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Medical professionalism on television: student perceptions and pedagogical implications

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Keywords
Humanities, medical education, professionalism, students, television

Disciplines
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Medical professionalism on television: Student perceptions and pedagogical implications

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Abstract

Previous research has pointed to the role television can play in informing health practices and beliefs. Within the academic setting in particular, some educators have raised concerns about the influence of medical dramas on students. Less research, however, draws on the perspectives of students, and this study therefore explores medical students' perceptions of medical practice and professionalism in popular medical television programs. Qualitative data from surveys of Australian undergraduate medical students showed that students perceived professionalism in dichotomous ways, with three main themes: cure-care, where a doctor's skill is either technical or interpersonal; work-leisure, where a doctor is either dedicated to work or personal life; and clinical-administration, where work is either direct patient care or administration. There continue to be imagined divisions between curing and caring for students, who express concerns about balancing work and leisure, and expectations that doctors should have little administrative work. Given students were able to identify these important

contemporary issues around professionalism on television, there is pedagogical value in using popular images of the medical world in medical education.

Keywords

professionalism; medical education; students; humanities; television

Introduction

There is an implicit social contract between the medical profession and society. Doctors will provide patient care with competence, compassion, integrity and accountability, and in return society awards the profession autonomy, independent self-regulation, trust and professional status (Cruess and Cruess, 2000). This contract is based on the understanding that the work of a professional requires a strong sense of moral dedication. However, there are increasing complaints that the medical profession is failing to appropriately fulfil its obligations to the contract. Sullivan (1999) claims that one of the major causes of public discontent has been the medical profession's increasing focus on technical expertise; with the rapid scientific expansion of the last half century, medicine has aligned its reputation to science. Consequently, the identity of the physician is more likely to be defined by technical expertise than by the moral and social role of medicine (Sullivan, 1999). The overall result has been a degradation of trust between the public and the medical profession, jeopardising the social contract on which medical professionalism is based.

Given that significant development of professional identity occurs during medical school (Monrouxe, 2010), medical educators have a major responsibility to

foster the development of a professional identity that goes beyond technical expertise to encompass moral and social responsibility at its core. Yet research shows that rather than instilling the values necessary for the social contract between the profession and the community, these values (such as empathy and compassion) tend to decline during students' journey through medical school (Hojat et al., 2009). This seems to occur despite the widespread curriculum reforms that have resulted from the increased attention to professional behaviour by the major organisations representing the health care professions in the US, Australia, and the UK (American Medical Association, 2001; Australian Medical Association, 2006; Australian Medical Association, 2010; General Medical Council, 2013).

The formal curriculum, however, is only one site of learning professionalism and probably not the most important. The clinical environment, in which students are usually immersed especially in the latter years of medical school, provides a myriad of role models and experiences which via passive enculturation have a powerful effect on the development of students' professionalism (Lempp and Seale, 2004). In the health care system students learn what is actually done and the hidden curriculum can override formal lessons learned about professionalism in medical school (Karnieli-Miller et al., 2010). However, the contradictions between the messages that students receive from the formal and informal curriculum not only are problematic in terms of professional development for students, they may also cause student confusion and cynicism (Newton, 2008). Medical students frequently encounter ethical issues in clinical practice which they are unable to resolve. At the lowest rung of the hierarchy within the medical team, they may feel disempowered to take what they see as appropriate action when

faced with an ethical dilemma (Kelly and Nisker, 2009; Wiggleton, 2010). Students who are unable to act in a way that is consistent with what they think is right experience moral distress, which has also been well documented among the nursing profession (Wiggleton, 2010).

There is, therefore, an imperative for medical educators to employ pedagogical strategies to assist students to identify and resist the negative influences of the hidden and informal curriculum. Furthermore, consideration needs to be given to the type of pedagogical practices used to develop student professionalism. Traditional teaching methods such as lectures and tutorials based around case presentations, though suitable for learning clinical science, may not be the most appropriate method of facilitating professionalism (Spike, 2008; Volandes, 2007). Lectures and even case studies often fail to capture the patient's experience of illness in a way that is emotionally engaging for students. The development of a professional identity involves personal transformation and personally significant learning and is grounded in emotional experience (Dirkx, 2008; McNaughton, 2013). Medical educators must seek to develop new ways in which to teach medical professionalism; ways that engage student emotions.

