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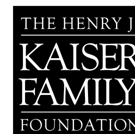


As Seen on TV: Health Policy Issues in TV's Medical Dramas

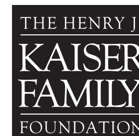
A Report to The Kaiser Family Foundation

July 2002

By Joseph Turow, PhD

Rachel Gans

University of Pennsylvania



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What ideas do U.S. mass media present to Americans about health policy issues? Television's hospital shows are an important place to look for answers to this question. These tales of the medical world are viewed by millions. *ER* has been one of the top series in prime time for several years beginning in 1994, with audiences of 20-30 million viewers each week. Other programs, such as *Strong Medicine* (2000- continuing), *City of Angels* (2000-2001), and *Gideon's Crossing* (2000-2001), have been less popular but have nevertheless drawn millions to their stories about patients and doctors in crisis. What, if anything, do these programs say about key debates facing the health care system?

Our report addresses this question by examining the extent to which, and the way in which, network television's prime time hospital dramas depicted health policy issues during the 2000-2001 season. We found that policy debates did, in fact, appear regularly in the programs, and, for the most part, in an evenhanded manner. At the same time, we found systematic limitations on the range of, and participants in, the debates. Such limitations, we suggest, may work against viewer knowledge and engagement in public issues.

BACKGROUND

Researchers have long recognized that news media coverage affects what the general public believes about health care (Bowen, Anderson, and Urban, 2002; Danovaro-Holliday, Wood, and Lebaron, 2002; McAlister and Fernandez, 2002; Meischke, Kuniyuki, Yasui, and Brodie, Kjellson, Hoff, and Parker, 1999; and Piotrow, Kincaid, Rimon and Rinehart, 1997). What has become increasingly clear in recent years is that fictional television can also play a significant role in shaping public images about the state of our health care system and policy options for improving the delivery of care.

Research has documented the role that entertainment TV plays as source of personal health information (Brodie, et. al., 2001). But beyond providing specific information about topics such as cancer, heart disease, or HIV, the 'cultivation theory' of media studies suggests that entertainment media are also likely to play a role in shaping viewers' broader conceptions of the health care system (Gerbner, Gross, Morgan and Signorielli, 1986). For example, studies from related fields have documented that entertainment television portrayals influence viewers' impressions of topics such as how much violence occurs in schools, whether most politicians are corrupt, or how many poor people or senior citizens there are in our society (Gerbner, Gross, Morgan and Signorielli, 1982; Mares, 1996; Shrum, 1997; Sprot, 1996; and Zillman and Brosius, 2000). The research suggests that fictional TV shows may also have an impact on viewers' perceptions of issues such as the quality of managed care, the rights of patients under current law, whether insurance companies are providing sufficient coverage, and end-of-life decisions. Related work suggests, too, that TV viewers may well mix what they see on news and entertainment together, thereby creating a composite sense of the world from both types of programming (Delli Carpini and Williams, 2001, 2000; Green and Brock, 2000; Shrum, 1997; and Mares, 1996).

Certainly TV dramas reach a much wider audience than most news programs. Beyond the size of their audience, some media scholars argue that entertainment TV's impact can be even more powerful than news in subtly shaping the public's impressions of key societal institutions. The messages are more engaging, often playing out in compelling human dramas involving characters the audience cares about. Viewers are taken behind the scenes to see the hidden forces affecting whether there's a happy ending or a sad one. There are good guys and bad guys, heroes and villains and innocent bystanders. Instead of bill numbers and budget figures, policy issues are portrayed through the lives of "real" human beings, often in life-and-death situations. These health policy discussions take place not only in hospital dramas, but also in dramatic storylines on programs like *Law & Order, The Practice,* and *The West Wing.*

Hospital dramas provide an opportunity for viewers to learn specifically what goes on at the center of high-intensity medicine. The dramas' fictional presentations open curtains on relationships between doctors and nurses, specialists and generalists. In ways that news reports cannot, they play out various assumptions about how health care ought to be delivered, about what conflicts arise that affect health care, and about how those

conflicts should be resolved and why. Doing that, hospital dramas represent an important part of viewers' curriculum on the problems and possibilities of health care in America.

Just how much attention does this dramatic curriculum pay to health policy issues? Are the health policy issues that hospital dramas depict also contemporary *public policy* issues—that is, topics that currently sit on the dockets of national or state legislatures or courts? Do the programs highlight dissatisfactions with the health care system that are not currently on the public's radar screen but might percolate into view at least partly because of such portrayals?

To answer these questions, we approached television's fictional hospital world with unprecedented depth. Using the method of quantitative content analysis, we explored the extent to which, and the way in which, arguments over health policy issues showed up on prime time television over several months. We examined in detail every first-run episode of every prime time hospital drama on network television from September 2000 through May 2001. The series were *ER*, *Gideon's Crossing*, *City of Angels*, and *Strong Medicine*. We examined a total of 74 episodes.

We aimed to explore the issues related to health care policy that arose in these programs. We therefore did not examine every reference to a health topic. Instead, we focused on the discussions of policy that explicitly argued for the pros or cons of a policy issue.

For the purposes of this study, then, a health policy issue is a disagreement or expressed dissatisfaction with government or institutional rules about non-clinical issues in patient care. These may be disagreements about the basic allocation of resources, such as money, time, and personnel, for patient care. Examples of these would be arguments about HMO's and their rules regarding access to care, or expressed dissatisfaction with Medicare's reimbursement amounts to doctors. Health policy issues may also involve ethical debates pertaining to patient care because of legal considerations or organizational rules. For instance, discussions between doctors about a patient's right to confidentiality or a patient's refusal of treatment in order to hasten death, would fall in the ethical category in our coding scheme.

Health policy issues differ from *clinical arguments* both in what they cover and in their implications for public policy. Clinical arguments involve health care workers debating the usefulness or appropriateness of certain procedures or medications. Society generally considers that health care workers have exclusive expertise to settle these types of disputes. Society does not take that position toward health policy issues. Instead, governments, advocacy groups, journalists, and the general public typically consider that citizens' opinions and the broad democratic process should influence how resources, ethics, and the law should be organized to impact patient care on issues ranging from universal health insurance to patients' rights to prescription drug coverage.

In the upcoming pages we discuss in more detail how we carried out this study and lay out our findings. First we present an overview of the number and frequency of health policy issues that appeared on these programs. We ask how many of the policy disputes in the hospital series reflected public debates now going on in U.S. courts and legislatures. We then discuss the specific issues that the programs acted out and the contemporary arguments that they ignored. That is followed by more detailed discussions of the key players engaged in the TV disputes—the doctors, nurses, patients and relatives who challenged or supported particular governmental or organizational rules, and the hospitals, insurers and other institutions referenced in those discussions. We analyze their positions on these issues and explore whether the programs were balanced or unbalanced in presenting different views of health care disputes. Finally, we distill our findings into comments about their possible implications for the health system, policymakers and the creators of television's hospital dramas.

We found that health policy issues do regularly enter the plots of prime time hospital series, although most such portrayals do not probe the issues in depth. Many of the issues in these TV dramas mirrored major public policy disputes taking place in the "real" world of congress, regulatory agencies and state legislatures. Other arguments that we saw in plotlines concern policies that are not on the public policy radar screen as yet, but repeated TV attention may well help put some of them there.

Many societal factors shape the ways in which members of the public develop their beliefs about the issues facing the health care system and what to do about them. As Americans worry about their physical well-being, the well-being of their aging parents, and their ability to navigate complex hospital realities, they inevitably encounter stories on television that speak to their concerns. This study helps us to understand the kinds of stories prime time hospital TV programs tell Americans about the problems that confront the health care system.

METHODOLOGY

OVERVIEW

From September 2000 through May 2001, *ER*, *Gideon's Crossing*, *City of Angels*, and *Strong Medicine* aired a total of 74 episodes. We trained and tested coders to reliably examine aspects of each episode that related to health policy issues. Using systematic content analysis procedures, the coders then analyzed all the episodes. To help determine whether the issues that coders found in the programs are also contemporary public policy issues (that is, topics currently the subject of attention by national or state legislatures or courts), we turned to experts at the Kaiser Family Foundation.

In this description of methods, we provide details about our sample, the specific ways we defined our terms, the nature of the measures used to describe and analyze the content, the training of our coders and their reliability test, and our approach to presenting the findings.

THE SAMPLE

We decided to focus on prime time hospital series out of a belief that their consistent focus on the relation of doctors and nurses with patients who are in jeopardy make them the source of many viewers' understandings of how the health care system works. The 2000-2001 TV season saw an unusual number of such programs. *ER*, on NBC from 1994, was (and continues to be) among the top-rated series on the air; it aired 22 episodes. *Strong Medicine* appeared on Lifetime cable network in the 2000-2001 TV season, aired 22 new episodes, and continues to be aired in prime time on that network. *Gideon's Crossing* (on ABC) and *City of Angels* (on CBS) fared less well. *Gideon's Crossing* lasted only that season, but it did air 20 first-run episodes. *City of Angels*, which premiered in January 2000 (1999-2000 TV season), aired only 10 new episodes in the 2000-2001 season; CBS canceled it as of December 2000. All episodes were one hour long, including commercials.

