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Are Television Deaths Good Deaths? A Narrative Analysis of Hospital Death and Dying in Popular Medical Dramas

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ABSTRACT

This study explores death narratives in the popular international medical dramas *Grey's Anatomy (USA)*, *Casualty (UK)*, *All Saints (Australia)*, and *E.R. (USA)*. Using narrative analysis, we characterize death portrayals in terms of the number and causes of the deaths, the types of characters who die, the narrative structures of the deaths, and themes found within the death stories. We then compare characteristics actual patients, physicians, and caregivers identify as important in a death experience with the characteristics of deaths portrayed in medical dramas. Our narrative analysis shows that death narratives in medical dramas lack narrative fidelity with the characteristics of “good” death experiences described in the literature.

Mediated experiences of death have become very common; in television, video games, and even social media, death is a ubiquitous theme (Durkin, 2003). Ironically, though fictive death is common in our mediated lives, actual death experience in Westernized medicine is a largely concealed experience—overseen by healthcare organizations in hidden spaces (Imhof, 1996). Studies suggest that most people witness death much more frequently through media outlets such as television than they do in the real world (Buchan, Gibson, & Ellison, 2011; Silveira, DiPiero, Gerrity, & Feudtner, 2000). Consequently, individuals may learn more about dying from mediated sources than from witnessing actual death experiences. Thus, as Sharf and Freimuth (1993) have argued, stories from entertainment television are potentially filling the “knowledge gap” individuals have about death with “narrative portrayals” (p. 141).

The way medical dramas portray death and dying is of particular interest, given the new capabilities of modern medicine, the growing aging population throughout the world, and the current attention to engaging patients in planning for their end-of-life care. Moreover, there is considerable debate and disagreement about what makes a “good” death (Meier et al., 2016). Clearly, many factors, including psychological, social, and cultural influences, shape individuals’ beliefs about death and dying (Durkin, 2003). But evidence suggests that throughout the world, while most would prefer to die at home, a larger portion of people die in the hospital or other health facilities (Broad et al., 2013). Although this disconnect is likely caused by a number of cultural and systemic factors, other academic work in this area suggests that patient wishes are often not carried out by healthcare institutions (More, 2014).

Given the worldwide prevalence of hospital deaths and the disparity between patient preferences and the

circumstances of their deaths, this study seeks to describe how deaths in medical dramas are portrayed and how a good death is represented in the stories they tell. This study then asks how television deaths compare to the way patients, providers, and caregivers within healthcare systems describe the characteristics of a good death. This inquiry focuses specifically on prime-time television medical dramas. Medical dramas such as *Grey's Anatomy*, *All Saints*, *Casualty*, and *E.R.* have been among the most popular, widely distributed, and longest running series in modern television (Brooks & Marsh, 2009). These fictional accounts of patients’ and providers’ experiences in healthcare institutions attempt a high degree of realism; they are consumed globally; and most importantly to this study, they are often regarded as a source of health information by viewers (Ye & Ward, 2010). The stories told by medical dramas are often powerful and persuasive, and, of course, prevalent. To understand the relationship between these fictive deaths and actual deaths, we first describe the characteristics of the fictive deaths. Then, we compare those characteristics with the experiences of patients, physicians, and caregivers described in academic literature.

To that end, this study presents a narrative analysis of two seasons of each of the popular medical dramas *Grey's Anatomy*, *Casualty*, and *All Saints*, as well as one season of *E.R.* As we examine representations of death in these medical dramas and compare their characteristics with characteristics patients, physicians, and caregivers identify in a “good death,” we argue that even though the narratives may fill a “knowledge gap” about death, the deaths in medical dramas lack narrative fidelity with the most common characteristics of a “good death.” Finally, we discuss the way medical dramas might address these issues.

Medical dramas as health narratives

As stated, narratives are powerful. They can have profound influence over individuals' perceptions and beliefs. They provide persuasive ways to make sense of uncertain situations, to explain decisions, and to infer value and judgments (Sharf & Freimuth, 1993). In his Narrative Paradigm Theory, Fisher (1985) argues that persuasive narratives are imbued with coherence and fidelity. Narrative coherence concerns the story's ability to logically hold together. Narrative fidelity concerns whether or not the story is true to viewers' experiences. Evaluating narrative fidelity includes examining the facts presented and the values embedded in the story (Fisher, 1985). Fisher conceived of narrative theory as inherently democratic in nature; any viewer or listener has the ability to judge the relative persuasiveness of a narrative. But Narrative Paradigm Theory can also be used as an empirical tool for assessing the persuasive techniques of health narratives (Lumpkins, 2012). It can be used to examine the logic of a health narrative and whether or not a health narrative is faithful to the experiences of those involved in medical events.