Background

In response to concerns about an overly scientific approach to health care, many medical schools worldwide have introduced the medical humanities into the curriculum to encourage students to explore the impact of the relationship between doctors and patients on the patient experience of illness and disability and to promote a patient-centred model of care. The humanities acknowledge the individual, the subjective and

the personal to counterbalance the scientific paradigm's conceptualisation of medicine in terms of the theoretical, the abstract and the objective. For Charon, engagement with the medical humanities can facilitate the development of the social and ethical dimensions of the medical professional's identity to promote a more patient-centred model of care:

> A scientifically competent medicine alone cannot help a patient grapple with the loss of health or find meaning in suffering. Along with scientific ability, physicians need to listen to the narratives of the patient, grasp and honor their meanings, and be moved to act on the patient's behalf. This is narrative competence, that is, the competence that human beings use to absorb, interpret and respond to stories. (Charon, 2001: 1897)

Care that is patient not disease focused is important not only for physicians to fulfil their ethical responsibility to the community and to individual patients, but also because it results in improved health status and efficiency of health care (Stewart et al., 2000). Charon (2012) makes a claim that clinical medicine is in fact a narrative undertaking, a conceptualization of medical practice which challenges practitioners to extend their view of professionalism beyond that of scientific expertise and to reclaim the art of medicine.

In addition to reconceptualizing the general understanding of medicine and health care, the medical humanities have been argued to benefit specific areas of medical education. For example, Salmon and Young (2011) advocate for the inclusion of humanities in the medical curriculum with a focus on teaching students about the art of patient-doctor communication. They argue that the frequently used terminology of

communication skills in medical curricula aligns with a scientific approach and wrongly implies that communication can be divided into discrete teachable components. For Salmon and Young, communication is imaginative, individual, and intuitive. Rule-based teaching can fail to emphasise that the meaning of communication is context dependent, varying with each individual patient and their unique personal and social histories and needs. Every communication episode is a unique event which unfolds as an integrated whole so that each part cannot be considered separately from that which has gone before it and from what will follow. Communication is inherently creative and therefore the pedagogy of the humanities and the creative arts has a place in medical education: "creative work depends on judgment rather than following rules, and learning makes good judgments and developing confidence in handling uncertainty and trust in one's own unique expression" (Salmon and Young, 2011: 220).

However, the ground swell of support for the introduction of the humanities into the medical school curriculum in the medical education literature may not be matched by a similar sentiment amongst the majority of faculty staff and students (Shapiro et al., 2009). There is widespread resistance in medical schools towards the inclusion of the humanities into the medical curriculum. For instance, although one study (Arntfield et al., 2013) found that fourth year medical students who undertook a one month intensive voluntary elective in medical humanities reported that this was transformative learning which they considered enhanced their ability to communicate with patients and to understand their patients' experiences of illness, the students also spoke about the resistance to the learning of humanities amongst their non-participating colleagues who used the words "fluffy", "unnecessary", and "soft" to describe the role of the humanities

within a medical curriculum. These words and the attitudes they signify may resonate with other medical educators who face similar challenges trying to incorporate humanities into a medical school curriculum. The students also suggested that the optional status of the medical humanities programme in their school of medicine works against the legitimacy of the humanities as a core component of a medical curriculum. On a positive note, Arntfield et al. (2013: 280) argued that the medical humanities elective provided a "counter-culture means of enhancing communication, collaboration and professional development". We would contend that although a counter cultural movement can support its participants' development, medical educators must promote the legitimacy of the humanities in medicine amongst the wider community of medical students and practitioners in order to forge widespread cultural change.

How do medical educators address widespread resistance to the inclusion of narrative study into the curriculum to engage student's emotions and challenge the messages they receive from the hidden and informal curriculum? There is a growing recognition that mass media such as television and film are a significant source of information to both the general public and medical students about the experience of patients and the patient-doctor relationship. Film and television offer powerful narrative persuasion "because entertainment television presents fictionalised accounts in narrative form, they are cognitively processed differently from factual information; there is evidence that receivers suspend counterarguments and become fully absorbed in the story being told" (Morgan et al., 2007: 144). Emotionally charged images, evoked through the medium of film or television, can provide opportunities to understand and

question current ways of seeing our relationships with and responsibilities to others (Arawi, 2010).

