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TWO DAYS IN THE TV-CLINIC, LOOKING FOR SOME CARE

VALENTINA CAPPI
Dipartimento di Storia Culture e Civiltà
Università di Bologna, I

SUMMARY

This article examines the representation of care and cure on digital terrestrial television in Italy. It studies a sample of TV listings from two different days of the week, two weeks apart, and analyses the narratives of healthcare depicted in informative and entertainment programming (from Elisir to House M.D., from Medicina 33 to Grey's Anatomy, from Mystery Diagnosis to Braccialetti Rossi). The aims here are to understand whether care and cure are represented as exclusive or complementary activities within medical practices; which characters are predominantly given technical expertise and which have supporting roles (doctors, nurses, the patients themselves or their family members); and which rhetorical strategies are used in single programmes in order to address the theme of care.

Medicine and Television: A Lucky Meeting

The world of medicine appeared first on Italian television more or less exactly when the medium itself appeared. On 26 January 1954, just three weeks after its inaugural TV broadcasts, the State channel Rai - Radio Televisione Italiana (at the time it was called Rai - Radio Audizioni Italiane, albeit for only a few months more) aired the first episodes of an informative science programme: *Conversazioni scientifiche*. The show dealt with topics ranging from healthy diets to twins, from psychosomatic medicine to sleep. A few months later *Dottor Antonio* débuted: it was the first Italian TV drama and an adaptation in

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four episodes of the eponymous novel by Giovanni Ruffini, which depicted the adventures of a doctor during the Unification. From the mid-50s, TV audiences witnessed the world of healthcare through the most varied forms and themes[1], taking up more time for networks and more space on schedules (thanks also to the introduction first of satellite and later digital TV from the 1990s), and gaining popularity for viewers. Stories about doctors and patients, progress in technology, alternative medicine and avant-garde treatments form a continuum of narrative practices relating to healthcare, with which audiences have become used to living (and interacting) on a daily basis. To question the reasons behind the success of medical television shows would require a discussion of its own. Suffice it to recall here only a few contributing factors. Firstly, medicine and care concern everybody. We all have health problems, we all interact with doctors or with unwell friends or relatives, we have all been frightened by the idea of falling ill and many of us are interested in preventing or delaying that from happening. Secondly, television continues to reach an audience that constitutes almost the totality of the Italian population (97.4%)[2]; it is identified by Italians as the third most important source of health information[3]; and 42.6% of people[4] state an interest in acquiring information when health is mentioned on TV. Furthermore, the iconography of medicine has always been spectacular and engaging and audio-visual languages are extremely inclusive, making it easy to understand why the marriage between medicine and television has found little difficulty. And finally, the success of medical shows is certainly related to the cathartic effect of the small screen. At a time when death is stated and restated, but at the same time constantly evaded[5], using the screen to observe the ways in which diseases work and applaud the heroic enterprises of health professionals allows us to exorcize illness and tame death (or, at least, the notions of both)[6]. While on the one hand medical television programmes "address basic anxieties about the security of individuals

in the world", as Clive Seale rightly argues, they moreover "reassure audiences that they are surrounded by an effective rescue service"[7]. In medical dramas, the "defibrillator *topos*"[8] resuscitates patients in every episode, and informative shows, like in *Medicina 33* or in *Elisir*, we get reassuring news every week regarding a cure for hepatitis or the fine tuning of a new piece of medical technology that can operate on bodies with the smallest margin of error. It therefore seems justified to hypothesize, adapting the categories formulated by Anthony Giddens (1991), that mediated and delocalized contact with illness and death can dispel the fears and insecurities connected to a lack of understanding of the medical/hospital universe. Indeed, one of the main effects of medical dramas is familiarizing their viewers with an otherwise foreign universe, that of medicine, according to research findings from the author (2015), from Solange Davin (2000; 2007) and Sabine Chalvon-Demersay (1999). An "impression of safety" that often emerges in accounts of spectators can be usefully illustrated in one example. Andrea, a 24-year-old student of psychology stated that he did not feel at all disoriented in the operating theatre when undergoing surgery, having seen such a context represented on TV: "I had an accident that required an operation on my whole elbow with ligament screws. Because I had bronchitis, on the day they couldn't give me a general anaesthetic, so I can remember ever minute of the operation, that I watched carefully for a couple of hours. I have to say, having been able to observe the workings of operating theatres on TV dramas and other shows calmed me down. I knew that the surgeon didn't have the time to talk to me, I knew that he operated on people daily for his job, and that the loud music on the radio was there to keep the team alert and active, not for their entertainment at the risk of injuring me. If I hadn't seen such scenes on TV I would have been much more worried"[9].

This brief digression aims to encourage the reader to contemplate the impact of care and cure on TV viewers, and more specifically

the modes of reception and the negotiation strategies that audiences adopt when consuming health-related TV products[10]. In this area, related studies remain patchy, as Atkin and Wallack (1990), Lupton (1994), Friedman (2004) and Regan et al. (2007) demonstrate. The results of my own field research in the area lead me to believe that the consumption of medical programming can be considered a first stage of self-treatment, where this is commonly defined as "the technical and symbolic systems and the combination of knowledge, representations and practices employed at an individual, familial or communal level, in order to address emergent threats or negative events that are perceived as dangerous for one's health before consulting healthcare professionals"[11]. Indeed, merely descriptive analysis of the representations of care and cure on TV would not be sufficient, rather they need to be studied more frequently from the point of view of their reception. This is no small matter, of course, considering that "the study of the ways in which medical practices and institutions are represented in the mass media and the reception of such representations by audiences is integral to interpretive scholarship attempting to understand the socio-cultural aspects of medicine and health-related knowledges and practices"[12].

The Genres and Formats of Care on Television

Up to now, I have referred to the worlds of medicine and care as interchangeable, when the one from the other is, of course, entirely distinct. While the world of care, intended broadly, includes processes, situations and players that often have nothing to do with the strictly medical, the world of medicine is nevertheless inextricably connected, permeated and oriented by care practices. In the same way, representations of care on TV draw from varied semantic fields (to give just a few examples: care for believers on behalf of religious institutions; care for children on behalf of parents, and vice versa; care for the environment and cultural heritage; care for animals; etc.).

In this article, however, I will take into consideration only those representations of care (with its double meaning of both care and cure) that can be explicitly ascribed to the fields of health and medicine. When limited in this way, how is care represented on television? Is it depicted in a univocal or heterogeneous way? Are care and cure represented as exclusive or complementary activities? Who is attributed predominantly certain skills (technical or relief support) or the position of carer (doctors, nurses, patients themselves or their relatives)? These are some of the questions that have guided my analysis of the TV shows taken into consideration here.