The Kaiser Family Foundation videotaped all 74 episodes off the air. The result is that we were able to evaluate the entire year's production of these hospital series. The approach allows for a high degree of confidence in our findings concerning the content of hospital-based TV programs from the season studied.

THE TERMS AND THE CODING INSTRUMENT

We conducted systematic content analysis on the 74 hours of hospital shows with the goal of exploring the extent to and the ways in which health policy issues made their appearance. As noted earlier, for the purposes of this study a **health policy issue** is a disagreement or expressed dissatisfaction with government or institutional rules about non-clinical issues in patient care.

In order to teach coders to systematically and reliably observe such disputes on TV, we defined our basic unit of analysis as a **health policy interaction (HPI)**. This is a scene in which a health policy issue appears. When more than one policy issue appeared in the same scene, we coded the scene as two separate HPIs.

An interaction about a health policy issue was coded if it included:

- Two or more individuals disagreeing about the policy issue. Example: A doctor argues with a hospital administrator that a patient ought to receive an expensive treatment even though the patient has no insurance that will cover it. The administrator responds that the hospital cannot afford to do that.

- One person disagreeing in words or action with what he or she contends (or knows) is the position of an organization or health care provider. A person saying "*You're not treating me properly because you don't like the reimbursement Medicare will give you*" <u>would</u> be coded even if the physician didn't respond directly to the comment. The reason is that the person's comment imagines a position that opposes hers.

- A person expressing dissatisfaction in words or action with an inability to obtain a desired treatment because of scarce resources such as money, an organ (eg liver), time with a physician or legal restraints against such a procedure (stem cell research for Parkinson's patients). For example, we would code the case of a patient who tells a health care provider, "You're not giving me antibiotics because I'm poor and I don't have insurance—that's persecution."

Note that a health policy interaction might be part of a larger **health policy incident**. That is, a story line within a series episode that deals with the same specific health policy issue. For instance, an episode might include three scenes in which health care providers and/or patients discuss a health policy issue. Every HPI received an incident number, even if it represented the only scene of that incident. Two or more health policy interactions that were part of the same health policy incident received the same incident number. That allowed us to track the extent to which a program episode emphasized a particular policy dispute.

Our primary focus was public policy issues, but we coded hospital policy issues as well; each type was given a separate code. A **public policy issue** is an argument over a rule imposed by a governmental entity such as a court, legislature or executive agency. A **hospital policy issue** is one that deals with rules established by a hospital or administrative agency without governmental authority.

We found that most HPIs we identified fell into one of two broad categories, resource related issues or ethical issues. Resource issues concern the basic allocation of resources, such as money, time, and personnel, for patient care. A conceptually different policy issue involves ethical challenges to policy that pertains to patient care. We developed coding rules to allow our coders to distinguish between the two types of health policy issues, **resource HPIs** and **ethical HPIs**.

Resource HPIs. Resource issues are disagreements about, or expressed dissatisfaction with, the basic allocation of resources for patient care by governments, businesses, or medical organizations. Resource issues reflect a real, imagined, or created *scarcity of resources* as the reasons for particular rules of allocation. Money, time, and personnel are examples of resources. To qualify as a resource issue, characters disagreeing had to make explicit mention of the problem's impact on patient care.

Debates about Medicaid would fall under this category. So would the failure to provide care (for example, mental health care) to a particular community or group (say, American Indians) because of cultural, racial or institutional factors. An argument about the refusal of a managed care organization to admit a patient to the hospital would be coded as a resource issue.

Ethical HPIs. Ethical issues are about the regulated codes of conduct pertaining to patient care. Should physicians give fresh needles to addicts? Should physicians allow patients to opt out of lifesaving treatments? As these questions suggest, ethical policy debates are disagreements about, or expressed dissatisfaction with, a private or public authority's rules of action regarding patient care that are *based on ethical concerns, legal considerations or organizational rules*. To qualify as an ethical issue, characters disagreeing had to make explicit mention of ethical, legal or organizational policies they were challenging or with which they were agreeing.

Both ethical and resource debates should be distinguished from *clinical debates*, which we did not code. Clinical debates are patient-care arguments among providers and between providers and other individuals which involve the most medically appropriate treatment. For example, a disagreement between two doctors over which medication to prescribe for a patient would be a clinical argument not coded in our study.

Note that whether an issue is coded as resource or ethical might depend on the particular nature of the discussion. Disagreements about abortion regarding whether an insurer would cover the procedure would make it a resource issue. Disagreements about abortion where a doctor does not wish to perform the surgery because of personal beliefs would lead us to code it as an ethical issue. Comments in which both scarce resources and ethics overlap with respect to the same health policy issue were coded as *overlaps*.

The Coding Instrument. These terms were at the heart of the coding instrument, which is essentially a questionnaire that coders were to ask about every health policy interaction. After identifying the program, providing the HPI with a unique identifier, and noting whether or not the interaction was part of an earlier incident, the coder noted whether the HPI centered on resources or codes-of-codes, or whether it overlapped the two.

With a resource issue, the coder chose from among 67 categories that knowledge of the health policy literature, preliminary viewing of the programs and conversations with experts suggested might show up. Examples of these issues were managed care arguments about cost, debates surrounding the cost of long term care, and racial, ethnic or social disparities in treatment. If the resource issue depicted did not fit one of the categories, the coder chose "other" and wrote in a description of the incident.

In the case of an ethical issue, the coder chose from among 22 categories that knowledge of the health policy literature, preliminary viewing of the programs and conversations with experts suggested might show up. Examples of these issues were patient rights issues such as informed consent, end of life issues such as the right to refuse treatment, and interactions around the ethical dimensions of malpractice or clinical trials. (Discussions of the effects of malpractice on medicine were coded as resource issues.)

After noting the topic of the HPI, the coder went on to answer questions about the individuals in the scene. The coder answered questions about all speaking individuals as well as about all non-speaking patients (for example, a patient in the scene who is lying, sedated, in bed). Afterwards came questions about the person's dramatic role, primary organizational affiliation, social age, ethnicity, gender, socioeconomic status and race. We also asked coders to note the person's position on the argument (for or against current policy), whether the show presents that policy stance favorably or not, and whether the person is a victim, villain, hero, or none of those.

However, in malpractice scenes, where the correctness of "current policy" was not at issue, coding for a person's position for or against current policy made no sense.

The same logic applied to six scenes that involved allegations of racial or economic discrimination influencing patient care. Because no one was arguing *for* discrimination, we noted the argument as health policy interactions but we did not code whether those involved were for or against the policy. Consequently, we instructed coders not to code the variable on current policy in all cases dealing with malpractice or allegations of discrimination.

The next section contained questions about the illness and disposition of patients in the scene. These were followed by questions about whether people in the HPI mentioned an "institution"— from hospitals to insurers to news media—in relation to the health system and, if so, whether the overall discussion of that institution in the HPI was positive, negative, or mixed. Finally, we asked coders questions about the HPI's overall presentation of public policy. Did the interaction either present or act out reasons for or against the policy? Did one or another side clearly prevail? Did the health care provider ignore or work around policy in treating the patient, and (if so) was that behavior depicted favorably? And did someone in the HPI note that the general issue discussed is being played out beyond that specific situation—for example, in other places or on national, regional or municipal levels?

TRAINING THE CODERS

We trained our coders to systematically and reliably answer these questions. The coders were nine undergraduates (sophomores, juniors and seniors) at the University of Pennsylvania who were paid for their work. They analyzed the programming in pairs, though one group included three students.

Training involved two months of intensive exercises in which the nine undergraduate coders met for weekly three-hour meetings to go over the codebook and coding rules. All had either previous experience with content analysis and/or knowledge of the medical profession. During training, coders were shown health policy interactions from the series selected as well as HPI's from previous seasons of *ER*.

We gave the students booklets that explained not only the rules for coding but also descriptions of the four shows they were to analyze and character lists for each program. Between meetings the trainees were given coding assignments, which we compared and discussed at the meetings. After the individual coders showed an understanding of the categories and a reliability in their analyses, we split them into groups of two (and one group of three) for the actual study. We felt that a pair's ability to discuss the material would heighten the reliability of the data.

Reliability. We performed two types of reliability testing. The first audited the coders' ability to identify health policy interactions. We gave the coding pairs tapes that contained 20 scenes with arguments; some of them were HPIs, while others were clinical or non-medical disputes. Coders had to mark on a codesheet which of the 20 scenes were HPIs. We then compared the reliability between the pairs. We had 100% reliability on this test.

The more complicated testing came when we gave students 16 health policy interactions to code in full. Scenes were taken from *Gideon's Crossing, ER,* and *Strong Medicine*. We randomly selected 10 variables to compare the student-pairs on reliability. We then ran the kappa statistic between each pair on each variable. After calculating *kappa* for each of the groups on the ten variables; we averaged the resulting *kappas*. All variables scored .80 or higher. The average kappa score was .91.