Given that we already know that medical students are keen watchers of television medical dramas (Czarny et al. 2008; Weaver & Wilson 2011), this enthusiasm may provide the pedagogical opportunity to challenge student resistance to narrative medicine and facilitate their learning about communication, ethics and professional identity. Indeed, television medical dramas canvass a number of topics that are obligatory components of any medical professionalism curriculum. Czarny and colleagues (2010) analysed two of the most popular television medical dramas, *House MD* and *Grey's Anatomy*, for bioethical and professional content, and found a rich portrayal of a number of complex bioethical issues such as consent, confidentiality, treatment refusal, health care access and equity, human experimentation, truth disclosure and death and dying. There are examples of commendable patient centred practice; more common, however, were clearly anomalous portrayals of professionalism (Czarny et al., 2010). This is consistent with a content analysis of television dramas by Chory-Assad and Tamborini (2001), which demonstrated the decline in positive portrayals of physicians in television since the 1990s. There is also research that points to negative television representations around other health issues, such as organ donation (Morgan et al., 2007). The concern is that the frequency of negative role models for medical professionalism on television may have an adverse impact on medical student development of an appropriate patient-centred approach to clinical care (Czarny et al., 2010). Moreover, medical television programs, like any popular genre, are subject to conventions and expectations that can limit complexity in character depictions, meaning

that the practice of medicine is more likely to be portrayed in terms of exaggerated conflict rather than a nuanced depiction of health care. Thus we might find doctors portrayed as heroes battling disease, incompetent colleagues, or recalcitrant patients, in a manner that perhaps reflects the exalted status doctors have often occupied in society.

Television's limitations do not, however, exclude its use in education. Other research finds positive elements in what fictional doctors may 'teach' students (Klemenc-Ketis and Kersnik, 2011; Lumlertgul et al., 2009). Television and film narrative elicit emotions intentionally (Plantinga, 1997), and so can provide a far richer illustration of the depth and breadth of human experience and opportunity for student engagement and critique than the lifeless case studies that are the usual trigger for tutorial discussions about the patient doctor relationship and professional values and ethics.

Despite the evidence about the potential lessons that can be learned by medical students from fictional doctors, more research is needed on the perceptions of medical students themselves. Medical educators will need to know more about how students are interpreting the media during their recreational watching, to develop appropriate pedagogical methods which will engage and challenge students to debate and critique the ways in which the media frame topics relevant to medical professionalism. Accordingly, the aim of this study was to explore medical students' perceptions of professionalism and role models on television programs.

Method

Study, setting and participants

As part of a larger study, medical students completed surveys about their viewing of medical television shows (Author XX). The study was conducted in an undergraduate medical school in a university in Australia. The participants were undergraduate medical students enrolled in a five-year course. In their first two years of study, students attend lectures and problem-based-learning tutorials, and also undertake early clinical exposure. In years Three, Four and Five, students are immersed in the clinical setting. At the time of this study, there were only four years of students enrolled because Year Four were the first cohort.

The survey was completed by 386 students, which was 85% of the total cohort at the time of survey (n=453). The mean age of students was 20.2 and over half were female (55.4%). Just over half the students were born in Australia (53.6%) and spoke only English at home (54.7%), while almost a third also spoke another language at home (31.3%).

Data collection

Data collection took place between January and March in 2010. Students completed surveys after lectures or tutorials. An online or in-person announcement was made about the study across all years, and students attending lectures and tutorials in the first semester of 2010 were invited to participate in the study.

To provide some context for the data discussed in this paper, a brief summary of the quantitative results of the larger study are given here. Results from the larger survey showed over 93% of the students watched medical television programs, with *House* and *Scrubs* the most watched programs, and other popular programs were *Grey's Anatomy* and *ER*. Over half the students discussed ethical and medical issues from television with

their friends and family, but the students ranked television extremely low as a source of information about bioethical issues. The survey provided a list of thirteen characters from *Grey's Anatomy* and eight characters from *House*. These were chosen because they were the main characters on the programs at the time of survey; the programs were chosen because they were the most viewed medical programs at the time. Students were asked to nominate those characters they most and least wished to be like in their own career, and were able to choose more than one. The most admired characters were Derek Shepherd and Miranda Bailey on *Grey's Anatomy*, and Cameron and Wilson on *House*. Least admired were Cristina Yang and Meredith Grey from *Grey's Anatomy*; House ranked highly both as someone students most and least aspired to be like in their own career. The surveys included space for the students to list any other character from television or other media they wished. The surveys also asked students to rate the programs for realism, treatment of ethical and professional issues, and the results showed most students believed professionalism was portrayed positively and were mixed about how well ethical issues were portrayed, as well as about the realism of the programs (Author XX).