This analysis focuses primarily on deaths in medical dramas—it examines the factual circumstances surrounding the deaths and the themes used to give meaning to these deaths. Previous studies have touched on some of the factual inaccuracies included in medical dramas. For example, the rate of death in medical dramas is nearly nine times what is expected in the average hospital (Hetsroni, 2009). Another study focused exclusively on representations of end-of-life care in medical dramas examined instances of patient–physician communication in end-of-life care, advance care planning, resuscitation, and expectation of death (Houben, Spruit, Wouters, & Janssen, 2016). It found that many of the communication issues important to implementing advance care planning were not addressed in the dramas studied.

The values used to give meaning to these deaths have also been questioned. These questions can be found even outside the boundaries of fiction, in new stories, for example. Seale (2004) examined news coverage of individuals who died alone and found that these deaths were often attributed to moral and social failings, when actually these individuals died alone for multiple reasons. The news narratives imbued the solitary deaths with negative moral judgments. Like the news stories, in fictional medical dramas, deaths are also often constructed to suggest certain values and morality. Death has, for example, been framed as productive for the healthcare system. One study of medical dramas found that deaths as a result of malpractice were often narrated as part of physicians' learning processes (Foss, 2011). These narratives shifted focus and viewer empathy from the dying patient to the learning physician, diminishing attention to the patient's experience. Thus, in narrative, both facts and values surrounding death are shaped according to a writer's vision and may lack fidelity with the experiences of actual patients and their families.

This study first aims to answer the following question through narrative analysis:

RQ1: How do television dramas portray death in the facts and values embedded in the stories they tell?

Narrative elements of a good death

A second inquiry regarding death narratives in medical dramas involves assessing their narrative fidelity with themes associated with a good death. This inquiry begins with an assessment of how the real-life counterparts to characters on medical dramas—patients, healthcare providers, and caregivers—define a good death within the healthcare system. Academics, medical professionals, and patients worldwide offer differing ideas of the elements a good institutional death (Hughes, Schumacher, Jacobs-Lawson, & Arnold, 2008). Despite their differences, all agree on several key themes. Communication about death might be one of the most fundamental aspects of accepting and coping with the death process. Communication helps orient the patient to seek out a good death or in the case of health professionals and caregivers, to provide a “good” death experience (Hughes et al., 2008). Effective talk about death includes expressing emotions, discussing patient goals and preferences, and reflecting on the patient's life (Goldsmith & Miller, 2015).

Another widely accepted feature of the good death is a patient's exercise of autonomous decision-making prior to death (Payne, Langley-Evans, & Hillier, 1996). Autonomy in end-of-life care includes the denial or affirmation of invasive treatments, choice of place of death, and choice of surrogate decision-makers. Because patient autonomy is considered a cornerstone of contemporary Western medical practice, even the act of delegating or deferring decision-making to others is important in these circumstances (Virdun, Lockett, Lorenz, Davidson, & Phillips, 2016). Finally, freedom from pain and suffering is an important characteristic of a good death under medical care, including pain management via medication at the end of life (Meier et al., 2016).

Patients, physicians, and caregivers differ in the importance of other characteristics of a good death. When asked to describe a good death, patients with advanced lung cancer defined a good death as painless, quick, peaceful, and preferably during sleep (Hughes et al., 2008). Some family members agree that sudden and swift death is more desirable (Aleksandrova-Yankulovska & Ten Have, 2015). However, while patients ranked spirituality a higher priority for a good death, family ranked quality of life, life completion, presence of family, and dignity higher (Meier et al., 2016). A meta-synthesis of patient and family concerns about end-of-life care found that patients are also concerned with financial issues such as cost of care, as well as the compassion of their healthcare providers (Virdun et al., 2016). Family and caregivers' descriptions of the good death include the caregiver's confidence in their ability to care for the patient, having meaningful social connections with both the patient and other members of their social circles throughout the experience, and support during the grieving process (Holdsworth, 2015).

Finally, health professionals frame the good death in institutional terms. Health professionals, including physicians,

nurses, and psychologists, have agreed on several common aspects of a “dignified death”: a quiet, private environment; freedom from pain; close proximity of family; and the exercise of patient autonomy when possible. They cite institutional problems that need to be addressed to ensure better end-of-life care, such as consistent physician communication, emotional support of family members and medical professionals attending to dying patients, and improved patient and family decision-making (Cipolletta & Oprandi, 2014). Another study of nurses also noted the importance of closure in the good death, for both family members of the dying person and staff members (Endacott et al., 2016).

These elements will be used to help answer the following research question:

R2: Do representations of death and dying in medical dramas include elements of a “good death” from any of the perspectives presented?

Methods

Medical dramas sampled

A total of 113 deaths were analyzed in this study. Two seasons each of the American medical dramas *Grey’s Anatomy* (season 9, 2012–2013, 24 episodes, 11 deaths; season 12, 2015–2016, 26 episodes, 14 deaths) as well as the British drama *Casualty* (series 29, 2014–2015, 46 episodes, 21 deaths; series 30, 2015–2016, 43 episodes, 20 deaths) and the Australian drama *All Saints* (season 11, 2008, 40 episodes, 18 deaths; season 12, 2009, 37 episodes, 18 deaths) were chosen. And one season of *E.R.* was chosen (season 15, 2008–2009, 22 episodes, 11 deaths). These dramas were chosen because they are some of the most popular and widely viewed medical dramas throughout the world, and they all present hospital experiences.