FINDINGS

This section presents the results of the coding and our analysis of the data. It starts with a bird's eye view of the programs' health policy issues, ranging from their overall number and frequency to their distribution in terms of resource, ethical and public policy issues. We then move in for a closer analysis of the specific issues involved—and of the issues that did not come up in the programs.

Zooming in even tighter, we look at the people who participated in the health policy arguments. We note the presence and likeability of patients, relatives, and the various health care providers. We explore their positions on the issues raised and the way in which the program portrayed their policy positions. We also note the extent to which, and the way in which, characters mentioned various institutional players such as hospitals, lawyers and government programs in their health care arguments.

Finally, we pull back a bit in our examination of the health policy scenes to explore whether or not those scenes presented balanced views—that is, positions for and against the current policy. We also ask about the nature of the "balanced" presentation. Are the characters who represent one position less credible than those who represent the other?

Interspersed with our tables and analyses we present *snapshot* boxes. These are short examples that illustrate and bring to life some of the patterns that we see in the data.

THE PRESENCE OF HEALTH POLICY ISSUES

We start by asking about the number of health policy incidents that occurred in first run episodes of *City of Angels*, *ER*, *Gideon's Crossing* and *Strong Medicine* during the 2000-2001 television season. A health policy incident is a story line within a program episode that deals with a specific health policy issue one or more times. Take, for example, a *Strong Medicine* story line in which Dr. Delgado and Dr. Stowe argue over whether a mother is required legally to give HIV medication to her infected son. The argument over this issue takes place in two separate scenes. We call each scene a health policy interaction. Together, the scenes comprise an incident.

Table 1: Number of health policy incidents and interactions in each program

Program	Hours Coded	Incidents	Incidents per Hour	Interactions	Interactions per Hour
City of Angels	10	9	.9	15	1.5
ER	22	30	1.36	47	2.1
Gideon's Crossing	20	13	.65	29	1.5
Strong Medicine	22	24	1.09	36	1.6
Total	74	76	1.06	127	1.7

Our coders found 76 such incidents during the 74 hourly episodes that they viewed. That amounts to about one health policy incident for every program episode. Table 1 displays the number of incidents in each series as well as the number of incidents per hour of each program. *ER* and *Strong Medicine* had a bit more than one per episode and *City of Angels* had just about one per episode. *Gideon's Crossing* acted out a health policy incident about once every 1.3 episodes.

Table 2: Number of health policy interactions in health policy incidents

Number of Interactions	Total Incidents (N=76)
1	66%
2	15%
3	12%
4	4%
5	3%
6	1%
Total	101*

*Total is greater than 100% due to rounding error.

Most health policy incidents did not have multiple scenes. Table 2 indicates that 66% of the incidents were comprised of only one scene of an episode—that is, of one policy interaction (HPI). Fully 81% of the incidents were comprised of one or two HPIs. We turn now to an analysis of the health policy interactions.

The health policy interactions. Our coders noted 127 health policy interactions in the 74 episodes. On average, an hourly program episode contained 1.7 HPIs. As Table 3 indicates, *ER* had the highest percentage of episodes with HPIs (77%), while *Gideon's Crossing* had the lowest (50%).

The average across all four series was that 68% of the episodes contained at least one HPI.

Table 3: Percentage of shows with at least one health policy interaction (HPI)

Program	Number of Episodes	Percentage of Episodes with an HPI
City of Angels	10	70%
ER	22	77%
Gideon's Crossing	20	50%
Strong Medicine	22	73%
Tota or Average	74	68%

We determined that 59% (75) of these health policy interactions were *public policy* issues—that is, arguments over rules imposed by government entities such as a court, legislature or executive agency. (See Table 4.) That translates to an average of 1 public policy-focused scene per episode. Examples of the 75 public policy issues were arguments over a patient being turned away for not having Medicaid coverage; over a policy prohibiting hospitals from distributing clean needles to drug addicts; over an HMO's refusal to allow a patient to be hospitalized for pain management; and over whether a physician's support of a patient's refusal of treatment was tantamount to assisted suicide.

Table 4: Policy focus of health policy interactions

Focus	HPIs (N=127)
Hospital Policy	9%
Malpractice	32%
Public Policy	59%
Total	100%

Arguments over *malpractice* covered 41 HPIs while 11 HPIs centered on what might be called *hospital policy*. HPIs relating to hospital policy centered on hospital protocol and power struggles over the right of physicians to determine care of their patients, issues that are not on the broader public policy agenda at this time. An example from *ER* was Dr. Benton's confrontation of Dr. Weaver about her decision to restrict Dr. Carter's ability to use and prescribe controlled substances because Carter had been addicted to such substances. An example from *Gideon's Crossing* was a patient's fierce desire to be included in a clinical trial, his last hope for a cure, despite not meeting all the qualifications set by the hospital's research protocol.

The malpractice HPIs centered on lawsuits or threats of lawsuits resulting from the violation or alleged violation of proper medical policy. Virtually an entire *Gideon's Crossing* episode, for example, told of the death of a patient due to a sequence of major medical errors. The case underscores that unlike other health policy issues, malpractice arguments did not focus on whether a rule should or should not be challenged. The disputes revolved instead around whether a doctor had violated a rule.

Table 5 indicates that the proportion of public policy scenes was highest in *Strong Medicine*, while *ER* was the most varied in types of health policy arguments. Importantly, the programs themselves rarely made the distinction between issues that were being discussed beyond the hospital and those that were not. As Tables 6 indicates, only in 8 (11%) of the 75 public policy interactions did anyone mention that the issue was one that was being discussed outside that particular health care situation.

Table 5: Percent of episodes with hospital policy, public policy, and malpractice interactions

Program	Number of Episodes	Percent with Hospital Policy	Percent with Malpractice	Percent with Public Policy
City of Angels	10	--	30%	50%
ER	22	23%	27%	45%
Gideon's Crossing	20	10%	25%	30%
Strong Medicine	22	5%	9%	64%
Total	74	11%	22%	47%

Table 6: Percent of public policy HPIs that note whether the debate relates to national, state or local issues.

	Percent of Public Policy HPIs (N=75)
Noted	11%
Not Noted	89%
Total	100%

In general, then, the hospital programs reflected public policy debates fairly frequently but did so without explicit reference to legislation or legal activities. The debates, instead, were acted out through plot lines that stressed the aspects of human drama inherent in the policy debates.

The issue types. In the 74 first-run episodes that appeared during the 2001-2001 season, 98 (78%) of the 127 HPIs centered on ethical issues related to health care; 17 scenes (13%) revolved around health resource issues; and 12 scenes (9%) involved an overlap of both resource and ethical concerns. (See Table 7.) With the overlap interactions counting in both categories, the numbers mean that, on average, ethical HPIs showed up roughly one and a half times an episode, while resource HPIs showed up a little less than once every other episode.

Table 7 indicates that the skew toward ethical issues was strong across all the programs. *City of Angels* had the highest proportion of ethical interactions (93%), and no resource HPIs. *Strong Medicine* had the highest proportion of resource HPIs at 22%. In all the shows, ethical issues comprised a major proportion of the health policy arguments, ranging from 66% to 93%.

Table 7: Percent of health policy interactions that emphasize resource or ethical concerns

Issue Type	City of Angels (N=15)	ER (N=47)	Gideon's Crossing (N=29)	Strong Medicine (N=36)	Total (N=127)
Resource	--	13%	10%	22%	13%
Ethical	93%	79%	66%	78%	78%
Overlap	7%	9%	24%	--	9%
Total	100%	101%*	100%	100%	100%

* Total is greater than 100% due to rounding error.

Additional analysis showed that not only were resource issues relatively scarce, the majority that did show up were not repeated or elaborated on in their episodes. All but 7 of the 17 cost-related interactions (59%) stood alone, unrelated to other issue interactions. By contrast, 38 (39%) of the 98 ethical scenes stood alone.

THE SPECIFIC HEALTH POLICY ISSUES

Table 8 presents in bold type all the specific health issues that appeared in the four programs. The issues in regular type represent those we thought might appear (based on knowledge of public policy issues) but did not. The table suggests that the programs presented a wide range of disputes over ways that resources, ethics, and the law should be organized to impact patient care. It should be noted that absence of an item such as AIDS does not mean that the topic was not discussed or mentioned on the program. It means, rather, that there were no health policy debates about it. Several shows did, for instance, depict patients with HIV or AIDS, but discussions about these patients did not bring up policy issues related to the subject.

Tables 9 and 10 help us go beyond the appearance of various issues to the frequency with which they showed up. Table 9 presents all the issues that showed up, while Table 10 collapses some of these categories to provide an overview of top areas of health care argument in the programs. Both tables indicate that:

- **Malpractice was by far the most frequent issue to appear in the four programs; it represented nearly one-third of all interactions.** In malpractice situations, providers argue whether a patient's unfortunate outcome should cause them to accept legal oversight with respect to what is traditionally their professional dominion over life-and-death procedures. For viewers, the message may be that even in the clinical area there are times when doctors can be held accountable to the larger society. (See *Snapshot 1*.)