In order to grasp what kinds of representations of care are broadcast to Italian spectators on a daily basis, I constructed a sample from two days of digital terrestrial programming in March 2015, picking one weekday and one from the weekend, at the distance of a fortnight. By consulting the listings of the most popular networks in the weekly magazine *Film TV*, I identified those programmes that had explicit health and medical themes, recorded them via a Sky HD decoder, and watched them back at a later moment.

The programming on Monday 2 March 2015 was as follows[13]: at 11.00 a.m. *Elisir* (Rai Due), at 1.05 p.m. *Grey's Anatomy* (La7d), at 1.50 p.m. *Tg 2 Medicina 33* (Rai Due), at 4.40 p.m. *House M.D.* (Italia 1), at 11.40 p.m. *Mystery Diagnosis* (Real Time). The programmes aired on Sunday 15 March 2015 were: at 08.25 a.m. *One Born Every Minute* (Real Time), and at 9.30 p.m. *Braccialetti rossi 2* (Rai 1). Despite the disparity of frequency between the weekday and the weekend, and bearing in mind that other networks were not included in this sample, the dissemination, in quantitative terms, of medical programming on Italian TV at all hours of the day is evident.

Before turning to their individual analysis, I believe that it is useful to recall the categories identified and employed by Massimiano Bucchi (2001) in order to classify the ways in which the theme of health - intended as cure, prevention, wellbeing, quality of life - is presented

in the mass media[14]. This taxonomy might constitute a first, useful criterion that gives order to the array of health communication, insofar as it allows us to pinpoint several particularities, aims and targets. Bucchi's first category is health education, and comprises communication regarding health protection, aimed at the majority or the entirety of a population, whose objective is predominantly prescriptive. Health education is therefore typically produced by institutional bodies, and utilizes the traditional media and its channels (posters, TV advertisements, newspaper and magazine articles) for a specific time period. The second, comprising information regarding new treatments, self-care, and broadly "advice" from doctors or experts, is addressed to an audience that is already interested in the subject of healthcare. It is usually transmitted via those media contexts that are specifically dedicated to health, such as the weekly supplements of some newspapers or specialist programming (e.g. *Elisir, Medicina 33*); this is the category of healthcare journalism. The third is that of health and medical information, which is broadcast in spaces that are not specifically dedicated to the theme and is addressed to a wider audience. Here the communicated technical content falls into the background (e.g. TV or printed news, etc.). Finally, there is the entire area of indirect communication on the subject of health and care/cure, which includes those broadcasts which do not have informative aims nor are specifically dedicated to healthcare topics. These are nevertheless types of communication that "contribute significantly to shaping the conceptions, representations and stereotypes on which public debates on the subject of health are later shaped"[15]. This category contains all of those products, from TV series (*House M.D., Grey's Anatomy*) to commercials and advertising, in which medical knowledge, institutions or scenarios are used to narrative ends. The four categories identified by Bucchi can in turn be interpreted in the light of a framework proposed by Mazzoleni and Sfardini (2009), which seeks to order the various genres of televised communication.

The framework - which takes inspired from that proposed by Renger and Wiesner (2007) to analyse the press - situates the genres of TV communication on a continuum according to the rhetoric of their address. At one extreme, we find the realm of information, which has a low entertainment value and a high informative function (including investigative and analytical TV reports, whose rhetoric is that of "discovery"). In a sense, programming such as *Medicina 33* would be located at the point where this area blurs into the next; that is, the multiform area of infotainment, which has equal entertainment and informative functions. Within this area we can situate the expanded and dramatized communication that is typical of Utility TV: television as agent in the service of the citizen, resolving the problems and questions of daily life. An example that is attributable to this area would be *Elisir*, which works above all "on the cognitive dimension of the viewer's knowledge and understanding, without overlooking the use of "emotive" elements or those relating to play and entertainment[16]. At the other extreme of the continuum, we have the lowest level of the informative mission, and the highest entertainment function: this would be the information/entertainment, where the elements of emotion and spectacle prevail over all else (this is the terrain of certain medical dramas and documentary drama).

It is not difficult to understand, even taking into consideration only the names of the programmes listed above, the level of variety of actors, processes and rhetorical strategies that are employed to depict just one theme. Nevertheless, one common feature emerges from a brief examination of the selected programmes: healthcare, as far as health professionals are concerned, appears predominantly as a mode of *curing*, as therapeutic techniques, rational actions that aim to repair the body and interventions from a kind of medicine that "has conceived of itself as a science, albeit an applied science, that is practical and professional: it is "knowing what to do" when facing disease, imbalance, disability"[17]. On the other hand, healthcare intended as

care - its personal dimension that refers more to the ability to take care of others, to "provide answers that are not necessarily and not only of a technical nature"[18] - is barely hinted at, it is pushed to the background, at times included only to pay lip service to the politically correct. Care does not appear to feature within the primary responsibilities of healthcare professionals (doctors or nurses) and for that reason is entrusted to groups of peers, affected family members or via the self-cure of the patient. Evidently, evaluating the representation of healthcare by means of single episodes or instalments of more complex series will not provide an exhaustive nor complete image of the media panorama in this area. Nevertheless, what follows can be understood as the results of a sociological experiment, of an alien who tunes into Italian television for a day and draws some conclusions (that are necessarily partial and restricted).

A 'Care-less' Tendency in Informative Programming

During the morning, the audience met two of Rai's long-standing shows. This begins at 11 a.m. with *Elisir*, a mixed format show that has sought to enliven health information by embracing the communication techniques of infotainment since its début on Rai Tre in 1996 (on Sundays, during prime time). Presented by Michele Mirabella, the programme has enjoyed much success, and with time has abandoned lighter entertainment (in the form of quizzes and VIPs in the studio) in favour of more direct medical information. In accordance with the network, Mirabella carries out a public service function; and though his presenting style is ironic and informal, at the beginning of the episode he stresses that "we are sure of the information we give because we consult experts". The episode of Monday 2 March begins with a clarification that is indicative for this discussion. Mirabella welcomes the spectators by saying "today we will deal with fat, on the role of fats […] not of fat people, of the obese, but the role of fats in the blood. And then we will talk about the

prostate and about prevention". This opening sentence is particularly significant in that the presenter immediately clarifies that the show's attention will not be on a group of people or their condition of sufferance, but on a measurable entity that can be isolated from the experience of sickness. When situated within an imagined community of "informers" that includes the presenter, writers and doctors hosted in the studio, Mirabella continues, affirming that "we are certain that the prevention of cardio-vascular diseases is reliant on the regulation of fats in the blood. We are addressing this issue now as there are new treatments, new cures on the horizon. Letting people know about these treatments is one of many satisfactions for us here on *Elisir*". The buzz word of the episodes, which the presenter will highlight soon after, is "cholesterol". Mirabella immediately associates himself with a traditional, biomedical approach of an etiological framework[19]. If the causes of those diseases are fats, it would suffice simply to find the right way of eradicating them or keeping them under control. For this reason, following all kinds of questions posed to the expert of the day - a full professor of internal medicine from the University of L'Aquila - Mirabella eventually tells the spectators that it is necessary to develop higher levels of good cholesterol by means of physical exercise and a healthy diet. Up to this point, the spectator would struggle to grasp the innovation of the treatments (or cures) that the show is proposing. Then the presenter takes the floor again to ask the crucial question: "Diets are not enough, the careful management of our lives is not enough, long walks at a steady pace are not enough […] this needs treatment. What should we do?". The doctor's response: "Fortunately, for years now we have these drugs, called statins, which are not the only drugs to combat cholesterol, but without a doubt are the foundational stone on which the fight against cholesterol is built". The "guilty parties" are the blood fats, and a pharmaceutical treatment is necessary to destroy them. The only really efficient cure, in this case, is a pharmaceutical, and nothing else.