E.R., a medical drama set in the emergency department of a fictional Chicago hospital, ran for 15 seasons. At its peak, the show’s viewership in the United States alone was between 30 and 48 million viewers (Toff, 2009). Although the final season of *E.R.* finished in 2009, the show is still considered one of the most award-winning in television drama history, having won 124 Emmys and a Peabody Award (NBC, 2016). *Grey’s Anatomy* (in its thirteenth season) is an American medical drama that follows the lives and careers of a group of Seattle surgeons. It has been one of the top-rated medical dramas throughout its run, and is among the top-rated U.S. programs for the 18–45 age group (Kissell, 2015).

The British show *Casualty* is the longest running medical drama in the world, having aired for over 30 years (Love, 2010). Set in the emergency department of the fictional Holby City Hospital, the series is now in its 31st season. The Australian medical drama *All Saints* aired for 12 seasons and is also set in the emergency department of a fictional hospital. It follows the lives of the staff and patients treated there and was one of the Australia’s most popular dramas. All have been aired both nationally and

internationally, and they have each been translated into several languages.

The seasons of each show analyzed were chosen using several criteria. First, upon screening episodes of each show, it became clear that episodes in which a major character of the series died offered some of the richest opportunities for narrative analysis, as well as a contrast for the treatment of the deaths of non-recurring characters. Thus, the earliest season chosen involves the death of one of the major characters of the series. In the series *E.R.*, the oldest series in the sample, the final season also included the death of a major character, so it was the only season of that series chosen. Second, the most recent complete season of each series was chosen. Because interest in end-of-life care has become more prominent in recent years, we chose a more recent season of each series so that historic differences could be accounted for. Finally, these seasons were chosen because they represent both peak-rated seasons and subsequent seasons.

Narrative analysis

Narrative analysis is a type of content analysis that involves taking apart the logic of stories to determine their meanings (Fisher, 1985). This method has been used to analyze content throughout the social sciences and in psychology extensively; it is often used to analyze media content such as television programs (Gauthier, 1999). Although there are many theoretical avenues through which narratives can be studied, common to all these approaches is the identification of features including characters, plot, narrative structures, and themes (Cullum-Swan & Manning, 1994). Thematic analysis involves piecing together the narrative elements to construct an overarching idea (Altheide, 1996).

A second step in narrative analysis using Fisher’s (1985) Narrative Paradigm Theory is the test of narrative fidelity. This part of the analysis involves an examination of the facts and values included in the narratives to see if these deaths “ring true” with lived experiences. Thus, this narrative analysis is divided into two parts: (1) a summative analysis of each death storyline, examining its narrative features and (2) a directed analysis of all death scenes based on characteristics of a good death described by patients, caregivers, and healthcare providers.

All seasons studied in this analysis were coded in multiple passes. The initial round of coding involved identifying deaths, both on-screen and off-screen. Once deaths were identified, scenes connected to the death were watched and coded again for manifest features of the narratives, including characters, plot, and narrative structures. Thematic codes were developed and applied through additional viewing. Finally, the directed analysis was performed using the following categories: communication among patients, physicians, and caregivers about death; autonomous decision-making related to the circumstances of the death; freedom from pain and suffering; discussion of spirituality; discussion of financial issues; patients’ and caregivers’ social connectedness and emotional support; and closure in the death experience.

Findings

Findings from the summative analysis

Deaths

Of those 113 deaths included in this sample, 25 occurred in *Grey's Anatomy*, 11 occurred in *E.R.*, 41 occurred in *Casualty*, and 36 occurred in *All Saints*. Among the deaths, 60 are accidental or the result of a crime, including car crashes, plane crashes, explosions, drug overdoses, and murder; 35 are due to a chronic illness such as Alzheimer's disease, heart disease, or Lou Gehrig's disease; 15 are due to medical mistakes; and three are due to a refusal of treatment.

Characters

Those who died range in age from infants to over 90. Although many characters' ages are not indicated and could not be precisely calculated, characters fall into the following age ranges: under 18, adult ages 19–64, and adults 65 and over. In sum, 20 deaths involve children under 18, 14 involve adults who appeared to be over 65, and 79 deaths involve adults under 65. The characters are fairly evenly divided by gender, with 58 men and 55 women represented. Although some of the deaths occur among patients who do not have enough of a backstory to be identified racially, the majority of the patients who die—68—either identify as white, or appeared to be white.

Of the characters who die, 12 are included in a story arc told over multiple episodes of a series. Of these characters, five are healthcare providers who face terminal illnesses. Others are recurring patients or relatives of the healthcare providers.