  Malpractice scenes were quite distinctive among the hospital programs' health policy interactions in mixing resource and

Snapshot 1
Gideon's Crossing episode, "Clinical Enigma"

David Porter arrives at the hospital complaining of mild chest pain. Twenty-four hours and multiple major medical errors later, he is dead. His upset and angry wife wants answers and brings a lawsuit against the hospital. Dr. Gideon feels that the hospital should apologize and settle with Mrs. Porter. The hospital's chief administrator, Dr. Cabranes, disagrees. He argues that the hospital has an obligation to protect its doctors and reputation. He feels they should settle but make no admission of guilt. Mistakes happen, he says, and the hospital needs to be able to function despite them. Paying out huge sums of money in lawsuits, he argues, will only hinder the hospital's ability to provide good care.

At the same time that Dr. Gideon sympathizes with Mrs. Porter's desire for the truth, the younger doctors in the hospital who made the errors worry about their careers and how the lawsuit will affect each of them. In a meeting with the lawyers about a possible settlement, Mrs. Porter states that she wants an apology, a public admission of culpability and an announcement of the names of the doctors responsible. Dr. Cabranes refuses. He is willing to giver her some money but feels he must protect his staff. Mrs. Porter rejects the settlement offer, and Dr. Gideon is left feeling conflicted about the best way to proceed.

Table 8: Issues raised (bold type) and issues not raised (regular type) in health policy interactions

RESOURCE ISSUES		ETHICAL ISSUES
Abortion	Nursing Shortage-Low Pay	Biotechnology-Cloning
AIDS-Cost of Care	**Other Resource Issues**	**Biotechnology-Stem Cell**
AIDS-Research Priorities	Research-Financial Constraints	**Clinical Trials-Experimental Procedures**
Cost Containment-Doctors	**Research-Other**	**Clinical Trials-Other**
Cost Containment-Malpractice	Uninsured	**End of Life-DNR**
Cost Containment-Needless Procedures	Uninsured- Children	End of Life-Doctor Assisted Suicide
Cost Containment-Other		End of Life-Hospital Stay or Leave
Cost Containment-Patients		End of Life-Living Wills
Disparities-Discrimination		**End of Life-Other**
Disparities-Hiring Practice		End of Life-Quality of Life
Disparities-Provision of Care		**End of Life-Refuse Treatment**
Disparities-Resource Allocation		Malpractice-Illegal Actions by Doctors
ER Closure-Scarce Resources		**Malpractice-Major Medical errors**
HMO- Price/Cost		**Malpractice-Other**
HMO-Doctors Covered		**Malpractice-Threats**
HMO-Inability to Sue		**Patient Rights-Children's Rights**
HMO-Other		**Patient Rights-Confidentiality**
HMO-Prescription Coverage		**Patient Rights-Informed Consent**
HMO-Treatment Coverage		**Patient Rights-Other**
HMO-Treatment Interference		**Patient Rights-Privacy**
Insurance- Price/Cost		**Religious Prohibitions**
Insurance-Doctors Covered		
Insurance-Prescription Coverage		
Insurance-Treatment Coverage		
Insurance-Treatment Interference		
Long Term Care-Chronic Illness		
Long Term Care-Home		
Long Term Care-Hospice		
Long Term Care-Nursing Homes		
Medicaid- Payment Scale to Doctors		
Medicaid- Prescription Coverage		
Medicaid-Doctors Covered		
Medicaid-Eligibility		
Medicaid-Quality of Care		
Medicaid-Treatment Coverage		
Medicaid-Treatment Interference		
Medicare-Doctors Covered		
Medicare-Other		
Medicare-Payment Scale to Doctors		
Medicare-Prescription Coverage		
Medicare-Treatment Coverage		
Medicare-Treatment Interference		
Mental Health-Services		
Mental Health-State Facilities		
Nursing Shortage-Few Skilled Nurses		
Nursing Shortage-Labor Disputes		
Nursing Shortage-Long Hours		

Table 9: Frequency of issues raised in HPIs

Issue	Percentage of HPI (N=127)	Issue	Percentage of HPI (N=127)
Malpractice-Suits	13%	Medicinal Marijuana**	1%
End of Life- Refuse Treatment	7%	Malpractice Fines**	1%
Malpractice-Threats	6%	Doctor's Authority**	1%
Patients Rights- Children's Rights	4%	Credential Issues**	1%
Patients Rights-Other	3%	Allocation of Space**	1%
Malpractice-Other	3%	Accusation of Policy Violations**	1%
Cost containment-Malpractice Suits	3%	Medicare-Other	1%
Biotechnology	3%	Medicaid-Treatment Coverage	1%
Patients Rights- Confidentiality	2%	HMO-Treatment Coverage-Malpractice Suits	1%
Female Circumcision**	2%	HMO-Treatment Coverage	1%
Doctors with Drug Problems Dispensing Drugs**	2%	HMO-Quality of Care-Malpractice Major Medical Errors	1%
Chain of Command**	2%	HMO-Other	1%
End of Life-DNR	2%	Drug Reimbursement Policy	1%
Disparities-Discrimination	2%	Disparities-Provision of Care	1%
Cost Containment-Malpractice Threats	2%	Clinical Trials-Experimental Procedures	1%
Cost Containment-Malpractice Other	2%		
Clinical Trials-Other	2%	**Total**	**106%***
Patients Rights- Privacy	2%		
Social Services**	2%		
Pediatric HIV Protocol**	2%		
EMS Protocol**	2%		
Doctor-Patient Sexual Relations**	2%		
Clean Needles for Drug Addicts**	2%		
Malpractice-Major Medical Errors	2%		
HMO- Doctors Covered	2%		
End of Life-Other	2%		
Disparities-Resource Allocation	2%		
Cost Containment-Other	2%		
Religious Prohibitions	1%		
Tuition Restrictions**	1%		
Teaching Hospital Etiquette**	1%		
Sterilization**	1%		
Law & Doctors**	1%		
HAZMAT Protocol**	1%		
Rights of Homosexual Partners**	1%		
Policy Violation**	1%		
Parental Consent**	1%		

* Total is greater than 100% due to rounding error.
** Topics added as a result of coding.

ethical issues. As Table 9 indicates, fully 9 of the 12 "overlap" HPIs involved malpractice. The shows presented malpractice suits (or the threat of suits) both as a challenge to the ethical standards of the physicians involved and as a potential threat to the resources of the institution. Administrators, in particular, pointed out how malpractice cases were eroding their hospital's ability to contain costs.

Table 10: Most frequent issues raised in health policy interactions (collapsed categories)

Issues	Frequency	Percent of Total HPIs (N=127)
Malpractice	37	32%
Patient Rights	14	11%
End of Life	14	11%
Disparities	6	5%
HMO	5	4%
Clinical Trials	4	3%
Biotechnology	4	3%

One reason for the relatively large proportion of malpractice HPIs was that every hospital program used it as a major story line during the 2000-2001 television season. Malpractice was compelling from a dramatic standpoint because it merged the tension of patient jeopardy, the threat to hospital finances, and the angst of doctors and nurses who argued over whether they had made irresponsible decisions. The arguments were dramatically compelling because many included doctors' own fears that suits would ruin their careers. Because malpractice often befell the continuing characters when it came into a storyline, it tended to appear in multiple episodes.

- **Patient rights and end-of-life issues came next in frequency.** Patient rights interactions centered on legal, ethical, or organizational arguments over such issues as informed consent, confidentiality, and children's rights in the health-care setting. (See *Snapshot 2*.) End-of-life scenes involved characters disagreeing over individuals' legal, ethical or organizational prerogative to make decisions about the care they would receive as they move toward death. (*Snapshot 3* provides an example.) Together, these topics represented about one-fourth of the interactions. All 14 of the end-of-life, and 13 of the 14 patients' rights scenes reflected actual current national public policy debates.

- **Managed care, social disparities, clinical trials and biotechnology round out the types of issues that appeared 4 or more times.** *Managed care* refers to scenes in which characters disagreeing about the use of resources explicitly mentioned "HMO" or "managed care" or a specific managed care program. Issues that centered on social disparities were arguments that made explicit mention of unequal treatment of racial, ethnic or other groups in ways that affected patient care. (See *Snapshot 4*.) Arguments around clinical trials involved ethical, legal, or organizational challenges to specific experimental procedures or medical research projects performed on patients, focusing on the implications of those projects for patient care. *Biotechnology* arguments were similar, involving ethical, legal, or organizational challenges to stem cell research for patient care.

Table 11 details the nature and frequency of all 75 health policy interactions that reflected national public policy debates. The table calls attention to the wide gamut of public policy colloquies that the program creators tapped for their stories. These range from bioethics arguments and religious prohibitions to disputes about the propriety of giving clean needles to drug addicts. Seventy-eight percent of the public policy issues had an ethical focus while 18% centered on resources, and 4% were cases that

Snapshot 2
Strong Medicine episode, "Miracle Cure"

Dr. Stowe diagnoses Jane Hogan, a pilot with a commercial airline, as having a brain disease with no cure. She is pre-symptomatic although the disease promises to eventually result in muscle spasms, mini strokes, dementia and death. Dr. Stowe urges Jane to resign, pleading with her that the illness will affect her ability to perform her job, jeopardizing herself and her passengers. Jane refuses.