It is clear that in a programme that lasts one hour it would be impossible to broach all of the particulars of the topic of "fats"; nevertheless, the authors of the show decided to exclude entirely the social dimension of the problem. We hear that the accumulation of fats in the blood is principally due to an unhealthy diet, but nobody questions why, for some people at least, it would not suffice to correct this simply with recourse to a healthier diet or physical exercise. Despite the fact that research in this sector (e.g. in Brewis, 2011) has been ongoing for many years, there is no allusion to the possibility that unhealthy eating could have a socio-economic origin, and often concerns the poorest strata of society[20]. Despite the fact that food is notoriously a great way to de-stress, and that many dietary disorders have psychological or psychosomatic origins, Mirabella prefers to offer a pharmacological solution to a problem that is posed quite generally, without questioning the dynamics that produced it, nor when it might be more useful to act via an holistic approach that is centred on the person her/himself, in order to bring about longer-lasting effects.

In the second part of the instalment, the discussion turns to possible problems with the prostate, to tests that it is wise to undertake at different ages in one's life, and to the completely different attitudes that men and women have towards prevention. It would be of little use to address here the issue of when prevention became a type of healthcare (a means not only of care but also to cure), calling into question that age-old saying that "prevention is better than cure" which ratifies a distinction between the two processes. Today, prevention is just one of many aspects that links to the subject of health, intended not only as an absence of disease but as a general condition of psycho-physical wellbeing, that demands constant care and attention "in perspective", too. At the end of the transmission, Mirabella observes that, as far as the male approach to prevention is concerned, "his first defence is his girlfriend (let's hope she is listening), second is his

general practitioner". This element reaffirms a deeply stereotyped reality: care, intended less as treatment than as taking responsibility for the management of somebody's entire life, is entrusted first and foremost to relatives, and especially to female relatives. Men are not able to take care of themselves because, the doctor affirms, "by nature he is a coward, because when a problem emerges he would wait two years, that would be two weeks for a woman, to go and see a doctor". The reasons that cause men and women to have differing attitudes towards prevention, and the implications of this, are not expanded upon during the course of the programme.

At 1.50 p.m., it is the turn of *Medicina 33*, a similarly long-running program that has had no less success than *Elisir*, which follows the 1 p.m. Tg2 news on Rai 2. First aired in 1982 with the name *Trentatré*, recalling when doctors on home visits would say to patients "dica 33" ("say 33" – the equivalent of a doctor asking a patient to cough or breathe deeply while listening to their chest with a stethoscope). The show changed its name in 1985 and its presenter only in 2014, when Luciano Onder left and Laura Berti took his place. The opening credits of the programme show a rotating cube in a 3D graphic effect, the faces of which show images of an ordinary doctor-patient meeting, a researcher examining a test tube, a doctor carrying out an ultrasound and a patient lying on a hospital cot, Rita Levi Montalcini (symbolizing research), and finally three doctors in surgical masks in the operating theatre. These represent some of the "faces of medicine", and only a few of the areas covered in the programme. The rotation of the cube does not prioritize any particular images, but four of five denote aspects that are more linked to cure than to care. Only one of the five images implies that the more human and less technical competence, that is taking care of people, is also an aspect of medicine: in this case, it is exemplified by the dialogue between the professional and the lay person. This episode covers two topics, as in the case of *Elisir*: a new diagnostic technique, and a commentary

on some recently-published statistics on the use of pharmaceuticals by Italians. The episode begins, channelling *Elisir* further still, with the presenter stating "Today we will show you a very innovative diagnostic technique. It is called OCT, it studies our arteries from the inside, and it is capable of identifying those plaques that a coronarography might miss". The leitmotiv of the prevention of cardiovascular diseases, and in particular cholesterol in the blood, connects the two programmes. The combination of the different aspects of a single theme at different times, chosen more or less arbitrarily, appears to set an agenda in matters of health; it expresses a salient issue, placing it on the order of business in a public scenario. As such, *cure* sits centrally on the order of business for informative programming. The description of the new procedure is provided by a cardiologist from the San Giovanni Addolorata Hospital in Rome, "where the technique is carried out at the bed of the patient". The doctor explains that a man who was admitted for a sharp pain in his chest was first given a coronarography, however that this did not provide clear enough images. Once the OCT had been completed, it was possible to identify arterial plaque and insert a stent. We barely see the patient: we only see doctors in a room, examining the images of his arteries on monitors. In this case, the patient is no more than a dummy, and his role in the enactment is to support, in flesh and blood, a technical, scientific demonstration. After all, what is important, for this service is not the patient but the technique. Once again, healthcare is represented in its most instrumental and technological phases via a computerized diagnosis. Surprisingly, the first indication of the doctor-patient relationship and therefore of the more human dimension of healthcare appears in the second part of the programme, which is dedicated to " how many and which pharmaceuticals are consumed in Italy". To provide a commentary on this data, the programme turns to the vice-secretary of the Italian Federation of Family Doctors in Rome. The base assumption is that

"in general, experts have warned, we are consuming too many drugs, and we rely on them chiefly in the demand for health". It seems therefore that even patients are looking for cures, in the shape of medicine. When the programme comes to address the question of antidepressants, which are the most-prescribed drug within their category, yet hold a record for inconsistent prescription or use, the presenter asks the guest if such misguided treatments are evidence of a detachment between doctor and patient. The doctor promptly says no: "interrupted use of antidepressants happens because patients are a little more difficult". Then he adds: "It is true that there should be a more direct relationship. Sometimes there is, but not always, and when they feel a bit better, they tend to let it slip". We might note here that, in this case too, treatments, particularly long-term treatments, are the responsibility of the patient: it is their own fault if they nonchalantly abandon their treatment. Nevertheless, it has been demonstrated elsewhere[21] that a more continuous dialogue between doctors and patients produces greater compliance on behalf of the latter, who benefit from having looked carefully at the pros and cons of certain pharmaceuticals with their doctor. The question of the doctor-patient relationship disappears as the programme continues: there is no further comment on what might be the best approaches in the relationship, nor on what strategies might improve compliance in certain patients. A general practitioner whom I interviewed in Bologna explained that simply prescribing a drug is not necessarily taken for granted nowadays. It is necessary to dedicate time and patience to a dialogue with the patient, listening to him, in order to mete out a compromise: "You sometimes give up on a perfect medicinal treatment so as to regain the patient's compliance. If, on the other hand, you say "this must be taken", "but seriously", "it must be taken, full stop", the patient will walk out, throw away everything, and not take anything. In that case you have failed not only to communicate with them but also to reach the intended outcome"[22].