Narrative structures

All but four of the deaths included in the sample involve multiple scenes. These four deaths are of victims of mass casualty events that include multiple, simultaneous treatment sequences. Of the remaining deaths, we categorized the narrative structures in two ways. First, we categorized the extent to which each story arc covers the death experience of the patient. We asked (1) whether the story included lead-up to the death in which the patient interacted with others, such as discussion of the illness, end-of-life care decision-making, or other development of backstory; (2) whether the story included scenes showing actual corporeal death (Do we see the actual death?); and (3) whether any after-death story was covered, such as body preparation, funeral services, or other mourning activities. In this part of the analysis, we found that 31 of the deaths include backstory; 34 show actual, physical death; and 15 include post-death story. Because we found multiple scenes in which healthcare providers discuss patient deaths after they occur, we secondly searched for scenes involving discussion and explication following the death. We found 43 deaths in which further explication was done by health providers.

Themes

We found that the themes of death stories are told largely in terms of the relationship between the healthcare institution

and the patient. Because physicians and other healthcare providers are at the center of these dramas, the major sense-making function of these stories is how they inform the development of the provider (usually a physician) and how they inform the development of healthcare institutions (usually the hospital in which the drama is set). The key themes that emerged in our analysis were (1) Faulting Healthcare Institutions, (2) Faulting the Patient or Caregiver, (3) Dying a Hero, and (4) Offering a Dying Life Lesson.

Faulting the healthcare institution. The most common theme among these deaths has to do with providers' blame and fault surrounding the death. These deaths involve the exercise of medical judgment, ethical issues, and medical mistakes. These situations often involve good intentions gone bad. In an episode of *E.R.*, for example, an experienced trauma nurse allows a patient with a severe skin infection to leave the emergency room with an intravenous line still in because the patient wants to leave to take his G.E.D. test. Hours later, the patient is rushed back into the E.R., having used the line to inject an overdose of heroin.

In an episode of *Casualty*, treating emergency physicians assume that a woman who has come to visit a patient dying of injuries in a car accident is the patient's surrogate decision-maker. She decides to take the patient off life support, and the patient dies before the staff realize that she is not the patient's surrogate, but is, in fact, the mother of a boy the patient killed. These and similar instances from other medical dramas underscore the fact that patient deaths often involve the character development of series regulars—healthcare professionals who must learn from their mistakes. This focus means that death narratives are often structured around the medical professionals' experience of them, as opposed to patient and family experiences.

Faulting the patient or caregiver. Three of the medical dramas include a death narrative in which death is hastened because the patient refuses a likely successful treatment based on religious beliefs. Two examples of this type of fault deal with the treatment of patients whose faith prevents their accepting treatment. In an episode of *Casualty*, Ash, an experienced physician, becomes so frustrated with his inability to treat a patient because she is a Jehovah's Witness that he attempts to give her a blood transfusion and is only stopped when several colleagues physically block him. In an episode of *Grey's Anatomy*, a young injured skateboarder cannot have blood transfusions, and he will die. There is no dialogue with the patient because he is unconscious, but the two scenes leading up to his death involve young interns frustrated by having to honor his family's religious preferences. Blame or fault is placed on the religion, with one intern stating, "This is so stupid!"

Several of the deaths also involve placing blame on caregivers. When Adele Webber, the wife of *Grey's Anatomy's* Chief of Surgery Richard Webber, dies, the dialogue focuses on Richard's feelings of guilt. Adele, who has early onset Alzheimer's disease, has been living in a nursing home for years. Both Adele and Richard begin new relationships during

that time, and while Adele is having surgery, Richard reveals that he stopped visiting her because his visits confused and upset her. Her death is framed by scenes in which Richard discusses his guilt about neglecting her. Additional sources of fault include religious and social institutions. Similar examples from *All Saints* and *Casualty* include inattentive or frustrated caregiving for elderly patients with progressively disabling conditions such as dementia and motor neuron disease.

Dying a hero. Another sense-making theme related to patient deaths is that of heroism. One such heroic act is saving the lives of others through organ donation. The theme of heroism through organ donation is present in three death narratives. These stories all culminate with family members having to come to terms with the patient's choice and having to accept the loss. In the episode of *E.R.* in which physician Greg Pratt, a recurring character, dies, Pratt's brother must come to terms with Pratt's brain death to authorize organ donation. Another act framed as heroism in dying is the death of a young mother whose baby was born after the mother is severely injured in a car accident. In this episode of *Grey's Anatomy*, the young mother is praised for "holding on" for her child.

Offering a dying life lesson. A final theme weaved into the narratives of 11 dying patients is that of the wise man (all male characters). In each case, the character manages to impart wisdom on others or give sage advice before his death. In an episode of *E.R.*, for example, a founding physician of the hospital in the series, Dr. Oliver Kostin, has late stage Alzheimer's disease and is admitted to the E.R. for treatment. His Alzheimer's has advanced so that he can only say his name. As the E.R. staff tends to him, he tries on several occasions to communicate something to them. He is finally able to write tuberculosis (TB) on a piece of paper. It turns out that the woman in the bed next to his, who was thought to have a rare and deadly cancer, is suffering from TB. The E.R. staff recognizes that Dr. Kostin is saving one last patient with expertise from his many years of treating the disease. In *Casualty*, this theme is embodied by the character Alfred Maxwell, a physician suffering from Motor Neuron Disease, a degenerative condition that ultimately causes a lack of muscle control. Although he grows less able to communicate through the arc of his story, he dispenses a great deal of advice to Connie, an experienced physician, who views him as a mentor. This story is of particular interest because he also challenges her notions of compassion and ethics when he asks for her assistance in taking his life.