Of the 386 students completing the surveys, 286 (74%) provided answers to the open-ended questions discussed in this study. These questions asked students to explain why they felt some programs were more or less realistic than others in their treatment of ethical, medical, and professional issues; what they thought about medical role models generally, and why they chose particular characters as positive or negative role models.

Responses ranged from one or two words to several sentences. In total, the open-ended responses provided over 10,000 words for data analysis. Given that the aim of

this research was to explore what students consider to be professional behaviour for doctors, the data pertaining to the programs' characters proved most relevant.

Ethical approval

The study received approval from the human research ethics committee at the university. Participating in the study was voluntary. Data were stored securely, and all responses were assigned numerical codes to protect privacy. These numerical codes were three digits, beginning at 100, and are included here in brackets after each quotation to designate the particular student response.

Data analysis

A research assistant entered the students' responses to open-ended questions into Microsoft Word. Each author read the data multiple times, interspersed with team meetings to discuss and develop impressions and themes. The approach to data analysis in this study was inductive. Although we were interested in exploring students' views of professional behaviour for doctors, which to some extent necessarily influenced our reading of the data, we did not test a hypothesis or theory against the data as is the case in a deductive approach (Thomas, 2006). Instead, our analysis drew on a conventional process akin to what Thomas (2006) describes as a general inductive approach; that is, one that uses "detailed readings of raw data to derive concepts, themes, or a model through interpretations made from the raw data by an evaluator or researcher" (Thomas, 2006: 238). The analysis comprised several stages, including preparing the data files into a common format; reading the data closely; developing themes; and revising and refining those themes (Thomas, 2006). These steps were not necessarily discrete or linear, for qualitative research is flexible and stages can overlap (Polit and Beck, 2010).

Accordingly, we continued to closely read the data even after developing our initial themes as we worked through our results. Although the team noted other more minor themes and issues from the data, the final agreement between the research team members led to three main themes identified in the data related to professional behaviour for doctors, which are discussed below.

Finally, we acknowledge here the philosophical assumptions behind our interpretations of this data, which are aligned with an interpretivist paradigm. Thus, we note that our interpretations of the data are inevitably influenced by our own backgrounds and cannot be entirely free from bias (Bunniss and Kelly, 2010). Despite this, the team comprises three researchers, of both genders, a range of ages, and with different backgrounds in and outside of medical education and humanities, and these differences may alleviate some of the biases. The three authors read and analysed the data, discussed as a team, and agreed on the findings. We include representative extracts from the data to support our interpretations and to retain the richness of the data (Elo and Kyngäs, 2008), and these extracts have been edited only to correct spelling or to enhance readability. We also include data that contradicts our main conclusions, a strategy that can aid quality in research (Mays and Pope, 2000).

Results

Entertainment or education? Role models on television

The data showed contrasting views about the overall influence of medical television programs on students and the public. As some students wrote, “they are good entertainment. As medical role models they are usually lacking and should not be

viewed as such" (Student 237), because "Real medical professionals are much more influential" (475). Other students were concerned that "they give non-med people the wrong idea about what happens in hospitals, that professionalism doesn't exist and that patients are often neglected/ maltreated" (284), or that "They promote glamorisation of the medical profession, tending to increase public interest in medicine/ health (may be a good thing), may be sometimes confusing to follow for laymen" (402).

In contrast to negative responses were enthusiastic comments that reflected the extent to which students identified with particular characters and used these fictional role models to reflect on their own beliefs about medical practice and professionalism. Our analysis showed that the students perceive divisions between oppositional elements of medical professionalism. Accordingly, we have arranged our discussion of these findings into three dichotomous subthemes: cure-care; work-leisure; clinical-administration.

Theme 1: The cure-care dichotomy

The first theme in the data reveals students' beliefs about an imagined division in health between curing and caring. The two facets reflect an opposition between technical skill, expertise, knowledge and interpersonal ability, empathy, and emotional intelligence. For the most part, the students categorised these groups of qualities in separate, distinct ways that implied the two types of skill did not coexist within an individual doctor or that this was an exception.