Medicina 33 therefore indicates fleetingly the fact that medicinal treatment (cure) can be more efficient when it is contextualized within the context of care, of its responsibility being provided to the patient by the doctor, but the discussion is not at all developed.

The Art and Science of Care: Medical Dramas and the Reversal of Stereotypes

While *Medicina 33* was concluding, an episode of *Grey's Anatomy* was on-going on another channel: La7d, which broadcasts re-runs from the first episode of the first season (subscribers to Sky could watch the final episodes of the 11th season during the same weeks).
Grey's Anatomy is a medical drama that narrates the professional activities of a group of surgery interns at the Seattle Grace Hospital. From the opening credits it is clear that the romantic thread of the story is by no means secondary: medical images are rapidly interchanged with romantic situations. *Grey's Anatomy*'s narrative structure tends towards repetition. In every episode, the voice-over of the protagonist, Meredith Grey, introduces an ethical or emotional dilemma which functions as a backdrop to the medical problems of the patients and the personal problems of the protagonists. In this way, the life stories of the protagonists become medicalized: a medical language is applied to the lived experiences even in those circumstances that transcend the context of healthcare. In the pilot episode, the first of the two broadcast on La7d on 2nd March, the interns are on their first working day at the hospital, and their superiors teach them the rules in what appears little more than military training: "Your first shift starts now and lasts 48 hours. You're interns, grunts, nobodies, bottom of the surgical food chain. You run labs, write orders, work every second night until you drop, and don't complain". For the moment, the preparatory rules leading up to the "cure" are simple: try not to kill someone. The concern shared by all is whether they will be able to employ the right surgical procedures, and therefore succeed in assisting as many

operations as possible. We see George, the clumsiest intern, visibly shaking in the operating theatre, repeating to himself "Open, identify, ligate, remove, irrigate, close. Open, identify, ligate, remove, irrigate, close". For George, the procedure is everything, all he needs to complete the operation. In the mean time, Meredith is dealing with a patient who pages her via an emergency code. Once she has hastened to the patient's room, she discovers there was no emergency, but that she called her because she was bored: as she recounts, "I had to go all Exorcist to get her to even pick up the phone". The doctor replies that she is not there for her entertainment. Alex Karev, the biggest braggart among the interns, finds himself showing off his status right away: he orders a nurse to give antibiotics to a patient. When the latter asks him if he's sure about the treatment (which in fact turns out to be wrong), Karev responds arrogantly: "Well, I don't know. I'm only an intern. Why don't you go spend four years in med school and then let me know if it's the right diagnosis? She's short of breath. She's got fever. She's post-op. Start the antibiotics. God, I hate nurses".

These three stories give us some indication of the representation of healthcare in this particular episode: fundamentally, caring about other people is not that kind of social interaction that we might expect to see between colleagues, between doctors, or between doctors and nurses[23]. Regarding the role of nurses, an observation that is valid in all medical dramas (with the exceptions of *ER* and *Nurse Jackie*): despite the hospital setting, where nurses have categorical roles and ultimately are of a much greater number than the doctors, they appear merely as extras who speak little and whom are never named. They appear among varied figures that intervene during emergencies, administering medicine to patients or periodically checking drip-feeds. From this perspective, when it is present, care is nonetheless the prerogative of doctors.

The initial concerns of the young doctors relate not so much to their relationships with patients than to the reparation and exploration of their

organs. Furthermore, the interns prefer to relate their close experiences with surgery to one-another, rather than spending a few minutes more in the patient's room. This is precisely what occurs for Meredith's patient, who is doubtless demanding and plaintive, yet is forced to pretend to be seriously ill to be able to talk with her own doctor.

The first episode is clearly dedicated to training the interns to the curing process. The one lesson about caring that George learns the hard way pertains to foresight, when he loses a patient in surgery yet had promised the family that everything would be fine. Dr Burke, his supervisor and a severe, demanding surgeon, has few doubts: "You what? They have four little girls. This is my case. Did you hear me promise? The only one that can keep a promise like that is God, and I haven't seen him holding a scalpel lately. You never promise a patient's family a good outcome! I thought you make promises to Mrs Savitch? You get to be the one to tell her that she's a widow". The care that George ultimately puts into communicating her loss to Mrs Savitch is the same that Burke had urged him to adopt before the operation: reassuring patients is one thing, promising a good outcome to surgery is entirely another. As well as demonstrating a lack of care, characteristics like competition, a concentration on the most technical aspects of medicine and the refusal of human contact on behalf of the interns can be read as an attempt to gain authority in the eyes of patients and their superiors, and to ratify a different status to non-professionals. Jecker and Self (1991) suggest that this is a possible motive for which medicine, historically speaking, has more often been linked to cure than to care: "the presence of fierce competition and marginal status during its early years forged a mission for medicine that focused on achieving cultural authority and an elite status for its practitioners. Efforts to gain authority and status required physicians to stand apart from laypersons and develop exclusive modes of language, technique and theory. This puts physicians at odds with activities, such as patient empathy and care, that

call upon abilities of engagement and identification with others"[24]. The question of the relationship with patients, which is by no means neglected over the course of later seasons of the show, is introduced from the beginning of the second episode. Meredith's voice-over states: "It's all about lines. The finish line at the end of residency. Waiting in line for a chance at the operating table. And then there's the most important line, the line separating you from the people you work with. It doesn't help to get too familiar. To make friends. You need boundaries between you and the rest of the world. Other people are far too messy. It's all about lines. Drawing lines in the sand and praying like hell no one crosses them". Doctor-patient relationship is not mentioned, if not via the synecdoche of the operating table. The patient is just body, matter on which to operate. And yet it is clear that patients are included too in "the rest of the world" that Meredith mentions. The emotional distance that the surgeon must maintain, they claim, is exemplified through the episode via two ploys, one tragic and the other comic. In the first case, a young rape victim arrives in the emergency room, with shoes among her personal effects that are identical to those worn by Meredith that same morning. In that moment, Meredith sees herself on the stretcher, she sees herself as a patient: in need, fragile, vulnerable. This causes her to take particular care of the patient, and to worry continuously about her condition. In the second case, Cristina Yang and Alex Karev, the two most cynical interns who are least inclined to human contact, complain at one point that there is a lack of sick people: "Don't people get sick anymore? I mean, how are we supposed to get any OR time if everyone's gonna just live?". With nothing else to do, they decide to visit the patients' rooms and attempt the least stimulating part of their job: communicating prognoses to family members. "Look. I'll take ten, you take ten. Get in, get out. No smiling, no hugging, no letting them cry. Just be quick about it". Reeling from unwelcome embraces given by relatives earlier in the morning, the