Findings from the directed analysis

These themes make clear that the fault-themed deaths are untimely and generally "bad" deaths, while deaths involving themes of heroism and wisdom are "good." But the elements that commonly define a good hospital death include open communication about death with friends, family, and physicians; autonomous decision-making throughout the death experience; and freedom from pain and suffering. The

majority of the deaths examined in this study do not contain these characteristics.

Communication about death

Communication about death with physicians and families is found in only 13 of the deaths studied. This communication includes discussion of the process of dying, the potential for pain and suffering, and coping with eventual loss. The storyline with perhaps the most conversation about death and the process of dying occurs in *All Saints* with the character Ann-Marie Preston, a patient and eventual love interest of series regular Dr. Bart West. Ann-Marie is diagnosed with cancer early on in the season, and her health declines rapidly. When she refuses invasive treatment in favor of a hastened death, much of the story focuses on Bart's inability, as a physician committed to saving lives, to accept her decision. Many of their conversations focus on her quality of life, the level of pain the treatment would cause, and her desire to be at peace with the process of her death. Bart ultimately agrees to accept her decision and to take care of her as she nears the end of her life.

Autonomous decision-making

A second common element of good deaths, autonomous decision-making, is present in 19 of the deaths studied. These decisions are mostly made by the patient off-screen, and well in advance of their hospital treatment. One exception is the death of Dr. Mark Sloan in *Grey's Anatomy*. As Sloan realizes he is too sick to recover from his injuries, his friend, Dr. Richard Webber, helps him fill out an advance directive. Ultimately, curative care is withdrawn from Sloan, and he dies surrounded by his fellow physicians. Although the vast majority of deaths in medical institutions involve these kinds of decisions, this decision-making scene is the only one involving the discussion of advance care planning that is followed in the story through to the patient's death. Similarly, Alfred Maxwell, the physician in *Casualty* who had Motor Neuron Disease, has signed a Do Not Resuscitate (DNR) order, which is found during a last attempt to render cardiopulmonary resuscitation (CPR) on him.

Pain and suffering

In about half of the deaths, there is presumed freedom from pain and suffering at the end of life. Patients do not appear to experience pain, but in none of the death scenes are pain medications or other opiates specifically given to reduce pain. However, these deaths primarily involved comatose patients and patients being removed from life support.

Spiritual affirmation

Among the elements of good death important to patients, spiritual affirmation is most lacking in medical dramas. Although some affirmations of life experiences and "closure" between characters occur before, during, and after some of the deaths, spiritual affirmation is not present in any of the deaths. In four cases, funerals are shown, but the funeral scenes focus less on spiritual convictions of the patient and more on the coping and grief of the affected healthcare

providers. Of the dying patients who could speak, none mention or make reference to higher powers, spiritual goals, or any type of rites or rituals.

Caregiver concerns

Elements important to caregivers are present, but are infrequent. Among the handful of deaths in which family and caregivers are present, few address the complexities and stresses of caring for the dying. Although 12 of the deaths deal to some degree with family and caregiver grief, these expressions of grief are short and generally show sadness and anger. Only the death of Ann-Marie Preston discussed above reveals more of the important elements of the caregiver experience such as fatigue, emotional burdens, and isolation. This death experience is unique in the sense that it ultimately occurs at home, outside of the hospital in which the majority of the series is filmed. In caring for Ann-Marie, Bart becomes withdrawn from colleagues and is preoccupied with Ann-Marie's well-being when interacting with other characters. While he is not shown caring for her physical needs, brief conversation about his coping with his role as caregiver does take place.

Discussion

This study offers several key contributions and findings. In response to our first research question, in which we sought to describe death narratives in medical dramas, we found several key characteristics of death and dying that lack narrative fidelity with current experiences of death and dying. We found in our sample of medical dramas, much like Hetsroni (2009) and Tercier (2002), that these programs continue to include representations of death that are factually inconsistent with current data on death and dying. It is true that the majority of people in the countries of origin for these medical dramas die in healthcare institutions (Broad et al., 2013). But the leading causes of death in these countries are heart attack, stroke, and Alzheimer's disease (World Health Organization, 2017). The overrepresentation of traumatic deaths in our sample suggests that medical dramas focus more attention on deaths due to accident, as opposed to deaths due to disease, which are more common in reality. Moreover, focusing on deaths due to accident inherently leaves out many of the important questions surrounding what makes a good death, and patients who die under these circumstances make few, if any, decisions about their final care.