Dr. Stowe speaks to the hospital administrator, Dr. Jackson, and confesses that she wants to tell the airline about Jane's disease. Dr. Jackson reminds Dr. Stowe about her ethical and legal obligations to her patient. These obligations, he says, require her to remain silent. Dr. Stowe responds by asking about her ethical obligations to the people in the plane when Jane has a stroke at 30,000 feet. She feels that this case represents an exception to doctor-patient confidentiality because it represents a public health risk. Dr. Jackson urges her to remain silent, fearing for her career and the implications for the hospital as well.

Ignoring Dr. Jackson's warnings and the patient's wishes, Dr. Stowe calls the airline to report Jane's condition. The patient comes back to hospital furious with Dr. Stowe. The airline has fired her and she blames Dr. Stowe for ruining her career and failing in her responsibility to her, the patient. Arguing that Dr. Stowe took her career, she says she will go after Dr. Stowe's. Before she can report Dr. Stowe, Jane is involved in a crash with her private plane. Dr. Stowe is left wondering if the crash was a result of the brain disease or a suicide resulting from Dr. Stowe's own breach of doctor-patient confidentiality.

Table 11: Frequency of health policy interactions with a public policy focus

Issue	Percent of Public Policy HPIs (N=75)	Percent of HPIs (N=127)
End of Life- Refuse Treatment	12%	7%
Biotechnology	5%	3%
Other-Social Services	5%	3%
Patients Rights- Children's Rights	5%	3%
Patients Rights-Other	5%	3%
Disparities-Discrimination	4%	2%
End of Life-DNR	4%	2%
Female Circumcision**	4%	2%
Clinical Trials-Other	3%	2%
Patients Rights- Confidentiality	4%	2%
Cost Containment-Other	3%	2%
Disparities-Resource Allocation	3%	2%
End of Life-Other	3%	2%
EMS Protocol**	3%	2%
Clean Needles for Drug Addicts**	3%	2%
Pediatric HIV Protocol**	3%	2%
Patients Rights- Privacy	3%	2%
HMO- Treatment Coverage	1%	1%
HMO- Doctors Covered	3%	2%
Clinical Trials-Experimental Procedures	1%	1%
Disparities-Provision of Care	1%	1%
HMO- Other	1%	1%
Medicaid-Treatment Coverage	1%	1%
Medicare-Other	1%	1%
Accusation of Policy Violations**	1%	1%
Credential Issues**	1%	1%
Doctor's Authority**	1%	1%
Law & Doctors**	1%	1%
Medicinal Marijuana**	1%	1%
Policy Violation**	1%	1%
Rights of Homosexual Partners**	1%	1%
Sterilization**	1%	1%
Teaching Hospital Etiquette**	1%	1%
Parental Consent**	1%	1%
Malpractice Fines**	1%	1%
Religious Prohibitions	1%	1%
Research-Other	1%	1%
Allocation of Space	1%	1%
Total	100%	59%

** Topics added as a result of coding.

overlapped ethical and resource issues. Among the most frequently appearing public policy issues were those on end-of-life and patient rights.

Much less noted were insurance-related public policy issues that have received a lot of coverage in the news (Brodie, Altman, Brady, and Heberling, 2002). Although issues surrounding HMOs' provisions of inadequate care showed up in six scenes (see *Snapshot 5* for an example), these TV hospitals ignored a raft of major public debates about the uninsured, Medicare and Medicaid. Long term care did not appear at all during the particular television season studied, and there were just two passing references to the uninsured in scenes that mainly focused on other issues. Discussions of Medicare (a government-sponsored health care program for senior citizens) showed up twice in 74 hours, and Medicaid (a health care program for the poor) appeared once as a health policy issue. In fact, the only mention of Medicaid was an apparent mistake: it came in an *ER* episode in which one doctor says an elderly patient has Medicare, while later in the episode another doctor says to send him to Wisconsin so he can have a "new state, new Medicaid program and a whole new set of doctors to piss off."

THE PARTICIPANTS IN HEALTH POLICY ARGUMENTS

When creators of hospital TV programs choose which characters will argue about health policy, their decisions may be quietly asking and answering a question for viewers. The question: Who should legitimately be engaged in debates about non-clinical health policy within a hospital environment? The answer that we found: mostly doctors.

This section shows that although patients, relatives, friends, lawyers, non-physician providers and others did appear in health policy interactions, physicians dominated the discussions. We look at just how much they dominated as well as at the presence and likeability of the patients, relatives and various health care providers who engaged the issues. We also explore who among these groups were most likely to challenge or support current policy, and how the programs treated their policy stances.

Tables 12 and 13 set the stage for our examination of the participants in health policy arguments. Table 12 notes how many of the HPIs contained certain types of characters; if a scene contained more than one of the same type, that type was noted only once. Table 13, by contrast, looks at all the characters who appeared across the scenes. The same character was counted more than once if he or she appeared in more than one HPI. We found 327 characters in the 127 HPIs.

Table 12: Percent of health policy interactions featuring key character types

Character Types	Percent of all HPIs (N=127)	Percent of HPIs with a Public Policy Focus (N=75)
Administrative physicians	43%	36%
Non-Administrative Physicians	80%	83%
Nurses	10%	12%
Patients	35%	43%
Patient's Friends and Relatives	14%	23%

Table 12 shows that at least 80% of all 127 HPIs included one or more physicians; 43% saw at least one administrative physician (a chief of service or head of hospital) and 80% included at least one doctor who did not appear in an administrative capacity. Nurses appeared in only 10% of HPIs. Patients showed up in about one of every three scenes in which health care issues came up, while their friends or relatives came into only one in seven scenes. As Table 12 indicates, when it came to arguments that reflected public policy debates, higher proportions of patients and their friends and relatives were involved compared to the sample as a whole. Interestingly, the percentage of administrative physicians who appeared in public policy HPIs declined compared to the entire sample.

Table 13 carries the numerical dominance of physicians in HPIs further. It indicates that doctors far outnumbered all other types of participants. Physicians made up 64% of all characters. (Administrative physicians—chiefs of service or heads of hospital—made up 21% and non-administrative doctors made up 43% of the total.) By contrast, patients made up 14% of characters who showed up in health policy interactions.

Table 13: Percent of all characters in health policy interactions

Character Types	Percent of all Characters in HPIs (N=327)
Administrative Physician	21%
Non-Administrative Physician	43%
Nurse	4%
Social Service Workers	2%
Administrators	0.3%
Patient	14%
Patient Relatives or Friends	8%
Other	2%
Lawyer	6%
Total	100.3%*

* Total is greater than 100% due to rounding error.

Snapshot 3
ER episode, "Rampage"

An HIV-positive man, Mr. Jeffries, arrives at the hospital with a gun-shot wound to the stomach, the victim of a random carjacking. Dr. Benton and Dr. Finch explain to the man that he will need surgery to fix the damage done by the bullet. He refuses the treatment, declining to sign the consent form for surgery or accept a blood transfusion. Mr. Jeffries explains that his viral load is rising and that he will most likely die within the year. He has lost the people most important to him and has not spoken to his family in years. He is ready to die. He feels the gunshot wound has merely shortened the uncomfortable and painful remainder of his life. Dr. Benton and Dr. Finch try to convince him to agree to surgery, arguing that people can live with HIV. Mr. Jeffries is adamant.

Dr. Finch agrees to let the patient die, but Dr. Benton feels that by not performing the surgery they are helping Mr. Jeffries commit suicide. As a doctor, he feels uncomfortable allowing that to happen. Dr. Finch suggests that Dr. Benton get a court order if that is the way he feels, but otherwise they must respect the patient's desire. When the patient loses consciousness, Dr. Benton finds a way to circumvent the policy. Pretending that the patient never made his wishes known, Benton gets another doctor to cosign the consent form for surgery, thereby bypassing both Dr. Finch and the patient's wishes.

Their friends and relatives made up 8%. Nurses comprised 4%. Social service workers represented only 2% of the participants in health policy interactions.

Table 14 presents the character types in terms of general likeability. It indicates that the overwhelming proportion of those involved were presented positively, in a mixed (that is, with both positive and negative qualities), or unclear manner. Few were generally unlikeable. Physicians, who dominated the casts, clearly comprised the greatest number of likeable people.

Table 14: Likeability of character types in health policy interactions

Character types	Likeable	Not Likeable	Mixed	Unclear	Total
Administrative Physician (N=68)	46%	22%	28%	4%	100%
Non-Administrative Physician (N=140)	59%	2%	35%	4%	100%
Nurse (N=13)	69%	--	--	31%	100%
Social Service Workers (N=6)	33%	--	33%	33%	100%
Administrators (N=1)	--	--	100%	--	100%
Patient (N=46)	13%	9%	22%	57%	100%
Patient Relatives or Friends (N=25)	16%	20%	36%	28%	100%
Other (N=8)	38%	--	13%	50%	100%
Lawyer (N=20)	5%	25%	5%	65%	100%

Doctors and nurses. The numerical dominance of physicians in health policy interactions meant that a large percentage of the arguments took place among doctors. Table 15 indicates that providers' positions in the hospital hierarchy made a difference in terms of whether they challenged or supported policy. Note that the "no stance" row indicates a separate type of interaction where "position on the status quo" is not an applicable term. That is because malpractice arguments center on the violation of policies rather than on the correctness of policies themselves.

