Doctors on display: the evolution of television's doctors

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Doctors have been portrayed on television for over 50 years. In that time, their character has undergone significant changes, evolving from caring but infallible supermen with smoldering good looks and impeccable bedside manners to drug-addicted, sex-obsessed antiheroes. This article summarizes the major programs of the genre and explains the pattern of the TV doctors' character changes. Articulated over time in the many permutations of the doctor character is a complex, constant conversation between viewer and viewed representing public attitudes towards doctors, medicine, and science.

This article seeks to both draw attention toward and explain the evolution of television doctors. First portrayed as caring but infallible supermen with smoldering good looks and impeccable bedside manners, *today's* TV doctors seem to have regressed. If they're good looking, they're arrogant. If they're competent, they have a god complex. If they are well mannered, they are weak. What happened? The answer may be found in an analysis of our relationship with the televised representations of doctors and medicine over time. One major work has addressed this genre previously. Turow's tremendous *Playing Doctor* (1989) captured the production stories and public reception to TV doctors from the first program, *Medic* (1954), up to the late 1980s with *St. Elsewhere* (1). This paper extends his analysis and deepens it to include, beyond description, a broad understanding of this genre that would both support past data and explain future data.

At first glance, television shows are there for our entertainment. However, to entertain requires a connection with the audience. Television may entertain by distortion; it may "amplify and refine the anxieties, hopes and despair of culture and society," but the substrate is recognizably ours (2). Arthur Caplan, a bioethicist, argued that "viewers get what they want from medicine on television" (3). The fact of popularity on television in any time and space is a signal that the show powerfully communicates a succinct, if stylized, representation of social preferences vis-à-vis the subject portrayed. It is therefore crucial for the clarity of this study to discuss only the most important, most popular shows. The study is further limited to only the most popular primetime programming where medicine and doctoring is central.

When we discuss the popular medical programs of the 1950s, we are, by necessity, discussing the people of the 1950s, and so it goes for all decades. Thus, as we consider how the characters and plot lines change over time, we shall see, reflected in those transformations, the concomitant causal changes in the preferences of the viewing public. Articulated over time in the many permutations of the doctor character is a complex, constant conversation between viewer and viewed representing public attitudes towards doctors, medicine, and science. Several studies have shown that public attitudes towards doctors are affected by TV portrayals and that those portrayals are becoming increasingly negative (4–6). Others have shown that the less flattering images of contemporary doctor shows "may exert an influence on the public perceptions of physicians" (5).

Now that we have developed the theory, let us restate the question: How and why did we end up with a representation of doctors and medicine like the one in *Grey's Anatomy* and *House*? Following our logic, to answer our question we appropriately begin with the first and foremost prime-time TV doctor show, 1954's *Medic*. The shows examined in this study, and the episodes viewed, are outlined in the *Table*.

MEDIC

Medic was the product of a joint venture between NBC producers and the Los Angeles County Medical Association. Theirs was a one-dimensional and flattering representation of doctors and medicine. Thus, from the outset of this genre, doctors were portrayed as undeniably holy and the aims of medicine as unquestionably good. Marvel at how the narrator introduced each and every show: "Guardian of birth, healer of the sick, comforter of the aged, to the profession of medicine, to the men and women who labor in its cause, this story is dedicated."

Accordingly, each week *Medic* would offer a 30-minute episode in support of these themes that would follow in quasieducational fashion one patient or one doctor receiving or delivering a diagnosis and treatment. The first episode showed TV's first scenes from a live human birth. Another was representative: a young woman found a lump in her breast. The diagnosis was cancer, and it was devastating. Yet a doctor was there to shepherd her through those feelings. And along the way we're all treated to, in excruciating detail, the process by which she is cured. We

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Table. Television programs viewed