two rapidly and mechanically set to communicating the information, hastily evading embraces and any relation with patients and their families. This signals that care is a part of the doctor's job, but it is the least stimulating, most embarrassing, and most disagreeable part. In the mean time, another two declinations of care materialize. Izzie, another intern, goes to medicate a Chinese girl hidden in the car park outside the hospital, having understood that the latter does not have medical insurance. Izzie therefore risks her own position, but demonstrates that she is not a rigid and insensitive doctor. Meanwhile, Doctor Derek Shepherd, the hospital's neurosurgeon, has watched over the rape victim all night. His motivation is simple, as he explains to Meredith, and once again relates to recognition, to putting oneself in the shoes of the suffering person. Derek explains that he has four very maternal sisters, and they certainly would have come immediately should something similar happen to him, as he would want them to be. With no parents, and having moved to Seattle just three weeks before, the patient would otherwise have nobody waiting for her when she wakes up. In this case, the simplest demonstration of care - being close to someone in a moment of sufferance - is embodied by a doctor, a man, whom from the first episode has been characterized as the series' sex symbol, and who is a specialist in one of the most technical branches of surgery.

Grey's Anatomy therefore reverses the stereotype that care is entrusted to female figures, helpers or in ancillary roles, by depicting a neurosurgeon at the bedside of one of many patients for a whole night, and a female intern (Cristina Yang) as unscrupulous and horrified by human contact.

The afternoon's schedule continues with reruns of the fifth season of the extremely successful series *House M.D.*, broadcast on Italia 1, which introduced the politically incorrect to the field of healthcare on TV. Indeed, while before the début of *House M.D.* "most shows focused on a high level of expertise coupled with a human approach

to medicine, where curing and good bedside manner go hand in hand"[25], in this series the protagonist affirms in one of the very first episodes that "humanity is overrated": the human touch has no place in House's medical practice. On the contrary, he "firmly establishes medicine as a scientific endeavour. The scientific method and logical deduction are his primary means of discovery, with his interest in patients only extending as far as his interest in their various maladies. House sees bodies, and the symptoms they exhibit, as pieces of a logical and solvable puzzle"[26]. The series, which in 2008 won the award for the most watched TV series in the world[27] having been distributed in 66 countries, narrates the experiences of Gregory House, an eccentric and misanthropic doctor who battles with extremely rare clinical cases. The intricate diagnostics of the show are emphasized more than in any other medical drama, to such an extent that "every episode is resolved with a lesson in how to engage with patients in critical conditions, using more-or-less orthodox methods"[28]. In reality, the point is this: the more-or-less orthodox methods are precisely those that make the difference between care and cure. Not only does medical technology take preference over patient-centred approaches in House's modus operandi, but moreover the disrespectful and sadistic way that runs his clinic is ultimately legitimated since it is effective. The series produces an image of doctor-patient interaction that is characterized more in terms of the reparation of a sick body than of care for a person. For House, the patient is "first and foremost an object to explore scientifically, not someone with whom to engage in idle chatter"[29]. Indeed, one of the statements made by House in the first episode has become famous: that he became a doctor not to treat patients but to treat illnesses. The narration of the patient is therefore superfluous, if not actually deceptive. House does everything he can to avoid interacting with the patients, he does not want to see them, nor talk to them, he does not check up them except from behind electronic screens[30]. The total alienation of the

patients from their sickness and from their own doctor is denied, for House, in favour of Evidence Based Medicine, that same kind of medicine that has produced "a shift in the scientific foundation of medical knowledge from care for the individual to epidemiology and the health of the populace"[31]. As such, in the first episode aired by Italia 1 on Monday 2 March[32], House enters the patient's room only at the 49th minute, when the episode is about to end (and the "case" is mostly resolved). Until that moment, his hypotheses were based on information gathered by his assistants from tests and examinations. And his assistants waste no less time than House chatting to the patient: while doing an encephalogram and monitoring her, first from behind a glass wall and then from a computer screen, at a certain point they notice that her heart-rate flat-lines. They leap up, worried that she may have arrested, and only then notice that she is no longer in the room. This episode is not enough to make the doctors understand that a little more attention for the patient would not only lead them toward the care, but moreover help them gather clinical data more efficiently. In fact, a few sequences later, we observe another test on the patient, who is hooked up to a sensor. She asks, "will it hurt?". "No, give me your arm", answers Dr Taub, one of House's assistants. "You can ask nicely". As though it were somehow needed, the doctor even justifies his own lack of humanity, saying "I learned at the med school you don't actually cure with kindness". House's approach is infamous among his colleagues, to the extent that when a need emerges to liberate an office, the hospital director opts for House's, noting ironically that "other doctors actually use their offices for crazy stuff like seeing patients. Not throwing a ball against the wall and calling it work". The reply she receives is: "it's his process. That ball saves lives". Evidently the question of care vs cure is particularly carefully articulated in this episode. It might seem that House is dedicated only and ex-

clusively to finding a cure – and the subtext is certainly this – however, the finale of the episode complicates such a simple reading. The patient is a personal trainer who is obsessed with her figure; despite all of the pharmaceuticals with which the doctors experiment, at the end of the episode she feels better when given a slice of chocolate cake. House defines it as "your cure". She is diagnosed with hereditary coproporphyria: the body of the patient does not make enough of a certain enzyme, important for liver and other vital organs. The treatment is a high carbohydrate diet, rich in sugar. The patient asks if it "is treatable", and House tells her that she needs to follow a diet that is rich in sugars. At that point, the patient asks if there is another option; House's response is negative: there is a drug that controls its symptoms, but it is not a cure. The patient opts to begin with this[33], but House does not oppose her choice, conceding: "Understand. There's not many people who have the guts to admit they'd rather be pretty than healthy. The income's better and you get more action". His angry and disheartened assistants react differently: "I bought it. I bought that it was really about trying to make people's lives a little better". This circumstance thus recalls the affirmation of Jecker and Self, for whom "it is unfortunate, as well as confusing, then, to assume that doctors cure, as *opposed* to care"[34]. Beginning with the assumption that attempting to cure a patient is ordinarily an expression of physician's care for the patient, Jecker and Self consider it more opportune to propose a distinction, within the semantic field of care, between *care of* and *care about* the patient. They write: "a health professional who cares *about* a patient makes a cognitive or emotional decision that the welfare of the patient is of great importance. Caring about requires keeping the patient's best interest in the forefront of mind and heart. By contrast, a health professional who cares *for* a patient engages in a deliberate and ongoing activity of responding to the patient's