Table 15: Health care practitioners' positions on current policy in HPIs

Position	Administrative Physician (N=68)	Non-Administrative Physician (N=140)	Nurse (N=13)
For current policy	41%	33%	31%
Against current policy	10%	31%	36%
Unclear	2%	3%	8%
No stance*	47%	33%	23%
Total	100%	100%	100%

* These were scenes where the characters argued about malpractice or discrimination. When these issues came up, characters did not argue for or against policies on malpractice or discrimination but over whether or not a violation of the policies occurred. See text.

The table shows that providers farther down the hierarchy of institutional power were more likely to advocate overturning established policy positions. Administrative physicians were substantially more likely than non-administrative physicians to support current health care policy. Moreover, non-administrative physicians were far more likely than their administrative counterparts to challenge current health policy. The few times that nurses showed up, they were even a bit more likely than non-administrative doctors to advocate going against the status quo.

It turned out that position in the hierarchy also had some consequence for the way in which the programs judged a doctor's policy stance. Tables 16 and 17 indicate that the programs *were* somewhat more likely to portray the argument

Snapshot 4
Strong Medicine episode, "Drugstore Cowgirl"

Dr. Delgado asks Dee-Dee, an African-American ex-con who has sickle cell anemia, why she hasn't taken the medicine Dr. Delgado prescribed. The patient replies that her pharmacy doesn't carry the drug. She angrily asks Dr. Delgado why she prescribed medication to which she cannot get access.

Stung and confused by Dee Dee's remarks, Dr. Delgado visits the pharmacy. The pharmacist informs her that Demerol and other drugs are simply too expensive for the customers in the area who do not have insurance. He maintains that in order to stay in business he can't carry those drugs. The neighborhood is too poor, he argues, and all the other drugstores have gone out of business for that reason. He also suggests that local addicts may rob him if he carries such medications. Dr. Delgado replies that if he doesn't carry the drugs, they are unavailable as far as the patients in that neighborhood are concerned. Upon hearing Dr. Delgado, other patrons in the store complain about the long journey they must take to get the drugs they need or their predicaments of not being able to take medicine because the pharmacy doesn't stock them anymore.

Convinced by Dr. Delgado's promise that her hospital clinic will reimburse him for the drugs he carries, the pharmacist relents and agrees to carry the drugs. Dr. Delgado posts a sign at the clinic that his pharmacy now carries the drugs. As a result, the pharmacy is held up and the pharmacist is killed. The story ends even more unhappily—the police suspecting Dee-Dee for the murder despite her innocence, and the last pharmacy in the poor neighborhood closing down.

positions of non-administrative physicians more positively than the positions of administrative physicians. The tables also show, however, that overall the programs didn't depict providers' arguments in either a consistently positive or negative way. Programs typically portrayed provider positions in a "mixed" way, indicating that there were both positive and negative aspects to their policy arguments. Tables 16 and 17 show that with non-administrative physicians—the largest group of providers—this complex, "mixed" portrayal of the policy stance applied no matter whether the doctor was for or against the status quo. When it came to administrative physicians, a "mixed" portrayal was more likely to show up with a provider who supported the status quo. In the few cases where the episodes showed these people against the status quo, creators tended to portray them positively.

Table 16: How do programs present the policy stance of administrative physicians?

	Doctor Favors Current Policy (N=28)	Doctor is Against Current Policy (N=7)	No stance* (N=32)
Positive portrayal	18%	43%	--
Negative portrayal	11%	--	--
Mixed	64%	57%	--
Unclear	7%	--	--
Not applicable*	--	--	100%
Total	100%	100%	100%

* These were scenes in which the characters argued about malpractice or discrimination. When these issues came up, characters did not argue for or against policies on malpractice or discrimination but over whether or not a violation of the policies occurred. See text.

Table 17: How do programs present the policy stance of non-administrative physicians?

	Doctor Favors Current Policy (N=6)	Doctor is Against Current Policy (N=44)	Unclear (N=4)	No stance* (N=46)
Positive portrayal	35%	36%	--	--
Negative portrayal	4%	9%	--	--
Mixed	57%	55%	25%	--
Unclear	7%	--	75%	--
Not applicable*	--	--	--	100%
Total	100%	100%	100%	100%

* These were scenes in which the characters argued about malpractice or discrimination. When these issues came up, characters did not argue for or against policies on malpractice or discrimination but over whether or not a violation of the policies occurred. See text.

The patients. Compared to physicians, patients had a relatively small part in arguments about their health care. Table 18 reveals that a patient was portrayed as involved in a health policy argument in 25 of the 46 scenes in which patients appeared. That means that although patients appeared in about one-third of the 127 health policy interactions, they actually had input into only one-fifth of them.

Table 19 indicates more than half of the 45 patients who appeared could be classified as adults (between the ages of 24 and 64). Fewer were children and teens, and even fewer were senior citizens (ages 65 and older).

Snapshot 5
Gideon's Crossing episode, "A Routine Case"

Maria Montoya, an Hispanic cleaning woman and the wife of one of Dr. Gideon's former patients, arrives at the hospital suffering from advanced leukemia. Her HMO physician had mistaken it for a routine case of asthma. Angered that the HMO physician had never performed a blood test or a chest X-ray, Dr. Gideon gets even more annoyed when he can't reach Maria's doctor by phone.

Dr. Gideon decides to visit the HMO, where he meets Dr. Matthews, who misdiagnosed Maria. When Dr. Gideon questions the diagnosis and the amount of time he spent with Maria, Dr. Matthews responds that there are 10 Maria Montoyas in his waiting room every day—that he has followed the "clinical" algorithm that dictates procedure and so is not to blame. Dr. Matthews adds that the HMO will not allow Dr. Gideon to continue caring for Maria because he is not affiliated with the HMO.

When Dr. Gideon tries to convince Dr. Cabranes, the chief administrator at his hospital, to care for Maria for free, Dr. Cabranes responds that the hospital cannot afford it. Dr. Cabranes argues that the hospital can not afford to give its expensive and state-of-the-art services away as charity. He adds that in some ways a hospital like theirs can exist because of HMOs that see 10 patients an hour and take the burden off hospitals. However, Dr. Cabranes does put Maria in touch with a lawyer who can help her get money for her treatment from the HMO.

Maria's condition worsens and it becomes clear that she will die as a result of the HMOs misdiagnosis. She sues the HMO for malpractice; at the deposition Dr. Gideon encounters Dr. Matthews, who says defensively, "I am sorry your patient is going to die. It happens." The HMO loses the lawsuit, but Dr. Gideon is left unsatisfied.

Table 18: Extent of patient involvement in health policy interactions

Patient Involvement	HPIs (N=127)
No Patient	6%
An Abstraction	3%
Real Person-discussed but not seen	56%
Real Person-seen and involved in argument	20%
Real Person-seen, uninvolved, but able to be involved	6%
Real Person-seen, uninvolved and unable to be involved	10%
Total	101%*

***** Total is greater than 100% due to rounding error.

These 45 patients did not by and large make a positive or negative impression. Because so many did not speak or were unconscious, coders found it impossible to designate likeability over 50% of the time. As Table 20 shows, if only the 25 patients who were actively involved in arguments are taken into account, most were characterized by "mixed" likeability. These were people who showed both positive and negative qualities in their movement through the episode. There were, in addition, several "unclear" cases and three negative ones. Only one in four of the patients appeared straightforwardly likeable.

Table 19: Social age of patients appearing in health policy interactions

Social Age	Patients (N=45)
Child	16%
Teen	11%
Adult	62%
Senior Citizen	9%
Mixed Group	2%
Total	100%

Note from Table 21 that 10 of the 25 patients who were active in health policy interactions appeared in arguments that dealt with malpractice or discrimination. Therefore, only 15 patients actually took positions for or against a current policy. The table provides three cumulative insights about these 15 patients. It details whether they challenged or supported the health care policy. It notes the way the program portrayed their positions on public policy. And it brings these findings together to see if the programs tilted toward patients who did or did not support current policy.

Table 20: Likeability of patients who appeared in health policy interactions

Likeability	Involved Patients* (N=25)	All Patients (N=45)
Likeable	24%	13%
Unlikeable	12%	9%
Mixed	36%	22%
Unclear	28%	56%
Total	100%	100%

* Those seen and involved in the argument. See Table 19.

The table suggests that the programs' creators presented a rather complex portrait of the patients' positions. It does indicate that 10 of the 15 patients who took part in policy arguments spoke up against current policy and 5 stood in favor of the status quo. The table also shows, though, that the programs portrayed neither consistently positive nor negative attitudes toward the patient's arguments. Programs typically portrayed patient positions in a mixed way.