Program	Network	Air dates	Episodes	Episodes viewed
Medic	ABC	1954–1956	59	Complete first season
Dr. Kildare	NBC	1961–1966	190	All clips available using Google video and YouTube
Ben Casey	ABC	1961–1966	153	All clips available using Google video and YouTube
Marcus Welby	ABC	1969–1976	169	Season 1, 10/26 episodes; season 2, 4/26 episodes; season 3, 3/25 episodes; season 5, 1 episode
*M*A*S*H*	CBS	1972–1983	211	Complete first and eleventh seasons, variable programs otherwise (1–4 per season)
St. Elsewhere	NBC	1982–1988	137	Complete first season
Doogie Howser, MD	ABC	1989–1993	97	Complete first season
ER	NBC	1994–2009	320	Complete first to sixth seasons; variable programs thereafter (1–10 per season)
Scrubs	NBC, ABC	2001–2010	181	Complete first to sixth seasons; variable programs thereafter (1–3 per season)
House	Fox	2004–present	97	Complete first to sixth seasons
Grey's Anatomy	ABC	2005–present	126	Complete first to sixth seasons

are shown how the patient is draped in a sterile field. We get an extended close-up of the surgeon's large and sturdy shoes. The pathologist even makes an appearance to teach us how frozen sections are made. Later, he shows us through the eye of his microscope a picture of her infiltrating ductal carcinoma. Much like this episode, so went the rest.

Medic drew a large audience because of the prominent role played by technology. In the postwar era of booming living standards and wildly proliferating technological advances, doctors occupied a very special and lucky place. *Medic* was a weekly exposition on the process of translating scientific advances into the ability to cure diseases, many of which—e.g., bipolar depression, epilepsy, and cancer—were presented as treatable for the first time (largely because they were). Eager to associate with this power (and its prestige), medical associations raced to lend their approval to *Medic* and its successors (1, 4, 7). To wield this power (and deserve the prestige), the producers of *Medic* cast doctors as incorruptible, "omnipotent and priest-like" (8). Furthermore, these doctors were singularly committed to the cause. For his frequent absences from the home, one of *Medic*'s family physicians discovered his wife had left him. Later she returned, having reasoned that his work deserved what he gave it.

At first, viewers described *Medic* as "the most important show in the history of television" (1). It was, however, always about matters of life and death. The format grew old fast. In less than 2 years, *Medic* had degenerated into an "insufferable melodrama" (9). Up against *I Love Lucy, Medic* chose to fight farce with tragedy. It lost (10). Establishing medical drama as a melodramatic bore, *Medic* went down and took with it all demand for medically themed prime-time programming.

DR. KILDARE

It would take 5 years to find the next TV doctor, Dr. Kildare. First made popular in the 1930s on the pages of *Cosmopolitan* magazine, his was the story of a young intern (1). *Kildare* continued *Medic*'s focus on acute presentations of and, usually, the cures for illness. But it was the novel fact of his internship that was crucially important for both the popularity of the program and the plot. As such he partook in universal rites of passage—coming of age, becoming confident, becoming competent—and his internship also set up the core relationship of the program, between himself, the student, and his mentor, Dr. Richard Gillespie.

Gillespie taught Kildare, and us, that "there's nothing special about a doctor" and that "a doctor doesn't escape from his professional obligations. He escapes into them!" (1). Under this tutelage, Kildare became a proud and esteemed physician. At first, he was anything but; he stumbled over carts, fumbled with charts, and was never sure of himself. Yet, he learned from his experiences and steadily grew.

By the third season his transformation had become evident in what is arguably the most beautiful scene in the genre. Kildare, still an intern, spoke up at a morbidity and mortality conference to rebuff the claims of a venerated surgeon. This surgeon, Kildare argued, did not listen to the patient, a frail woman whose dying wish was reconciliation with her brother. Instead, he scared her into a risky operation without disclosing its minimal upside and high mortality. Before a hostile audience, Kildare took a stand for humanism and compassion against the arrogance of a fruitless and blind heroism. As fated, the patient's brother arrived at the hospital hours too late, and no one except for a lowly intern was brave enough to call that an injustice. *Kildare* did not want to portray doctors as gods but rather as flawed human beings who—through and within the demands, obligations, virtues, and values of medicine—are elevated to partake in something far greater than themselves.

Kildare departed from *Medic* in two important ways. First, while there was still a role for the technology of medicine, the primary focus was on the doctor and his process. Second, in *Kildare*, the doctor was a more complete human being. He was flawed and learning; he was vulnerable and emotional; and he

was a sexual being. Others have incorrectly argued that doctors only started having sex in the later representations of the genre (1, 3). Kildare would fall in love with his patients, a feature of this program that apparently generated interest in female viewers (11). The sexual attraction of and to doctors was carried to great effect in *Kildare's* equally popular contemporary.