Second, when we examined which characters were dying in these medical dramas, we found a disproportionate number of deaths of characters who appeared to be under 65. Global life span estimates suggest that particularly in wealthy countries, death is much more likely to occur after age 65 (World Health Organization, 2017). The medical dramas in this sample do focus on accidental deaths, which can happen to someone of any age, and while these deaths may not seem factually inconsistent to viewers, this means these narratives overrepresent a type of death experience that viewers will likely not witness or experience. If, as other research has argued, viewers see medical dramas as a source of health information, these narratives offer little in the way of useful information (Ye & Ward, 2010). This is important as we move into a world where

patients, physicians, and caregivers will be required to be much more involved in the dying process than television dramas reveal. These dramas teach viewers very little about how to prepare for or create a good death.

Finally, we found that the narrative structures and themes that framed these deaths focused on healthcare professionals and healthcare institutions. This may seem an obvious point—after all, medical dramas are at their core about hospitals and healthcare professionals. But our analysis reveals the effect this framing has on the death stories they tell; these stories are less about the dying and more about the way hospitals and (usually) physicians make sense of these deaths. What viewers may not realize is that this framing is more instructive of institutional or “medicalized” beliefs about death and much less about the kind of sense-making families, caregivers, and even the dying undertake when considering a good death (Jain & Slater, 2013). We do not argue here that medical dramas are tasked with representing the personal, cultural, and spiritual dimensions of death, but note that framing deaths more as institutional events leaves out many patient and caregiver concerns, especially those surrounding the role of autonomy in a good death.

This absence leads to our second research question. We found significant differences between the way patients, caregiver, and physicians describe a good death and the way death is portrayed in medical dramas. We found that these individuals describe a good death in terms of the dying experience, which is influenced by preparations made before dying. The dramas narrate little of this, which presents a problem with the narrative fidelity between the way good deaths are constructed by patients, physicians, and caregivers in reality and the way deaths are deemed “good” in medical dramas.

Another important issue of narrative fidelity missing in these death narratives includes patient autonomy. The majority of the actual death scenes depicted in these medical dramas involved invasive medical intervention, such as CPR or surgery, immediately prior to death. In only roughly 20% of these representations were there an exercise of patient decision-making related to the circumstances of the patient's death. Patients had little, if any, choices to make. This runs counter to the theme of autonomy patients have identified as important in a good death experience. This representation is particularly concerning, given the current focus by healthcare institutions on early advance care planning for expressing patient goals for end-of-life care (Brinkman-Stoppelenburg, Rietjens, & van der Heide, 2014).

Finally, these fictional depictions of hospital death lack the spiritual affirmations patients state they want in their death experience. Although several funerals associated with the deaths are shown, no religious symbols or rites other than burial are shown. Death in these medical dramas is generally portrayed as an a-spiritual experience for both the dying and their families and physicians. This absence might be attributed to television's unwillingness to address what could be controversial subject matter that causes some audience members discomfort. But this absence underscores the lack of narrative fidelity with the good death experience patients, in particular, desire (Meier et al., 2016).

These ways in which the narratives lack fidelity with the good death patients, physicians, and caregivers describe have important implications for both media researchers and media storytellers. Further work should be done by media researchers to identify the extent to which the incongruities found in this analysis are cultivated within communities of viewers. The influence of medical dramas on perceptions about death and dying among viewers is particularly important given the aging population and the remarkable rise in medical interventions that forestall death (Karp, 2007). Because medical dramas influence individuals' healthcare perceptions and decision-making, effects of their portrayal of death on the aging population may be of particular relevance. Previous research has identified that elder characters are underrepresented in television, and elders' responses to issues such as chronic illness, the dying process, and death in the content of programming might also be underrepresented (Signorielli, 2004).

By examining narratives of death and dying in the programs in our sample, we have extended this work to include not only representations of death and dying, but themes these stories focus on. Our research lays a foundation for subsequent work examining the cultivation effects of the way death and dying are framed in medical dramas. Because these effects have been found in the work of Chory-Assad and Tamborini (2003), Kline (2003), and others, we argue that future research should focus on the way varying levels of viewing medical dramas influence individual expectations of the death and dying experience, and even more importantly, how these expectations influence the way caregivers and family members deal with or fail to deal with the death of a loved one.

Additionally, these findings are also relevant to media producers, scriptwriters, and content creators. So many stories, not only those in medical dramas, involve death. More attention to the death process like the one most people will experience might not make for good entertainment television, but because medical dramas can be used to educate viewers on public health matters, these programs could and perhaps should include more attempts at accurate education of the hospital dying process. To put it more plainly, it is unlikely that viewers will experience some of the unusual, amazing, and innovative procedures they see on medical dramas, but they will all die. The sense-making characteristics of death narratives in medical dramas could help viewers navigate the complexity of the death experience and help viewers face the inevitable.