Table 21: How do programs present the policy stance of patients?

	Patient Favors Current Policy (N=5)	Patient is Against Current Policy (N=10)	No Stance* (N=10)
Positive portrayal	20%	--	--
Negative portrayal	--	40%	--
Mixed	80%	60%	--
Unclear	--	--	--
Not applicable*	--	--	100%
Total	100%	100%	100%

* These were scenes in which the characters argued about malpractice or discrimination. When these issues came up, characters did not argue for or against policies on malpractice or discrimination but over whether or not a violation of the policies occurred. See text.

Others. We pointed out earlier that relatives and friends of patients appeared in only 14% of the 127 health policy interactions (Table 12) and comprised only 8% of the 327 characters (Table 13). Table 22 notes that that relatives or friends were also far more likely to speak out against health care policy than to support the status quo.

As Table 22 illustrates, these challenges to policy did not necessarily mean that the programs portrayed their angry positions as wrong. Consistent with our findings about doctors and patients, we noted that the hospital dramas portrayed relatives and friends as having both good and bad ("mixed") aspects to their arguments. Still, programs had a substantially more negative evaluation of the policy positions taken by patients' relatives and friends compared to the policy positions taken by physicians and patients. Moreover, all of the negative evaluations came about as a result of their attempts to challenge current policies. Looking at the data, and

watching the shows, it is hard to avoid the impression that television's hospital series often portrayed the opinions of patients' relatives and friends as a nuisance in health policy discussions.

Table 22: How do programs present the policy stance of patients' friends and relatives?

	Friends and Relatives Favor Current Policy (N=1)	Friends and Relatives are Against Current Policy (N=21)	No Stance* (N=3)
Positive portrayal		5%	
Negative portrayal		24%	
Mixed	100%	62%	
Unclear		10%	
Not applicable*			100%
Total	100%	100%	100%

* These were scenes in which the characters argued about malpractice or discrimination. When these issues came up, characters did not argue for or against policies on malpractice or discrimination but over whether or not a violation of the policies occurred. See text.

Lawyers didn't take policy positions in their arguments because all the scenes in which they appeared dealt with malpractice, where they denied violations of policy rather than challenged it. As Table 14 showed, however, when it came to general likeability the proportion of positively portrayed lawyers (5%) was far lower than any other group, and their proportion of negative portrayals (25%) was higher than even that of patients' relatives or friends. At least part of the reason may have to do with their role in the shows. The 20 lawyers who appeared showed up for a very specific purpose: to engage in malpractice arguments against physicians. These data suggest, and discussions with our coders confirmed, that when it came to malpractice the programs generally encouraged sympathy for the physicians over the lawyers fighting them.

INSTITUTIONAL PLAYERS NOTED IN HEALTH POLICY ISSUES

Apart from the individuals directly involved in health policy interactions, viewers of the programs also heard characters mention specific institutional players as related to the issues. Knowing that all four programs took place in a hospital and that the dominant issue was malpractice, it is not surprising that the most frequently mentioned players were hospitals and lawyers (see Table 23). They made up fully one-half of the 112 institutional mentions. Most of the others (28 of the 55) were scattered across a variety of federal, state and local agencies. The small number of scenes in which HMOs, Medicare and the uninsured came up as issues explains most of the other mentions.

Table 24 indicates that a great number of institutional players were simply mentioned *neutrally*—not discussed positively or negatively—during an interaction. Characters noted hospitals neutrally or both positively and negatively (that is, in a *mixed* manner). The characters noted lawyers negatively in 6 scenes, but there were also 14 scenes in which lawyers were noted in neutral, mixed or positive ways. Private insurance companies and HMOs stood out as exceptions to this rather balanced approach to institutions. HMOs, especially, appeared negatively. They were noted unfavorably each of the 6 times they were mentioned.

Table 23: Mentions of institutional players in the health policy interactions

Institutional Player	Number of HPIs in Which They are Mentioned	Percentage of HPIs in Which They are Mentioned (N=127)*
Hospital	37	29%
Lawyers	20	16%
Insurance Companies other than HMOs	7	6%
HMOs	6	5%
Fed Legislative Branch of Government	5	4%
Social Services	5	4%
State-City Legislative Branch of Government	4	3%
State-City Regulatory Agency	3	2%
State-City Judicial Branch of Government	3	2%
Federal Regulatory Agency	3	2%
News Firms	2	1.5%
Medicaid	2	1.5%
State-City Executive Branch of Government	1	1%
Advocacy or Consumer Groups	1	1%
Medicare	1	1%
Police	1	1%
Military	1	1%
Entertainment Firms	1	1%
Other	9	7%
Total Number of Mentions	112	*

* The percentages should not be added because sometimes a single HPI had more than one mention of an institutional player and some HPIs had no mentions at all.

WERE ARGUMENTS FOR OR AGAINST POLICIES PRESENTED IN A BALANCED MANNER?

The mention of institutions in a typically neutral or mixed manner parallels a consistent finding of this report: the hospital series' tendency to present the likeability of characters as positive, mixed or unclear and their positions on health policy issues as mixed or neutral. There were exceptions. While coders noted most depictions of lawyers as "unclear," they also found that the shows portrayed lawyers unfavorably a quarter of the time they appeared, mainly when they supported the non-hospital side in malpractice disputes. In addition, about one-third of the time characters mentioned lawyers it was with a negative tone. Overall, however, the programs resisted presenting the people participating in the health care policy arguments in a negative manner. More important, the programs presented the individuals' health care policy arguments as not open to simple formulations of good or bad, right or wrong. (See the example in *Snapshot 6*.)

This sense of complexity carried through to the overall portrayal of arguments for or against health care policies in the programs. Tables 25, 26, and 27 summarize what we saw. All three tables present data about the 80 scenes in which health care policy was challenged by someone and defended.[1] Table 25 presents conclusions about the shows' depiction of the policies. By examining the specific treatment of characters' arguments in interactions, we noted what positions the shows appeared to favor. When the scene appeared to favor the character who spoke against current policy, that scene would be considered a depiction "against current policy." When the scene appeared to favor the character who spoke for current policy, that scene would be considered

Table 24: Attitude toward mentioned institutional players

	Positive (#)	Negative (#)	Neutral (#)	Mixed (#)*
Hospitals	2	2	21	12
Lawyers	2	6	8	4
Insurance Companies other than HMOs		4	3	
HMOs		6		
Federal Legislative Branch of Government	1	1	2	1
Social Services	1	1	3	
State-City Legislative Branch of Government	1		3	
State-City Regulatory Agency	1	1	1	
State-City Judicial Branch of Government			3	
Federal Regulatory Agency [Unclear (1)**§**]		1	1	
News Firms	1		1	
Medicaid		1	1	
State-City Executive Government		1		
Advocacy or Consumer Groups			1	
Medicare			1	
Police		1		
Military			1	
Entertainment Firms				1
Other		2	6	1
Total Number of Mentions (112)	9	29	54	19

*Mixed positive and negative. **§**=one additional mention here was *unclear*

Snapshot 6
City of Angels episode, "Smoochas Gracias"

A young African girl brings her 12 year-old sister to the hospital claiming that the girl fell off her bicycle. It quickly becomes apparent to the doctors in charge that the girl has been circumcised. Although they all agree that female circumcision represents mutilation and is abhorrent, they argue about the proper way to handle the case. Doctors Palmer and Sifax insist that what they see is clearly child abuse and that by law they must inform social services. They also argue that they must intervene to save the family's youngest daughter from facing a similar fate. Dr. Stewart, who has spent many years in Africa, contends that calling social services will lead to the dire consequence of breaking up an otherwise strong family. He explains to his colleagues that in Somalia female circumcision is a sign of purity and that the parents who performed this operation on their daughter might be very caring and fit. They have, he points out, sacrificed much to bring their children to the U.S. to escape the brutality of Somalia's war.

In the end Dr. Palmer and Dr. Sifax win the argument, and officers from social services take action. The parents appear caring and are shocked by the intervention of the state. They try to escape the hospital with their daughters. As the father runs through the halls calling out his daughters' names, he is chased by the police and knocked down to the ground. He is handcuffed, and he and his wife are arrested in front of their sobbing children, leaving all the doctors wondering what was the right thing to do.

[1] The tables do not include the 51 health care policy arguments related to malpractice or discrimination. As we noted earlier, these types of arguments did not revolve around the correctness of the policy—no one was in favor of malpractice or discrimination—but rather to whether or not its violation occurred. Coders consequently could not indicate a person's policy stance on these two issues.

a depiction "for current policy." When characters in a scene appeared equally persuasive in their health care arguments, we considered the scene a "balanced depiction."

Table 25: Programs' attitude toward policies debated in health policy interactions

Program Attitude	HPIs (N=80)
Against the Current Policy	30%
Balanced	45%
In Favor of the Current Policy	25%
Total	100%

Findings on the scenes' presentation of policies were in most cases consistent with the tendency of the hospital series to introduce complexity into characters and their policy positions. The table indicates that 45% of the scenes were balanced—that is, each side was equally persuasive. The table also indicates little tilt for or against current policy in the non-balanced scenes, with just a slight edge for scenes that challenged current policy.

