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THE BODY AND VISUAL BOUNDARIES:

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ABSTRACT

Dick, Marie L. Ph.D., Purdue University, December, 2004. The Body and Visual Boundaries: A Study of Patient Images in Televised Sexual Health News Reports. Major Professor: Charles Stewart.

This dissertation's focus involves formerly private medical examinations/procedures in television sexual health news reports. Based on post-structural theory, this dissertation includes a consideration of social concerns related to body boundaries, privacy, medical paternalism, and medical dependency. In particular, these concerns serve as the theoretical backdrop for an investigation of patient images depicted in television sexual health news reports.

This dissertation uses Critical Discourse Analysis as a methodology. The first phase in this methodology involves a content analysis of the patient images in television sexual health news reports. Included in this analysis is a comparison of differences between male and female patients. The second phase draws on a comparison between image coverage on ABC, CBS, CNN, and NBC. Additionally, a historical/contextual interpretation suggests theories regarding how and why the patient images are portrayed as they are.

The content analysis results supported some theoretical premises undergirding this study. In particular, the inclusion of patient body invasions, depiction of patients in medical clothing and undergoing procedures, and the greater number of physician

portrayals than patient portrayals in the sample supported theoretical concerns related to privacy, surveillance, and medical paternalism. Additionally, the results indicated that male and female patients were portrayed differently, particularly in the clothing, physician touching activity, and body invasions categories. Finally, the results evidenced a high degree of uniformity across the networks which concurred with reported concern of uniformity in news production.

However, the results contradicted theoretical concerns in a number of ways. For example, the results indicated that more female than male physicians were included in the sample which contradicted numerous mass media and gender studies citing a dominance of males portrayed in authoritarian positions. Likewise, more stories directly related to female-specific health issues were included in the sample which countered arguments of male-centered bias in health news reporting. Similarly, contrary to media and gender critiques, although female patients were shown receiving more body invasions than male patients in the sample, male and female patients received body invasions in intimate areas (based on Western modesty norms) to the same degree.

Finally, in addition to the results, the history of medical education, current medical practice, industry constraints, and feminist theories are presented as possible reasons for the image choices.

CHAPTER ONE

TELEVISION, THE BODY, IMAGES, AND HEALTH

INTRODUCTION

On January 19, 1953, the I Love Lucy show created a social stir when producers included Lucy's son's birth on episode fifty-one (http://www.buyersmls.com/americantv/lucy.htm). Although the details of the delivery were never shown, the public interest was piqued because this was the first time the intimacy of a couple bringing a child into the world was shared with the television-viewing public. The public response included mixed reviews over addressing something as personal as pregnancy on television. In fact, the producers were required not to use the word "pregnant" in the show (http://www.tvacres.com/censorship_lucy.htm).

This is a far cry from the November 11, 2002, Good Morning America segment "Baby, oh baby" in which a number of births in various U.S. hospitals were aired live and in intimate detail for the general television audience. Today, from birth to emergency room drama, events once confined to medical facilities are documented on television (Lupton, 1994), giving Shakespeare's line "all the world's a stage" (Mowat & Werstine, 1997, p. 83) a modern twist. Along with these increases in body visibility, the importance of the body, its positioning, and its portrayal in society have increased in philosophical theorizing (Williams & Bendelow, 1995). In particular, the medical patient's body, addressed in Michel Foucault's The Birth of the Clinic (1975), The History of Sexuality An Introduction Volume I (1976), and Discipline and Punish The Birth of the Prison (Foucault, 1975), has received consideration in terms of its *social* significance.

Relatedly, modernity has ushered in new stages and degrees of visibility for the body giving rise to critical questions about related social impact. In her ethnographic

account "Telling the story of birth," Paaige Turner (2003) writes, "The moment of birth, the emergence from one world to another, is perhaps one of the most personal moments a mother or child will ever experience. Our private experiences, however, are often defined and negotiated in very public ways such that the boundaries between the personal or private and the public become reciprocally fluid, negotiated, and political (Clark and Lange, 1979; Deetz, 1992; Fraser, 1989; Parkin, 1990)" (p. 153). Arguably, then, the social impact of the body-as-patient may increase as it moves from the confines of medical buildings to a televised stage.