These distinctions were evident in how students discussed their impressions of the television characters. Some participants rejected those characters who they felt were

too focused on the technical aspects (curing) of medical practice at the expense of interpersonal skills (caring). Gregory House (*House*), for example, was often chosen as a negative role model for this reason: "House gives medical students a bad representation of how knowledge is more important than personal skills and respect" (103). House was seen as having "poor interpersonal skills" (112) with a "Poor bedside manner" (168) who was "Too distant from patients" (109). The detective-style format of *House* meant that for some students, House was a deficient role model because he "Sees patients as puzzles, as opposed to real people" (380). Some participants blamed the lack of realism in the shows for these stereotypical depictions: "House is unrealistic as he usually shows no concern for a patient other than to cure the disease" (472).

In contrast, students admired characters who displayed good interpersonal skills. Izzie Stevens (*Grey's Anatomy*) was admired because she is "empathetic and cares" (288) and has "the ability to empathise with both peers and patients" (297). Allison Cameron (*House*) also garnered positive responses because she is "Professional and mature, empathic, compassionate" (109), and "Caring, compassionate, thinks about the patient and not just the disease" (249). Yet alongside comments that highlighted the importance of interpersonal abilities were, conversely, statements that criticised characters for displaying these attributes. Thus we find a sense that although caring and compassion are important qualities for doctors to display, they must not demonstrate these qualities *too* much, lest it affect medical practice. A common complaint against some characters was that they were "too emotional" or "overly emotional". Students suggested that Cameron's emotions affected her medical "judgement" (158; 367). This apparent failing of being *too* compassionate appeared elsewhere, as with a student who

chose Izzie Stevens as a negative role model because she is "Overly emotionally involved, which I suspect will be a personal weakness of mine" (460). Such comments suggest that students can look to fictional role models as they contemplate their own professional identity as (future) doctors, and as they develop their own beliefs about the important elements of medical professionalism.

Theme 2: The work-leisure dichotomy

A second theme in the data related to a division between professional and personal lives, which was an unexpected finding given that our survey included no reference to work-life issues at all. This theme is concerned with students' beliefs around the competing demands of work and social lives in medical practice. As with the cure-care theme, the work-leisure theme relates to a belief that a doctor is at risk of being either too committed to work or to a social life.

The chief character appearing in this theme was Miranda Bailey (*Grey's*), who remarkably embodied both success and failure in her approach to professional and personal spheres. Some students believed she was a positive role model because she "is achieving balance in life" (453), and she "shows a realistic balance between work and family" (225). The realities of balancing the demands of family and work made Miranda a popular choice because she "has to deal with family issues" (307), which seemed to make her more relatable to the students. Others felt this was an area in which Miranda was a poor example, because she is a "Female surgeon dealing well in her career but struggling with family life and getting balance right" (479) and she "sacrifices family for work" (452).

If being too dedicated to work was seen as a negative quality, the other danger was seen in jeopardising one's professionalism by being too committed to maintaining a personal life. This is seen in students who responded that Meredith Grey (*Grey's*) was a poor role model because she has "Too many personal issues which she brings to the workplace" (219) and she is "always consumed/ distracted by her personal life, which affects her practice as a doctor" (150). Good doctors were seen to be those who "do not allow personal issues to affect practice" (208); for other students, being "dedicated" to the medical career was a positive attribute (192).

Overall the responses showed a concern around balancing a dedication to medicine with a personal life. Students admired characters who "seem to be committed [to being a good doctor], but also have [social] lives" (174), or who have a "career focus, but maintain a cool personal life" (351). Thus, and similar to the cure-care theme, we have a dichotomy between those characters admired for their absolute dedication to work to the exclusion of personal time and those characters admired for maintaining a social life, with most comments showing a preference for balancing the two aspects.

Theme 3: The clinical-administration dichotomy

The third theme we identified was related to a perceived dichotomy between clinical and administrative work. Although this theme involved oppositional aspects (patient care and administrative work), there was much less evidence that a balance was desirable, as was the case with cure-care and work-leisure.