BEN CASEY

Ben Casey offered a counterpoint to *Kildare*. Not a student, he was an established neurosurgeon; far from vulnerable, he was supremely confident. His show is worth discussing for four reasons. First, both he and Kildare were extremely popular, especially with women—Kildare for his vulnerable tenderness and Casey for his brash operating room bravado (11, 12). Second, it was this very trait that attracted doctors to the program. *Ben Casey* brought real doctors into the active audience for fake doctors; "pulling a Ben Casey" even became part of the rounds lexicon for hot-headedness (13). Third, these shows were given the full and public seal of approval by the American Medical Association, whose members helped to write the episodes. Together with the producers, they yielded a presentation of doctors as strong and admirable and medicine as sophisticated and helpful (1). Accordingly, despite their differences in character, they were mostly a homogenized blend of the same: dependability, moral strength, and sex appeal. The shows were equally complex in plot as well. *Casey*, like *Kildare*, concentrated on the full drama of the human condition and explicitly conveyed that intention each week, opening with the words, "Man, woman, birth, death . . . infinity." Fourth and finally, this complexity was ultimately exhausting for viewers. Deemed "too cerebral," perhaps even "over the heads of the masses," the public rejected the genre en bloc, opting for lighter fare like the *Beverly Hillbillies* and the *Wild, Wild West* (1). Responding to this new desire for simple entertainment, producers came up with a program that offered a total departure from the challenging moral ambiguity of *Kildare* and *Casey*. Four years after *Kildare* and *Casey's* exit, ABC brought us *Marcus Welby, MD*.

MARCUS WELBY, MD

Welby, the senior partner in a two-man family practice in California, was the product of a joint venture between ABC and a fledgling, newly founded American Academy of Family Physicians (1). Whereas his predecessors tended to focus on the acute presentation of illness and therefore the method and technology of diagnosis and treatment, *Welby* shifted the emphasis to chronic disease and health maintenance. In so doing, *Welby* effectively marginalized technology to leave us alone with the patient-doctor relationship and the conversation therein.

This starring role for the patient-doctor relationship is what makes *Welby* so well remembered. There are, to this day, persistent references to the many virtues of his medicine. The image of *Welby* has come to express with exquisite symbolic economy the public's apparent dissatisfaction with today's medicine. Even the fashion designer Donna Karan wrote, "When my husband fell ill, I so wished we could turn back the clock and return to Marcus Welby, MD, who we all knew when I was a kid" (14).

Episode to episode, Welby addressed any issue of the human condition. Over the years, he tackled (in addition to chronic disease) wayward children, failing grades, strained marriage, substance abuse, and other domestic ills. With the sentimentality of hindsight, and in contradistinction to the fast-paced clinics of managed care, this has served to redefine Welby's nature as caring and compassionate. Welby is forever the doctor who listened, the doctor who cared, captured in the opening credits of him driving through the night for house calls. Yet he tackled these issues on his program because, it seemed, *only* he could fix them. Welby had power over his patients, all of whom looked to and needed him for guidance. His paternalistic methods were not unlike those of the other doctor characters of the 1950s to the 1970s (8, 15), but Welby did it best. Viewed *in situ*, however, his methods seem crude, chauvinist, and dated. To watch his program once more, one is repaid with a very different Welby than the one represented in the present media. A misogynist, he routinely (and inexplicably) snapped at his secretary. He was not married but dated a woman who was continuously reminded that she came second to his job. And he always refused patient input, telling one young woman who came to him pregnant out of wedlock that, for her, "adoption is the only workable way."

Inconsistencies aside, for the purposes of our analysis we are concerned only with how *Welby* was viewed in his own time. The truth is that by his end, he was nearly driven off the screen by a reactive and angry public. Derided as "too good to be true," he was accused of unfairly inflating expectations of doctors with his "two-man ICU." Feminists considered him a menace to women, suffering from "white knight syndrome" (1). In keeping with our thesis, *Welby* was only on air as long as he represented popular sentiments, and he was at odds with those sentiments by the early 1970s. As for how and why those public attitudes changed, that is best told as the story of a book.