The range of possible considerations of the body in the mass media is extensive. Based on a review of the literature, I focus on three areas in this dissertation. First, the subject for this dissertation involves the inclusion of formerly private medical examinations/procedures in television sexual health news reports. Therefore, in this dissertation I will consider the social implications of privacy. Second, the dissertation subject of health news reporting calls for a consideration of related media effects on health. Finally, media effects research often addresses representation across social groups (Hall, 1997). Although a number of groups could be considered, included in this dissertation is a description of difference between the portrayals of female versus male patients. In sum, this dissertation's focus rests at the nexus of privacy, health, and gender representations in television news sexual health reports.

Research Parameters

The study of medical patient portrayals on television is too broad for one study. Therefore, the following parameters guide this inquiry. First, the research sample is

limited to patient images used in television news programming. Second, the research sample isolates patient images related to sexual health. Finally, news segments sampled for analysis are taken from the major networks which are ABC, CBS, NBC, and CNN[1].

Focus on Television News

The first inquiry parameter limits description to patient images in televised news stories. A television news focus breaks from traditional health on television research that has tended to focus on entertainment programming. In their review of mass communication and public health, Atkin and Wallack (1990) state, "This focus [content analyses of entertainment programming] should be broadened to measure what is being presented beyond the confines of network TV series. There is a need to chart the dimensions of these relatively neglected types of content: hard news in TV newscasts (a substantial portion of all news items related to public health . . .)" (p. 33).

Along with researching a fairly neglected genre in mass communication and public health, news programming is of particular interest because it suggests objectivity and neutrality of portrayal across issues and social groups. Newsmakers claim that their general purpose is to inform, rather than to entertain. Consequently, unlike mass mediated entertainment, television news does not hold as a defense against social critiques that audiences understand and accept broadcast images as fantasy. It is the closest version of mirroring reality the mass media contains, and as a result may have a strong and unique impact on the lives of viewers. Unlike entertainment programming, the main thrust of health news reporting is to inform viewers of new and changing

[1] Fox news was not included because it was first broadcast after 1990.

medical news. In fact, "editors believe strongly that they have an affirmative duty to keep their audience informed, even if there is no market demand for the information" (Meyer, 1990, p. 54).

The use of expert opinion and the exclusion of more sensationalistic or tantalizing ploys further the argument to attend to news research. Typical sensationalistic images or sexual ploys commonly found in televised advertisements and programs do not fall within the acceptable choices for television news reporting footage. Television news broadcasts do not include perfunctory sex scenes or tantalizing nudity commonly found in televised entertainment, nor would such ploys fit within the FCC's Safe Harbor laws during which most news programs are broadcast. Moreover, news tends to focus on reality and a sense of credibility. In terms of potential audience impact, "the news media have the weight of 'expert' opinion, 'reality' and 'fact' behind them as well as their dramatic and entertaining qualities to attract audiences' attention" (Lupton, 1992, p. 30).

Despite this sense of duty to public information, fact, and reality, the breadth and type of coverage evidences newsmakers' choices (in terms of what is covered and how it is covered) and is based on both cultural and industry-dictated forces. "The importance of cultural factors, particularly in the media, in both imparting health information and impacting on the nation's health has been noted for more than a decade" (Signorielli, 1993, p. ix). News, like other media genres, is restricted by culture because "news also must be inoffensive, fit into existing constructs (typically stereotypes), have a window of credibility, and be able to be packaged in small discrete chunks or bites . . . (Dominick, 1990; Meyer, 1990)" (Signorielli, 1993, p. xi).

Relatedly, news is created consensually within the industry (Meyer, 1990; Wallack, 1989). It is not that news is controlled due to organizational monopolies as much as industry-wide consensus born out of time constraints. "Editors have so many decisions to make, so many inputs and so little time to reflect, that they are understandably nervous about their own ability to judge the news. And so they watch each other" (Meyer, 1990, p. 55). This consensus, ultimately, leads to industry-wide uniformity in story, text, and image choices. In effect, industry-related constraints force reporting of the middle and acceptable grounds.

