privileging of the 'normal', 77–8
 project, 71–3
 rejection of portrayals of/by disabled, 77–8
 storylines discussed, 73–4
 storylines focused on by research participants, 74
 and women diarists, 79–80, 83
 'social' model of, 20, 66, 271
 discourse, as system of representation, 8–9
 discourse analysis, 271
 discursive approaches, 7, 9
Divided, The, 239, 240
 doctor/patient relationships, 144
 documentary research, 271
 Donaldson, L. J., 48
 Dormandy, Thomas, 255
 Douglas, Mary, 161, 163
 Downs, A., 124–5
 drug use/users in films, 230–1, 234–51
 anti-drug messages, 241
 association with crime and threat, 238–9
 Chinese Opium Den, 234, 237–8
 depicted as hapless and tragic, 239, 242, 246, 247, 248
 depicted as unhealthy, 235
 Easy Rider, 235, 241–2, 243, 243, 246, 247, 248
 Easy Street, 238–9
 'good versus evil' discourses, 235
 The Man with the Golden Arm, 235, 241, 246, 247, 248
 and the Oriental, 240
 origins of storylines from literature, 237–8
 racist element, 240
 and silent films, 237–40
 Trainspotting, 235, 239, 243–6, 244, 247, 248
 drugs, prescription, 136, 145
 Duff, K., 38
 Dutroux child murders, 96
 Dyer, R., 90–1
- Eastenders*, 26, 27, 74, 75–6
Easy Rider, 235, 241–2, 243, 243, 246, 247, 248

- Easy Street*, 238–9
 Edison, Thomas, 237, 238
 effects model, 17–18
 Ellis, John, 8, 229
 email, 135, 137, 138
Emmerdale, 68–9
 Enlightenment, 152, 229
 ‘entertainment–education strategy’, 57
 Entwistle, V. *et al.*, 95
ER, 19, 22–41, 74
 Americanness of, 33–4
 contrast with other broadcasts, 34–5
 following, 22
 health and illness identities, 39–40
 identification with medical
 students, 27–8
 learning from, 27–9
 as a medical documentary, 23–6
 realism(s), 23, 29–37, 40
 as reliable and trustworthy source of
 knowledge, 23, 25
 as a socio-political drama, 26–7
 and speed, 31
 study details, 23
 ethnic minorities, 19
 attitude towards health, 58
 cultural differences, 47–8
 debate between Said and Spivak, 58–9
 and health promotion campaigns
 19, 47–62; *see also* Malaria Radio
 Campaign
 health promotion strategy limited
 by availability of resources, 48
 language differences and difficulties
 related to health services, 54
 population, 47
 seeking of up-to-date mass media tools
 rather than radio, 56
 stereotypical portrayals of, 59
 struggling with long-standing western
 myths and challenging of, 58
 use of mass media as effective tool for
 health promotion, 53–5
 eugenics, 154, 209
 Ewles, L. and Simnett, I., 5
 Fairclough, N., 193
 Falkirk and District Royal Infirmary, 184
 false memory syndrome (FMS), 95
 Featherstone, M. and Lash, S., 146
Fetishes, 216
 film, depiction of drug use in *see* drug
 use/users in films
film-noir, 91
Financial Times, 120–4, 122
 Fiske, J., 4, 67, 69, 83, 126
 food scares, 119–20
 Foucault, Michel, 7, 8–11, 152, 221, 238
 concept of discourse, 8–10
 conception of power, 9, 10
 The History of Sexuality, 218
 on knowledge, 8, 10
 notion of *Ars Erotica*, 157, 164
 and Panopticon, 164, 273
 and *Scientia Sexualis*, 160, 166
 on subject, 10–11
 Frankfurt School, 17
 Freeman, M., 143
 Freud, Sigmund, theory of creativity, 252
 Furedi, F., 235
 Gauntlett, D. and Hill, A., 79
 Geertz, H. C., 9
 genre, 271
 Gerbner, G. and Gross, L., 35
 Gibbs, H. and Ross, A. D., 31
 Giddens, A., 76, 92, 139, 142,
 144, 145
 Gilliland, Eric, 107