Because medical dramas also have the power to change viewers' attitudes toward health conditions and health institutions, we finally argue that incorporating more common elements of a good death described by patients, physicians, and caregivers could encourage viewers to seek a death experience that is more consistent with their desires. As stated earlier, autonomy is one of the elements described across groups as important. But the disparity between patients' stated preferences for death at home and with less invasive medical care and their actual death experiences suggests that patient autonomy to make their own choices may not ultimately prevail in end-of-life care. We argue that at a minimum, medical dramas could include this reality in some storylines.

This study has several limitations. Our sample represents only a small number of the many medical dramas now accessible through various media platforms. Although the dramas we chose are among the most viewed worldwide, our results cannot be imputed to the multitude of medical dramas now available to viewers. We also did not seek the assistance of multiple coders for this narrative analysis; thus, the results reported here are limited by interpretation. This particularly applies to our assessment that the majority of patients who died were under 65—our results are based on our visual assessment of the patients we coded only. Although we felt our interpretation was germane to the subject matter here, further objective studies should be done. Finally, we note that the effects of these programs on viewers have not been assessed in this work. Future studies are needed to determine the extent of medical dramas' effects on viewers' attitudes about death and to determine strategies for dealing with these effects.

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References

- Aleksandrova-Yankulovska, S., & Ten Have, H. (2015). Survey of staff and family members of patients in Bulgarian hospices on the concept of "good death". *American Journal of Hospice and Palliative Medicine*, 32, 226–232. doi:10.1177/1049909113516185
- Altheide, D. L. (1996). *Qualitative media analysis*. Thousand Oaks, CA: Sage Publications, Inc.
- Brinkman-Stoppelenburg, A., Rietjens, J. A., & Van Der Heide, A. (2014). The effects of advance care planning on end-of-life care: A systematic review. *Palliative Medicine*, 28, 1000–1025. doi:10.1177/0269216314526272
- Broad, J. B., Gott, M., Kim, H., Boyd, M., Chen, H., & Connolly, M. J. (2013). Where do people die? An international comparison of the percentage of deaths occurring in hospital and residential aged care settings in 45 populations, using published and available statistics. *International Journal of Public Health*, 58, 257–267. doi:10.1007/s00038-012-0394-5
- Brooks, T., & Marsh, E. F. (2009). *The complete directory to prime time network and cable TV shows, 1946-present*. New York, NY: Ballantine Books.
- Buchan, B., Gibson, M., & Ellison, D. (2011). Reflections on the death scene. *Cultural Studies Review*, 17, 3–15. doi:10.5130/csr.v17i1.1970
- Chory-Assad, R. M., & Tamborini, R. (2003). Television exposure and the public's perceptions of physicians. *Journal of Broadcasting & Electronic Media*, 47, 197–215. doi:10.1207/s15506878jobem4702_3
- Cipolletta, S., & Oprandi, N. (2014). What is a good death? Health care professionals' narrations on end-of-life care. *Death Studies*, 38, 20–27. doi:10.1080/07481187.2012.707166
- Cullum-Swan, B., & Manning, P. (1994). Narrative, content, and semiotic analysis. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 463–477). Thousand Oaks, CA: Sage Publications.
- Durkin, K. (2003). Death, dying and the dead in popular culture. In C. D. Bryant (Ed.), *The handbook of death and dying* (pp. 43–49). Thousand Oaks, CA: Sage Publications.
- Endacott, R., Boyer, C., Benbenishty, J., Nunn, M. B., Ryan, H., Chamberlain, W., ... Ganz, F. (2016). Perceptions of a good death: A qualitative study in intensive care units in England and Israel. *Intensive and Critical Care Nursing*, 36, 8–16. doi:10.1016/j.iccn.2016.04.004
- Fisher, W. R. (1985). The narrative paradigm: An elaboration. *Communication Monographs*, 52, 347–367. doi:10.1080/03637758509376117