The comments about clinical and administrative tasks mostly referred to hospital administrators, such as Cuddy (*House*). Responses focused on the lack of clinical time

as a reason for disliking Cuddy: “She’s smart as well, but she doesn’t practice anymore, as she is only involved in admin and legalities etc” (216). Cuddy was often rejected as role model because she has “No/little patient contact. Admin-type job” (291) and is “not a clinician” (341) but is an “administrative doctor” (402). Cuddy was dismissed as a “Medical administrator [with] minimal clinical contact” (314), because she “Focuses on administrative side, not clinical” (342). These comments were repeated elsewhere about the character. This theme implies that a doctor’s work does (or should) not involve many administrative or legal responsibilities. Not all students responded to Cuddy in administrative terms, of course; several comments instead outlined her positive and negative qualities related to principles, ethics, compassion and caring. Yet there was a sense that the so-called real work of a doctor ought to be primarily if not solely that of treating patients.

Despite these negative responses, other students admired these characters because of their ability to successfully adhere to policies and procedures. For instance, a student wrote that they appreciated Cuddy “because she works within the boundaries of health care structures” (150). Cox (*Scrubs*) was a positive role model for one student, who wrote that “he deals well with the hospital’s issues” (467). Again, Cuddy was chosen as a positive role model because she demonstrates this ability: “She has to run the department and deal with staff and to rein in House” (455). Other comments showed that students were conscious of their own future professionalism and career expectations. One student wrote that they did not wish to be like Cuddy in their career because of the financial implications that can potentially compromise health care: “I

would not want the responsibility of deciding between patient's best treatment and what price that should cost, and have to deny doctors the right to treat their patients" (208).

Discussion

Our findings show that the students were critically engaged with the fictional representations of doctors on television. Although the larger study showed that students ranked television extremely low as an influence on their bioethical beliefs (Author XX), the responses here suggest that students nonetheless may identify with some characters to an extent that shows the fictional world of medicine on television is one that does play some part in their emerging professional identity, whether that is in accepting or rejecting particular characters as role models for their own future practice as doctors.

The results show that television characters can be a useful lens through which to examine students' own beliefs about medical practice. The medical students were generally united in their perceptions of what constitutes medical professionalism and good medical practice. The students usually preferred characters who displayed technical and empathetic abilities, maintained a balance of work and leisure, and who worked primarily in direct patient care rather than administration. Perhaps in some ways, medical television operates as another element of the informal curriculum, and thus exploring student reactions to characters in this study has exposed student beliefs about the longstanding, implied dichotomy at the heart of medicine between the opposing elements of cure and care. Students may see the need for these dichotomous elements to be in balance, but the balance point varies with the student's view of the goals of medicine. As Epstein (2000: 805) points out, patient-centred care recognises

the importance of “knowing the patient as a person, in addition to accurately diagnosing their disease”. On the basis of the findings that students may not see caring as an integral component of professionalism but instead as a separate element to curing, it would appear that educators have some way to go in promoting the biopsychosocial model of medical care, despite efforts to address patient-centred care in medical curricula (Boudreau et al., 2007).

The results also highlight particular expectations and concerns that some students have about medical practice in contemporary society. The concern about balancing work and personal commitments is an issue for many students and the impact on the medical profession is already beginning to be realised (Wilson and Harding, 2009). The challenges of balancing competing commitments can be influenced by gender (Emslie and Hunt, 2009; Gander et al., 2010) and also age, with younger generations valuing leisure time more than older workers (Twenge, 2009). Junior doctors in particular can find it difficult to balance the demands of work and their social lives (Gander et al., 2010), although as Twenge (2009) notes, the most vocal people about work-life balance are more often new graduates without children of their own, who may have unrealistic expectations of leisure time.

Our findings showed a belief amongst some students that the work of a doctor should be primarily if not solely clinical and should not involve many administrative duties. Clinical medicine has been the focus of medical schools and it is not surprising that students come into medicine with the aim of becoming a clinician. It is interesting that some students perceive a difference between a clinician doing the best for his or her patient and the administrator doing the best for the hospital. Certainly there is a

discrepancy between fictional portrayals of medicine where most television doctors are only pictured in direct patient care and the realities of medical practice where doctors can spend almost as much time on administrative work as patient care (Ammenwerth and Spötl, 2009). Given that high administrative loads can contribute to job dissatisfaction amongst general practitioners, it might be that medical schools need to ensure their students have realistic expectations of a doctor's responsibility in administrative matters (Van Ham et al., 2006).