Examination of the data from the standpoint of resource and ethical issues (Table 26) reveals that the slight tilt against the status quo came from resource issues. These were scenes in which doctors opposed hospital administrators' cost-saving policies that were harming a patient's health. The table also shows that ethical scenes tended to slightly favor current policy.

Table 26: Programs' attitudes toward policies debated in resource and ethical health policy interactions

	Issue Type		
Program Attitude	Resource (N=11)	Ethical (N=69)	Total (N=80)
Against the Current Policy	55%	26%	30%
Balanced	36%	46%	4%
In Favor of the Current Policy	9%	28%	25%
Total	100%	100%	100%

Tables 27 slices the data a different way, by whether or not the argument related to a contemporary public policy—a topic that currently sits on the dockets of national or state legislatures, regulatory agencies or courts. As the table shows, it was the "hospital policy" scenes—related to protocol and professional privilege—that focused greater attention on reasons against the current policy. When it came to the health policy interactions that reflected major issues of the day, the overall presentation was much more even-handed. Almost half of the 69 scenes presented balanced reasons for and against the public policy. As for the rest of the interactions, half went for the policy and half against it.

Table 27: Programs' attitudes toward policies debated in hospital policy and public policy HPIs

	Policy Focus		
Program Attitude	Hospital Policy (N=11)	Public Policy (N=69)	Total (N=80)
Against the Current Policy	55%	26%	30%
Balanced	27%	48%	4%
In Favor of the Current Policy	18%	26%	25%
Total	100%	100%	100%

CONCLUDING REMARKS

Our systematic analysis of a recent season of prime time hospital series yielded three especially important findings about the presentation of health care policy issues. We can state them concisely:

- Health care policy issues appeared regularly in the programs. An average of one policy-related issue was addressed per episode, with an average of 1.7 individual interactions, or scenes, in each episode.

- More than half (59%) of the interactions reflected public policy debates as opposed to hospital-based policy issues or malpractice cases.

- About 50% of the scenes that involved health care policy disputes presented the viewpoints in an evenhanded manner. Among the rest of the scenes, the ones that favored current policy were balanced in number by the ones that bolstered anti-policy positions.

The findings demonstrate that television hospital shows do present issues about U.S. health care. They also suggest that the series do not, on balance, come out "for" or "against" the status quo. In fact, the scenes' balanced presentation of arguments is only one feature of the programs' rather complex approach to issues. Another is the typically "mixed"—not just positive or negative—mention of institutional players related to health care policy arguments, with the exception of lawyers, insurance companies, and HMOS, where the depictions were largely negative. Yet another finding is the programs' typically "mixed" evaluation of the positions that characters—even likeable characters—have chosen to take on the issues.

Our viewing of the programs—and our debriefing session with the coders—confirms that the data mirror important features of the hospital plots. Story lines that centered on health care policy arguments often underscored the ethical, legal and even organizational dilemmas involved. Physicians struggled with one another, and themselves, to find the best course of action. Answers were not obvious, and the plots even seemed to purposefully want to challenge, even jar, viewers emotionally and intellectually about such issues as needle exchange, patient confidentiality, the right of a desperately ill child to choose death instead of treatment, and even malpractice.

One likely take-home message for viewers: health care policy arguments often do not lend themselves to easy solutions. Policy analysts may consider that a useful point to make at a time when so many factors impact on patient care. An added bonus of the dilemma-filled nature of health policy interactions is that viewers may talk to friends about the intriguing story lines. Complex policy scenes may become part of people's conversations about television, especially when merged with items people note in the news. These depictions may stimulate thinking and encourage people to see other points of view.

We do not mean to suggest that the presence of health policy issues in TV's medical dramas are by themselves enough to affect the presence or absence of issues on the national agenda. The issues depicted on the programs do not take up a large amount of screen or story time, and the programs seldom mention that these issues relate to ongoing public policy debates. Nevertheless, the programs may help to stimulate thought and discussion by showing people how health policy issues might play out in "real" people's lives.

While these features of the programs may have stimulated discussion, our data suggest that other aspects of the health care policy scenes may have worked against public knowledge and action. Consider the low visibility of resource considerations to the programs' health policy issues. An integral part of so much contemporary public health policy debate, these arguments about cost came up in only 23% of the programs' health policy interactions.

Additional features of the programs may have worked against viewer knowledge and action. As we have seen, characters hardly ever pointed out that their arguments were speaking to issues that resonate beyond their hospital to the larger, "real world." Moreover, the shows portrayed doctors as dominating discussions around health policy issues. Nurses, social workers, and other members of the health care team hardly existed in policy

scenes. Patients and their friends and relatives had little input into policy arguments—and a higher proportion of the input they did have was depicted more unfavorably than it was with health care professionals. Series in which doctors are depicted as dominating the arena do not suggest that the health care system invites, or even provides opportunities for, public involvement in key debates about health policy issues.

Our strong impression from viewing the current (2001-2002) season of *ER* and *Strong Medicine* is that these episodes very much parallel the findings presented here. Several question then arise:

- What exactly do people learn from a view of health care policy issues that is complex and challenging but that also obscures the political/legislative and cost-related nature of the debates?

- Do the prime time hospital plots stimulate discussions of health care policy?

- To what extent and how, do people link their personal experience of health care, news reports on health issues, and behind-the-scenes experiences of health care arguments in hospital shows into an understanding of the health issues and their positions on them?

- Can dramatic scenes from these programs be used to encourage discussions about ethical, legal, organizational and resource issues in health care?

Clearly, the primary mission of prime time hospital series, like virtually all network TV, is commercial entertainment. Nevertheless, we found that the programs' creators often draw on public policy debates for their stories and that characters in them become involved in intense health care policy arguments. For people concerned about health policy issues and the way U.S. mass media contribute to public thinking about them, this study is a clear signal that prime time hospital tales and their consequences should be a topic of continuing discussion and analysis.

REFERENCES

Brodie, M., Kjellson, N., Hoff, T. and Parker, M. (1999). Perceptions of Latinos, African Americans, and Whites on media as a health information source. The Howard Journal of Communications, 10(3), 147-167.

Brodie M., Altman, D., Brady, L. and Heberling, L. (2002, January/February). A Study of Media Coverage of Health Care Policy, 1997-2000. Columbia Journalism Review, (Supplement).

Brodie, M., Foehr, U., Rideout, V., Baer, N., Miller, C., Flournoy R., Altman, D. (2001, January/February). Communicating Health Information Through the Entertainment Media. Health Affairs, 20(1), 192-199.

Danovaro-Holliday, M., Wood, A. and Lebaron, C. (2002). Rotavirus Vaccine and the News Media, 1987-2001. Journal of the American Medical Association, 287(11), 1455-1462.

Delli Carpini, M.X. and Williams, B. A. (2000). Methods, Metaphors, and Media Research: The Uses of Telelvision in Political Communication. Communication Research, 21, 782-812.

Delli Carpini, M.X. and Williams, B. A. (2001). Let us Infortain You: Politics in the New Media Environment. In W.L. Bennett and R. Entman, (Eds.), Mediated Politics, Communication in the Future of Democracy (chapter 8). Cambridge, U.K.: Cambridge University Press.

Gerbner, G., Gross L., Morgan M., and Signorielli, N. (1986). Living with Television: The Dynamics of the Cultivation Process. In J. Bryant and D. Zilmann, (Eds.), Perspectives on Media Effects (pp.17-40). Hillsdale, NJ: Lawrence Erlbaum Associates.

Gerbner, G., Gross L., Morgan M., and Signorielli, N. (1982). Charting the main stream: Televisions contribution to political orientation. Journal of Communication, 32(2), 100-127.

Green, M.C. and Brock, T.C. (2000). The role of transportation in the persuasiveness of public narratives. Journal of Personality and Social Psychology 79(5), 701-721.

Mares, L. (1996). The role of source confusions in Television's Cultivation of social reliability judgments. Human Communication Research, 23(2), 278-297.

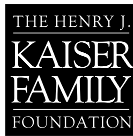
McAlister, A. and Fernandez, M. (2002). "Behaviorial journalism" accelerates diffusion of healthy innovations. In R. Hornik (Ed.), Public Health Communication: Evidence For Behavior Change (315-326). Mahwah, NJ: Lawrence Erlbaum.

Meischke, H., Kuniyuki, A. Yasui Y, Bowen, D.J., Anderson, R., and Urban, N. (2002). Information women receive about heart attacks and how it affects their knowledge, beliefs and intentions to act in cardiac emergency. Health Care for Women International, 23(2), 149-62.

Shrum, L. (1997). The Role of Source Confusion in Cultivation Effects may depend on processing strategy. A comment on Mares (1996). Human Communication Research, 24(2).

Sprott, Jane. (1996). Understanding public views of youth crime and the youth justice system. Canadian Journal of Criminology, 38(3), 271-290.

Zillman, D. and Brosius, H. (2000). Exemplification in Communication: The Influence of Case Reports on the Perception of the Issues. Mahwah: Lawrence Erlbaum Associates.



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