needs. Caring for, executed in an exemplary or excellent way, involves deciphering the patient's particular condition and needs"[35]. While it is clear that House does not possess any concern for what happens to the patient, at the same time he scorns that kind of paternalism that is "an attempt to justify performing (or omitting) an action that is contrary to a patient's expressed wishes, yet judged to be in patient's best interest"[36], which clearly aligns him with the "caring for" camp. It is certainly not reassuring relating to a doctor like House, but perhaps the mantra that justifies his approach ("What would you rather have? A doctor who holds your hand while you die or a doctor who ignores you while making you better?") should be reconsidered from a less Manichean point of view. The blurring of care and cure or of caring about and caring for reflects, in *House M.D.*, a further distinction that is common in the world of health: that between medicine as a science and as an art[37]. As Saunders writes, "the art and science of medicine are inseparable, part of a common culture. Knowing is an art; science requires personal participation in knowledge. Intellectual problems have an impersonal, objective character in that they can be conceived of as existing relatively independently of the particular thought, experiences, aims and actions of individual people. Without such an impersonal, objective character, the practice of medicine would be impossible"[38]. On the other hand, Saunders, continues, "Doctor factors such as emotions, bias, prejudice, risk-aversion, tolerance of uncertainty, and personal knowledge of the patient also influence clinical judgment. The practice of clinical medicine with its daily judgments is both science and art"[39]. For this reason, the author invites us to keep in mind the fact that "what is black and white in the abstract often becomes grey in practice, as clinicians seek to meet their patients' needs"[40].

Parents, Friends and Peers: Relationships as Care Communities

At 11.40 p.m., the evening schedule concludes with *Mystery Diagnosis*, an American TV show aired on Real Time Italia, which combines documentary, scientific information and fiction, and narrates the stories of patients who contracted "illnesses that baffle the experts". The episodes have a standard format: a prologue in which interviews and images introduce the mystery that will be resolved during the episode; then a voice-over that introduces the day's "case", which is complemented by the accounts of the patient, her/his relatives and the doctors. The representation of healthcare here is curious. As we note from the opening credits (and the title), the programme intends to talk about diagnoses, not ill people, and yet the diseases are deeply rooted in the biographies and lived experiences of the patients: images of bodies are interspersed with others of daily life, and the voice-over explains the extent to which the disease weighed on the lives of the patients, who surrounded them during the experience, what their anxieties were. The doctors are not depicted as inhuman, at best as professionals that are sometimes hasty and superficial. One of the characteristics of the "mystery" diseases is that they are not immediately recognized on first contact with the doctor. For this reason, during the course of the episode, patients usually consult more than one healthcare professional. The most interesting element for this discussion is that when the protagonists finally find the doctor who is able to diagnose correctly, who will resolve their difficult case and perhaps find a treatment, s/he is (*ex-post*) described as someone who was finally able to take the right care of them, something which had been absent in the previous interactions with doctors. When the protagonist of the episode is brought into a specialized clinic for genetic tests, on the basis of recommendations from other doctors, the relatives say: "Dr. Moreng made us feel at ease right away. She listened to what we had to say"; and "Finally, we had found someone who

was working for the good of Eleyna". In the next episode, following an appointment with a doctor that mistook a serious disease (paragonimiasis) for an influenza, the mother of protagonist Adam seeks out a specialist online who can solve their enigma. She recounts: "when I met the doctor, I was convinced that he would work out the cause. He calmed me down. He was very self-assured". Whether this is an exaggerated rhetorical strategy or not, the cure appears successful only when it also accounts for the worries and suffering of all the people involved. This representation of care is the opposite of that seen in *House*. Here, without a shadow of doubt, the capable doctor is depicted as one who cares not only for the patient, but also about the patient: paraphrasing House, a doctor who holds your hand *while* you get better.

In the factual series *One Born Every Minute*, a kind of docu-reality show that was broadcast on Sunday 15 March 2015 at 08.25 a.m., care and cure emerge principally in the moments in which the obstetricians do their rounds of the soon-to-be-mothers, and spend time chatting to the patients. This distracts and calms them during their contractions. We can observe how the midwives form a kind of community around the pregnant women, consulting one another and, in the episode in question, asking colleagues for help in breaking the water of a woman before calling the doctor, who "has a more direct approach". The attention for the psychological state of the women is constant. The more experienced patients, accompanied by their companions, are given greater privacy, while younger women are monitored more carefully and asked questions that seek to clarify their emotional state (in relation to their partners, too). In some ways, in part thanks to the effect of reality TV, the series naturalizes the role of the midwife, depicting a professional who deals contemporaneously with care and cure, making it difficult to separate the two moments or attitudes towards the new mothers. In this sense, the rhetoric of the show is by no means forced; on the contrary, the midwives are depict-

ed with upright characters, clear-headed and direct, but not intent singularly on the more technical aspects of their work. The spontaneity with which they are immortalized in their work makes the interconnection of care and cure less a finish line to aim for than the implicit foundation of the relationship between professional and patient.

A curious dimension of care and cure emerges during prime time, in the series *Braccialetti rossi 2*, produced by Rai Fiction and based on the book *Polseres Vermelles* by the Spanish writer Albert Espinosa. The series narrates the story of the lives, illnesses and recuperation of a group of adolescents who have been admitted to a hospital. Leo, the leader of the group, gives each of his friends one of the red wristbands that mark his operations. These become the symbol of the group. The last episode of the second series was aired on 5 March. In reality, the episode is slightly anomalous, insofar as much of it is not set in the usual hospital ward but outside, on the island of San Nicola, where the group travel to deliver the letter from a recently deceased patient to an old friend. Despite the change of scenery, the elements that characterize the series broadly are all present. Illness is a rite of passage that, in this context, overlaps with other rites, from infancy to adolescence, or from adolescence to adulthood. The community of peers (other companions, ill too or recently healed) accompany the group through this period of their life, as daily events assume different tones and bristle with difficulty. Those who have already lived such experiences become mentors, guides, a support and a helping hand during the transformations that the protagonists must face. Their parents, when present, are unable to face up to the dramatic situations that present themselves in their children's lives: they cannot understand or endure them, they despair, as (during this episode) in the case of the father of Flaminia, a blind girl who returns from an unsuccessful operation. The doctors and nurses are humane and compassionate people that are ready to agree to their patients' requests, though in