 Gilman, Sander L., 159, 255
 Giroux, H. A., 96
 Glasgow Media Group, 8
 globalisation, 271
 of mass media, 4–5
 gonorrhoea, 169, 173, 180
Good Housekeeping, 229–30
 Gordon, B. Omonskey and Rosenblum,
 K. E., 207, 209, 214
 governance, and the ‘active’ body,
 161–3
 governmentality, 271
 and the STI clinic duties, 164–8
 Gramsci, A., 18
 concept of hegemony, 9, 11, 92
 notion of media as mouthpiece of
 ruling elite, 120, 129

- Gripsrud, J., 5, 89, 90
 Gross, L., 35
- Hagen, I., 30
 Halberstam, J., 202
 Hall, Stuart, 6, 7, 9, 11, 18, 68, 90,
 123, 171
 Hallam, J., 3
 Halperin, D. M., 209
 Hamilton, Peter, 89–90
 Hawkes, G., 159
 Hayter, Alethea, 256
 health, broadening of definitions of, 228–9
 Health Development Agency, 48
 Health Education Authority, 54
 health identities, 37–40
 health promotion, 271–2
 health promotion campaigns/strategies
 and ethnic minorities, 19, 46–62
 increase in emphasis on self and
 monitoring of self, 153, 157–8,
 162–3, 227–8
 and sexual diseases, 157
 use of melodramatic serials in developing
 countries, 26, 28
 Hearst, William Randolph, 238
 hegemony, Gramsci's concept of, 9, 11, 92
 Henderson, Mae G., *Discourses of Sexuality*,
 222–3
 Henley, A. and Schott, J., 48
 heteronormativity, 272
 Higgs, P., 163
 'high' culture, 231, 253, 272
 Hill, A., 79
Himmel Og Helvite, 240
 Hird, M., 194, 199–200, 203
 Hirschfeld, Magnus, 186
 HIV/AIDS, 18, 121, 123, 136, 158, 160,
 167, 178, 227
 Hoggart, Richard, 11
Holby City, 22
Hollyoaks, 74
 home pages, 92, 140, 143, 145
 Homer, *Odyssey*, 235–7
 homosexuality 152, 161, 231
 negative association with illness in Mann's
 'Death in Venice', 265–6
Houston Chronicle, 106
Human Wreckage, 239, 240, 241
 Huxley, A., 245
 'hypermedia', 134
- iconography
 of sexual diseases, 156–81
 term and usage of, 158–9
- identity, and mass media, 5, 89
- illness
 identities, 37–40
 meanings, 37–8
 and Romanticism, 255–8
- image, 272
 impairment *see* disability
Independent, 124
 individualisation, 272
 internet, 92, 133–46
 dating sites, 139
 growth in use of, 133
 home pages, 92, 140, 143, 145
 identities written through text, 138
 meanings and relationships
 through, 143–5
 narratives of the self as challenges to
 authority, 140–3
 and new social spaces, 134–7
 and newsgroups, 92, 135–6, 137,
 138, 145
 origins, 135
 and professional/lay relationships,
 144
 representing digital selves and
 possibilities of intimacy, 137–40
 use of in purchasing prescription
 drugs, 145
 and World Wide Web, 136–7
 internet service provider (ISP), 140
 intertextuality, 212
- James, A. and Jenks, C., 96
Jim Rose Freak Show, 216
 Jorgenson, Christine, 185, 203
- Karpf, A., 3
 Katz, E., 5, 72
 Keil, T., 120
 Kellner, D., 6
 Kennedy, John F., 17

- Kerouac, Jack, 270
On the Road, 270
- King, L. *et al.*, 54
- King, M. and Watson, K., 117
- Kingsley, H., 25
- Kitzinger, J., 18
- knowledge, Foucault on, 8, 10
- Kristeva, Julia, 212
- Kuhn, A., 69, 70
- Kwan, S. Y. and Williams, S. A., 48, 54
- Lacey, Richard, 127
Lancet, 126–7
- Lang, T., 126, 127
- language, as system of signs, 7
- Lash, S., 146
- Lazarsfeld, P. *et al.*, 17
- Leach, J., 128
- Leichter, Howard, 228
- Liebes, T. and Katz, E., 72
- lifestyle, and health, 228, 229
- lifestyle programming, 229–30
- Lippman, W., 35
- literature, 231, 252–68