In sum, news, more so than other media forms, is structured by socially-accepted views of source credibility, cultural constructs, and consensus born out of industry-related constraints. In this, then, television news is a window into culturally-bound knowledges working within a society, as well as contributing to the creation and continuance of certain cultural knowledge constructions.

Focus on Sexual Health

The second inquiry parameter limits description to patient images taken from sexual health stories and stories related to examination of sexually-related organs/body parts. For example, news stories related to breasts, cervix, vagina, ovaries, penis, testes, and prostate are included in the study. These either relate specifically to sexual excitement or are sex specific. Sexual health is specified because related medical examinations and procedures typically involve greater degrees of personal invasiveness, particularly of private parts, than other health issues. Simply put, obtaining a prostate

examination is generally a more sensitive matter than an eye examination, particularly in terms of patient privacy during examination.

Within the medical system, the patient is, at times, "expected to give up his or her jurisdiction of the body over to the doctor" (Lupton, 1994, p. 94), and, although medically necessary, diverse sources provide evidence that patients feel detached and distanced from their bodies by "being forced to expose one's naked body and genital organs to the eyes of others on demand" (Lupton, 1994, p. 24). Furthermore, "in many accounts the feelings of helplessness, of losing control, of victimization are evident" (Lupton, 1994, p. 24). In particular, studies cite extreme dislike, humiliation, and avoidance as responses to sexual health examinations/procedures (Billings & Stoeckle, 1977; Debrovner & Shubin-Stein, 1975; Domar, 1985; Frye & Weisberg, 1994; Petravage, Reynolds, Gardner, & Reading, 1979; Weiss & Meadow, 1979). Based on patient sensitivity to these examinations and procedures, the choice to include footage on television involves greater concern over privacy and sensitivity than other, less personal, invasive, or sexually-related examinations and procedures.

Along with degrees of personal invasiveness, sex and sexuality are key variables in socialization and body politics. Signorielli (1993) writes, "There is considerable concern about sexual socialization in our society" (p. 51). Likewise, according to Moskowitz, Jennings, and Callahan (1995), "Sexuality and reproduction are never solely self-regarding and merely private. They always have both social consequences and social dimensions" (p. S2). For example, although degree of natural difference between the sexes is debated, male and female sexual functioning is physiologically different. Definition, understanding, and social valuation of these systemic differences, however,

have functioned as mechanisms of control, social positioning, political maneuverings, violation, pleasure, disparities in medical treatment, and sexual pre-determinism, to name a few. Turner (1992) contends, "The body is always socially framed and located. What it is to be a man or woman is a social definition, since physiology is always mediated by culture" (p. 59).

Part of this cultural mediation involves sexuality. Foucault (1976) argues that sexuality became medicalized which led to increased monitoring, recording, and categorizing of sexual health. The result was a suspicion about sexuality, as well as the creation and documentation of sexual deviance (Lupton, 1994). Along with suspicion, affiliating sexuality with medicine allows for greater discussion of sexuality. "Foucault contends that in contemporary western societies the individual's sexuality has reached such importance that it is deemed to constitute his or her subjectivity" (Lupton, 1994, p. 27). Therefore, sexual health not only relates to the most private of bodily examinations which often incite high patient anxiety, sexual health encompasses social issues beyond individuals' health.

This cultural mediation is clearly seen in the media. Based on her review of the mass media and health, Signorielli (1993) concludes that sexuality is an increasingly important topic in all mass media and its genres. Moreover, Signorielli (1993) discovered that "the treatment of sexual matters in the popular press has . . . become more frank and frequent, yet coverage tends to focus on sensational or sensitive issues. Citing Silverman-Watkins (1983) and fitting with Foucault's analysis, Signorielli (1993) determines that the consequence of this approach is that "sexual deviance, rather than sexual normalcy, becomes the focus of attention" (p. 56).

Yet, despite its attention to and fascination with sexual matters, the mass media underplay sexual issues which have wide-ranging health and social effects (Signorielli, 1993). Although not specific to television news, Meyer (1990) notes, "Freimuth, Greenberg, DeWitt, and Romano (1984) compared the frequency of newspaper mentions of types of cancer with their real world incidence. Editors evidently think their readers will be offended by mention of colon or rectal cancer, which ranks seventh in coverage but first in incidence. Cancer of male and female reproductive organs gets similar de-emphasis. Lung and breast cancer, on the other hand, are reported in rough proportion to their incidence" (p. 54).