- Foss, K. A. (2011). "When we make mistakes, people die!": Constructions of responsibility for medical errors in televised medical dramas, 1994–2007. *Communication Quarterly*, 59, 484–506. doi:10.1080/01463373.2011.597350
- Gauthier, C. C. (1999). Television drama and popular film as medical narrative. *The Journal of American Culture*, 22(3), 23–25. doi:10.1111/jacc.1999.22.issue-3
- Goldsmith, D. J., & Miller, G. A. (2015). Should I tell you how I feel? A mixed method analysis of couples' talk about cancer. *Journal of Applied Communication Research*, 43, 273–293. doi:10.1080/00909882.2015.1052832
- Hetsroni, A. (2009). If you must be hospitalized, television is not the place: Diagnoses, survival rates and demographic characteristics of patients in TV hospital dramas. *Communication Research Reports*, 26, 311–322. doi:10.1080/08824090903293585
- Holdsworth, L. M. (2015). Bereaved carers' accounts of the end of life and the role of care providers in a "good death": A qualitative study. *Palliative Medicine*, 29, 834–841. doi:10.1177/0269216315584865
- Houben, C., Spruit, M., Wouters, E., & Janssen, D. (2016). "Am I dying doctor?": How end-of-life care is portrayed in television medical dramas. *Journal of Palliative Care and Medicine*, 6. doi:10.4172/2165-7386.1000247
- Hughes, T., Schumacher, M., Jacobs-Lawson, J. M., & Arnold, S. (2008). Confronting death: Perceptions of a good death in adults with lung cancer. *American Journal of Hospice and Palliative Medicine*, 25, 39–44. doi:10.1177/1049909107307377
- Imhof, A. E. (1996). An *Ars Moriendi* for our time: To live a fulfilled life–To die a peaceful death. In H. M. Spiro, M. G. McCrea Curnen, & L. P. Wandel (Eds.), *Facing death: Where culture, religion and medicine meet* (pp. 114–120). New Haven, CT: Yale University Press.
- Jain, P., & Slater, M. D. (2013). Provider portrayals and patient–Provider communication in drama and reality medical entertainment television shows. *Journal of Health Communication*, 18, 703–722. doi:10.1080/10810730.2012.757388
- Karp, F. (2007). *Growing older in America: The health and retirement study*. Bethesda, MD: U.S. Department of Health and Human Services.
- Kissell, R. (2015, October 23). Ratings: ABC's "Grey's Anatomy" hits four-week high with 250th episode. *Variety*. Retrieved from <http://variety.com/2015/tv/news/ratings-greys-anatomy-250th-episode-1201625040/>
- Kline, K. N. (2003). Popular media and health: Images effects and institutions. In T. L. Thompson, A. M. Dorsey, K. I. Miller, & R. Parrott (Eds.), *Handbook of health communication* (pp. 557–581). Mahwah, NJ: Lawrence Erlbaum.
- Love, R. (2010, September 16). "Casualty" enters Guinness World Records. *Digital Spy*. Retrieved from <http://www.digitalspy.com/>
- Lumpkins, C. Y. (2012). Hollywood and breast cancer prevention among African American women: An analysis of breast cancer risk narratives in the California "Every Woman Counts Campaign." *Journal of Media and Communication Studies*, 4, 415–422. doi:10.5897/JMCS11.098
- Meier, E. A., Gallegos, J. V., Thomas, L. P. M., Depp, C. A., Irwin, S. A., & Jeste, D. V. (2016). Defining a good death (successful dying): Literature review and a call for research and public dialogue. *The American Journal of Geriatric Psychiatry*, 24, 261–271. doi:10.1016/j.jagp.2016.01.135
- More, S. (2014). *Dying in America: Improving quality and honoring individual preferences near the end of life*. Washington, D.C.: National Academies of Medicine.
- National Broadcasting Corporation. (2016). *About the show*. Retrieved from <http://www.nbc.com/er/about>
- Payne, S., Langley-Evans, A., & Hillier, R. (1996). Perceptions of a "good" death: A comparative study of the views of hospice staff and patients. *Palliative Medicine*, 10, 307–312. doi:10.1177/026921639601000406
- Seale, C. (2004). Media constructions of dying alone: A form of "bad death". *Social Science & Medicine*, 58, 967–974. doi:10.1016/j.socscimed.2003.10.038
- Sharf, B. F., & Freimuth, V. S. (1993). The construction of illness on entertainment television: Coping with cancer on thirtysomething. *Health Communication*, 5, 141–160. doi: 10.1207/s15327027hc0503_1
- Signorielli, N. (2004). Aging on television: Messages relating to gender, race, and occupation in prime time. *Journal of Broadcasting & Electronic Media*, 48, 279–301. doi:10.1207/s15506878jobem4802_7
- Silveira, M. J., DiPiero, A., Gerrity, M. S., & Feudtner, C. (2000). Patients' knowledge of options at the end of life: Ignorance in the face of death. *JAMA*, 284, 2483–2488. doi:10.1001/jama.284.19.2483
- Tercier, J. (2002). The lips of the dead and the "kiss of life": The contemporary deathbed and the aesthetic of CPR. *Journal of Historical Sociology*, 15, 283–327. doi:10.1111/1467-6443.00180
- Toff, B. (2009, April 3). Ratings: *ER* draws highest ratings for drama finale since *Murder, She Wrote*. *The New York Times*. Retrieved from <https://mediadecoder.blogs.nytimes.com>
- Virdun, C., Luckett, T., Lorenz, K., Davidson, P. M., & Phillips, J. (2016). Dying in the hospital setting: A meta-synthesis identifying the elements of end-of-life care that patients and their families describe as being important. *Palliative Medicine*, 31, 587–601. doi:10.1177/0269216315583032
- World Health Organization (2017). *Mortality and global health estimates*. Retrieved from http://www.who.int/gho/mortality_burden_disease/en/
- Ye, Y., & Ward, K. E. (2010). The depiction of illness and related matters in two top-ranked primetime network medical dramas in the United States: A content analysis. *Journal of Health Communication*, 15, 555–570. doi:10.1080/10810730.2010.492564