 association between illness, metaphors and pathology and protest, 257
 characterisation of individuals by illness images, 254–5
 depiction of tuberculosis, 258–60, 263, 265
 drug storylines in early, 235–6
 ‘negative’ illness images, 253, 254–5, 267
 ‘positive’ illness images, 253, 255–6, 257, 267
 Romanticism and illness, 255–8
see also Mann, Thomas; Mansfield, Katherine; Thomas, Edith
- Longhurst, B., 76–7
- ‘low’ culture, 231, 253, 272
- Luckmann, T., 90
- Lupton, D., 3, 109
- Lyotard, François, 272
- McCoist and MacAulay*, 215–16
- McHugh, Paul, 185
- McLuhan, Marshal, 2, 4, 56, 134, 137
- McQuail, B. and Windahl, S., 124
- Malaria Awareness Project within Asian Populations in UK, The* (report), 49
- Malaria Radio Campaign, 49–61
 content, 50
 evaluation of, 50–1
 failure of and reasons, 51, 52, 55–6
 and message content, 59–61
 and message delivery style, 57–9, 61
 origins, 49
 summary of, 52
 and use of radio as an appropriate message tool, 53–7, 61
- ‘male gaze’, 11
- Man with the Golden Arm, The*, 235, 241, 246, 247, 248
- Mann, Thomas, 257, 258, 263–7
 ‘Death in Venice’, 264–7
The Magic Mountain, 264
 negative association of illness with homosexuality, 265–6
 portrayal of cholera, 266, 267
 work densely populated with sick characters, 263–4
- Manning, S. and Schneiderman, L. J., 104
- Mansfield, Katherine, 257–8, 260–3, 265, 267
 conflating pregnancy with disease, 262
In a German Pension, 258, 261, 262–3
 relationship between her writing and illness, 260–1, 263
 representation of sexuality and poverty through symbolic use of illness, 261–2
 writing on physical realities of tuberculosis, 263
- Marchessault, Janine, 208–9
- mass media/media, 3–6
 conceptualisation of, 4
 and construction of public health ‘problems’, 120–2
 globalisation of, 4–5
 and identity, 5, 89
 representation of groups, 89–90, 91
 role and influence of, 120
 role of in policy making agenda, 91, 122–5, 129
- Mass Observation (MO) survey (1942/3), 169

- Mathiesen, Thomas, 217
 medical dramas/soap operas, 1, 22, 104
 as prime source of medical information, 29
 see also ER
- Melo, Fernando Collor de, 69
 Meredith, Stephen C., 263–4
 Miller, D., 8, 9, 119, 227
 Miller, D. *et al.*, 123
 Mirza, H. S., 58
 ‘missing children’ issue, 95
 MMR vaccine, 121
Modern Times, 246
 Modleski, T., 80, 83
 Monaco, J., 237
 Moody, N. and Hallam, J., 3
 moral panic, 272
 morality, 227–31, 272–3
 link with medicine, 152–3
 Morley, D., 18, 37
 Morris, J., 210
 Mort, F., 173
 Mulvey, Laura, 11, 83, 274
- Namaste, Vivien, 189
 narrative, 273
 National Viewers’ and Listeners’ Association, 17, 270
 Nazroo, J. Y., 48, 53
 Negrine, R., 39, 213
 Nelson, R., 69
 Newby, H., 122–3
 Newkirk, Steven, 100
 news, 190
 notion of selectivity in reporting of, 126
 newsgroups, 92, 135–6, 137, 138, 145
 newspapers, and childhood cancer *see* childhood cancer
 newsprint media, 91
 discourse on transsexuals, 189–203
 NHS Direct online, 134
 Nightingale, V., 68
 Nike advert, 210–12, 213
9½ Weeks, 216
 Norwegian cinema, 240
- O’Donnell, Hugh, 68–9, 70, 81, 84
Odyssey (Homer), 235–7
 Oedipal scenario, 73
 Oliver, M., 20, 66
 opium, 237–8, 239, 240
Othello, 240
- Pace that Kills, The*, 240
 Pakistan, malaria eradication campaigns, 60
 Pakistan Advice Centre (Sheffield), 19, 55
 Pakistan Community Centre (London), 60
 Pakistanis, 54, 56, 58, 60