M*A*S*H

Deep in the heyday of *Welby's* popularity, one Dr. Richard Hornberger published a bestselling novel about his experiences as a medic in the Korean War. By 1970, *MASH* made it to the big screen as a celebrated box-office success. Yet, when Hornberger tried to take his idea to television, he met with formidable resistance. He was rejected 17 times, told that it was simply "too dirty" for television (16). Producers were convinced that the public still wanted something like *Welby*. Eventually, though, CBS took a chance on *MASH*. As expected, despite critical acclaim, people were not yet ready. It would take a few years before the show achieved top-rated popularity, though by the series' exit, *MASH* would become the most watched show in the history of television. What had changed for *MASH* was the social context. Through the prism of the Vietnam War, the viewing public came to reject the paternalistic authority embodied by *Welby* and welcome the more chaotic, absurd perspective offered by *MASH*.

MASH asked the viewer to consider the meaning of medicine in a time of war, of healing amidst the hurting, of prolonging lives to prolong the killing. We have, in this program,

the first appearance of an antagonistic hospital administration in the form of the Korean War (and, by extension, the US army). Creator Larry Gelbart said that he "depicted medical men as not being in charge" (16). It was within and under the broader obligations of that administration that the otherwise noble intentions of medicine were corrupted beyond recognition. In the series pilot, Hawkeye Pierce confessed that "we're not concerned with the ultimate reconstruction of the patient. We're only concerned with getting the kid out so someone else can put on the finishing touches." It's not that Hawkeye was a bad doctor who didn't care about his patients—the opposite was true. No matter how hard he and his fellow staff worked, the fruits of their labor would only serve to further the aims of a war that the American people increasingly saw as unjust. While Americans were now willing to question the moral strength of medicine in a toxic social context, they were not ready to question the morality of doctors as doctors.

While *MASH* reigned, the otherwise wildly successful Michael Crichton shopped *ER*, then an unpublished novel about a bustling Chicago emergency room with doctors that were likely corrupted prior to their admission into the Hippocratic order. Though he wrote *ER* in 1974, it was rejected by every network until 1994. Apparently, the public had to become willing to accept the show's particular presentation of doctors before producers would offer it. Three events had to happen first: Watergate, *The House of God*, and *St. Elsewhere*.

The Vietnam experience introduced to the public a shrinking confidence in social institutions, and this trend was reinforced by Watergate. Reeling from the public betrayal of trust perpetrated by our nation's highest office, the public's response was sweeping. The national temperament towards its institutions, medicine and doctors included, was forever changed.

Published in 1978, Stephen Bergman's classic book, *The House of God*, is an irreverent take on medicine whose wild success exemplifies the public's new disposition (17). Bergman's hospital was staffed by learned old men who would be mentors in an earlier age but were now, instead, self-absorbed caricatures without a genuine concern for their patients. *The House of God* was also a place that took in enthusiastic young doctors and, in but 1 year, rendered them insensitive pessimists somewhat regretful to have chosen the medical profession. Theirs was a hospital that was less about patient care and more about the bottom line. Medicine, in the *House of God*, doesn't affect the human condition as much as it does the bottom line. Patients of the book's protagonist, Roy Basch, got better only when he started pretending to treat his patients. Each of the book's main characters, however, maintained a vulnerability and a conscience, reassuring the engaged reader of their potential for redemption.

The sensational but sympathetic, sardonic, and at times surrealistic representation of medicine that made *The House of God* a blockbuster hit was transferred directly to the small screen in the form of *St. Elsewhere*. Like *The House of God*, this new show's hospital featured multidimensional, complex doctor characters as they tried their hardest to maintain their humanity amidst the many pressures of its hierarchies, pitfalls, and demands.

ST. ELSEWHERE

St. Elsewhere was thematically similar to *MASH*. It too explored the life of a caring profession in a world of uncaring; a world of limitations, both financial and emotional; and a world of caprice, human and institutional. Its imagery, while often equally as poignant, was absurd and postmodern; a recurring male patient thought himself a character on the *Mary Tyler Moore Show* and the final episode implied that the entire program was actually the daydreams of an autistic child. *St. Elsewhere*, however, pushed the envelope. Then NBC president Brandon Tartikoff thought the show offered an "uncomfortably downbeat view of hospitals" (1). But here, unlike *MASH*, the character of the doctors themselves was examined critically.