the series they have only secondary roles. For a change, the real protagonists are the patients and the care community that they construct: the so-called rescue community mentioned above is represented here not by the doctors but by other patients admitted to the same hospital. As such, the group meet up in the evening in each other's rooms, and they reassure each other before going to bed. They quite organically persevere in their efforts to bring every person, even those that are suffering the most or unconscious, into their group and way of life. In this episode, the young Rocco spends his days in Bea's room, though she is in a coma, telling her the stories of their companions on the Island, encouraging her to follow his lead. He had been in a coma too, and tells her that shortly before waking up he dreamt of a pool, and that he woke up only when he finally found the courage to dive in. Bea will awaken only when Chicco, another patient in the hospital, apologises for having unwillingly caused the accident that brought her to the hospital. The whole community is watched over by Davide, an "ex-braccialetto rosso", who passed away during heart surgery, though appears invisibly to all but one of the group and can intervene in their reality. The series depicts countless representations of care, ranging from the sharing of fears and daily difficulties to small gestures of attention, such as when Chicco lends to Flaminia a piano that she had always wanted to play, despite her impaired vision. And when one of the group faces an aggressive disease with a low survival rate, and he decides to distance himself from the group, they remind him how he had helped each of them and so it is his turn to allow himself to be helped in return. The lyrics of the show's soundtrack is emblematic of this "communal care": "Take care of my secret and ask me if I am happy, be ready for the start of the world, tonight I will say "yes". Take care of my past and ask me If we are happy, be ready for the start of the world, it's wonderful saying "yes". Be ready, it's wonderful saying "yes". That way we'll learn to let it all

go, to not fear love so long as it is there, and let's bet whether there is more life in a miracle or inside a ward and laugh at a destiny that changes as we change our minds".

Unlike other medical dramas, *Braccialetti rossi* is less interested in showing how illness works than how young people respond to it. Indeed, the series suggests that ill people are ill people, but that they are also much more at the same time: the boy who falls in love, the one who struggles with his studies, and so on. Illness makes every thing and every experience necessary, important and intense, and it is often compared to a workout (and the depiction of hospital's rehabilitation gym supports this). Perhaps it is for this reason - as well as for the show's target audience, which includes very young spectators - that the young people are depicted as being full of life, despite their suffering. But the real unit of measurement for care in this series is the friendship that emerges among the protagonists: the group of the "braccialetti" is what allows them to overcome their daily difficulties, not least of all the solitude that often accompanies sickness. In scientific literature, as unfortunately in practice too, care is associated more with palliative medicine than with its many other branches. The series proposes an opposite message: the necessity that care permeates the entire experience of illness, and as such that it brings us to represent patients as dynamic and living at every stage, until the last day of one's life.

Closing Remarks

At the end of this overview of programming from a sample of two days, it is possible to maintain that care and cure are aspects of medicine that are depicted with different grades of complexity according to the genre of the programme in which they feature. In scientific-informative shows *Elisir* and *Medicina 33*, thanks to the rhetorical strategy of unadorned, candid information (which goes hand in hand with its implied scientific and objective basis), cure and its related

aspects prevail: new pharmacological treatments, new investigative diagnostic techniques, data relating to public health. The only emphases of the show relating to care are those which address prevention, that in any case call for the patient to adopt their own responsibility. Care is thus not presented as a prerogative, instrument or objective for health professionals. In medical dramas and documentaries, references to care are frequent and its representations are often composite, despite the fact that it is often one aspect of a hospital setting in which cure doubtless dominates. In *House M.D.*, care is characterized as a superfluous attention if not a hindrance to more efficient scientific methods that are typical of EBM. The diagnostic rationality of the doctor serves to repair bodies, and nothing else. However, the ultimate respect that House affords to the patient and their needs and desires makes of him a doctor that "cares for" the patient. *Grey's Anatomy* offers the spectator a variety of situations in which care and cure become explicit in the wards of a hospital. The series overturns diverse stereotypes, for example attributing the virtues of compassionate care to a male neurosurgeon and the characteristics of coldness, competition and distance to a young female intern. Professional care is a fundamental element of the healing process in the medical documentary *Mystery Diagnosis*, just as the professionalism of the midwives of *One Born Every Minute* is a quality that is taken for granted. And finally, one of the most original representations of care and cure is to be found in *Braccialetti Rossi 2*. The combination of humanity and the context of the hospital, that is the series' setting, is the only one, among those shows analysed here, that prioritizes care over cure. Illness forms a rite of passage that must be tackled collectively by a group that includes those who are facing it and those who already have. The most efficient form of care is the relationship with the group of companions, peers and other patients in the hospital.

Ultimately care is not excluded from televised representations of medicine, but the context in which it is most often portrayed is that of the fictional medical drama, the domain of the plausible but not of the real. While it is true that fiction is a powerful tool when in the hands of the spectator, insofar as it can "help individuals to take a distance, to imagine alternatives and thereby to question traditional practices"[41], we must hope that these alternatives can ultimately go beyond the screen and enter into our hospitals, if they have not already.

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1. For a catalogue of all shows with a medical theme on Italian television, see GISOTTI R., SAVINI M., *Tv buona dottoressa? La medicina nella televisione italiana dal 1954 ad oggi*. Roma, Rai-Eri, 2010; DIONISIO A., *Quando la medicina si fa in Tv. Benessere, salute e professione sanitaria rappresentate nel piccolo schermo*. Napoli, Guida, 2009.
2. Source: CENSIS, *47° Rapporto Annuale sulla situazione sociale del Paese: Comunicazione e media*. Roma, 11 Ottobre 2013.
3. Source: MONITOR BIOMEDICO 2014, *Informati ed insoddisfatti: verso una sanità minimale?* Roma, Fondazione Censis, 27 October 2014, p. 8. The other sources from which respondents claim to have acquired much of their medical knowledge include, in first and second places, general practitioners (73.3%) and specialist doctors (27.0%), followed by television (19.3%) and the internet (19.2%), which consign not only friends and family (14.8%) to a lower position, but also newspapers (8.2%), pharmacists (7.8%) and patient associations (0.9%).
4. Monitor Biomedico statistics are based on a nationwide sample of 1000 individuals.
5. CANGUILHEM G., *Il normale e il patologico*. Torino, Einaudi, 1998.
6. At the peak of *ER*'s success in the USA, many critics justified its popularity in relation to a growing anxiety over the efficiency of the health system. Even Stephen Spielberg, co-producer of the series, observed that "People are afraid to go to the emergency room, they fear not getting the right treatment and ending in the hands of pitiless doctors. In *ER*, though, they see that even

in the chaos of the emergency room, whoever comes gets decent healthcare; that the doctors are tired but at the moment of truth they are completely committed". (Source: BIZIO S., *Al pronto soccorso firmato Spielberg*. La Repubblica, 11 November 1994, p. 43, my translation).