 Panopticon, 164, 217, 273
 modern role and duties of STI clinics as, 157, 158, 164, 166
 Parker, H. *et al.*, 247
 Parsons, W., 92, 122, 123, 129, 144
 Parsons, Talcott, 274
 Penon, Michael, 100, 107, 108
 Pérez, Carlos Andrés, 69
 Petersen, A., 161
 Petersen, A. and Bunton, R., 162
 Philo, G. and Miller, D., 9
 Philo, Greg, 8, 18, 35
Plague, The (Camus), 254
 plagues, 254
 Polkinghorne, D., 142–3
 Pollock, G., 91
 polysemic, 273
 post-structuralism, 207
 Poster, M., 144
 postmodernism, 273
 Potter, W. J., 190
 power, 9, 208
 Preminger, Otto, 241
 print media, 91, 228
 and BSE crisis *see* BSE crisis
 and childhood cancer *see* childhood cancer
 role in creation of ‘panic’ around some issues, 121
 role of in policy making agenda, 122–5
 professional/lay relationships, 144

- public health issues, and BSE crisis
 see BSE crisis
 and cultural studies, 128–9
 mass media and construction of
 ‘problems’, 120–2
 see also health promotion campaigns/
 strategies
 ‘purity crusade’, 152
- queer theory, 201
 Quérel, C., 167
- radio, 133
 use of and appropriateness of in Malaria
 Radio Campaign, 53–7, 61
- Ramsay, JonBenet, 96, 97
- Raymond, J., 201
- reality, 89
 and representation, 90–1
 and television, 36
Reefer Madness, 234
- Reeve, Christopher, 210
- representation, 6–12
- Rochefort, Christiane
Les Stances à Sophie, 257
- Rodney King trial, 36
- Rohmer, Sax, 238
- Rolland, J. S., 97–8
- Romance of the Underworld, A*, 239
- Romanticism, 231
 and illness, 255–8
- Roseanne*, 39
- Rosenblum, K. E., 207, 209, 214
- Ross, A. D., 31
- Rozin, P., 227
- Sacks, Harvey, 100
- sadomasochism (SM), 154, 206–23
 and disability, 207–8, 209,
 214–17, 220
 freeing from sexual genital fixation,
 218–19, 220–1
 ‘life-worlds’ and scene of consensual,
 217–22
 media representations, 215–17
 motivations to engage in, 219
 social construction of, 214, 215,
 222
- Said, Edward, 58
- salmonella, 121
- Samsujjoha, R., 54
- Schott, J., 48
- Schwartz, T., 211–12
- science
 and BSE crisis, 126–8, 129
 and health coverage in press, 119
Scientia Sexualis, 160, 166
 scientific sexuality, 164
 and the erotic, 159–61
- Sculley, Leach, 151
- Seale, C., 3
- Second World War, 168–9
- Secret Sin, The*, 240
- Seedhouse, D., 229
- Selvin, J., 140
- semiotics, 7–8
- sex/sexuality(ies), 152
 entering of medical realm, 153
 problematisation of, 159–61
 scientific, 159–61, 164
 strong associations with dirt and
 sin by religions, 161
- sex abuse, 110
- sex change see transsexuality
- sexology, 152, 153
- sexual diseases, 156–81
 ‘active’ body and governance, 161–3
 antibiotics development and shift in
 notion of, 167, 177–8
 construction of as risk, 161, 162
 development of VD clinics, 157
 educated consumer as active
 patient, 177–9
 emphasis on cleanliness during Second
 World War, 169–70
 favouring of extreme state regulation
 of during Second World War, 171
 increase in emphasis on self and
 individual responsibility for in health
 promotion strategies, 153, 157–8,
 162–3, 164
 location of purity and health
 within home and responsibility
 of parents, 175
 marriage and sex in health promotion,
 175

- moving away of iconography from
 purity to consumption of
 desire, 163
 objects of blame during Second World
 War, 169
 postwar surveillance and the
 penetration of modern social
 spaces, 172–5