"Up until that time," creator Josh Brand recalled, "doctors were iconic. . . . Now they are human." Said one writer: "We demystify doctors" (18). Far from being invulnerable, doctors had bad things happen to them: they were shot by patients, diagnosed with cancer, and contracted HIV. Doctors also *did* bad things like drugs and adultery. Like in *MASH*, the characters here, too, had their doctoring curtailed by a corrupting hospital administration, this time a cost-cutting HMO named Ecumena. Though it was thematically dark, there was always an upside; something always happened to prove that these doctors and their medicine were worthwhile. This was the first show to have as main characters a cancer survivor, a successful black doctor, and a recovered drug addict.

One important story arc told the tale the best. Denzel Washington's character suffered from panic during a spurious malpractice lawsuit. In a moment of despair, Washington's character, emotionally exhausted, asked his peers, "Why do we do it?" Without words, his question was answered; the other doctors returned to their patients as if to say that there was something intrinsically rewarding about the practice of medicine, something sufficiently magnetic to draw these doctors in, each morning, to such a dysfunctional hospital. Beneath it all and in the most important sense, these were doctors "who do great work and really care" (18).

ST. ELSEWHERE TO ER

Doogie Howser, MD, while clearly a famous and lasting image in the history of this genre, did little to fundamentally alter its course. Similar to *Kildare, Doogie* was a coming-of-age story, this time about a boy genius whom we meet as a resident on the wards at the age of 16. Like any regular teenager, he was awkward around girls, got into trouble with a pal, and kept a record of his emotional growth in a diary. Unlike any regular teenager, he interrupted his driver's test to help an injured motorist. In truth, the medicine on this program was cast in a fairly positive light—the doctors did what was *right*, Doogie's rapport with patients was outstanding, and his father, another doctor, even used his vacations to serve the poor in Central and South America. His environment was, indeed, a throwback to the era before *MASH*. His was a hospital that challenged but did not corrupt. Like *Kildare*, he had a doctor-mentor (played in two forms by his father and chief) that shepherded his development. The patients of the hospital served as learning experiences not

only for medicine but always, crucially, for his own personal growth. Invariably the patients he met imparted him with the wisdom he needed to solve each episode's dilemma. Indeed, just like in *Kildare*, the hospital environment served to test one's convictions constructively rather than simply obstruct them *(MASH)* and enrich more than embitter *(St. Elsewhere)*.

Looking back on the genre, it is clear that there was a direct path between *MASH* and *ER* through *St. Elsewhere* where *Doogie Howser, MD*, was an outlier but not an aberration. *Doogie* was a popular program. Perhaps this was because of its positive representation of medicine, departing from the progressively darker iterations of its recent past. More plausibly its popularity was drawn from the combination of expert production (Steven Bochco), thoughtful writing, and the curiosity of its unique subject. Furthermore, as the uniqueness of its subject waned (in proportion to Doogie's pubescence) so too did its viewing population. Indeed, due to poor ratings the show was cancelled abruptly after the opening of the fourth season (19). Ultimately, *Doogie's* overwhelmingly positive, lighter-though-thoughtful representation of medicine could not stop the genre's negative progression. Indeed, the next show picked up almost exactly where *St. Elsewhere* left off.

ER

Though *St. Elsewhere* clearly paved the way for *ER's* representation of doctors, *ER* did away with *St. Elsewhere's* sardonic complexity. *ER* brought us, as the producers claimed, "a refocus on doctors" (20). But what we saw were doctors who found their jobs draining, even soul-sapping. More than one doctor left medicine over this program's tenure. The doctors lived in poverty. They had *unredeemable* drinking and drug problems. They had no meaningful lives outside of medicine; by and large, they had no friends, no family. One female attending, when asked if she was married, responded, "No, I'm a doctor." The rare doctors with families inevitably got divorced or their children became delinquents, both situations blamed—always—on their frequent absences from the home. The hero of the show (Anthony Edward's Dr. Mark Green) dealt with several tragedies: his dissolving marriage, his teenager's ecstasy abuse, and brain cancer, from which he died before he could achieve any peace. The series' most popular character (George Clooney's Dr. Doug Green) was a lonely lothario whose heroic actions only got him into trouble with hospital administrators. He became happy only after quitting medicine to live on a boat in Seattle Harbor. Noah Wylie's young Dr. John Carter was stabbed by a patient, developed an addiction to painkillers, and achieved self-actualization only after leaving the hospital for Africa. Poignantly, this exit motif was established early as, in the series pilot, a nurse committed suicide with sedatives stolen from the pharmacy.