7. SEALE C., *Media and Health*. London, Sage, 2002, p. 23.
8. Expression by LUSUARDI N., *La rivoluzione seriale. Estetica e drammaturgia nelle serie hospital*. Roma, Dino Audino, 2010.
9. From A. B.'s response to the questionnaire, completed on 08/12/2010 (my translation).
10. For a more detailed discussion of this point, cf. CAPPI V., *Pazienti e medici oltre lo schermo. Elementi per un'etnografia dei medical dramas*. Bologna, Bononia University Press, 2015; DAVIN S., *Urgences et ses spectateurs: la médecine dans le salon*. Paris, L'Harmattan, 2007.
11. PIZZA G., *Antropologia medica: saperi, pratiche e politiche del corpo*. Roma, Carocci, 2008, p. 189 (my translation).
12. LUPTON D., *Medicine as Culture: Illness, Disease and the Body in Western Society*. London, Sage, 1994, p. 19.
13. I have excluded from this list the TV series *Diagnosis: Murder*, broadcast that day on Rete 4 at 12 a.m.; though it is predominantly set in a hospital and its protagonist is a doctor, the show is commonly labelled and is recognisably a detective rather than medical drama. The show focuses on Dr Mark Sloan, who is dedicated to helping his police officer son to resolve murder cases, in the guise of a consultant for the police department.
14. Massimiano Bucchi in turn adapts the distinctions between categories proposed by PETERS H. P., *Mass Media as an Information Channel and Public Arena*. Risk: Health, Safety & Environment 1994; 5: 241-250.
15. BUCCHI M., *La salute e i mass media*. In: INGROSSO M. (ed.), *Comunicare la salute. Scenari, tecniche, progetti per il benessere e la qualità della vita*. Milano, Franco Angeli, 2001, p. 89 (my translation).
16. MAZZOLENI G., SFARDINI A., *Politica Pop. Da "Porta a Porta" a "L'isola dei famosi"*. Bologna, Il Mulino, 2009, p. 47 (my translation).
17. INGROSSO M. (a cura di), *Comunicare la salute. Scenari, tecniche, progetti per il benessere e la qualità della vita*. Milano, Franco Angeli, 2001, p. 10 (my translation).
18. VICARELLI G. (ed.), *Il paradigma perduto? Medici nel Duemila*. Milano, Franco Angeli, 2004, p. 11 (my translation).
19. According to Ingrosso, "the biggest effect of this "doing culture" has been the objectification of the body, the classification of our needs, the measurement

of risks. Doing demands an object of the action, which absorbs its impact and gives value to the effect. The agent and cause must produce results, potentially measurable but certainly effective, useful, beneficial results" (INGROSSO M., see note 17, my translation).

20. Alexandra Brewis writes: "People can be time poor, as well as money poor; awareness of this phenomenon is important in thinking about associations between income, poverty, and obesity-risk. […] Where people have sedentary or fixed-location jobs with long, inflexible hours, time poverty can be a real problem for both eating and exercising. Families in poverty tend to face the most difficult tradeoffs, because their choices are often so comparatively limited" (BREWIS A., *Obesity: Cultural and Biocultural Perspectives*. New Brunswick, Rutgers University Press, 2011, p. 69).
21. KELLEY J. M., KRAFT-TODD G., SCHAPIRA L., KOSSOWSKY J., RIESS H., *The Influence of the Patient-Clinician Relationship on Healthcare Outcomes: A Systematic Review and Meta-Analysis of Randomized Controlled Trials*. PlosOne 2014; 9: 94207.
22. From an interview with M. S., general practitioner, 64 years old, carried out on 04/03/2014 at his clinic, in Bologna (my translation).
23. As the series continues, we discover that the doctors and the interns, in order to survive the grievances of the world they inhabit every day, begin to take care of each other.
24. JECKER N. S., SELF D. J., *Separating Care and Cure: An Analysis of Historical and Contemporary Images of Nursing and Medicine*. The Journal of Medicine and Philosophy 1991; 16: 293.
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26. STRAUMAN E. C., GOODIER B. C., see note 25, p. 36.
27. Source: Eurodata TV Worldwide, *House is the World's Most Popular TV show*. Agence France Presse, June 12 2009.
28. GRASSO A., *Buona maestra: perché i telefilm sono diventati più importanti del cinema e dei libri*. Milano, Mondadori, 2007, p. 146 (my translation).
29. SCIBILIA G., *Spacciare la medicina nera per la bianca. Doctor House e la medicalizzazione*. Aut Aut 2008; 340: 174 (my translation).
30. *House* embodies the modern (late 19th, early 20th century) approach to medicine, precisely in the way it is described by Michel Foucault in *The Birth of the Clinic*. For a lengthier comparison between the two images of medical

practice, see CAPPI V., *Pazienti e medici oltre lo schermo. Elementi per un'etnografia dei medical dramas*. Bologna, Bononia University Press, 2015.

31. TOUSIJN W., *Opportunità e vincoli per una nuova logica professionale*. In: SPERANZA L., TOUSIJN W., VICARELLI G., *I medici in Italia: motivazioni, autonomia, appartenenza*. Bologna, Il Mulino, 2008, p. 150 (my translation).
32. The episode is the tenth of the fifth season, entitled "Let Them Eat Cake".
33. We might note that in this case, the patient demands care from the doctors, but when the responsibility for her health falls back to her, she opts for pharmaceutical treatment (a cure) rather than taking care of her own body, by adopting a different diet. This corroborates the suggestion that a cure is often a "convenient" solution, that frees the interested parties from having to face up to the most difficult and intimate aspects of the condition of sufferance.
34. JECKER N. S., SELF D. J., see note 24, p. 303.
35. JECKER N. S., SELF D. J., see note 24, p. 295.
36. JECKER N. S., SELF D. J., see note 24, p. 297.
37. Saunders writes: "for medicine as an art, its chief and characteristic instrument must be human faculty. What aspects of the faculty matter? We are offered the ability to listen, to empathise, to inform, to maintain solidarity: for the doctor, in fact, to be part of the treatment" (SAUNDERS J., *The practice of medicine as an art and as science*. Medical Humanities 2000; 26: 18).
38. SAUNDERS J., see note 37.
39. SAUNDERS J., see note 37, p. 22.
40. SAUNDERS J., see note 37, p. 22.
41. THOMPSON J. B., *The Media and Modernity: A Social Theory of the Media*. Oxford, Polity Press, 1995, p. 177.

Correspondence should be addressed to:
Valentina Cappi Piazza S. Giovanni in Monte 2 – 40124 Bologna, I
e-mail: valentina.cappi3@unibo.it