 privileging of scientific truths of sex over
 erotic pleasure in public health
 campaigns over, 160, 164
 questioning over effectiveness of health
 campaigns against, 180
 reconstruction of in imagery of the
 family, 173, 181
 role iconography of, 158–9
 safer-sex campaigns, 178
 seen as social threat, 157
 tensions between therapeutic value
 of drugs and promoting of
 licentiousness, 171
 wartime lay beliefs and deployment
 of iconographies of contamination,
 168–72
 women as locus for, 169, 173
see also STI clinics
- Shakespeare, Tom, 154, 210
 shame, discourse of, 230
 Shattuc, Jane, 19
 Shildrick, M. and Price, J., 222
 Shilling, C., 139
*Sick: The Life and Death of Bob Flanagan,
 Supermasochist*, 216
 sick role, 144, 274
 signs, 7
 Silverstone, R., 5, 71, 74
 Simnett, I., 53
 Sinatra, Frank, 241
 Smith, D. J., 79
 Smith, Robert, 184
 Smith, Gwen, 189
 soap operas, 274
 audience and, 68–71
 bringing isolated audiences together, 70
 and disability *see* disability
 feminist readings, 69, 70
 perceived as low cultural worth, 69
 popularity of in many cultures, 68–9
 portrayal of health care, 111
 provision of useful medical information,
 26, 29
 stigmatisation of health care
 administrators, 111
 Sontag, Susan, *Illness as Metaphor*, 254–5,
 256, 268
 Southwell, B., 117
 Spivak, Gayatri, 58
 Sreberny, A., 56, 59
 Stafford, R., 6, 18
 Stevenson, J., 230, 240
 Stewart, David, 101, 104, 105
 STI (sexually transmitted infections clinics),
 158, 162, 173, 180
 governmentality and duties of, 164–8
 modern role and duties of as
 Panopticon, 157, 158, 164, 166
 structuralism, 207, 274
 Stryker, S., 201
 surveillance, 274
 ‘synopticon’, 217
 syphilis, 157, 163, 167, 168, 169, 173, 180
- Tang, Otto, 100
 television, 4, 5, 36, 228, 229; *see also* soap
 operas
 therapy, 92, 144–5
 Thomas, K., 237
 Thomas, Edith, 258–60, 262
La Mort de Marie, 257, 258–9
Le Refus (The Refusal), 258,
 259–60, 267
 Thomas, K., 237
 Thompson, J. B., 4
 Torfing, J., 3–4
Toronto Sun, 103
Traffic, 240
Trainspotting, 235, 239, 243–6, 244,
 247, 248
 transsexuality/transsexual people, 153,
 184–203
 background, 185–9
 cost to society, 197–9
 criminal deviance, 196–7
 economic deviance, 195–6
 elements of moral panic model used
 by journalists, 199

- transsexuality/transsexual people – *continued*
 hormone therapy and surgical gender
 reassignment, 185–6
 and occupations, 191–2
 portrayals of by media, 186–7, 189
 positioning of as ‘ridiculous’, 192–3
 seen as undeserving, 191–9
 use of critical discourse analysis in
 study, 190–1
- tuberculosis, 254–5
 and creativity, 255
 literary texts on, 258–60,
 263, 265
 Romantic vision of, 256
- Tulloch, J., 39
Turner, B., 208
Turow, Joseph, *Playing Doctor*, 111
typification, 91
- uses and gratifications model, 18
- VD (venereal diseases) clinics, 157
Venezuela, 69
- video nasties, 18
viewing pleasures, 274
- Watson, K., 117
Wayne, John, 240
wellness movement, 228
Wilkins, L. T., 121, 129
Williams, K. and Miller, D., 119
Williams, S. A., 48, 54
Windahl, S., 124
Withington, S. and Samsujjoha, R., 54
Wizard of Oz, The, 239
Woolf, Virginia, 260
World Institute on Disability, Technology
 Policy Division, 210
World Wide Web, 136–7;
 see also internet
- Young, B. *et al.*, 98
Young and the Restless, The, 26
- Zola, I., 229
Zúñiga de Nacio, M. L., 56, 57