In *ER*, the hospital had become inhospitable. Rather obviously, this scenario reflects the public's growing unease with the method and manner of health care delivery. *St. Elsewhere* introduced us to angry patients and HMOs while in *ER* discordant patient relationships and the broken financing of medicine were developed, themselves, into central characters. In each episode, patients dreaded waiting times and complained loudly; they resented their brief interactions with doctors, and consequently the medical space became suffused with tension, anger, and hostility. This unease did not stop with the health care "system" as presented in *MASH* and *St. Elsewhere*; in *ER* it included the doctors.

One story from the third season sets the tone the best. Nurse Carol Hathaway, the most beloved nurse in the hospital, formed midway through the third season the wish to become a doctor. She took the MCAT, scored in the 87th percentile, and was promptly swept about the hospital by the ER faculty eager to keep her local. So the scene was set as an attending found her caring for a patient and stole her away to see "the biggest pancreatic pseudocyst that I have ever appreciated!" As the attending proceeded to mash on the poor patient's abdomen, completely oblivious to the pain she was inflicting, Nurse Hathaway shouted, "Stop, you're hurting him!" The attending replied: "Carol, if you're going to become a doctor, it's time you stop thinking like a nurse." In that moment it was as clear to Nurse Hathaway as it was to the viewers that to become a doctor was to become the kind of person more likely to confuse a patient for an interesting physical exam than to actually care for their well-being. She never did apply to medical school.

Despite such glaring defects, these characters' many foibles still mostly served to humanize them. At the end of it all, we felt sorry for them. Later in the show, that same doctor with the pseudocyst became an increasingly sympathetic character as she was revealed as a lesbian, lonely in private and discriminated against in public. In today's most popular TV doctor shows, however, sympathy for doctors is hard to come by, as these foibles have been elaborated into the basest representation of medicine yet.

HOUSE

Fox's *House* is about a pompous, drug-addicted, prostitute-abusing but omnipotent doctor, board certified in nephrology and infectious disease and in charge of the department of "diagnostic medicine" at a tertiary referral center. Each show begins with a patient's admission to House's service after a presentation that is sufficiently confusing so as to have bewildered a host of specialists on the outside. What happens under House's "care" sets the show apart in two ways. First, no matter how sick the patients may be, even if they were, as was one patient, wheelchair bound for the decade prior to their admission, they will walk out the door. Second, House actually does not talk to his patients, preferring instead to discuss them in the abstract as little more than a differential diagnosis on a white board. Indeed, the show progresses as House marches through his differential directing his thoughtless minions to deploy every diagnostic and therapeutic modality—regardless of how invasive or expensive—until the moment of the triumphant cure. His is a dangerously cavalier approach; it does not faze him as he is warned that his treatments could kill patients if he has made the wrong diagnosis. His behavior riles patients and hospital administration for the purpose of plot movement, but he gets the job done. So, no *ultimate* harm, no foul. At the end of each episode another patient is returned to health, and that is all that matters.

Central to *House* is the diagnosis. After all, he is the chair of "diagnostic medicine." More than one patient has barked an order to "diagnose me!" One patient with neurological symptoms even defected from Cuba in a rubber boat for a diagnosis from Dr. House. Another patient, frustrated with waiting times, took hostages in the clinic at gunpoint demanding a diagnosis. Virtually every episode has some dialogue that implies that a doctor's worth is based on his or her diagnosis. This emphasis on diagnosis shapes the rest of the patient-doctor interaction for two reasons. First, in *House*, all diagnoses have one treatment. Second, all treatments are curative and without side effects. In this world of black and white, there is no need for a doctor to be caring or even to care at all. When House is forced to attend clinic, he insults the patients for not having "real" ailments. In this world, the doctoring that would be supplied by a Welby type is superfluous and probably anathema.