Dichotomies can be useful ways to categorise and understand parts of the world, yet as Cixous (2008) reminds us, dual oppositions can become hierarchies where one element is favoured over another. Although Cixous's work primarily refers to gender, if we consider that medicine also has perceived dichotomies then we can interrogate them for their hierarchical implications. Our results suggest that curing and caring are, for the most part, valued equally and that students believe it is important for doctors to balance the two elements. The hierarchy of clinical and administrative work is obvious in our study, with comments clearly privileging patient care over administration. Less obvious is a hierarchy in the work-leisure dichotomy; most students indicated that work and leisure are both crucial aspects for doctors and must therefore operate in balance.

The paradoxical nature of these dichotomies is obvious and potentially a resource that can be exploited for the purposes of teaching professionalism. If television dramas are a means of engaging medical students in professional issues, why not incorporate them as a pedagogical tool within the medical school's formal curriculum? Watching and discussing medical television dramas together with a tutor provides students with the opportunity to examine relevant bioethical issues and explore and

critique a number of different professional identities, both positive and negative. The clinical environment may not be a safe place in which to critique the hidden curriculum given the personal involvement of students and their clinical supervisors and assessors in day-to-day events (Klemenc-Ketis and Kersnik, 2011). With careful selection, medical television dramas can engage students with important professionalism issues which are usually too abstract in the formal curriculum but perhaps too threatening in the clinical environment.

We acknowledge, of course, that in many cases television characters can provoke simplistic comparisons between curing and caring, with the characterizations often drawn in narrow ways to serve the demands of narrative conflict and drama. As noted in the Background, television may simply conform to genre conventions and societal attitudes rather than allow for nuanced representations and, as others note, medical television storylines can be subject to framing, where issues such as organ donation may be portrayed in highly unrealistic ways (Morgan et al., 2007). We could argue, then, that students are simply responding to the ways that television writers (and popular culture more generally) frame the types and roles of doctors, rather than their own conceptions Thus it might be possible to interpret the programs as confirming dichotomous portrayals, yet we do not think this is the case with our participants, who seemed cognizant of the tendency of television to present superficial characterizations. Further, the students' mixed and often contradictory opinions about characters and programs in our study show that there is some complexity in students' interpretations of television characterization.

We also note that participants in this study were not explicitly instructed about the programs in a directed learning format, unlike other research (Klemenc-Ketis and Kersnik, 2011; Lumlertgul et al., 2009), such as viewing a film in a tutorial and discussing the relevant issues afterwards. This suggests that to some extent students are drawing out these issues of professionalism from shows without any pedagogical intervention. However, we also acknowledge that our surveys did ask students to reflect on specific ethical and professional issues, including caring, which naturally points their attention to them. Despite this, we did not make any reference to work-life balance or clinical-administration roles in our surveys and as such these elements emerged of their own accord.

There is relatively little qualitative research that asks medical students to reflect on their perceptions of the issues associated with medical television, and therefore this study adds a valuable perspective to the debate on television communication and medical education: that of the students themselves. There are several limitations to this study, with its restriction to one university meaning that we cannot assume our findings relate to students in other medical schools, although we do not expect that similar settings would yield different results. Moreover, although we had a high participation rate, we acknowledge that open-ended questions on surveys do not necessarily provide rich data in qualitative terms. As such, we suggest that future research could elaborate on this topic by interviewing medical students in more depth, an approach that would allow follow up questions for any particularly intriguing areas. Finally, although the focus in this study was on medical education, the same possibilities for television and pedagogy are also available in other disciplines. For instance, recent research shows that

television can play some role in publicising particular professions and thereby potentially influencing recruitment, such as in forensic science and nursing (Weaver et al., 2012; Weaver et al., 2013), and therefore the interactions between particular professions and television portrayals warrant further scrutiny not just in medical education but elsewhere.

The strength of the polarities around curing and caring, work and social life, and clinical and administrative work perceived by medical students in television programs might seem surprising for students so early in their career. The study shows that not only are students able to discern important, contemporary issues from television programs that are designed to be entertainment, but that these fictional role models can be used to examine the students' own development of professional identity and beliefs about medical practice. The pedagogical use of such readily available material in stimulating discussion and debate around professionalism therefore seems logical.

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