What does it mean that, in today's most popular TV doctor show, the primary, if sole, purpose of medicine is to diagnose and cure rather than to care? We have in *House* a one-dimensional world wherein the doctor is simply and explicitly an employee of the patient. *House* presents a pornographic distortion of medical relationships wherein the therapy, not the therapeutic relationship, is central. The doctor of this paradigm is an extension of the patient by other means, a tool to be graded only by its utility. And in this paradigm the patient needs in a doctor not a fatherly character or a holistic approach but only an expert opinion. Doctoring in *House* has become untethered from its distracting human vessel. Free of the burdens borne out of the patient-doctor relationship of trust and mutual accommodation, medicine has been delivered, at last, from its interference. It is *because* House does not care that he cures. His uniquely shrewd calculations empower a bold recklessness that *allows* him to save lives. What does it mean that viewers voted this character the most trustworthy doctor on television (21)?

GREY'S ANATOMY

There's an inversion of this premise in *House's* popular contemporary, *Grey's Anatomy*. *Grey's* is supposed to be about a group of surgery interns at a general hospital in Seattle whom we are invited to follow through residency. The creator of this program, Shonda Rhymes, consistently eschews the importance of medicine in her show, saying that it is really "a relationship show with surgery in it" (22). In many ways, she is right; the residents seem, at times, far too occupied with themselves to even notice that there are patients in the hospital. Indeed, sex seems to be their highest priority: sex with other residents, sex with their attending physicians, sex with patients. In fact, after seven seasons, the web of sexual connections has become so tangled that we actually had a storyline that involved a spirochete changing hands three times despite never leaving the same call room. On the other hand, *Grey's* is very much a show about medicine, beloved as such by millions of people, medical and premedical students included. And just like her predecessors, Ms. Rhymes employs medical consultants to furnish the program with "realistic" patients and scenarios.

The effect to which *Grey's* patients are employed presents a problem. Whereas *House* uses rare disease for intrigue, the shock value of that condition is always secondary to the character of the suffering patient. *Grey's* offers us patients as extensions of the doctor by other means. First, these patients are bodies for practice. The residents jump all over each other for the chance to scrub in on complex or "hot" surgeries. They practice surgery on the dead with no qualms or self-questioning. Furthermore, the residents are loathe to interact with the patients outside the operating room. While *House* hates clinic days because he thinks himself above outpatient diagnoses, the residents of *Grey's* hate clinic because they think themselves above outpatients. Second, these patients are bodies to behold, circus freakery to entertain and be judged by the rarity and grotesqueness of their ailments. One self-satisfied resident, Grey herself, upon finding reduced visual fields on physical exam, screamed in the patient's face, "Yes! It's a [brain] tumor!" One episode introduced us to conjoined twins whose sole purpose prior to their separation surgery seemed to be to amuse the residents with the various indignities they endured as defecating and sexual beings. We were introduced to the twins as the attending demanded good behavior from the residents; otherwise, they wouldn't "see what's on the other side of the door." In another episode, the neurosurgeon's sister, while visiting the hospital, overheard that a woman with a split "didelphic" uterus was pregnant and proclaimed, "I've gotta see that!" Without the patient's consent, she was allowed to scrub in for a front-row seat at the cesarean section. This past season, the residents called a disfigured patient awaiting a face transplant "blowhole." Patients are not vulnerable people with diseases; they *are* diseases, and their connection with their doctor is contractual and convenient.

Viewing *Grey's*, a general fascination with both disease and medical intervention is obvious. Each week's disease or operation is generally taken from the headlines (domino renal transplantation, face transplantion, even a fecal transplant for refractory *Clostridium difficile* colitis). The technology and technique of medicine are celebrated, while those who deliver it are viewed much differently. While the doctor's craft—its utility and capabilities—seems elevated, the doctors themselves are fallen figures. Far from standing on a pedestal, the doctor has been completely demystified. Indeed, the project started by the writers of *St. Elsewhere* has been achieved. These doctors show no moral strength or leadership skills. One resident cut the power to a patient's left ventricular assist device to bump him to the top of the transplant list. They are constantly at odds with each other and the patients. We are told, time and again, that they became surgeons for the thrill of surgery, but one never gets the sense for why these residents became *doctors* in the first place.

In *House*, we learn what patients expect from doctors. In *Grey's Anatomy*, we learn why: doctors are just regular people who are both unable to control and possibly unworthy of the power granted to them by their profession. In *House* and *Grey's*, we have today a total severance of the patient-doctor relationship into once more but now toxic one-dimensional representations.

SUMMARY

The history of television's doctors speaks loudly of the character of the public's present and future conception of real doctors as well as their faith in the aims and institutions of modern medicine. Unfortunately, abstracted from our viewing of series over time is a fractured bond between doctor and patient that began as a mutually rewarding human relationship and devolved into the individual and bifurcated pursuit of base ends: of immediate and perfect cures for patients and of power and its spoils for doctors.

We began with doctor shows sanctioned by medical associations wherein a doctor could do no wrong. As Turow noted, "It came back to bite them" (3). In today's doctor shows, the doctor is far from "priest-like." The genre began by fusing the public's fascination with technology to a conception of the doctor that was unsustainable for several reasons. First, the supercharged expectations engendered by television doctors as curing and caring beings could not be supported by real doctors who were constrained by time and their own human foibles. Second, beginning with the Vietnam War, as confidence and faith in public institutions waned, doctors were not immune. Third, as the public became more familiar with medical technology, they began to demand it, rendering doctors into intermediaries for technology (23). Furthermore, the triumph of managed care and patient autonomy will likely support for some time the two types of dissonance between patient and doctor depicted in today's shows.

The persistent demand for doctors on TV, however, also represents a persistent fascination with the doctor's craft, science, and character. The opportunity for a positive change is there. If the history of this genre has taught us anything, it ought to be that it is and always has been in a state of flux, responding to extremes with corrections as needed.

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1. Turow J. *Playing Doctor*. New York: Oxford University Press, 1989.
2. Jacobs J. *Body Trauma TV*. London: British Film Institute, 2003.
3. Bilger B. TV's powerful doctor shows vs. the H.M.O. *New York Times*, December 22, 1996, p. H41.
4. Chory-Assad RM, Tamorini R. Television doctors: an analysis of physicians in fictional and non-fictional television programs. *Journal of Broadcasting & Electronic Media* 2001;45(3):499–521.
5. Pfau M, Mullen LJ, Garrow K. The influence of television viewing on public perceptions of physicians. *Journal of Broadcasting & Electronic Media* 1995;39(4):441–458.
6. McAllister MP. Recombinant television genres and Doogie Howser, M.D. *Journal of Popular Film & Television* 1992;20(3):61–70.
7. Holoweiko M. Good news—the pedestal is gone. *Med Econ* 1998;75(20): 54–56, 63, 67.
8. Malmsheimer R. *Doctors Only: The Evolving Image of the American Physician*. New York: Greenwood Press, 1988.
9. Gould J. Television in review. *New York Times*, December 24, 1954, p. 41.
10. Review of *Medic. TV Guide*, October 30, 1955, p. 41.
11. Gould J. High rating of Drs. Casey and Kildare reveal public's high interest in medicine. *New York Times*, March 12, 1962. Quoted in Turow, 1989 (1).
12. Carter R. What women really think about their doctors. *Good Housekeeping*, August 1961, pp. 149–153. Quoted in Turow, 1989 (1).
13. Behman R. Caseyitis: how the epidemic started and why it spread. *TV Guide*, September 22, 1962, pp. 15–19. Quoted in Turow, 1989 (1).
14. Karan D. Where is Marcus Welby, MD? *Huffington Post*, May 28, 2007.
15. McLaughlin J. The doctor shows. *Journal of Communication* 1975;25(3): 182–184.
16. Reiss D. *MASH: The Exclusive Inside Story*. Indianapolis/New York: Bobbs-Merrill, 1980.
17. Shem S. *The House of God*. New York: Richard Marek, 1978.
18. Special Features. In *St. Elsewhere: The Complete First Season* (DVD), Bonus Features. 20th Century Fox, 2006.
19. Prescription for success. In *ER: The Complete First Season* (DVD), Bonus Features. Warner Brothers, 2003.
20. Special Feature. In *Doogie Howser, M.D., Season One*. Starz/Anchor Bay, 2005.
21. Mann D. House call. *WebMD, the Magazine*, January/February 2007, p. 38.
22. Barnhart A. Is *Grey's Anatomy* taking *ER* supplements? *Kansas City Star*, February 10, 2006.
23. Nelkin D. An uneasy relationship: the tensions between medicine and the media. *Lancet* 1996;347(9015):1600–1603.