Likewise, Wallack (1989) reports that television stations have been reluctant to carry condom advertisements despite the urging of the U.S. Surgeon General. Moreover, in attending to the AIDS issue, television coverage offered a "sanitized" approach (Wallack, 1989, p. 358). Therefore, how sexual health is culturally-mediated on television is an important issue related to health and social effects.

Network News

Finally, with the proliferation of television options, including cable, satellite, and direct TV, study of television news at large is a huge undertaking. Therefore, in this study I examine network news programming only. Along with high viewership on the major networks, the parameter is born out of research efficiency. The television news archives at Vanderbilt University house the only comprehensive archives of news programming along with a searchable database of the major networks. Archived at

Vanderbilt University are news programs from the major networks (ABC, CBS, NBC, and CNN).

In summary, television images can be examined from numerous descriptive and prescriptive vantage points. At issue in this study is the increasing portrayal of health images on television drawn from medical examinations and procedures formerly reserved for the privacy of a healthcare facility. Specifically, I isolate medical patient images in major television network news reports related to sexual health.

Content Preview

Having described what this dissertation encompasses, I will move into why this investigation is needed, based on societal importance and gaps within health and mass communication research. Once the need has been established, I will explain how this is best approached theoretically, and what pertinent problems and salient issues the theoretical framework illuminates. The literature review and theoretical framework, in turn, provide the focus for research questions and use of Critical Discourse Analysis as a methodological framework. Critical Discourse Analysis is a multi-phasic approach utilizing different methodologies pertinent to discursive, production, and social practice phases.

Following the presentation of how I have arranged the study methodologically, I will present two of three phases in the methodological framework, content analysis and historical/critical analysis, along with results and analyses respectively. Finally, I will describe the last methodological phase intended for future consideration.

Toward that end, this dissertation contains the following chapters:

(1) introduction and literature review evidencing social importance and research need

(2) theoretical framework, related problems, and salient issues

(3) research questions and methodological framework

(4) textual analysis results

(5) discursive analysis

(6) conclusion

RATIONALE FOR CRITICALLY EXAMINING HEALTH IMAGES ON TELEVISION

Television is a popular and powerful communicative force in society. Aside from functioning as an information dissemination tool, television widely shapes popular consciousness (Barner, 1999; Ganahl, Prinsen, & Netzley, 2003; Wallack, 1989). "What distinguishes television most of all as a shaper of popular consciousness and behavior is its sheer ubiquity and pervasiveness: most of us watch TV far more than we watch films, listen to radio, or read" (Scheuer, 1999, p. 19). Although debates still rage as to the degree of television's personal and societal effects, there is little doubt about its significant effects. At most, the mass media affect social change and socially construct reality (Fairclough, 1995). At the very least, individuals learn about reality and social norms through television (Atkin & Arkin, 1990; Wallack, 1989), a phenomenon strongly supported by empirical evidence (Ogles & Sparks, 1993).

This occurs through a process explicated in the cultural indicators perspective involving the creation of audiences' shared perceptions and images by television – the "most pervasive medium" (Pfau, Mullen, & Garrow, 1995, p. 442). These shared images, in turn, teach audiences about the world (Pfau, Mullen, & Garrow, 1995). As noted by Sookkyung (2002), "TV is both a reflection of reality and, at the same time, it constructs and reconstructs reality in various ways" (p. 243).

Television, the Body, and Health

Part of that socialization relates to body image, behavior, and body care. "More and more Americans – and young Americans in particular – see themselves through the lenses of popular images of the body" (McQuade & McQuade, 2000, p. 200). "To judge from consumer culture, the body is the celebrated center of public life" (McQuade & McQuade, 2000, p. 97). In a sense, the body has attained a "rhetorical existence; it has become a floating metaphor that no longer needs to refer to a corporeal body to have significance" (Stormer, 1997, p. 177). How this metaphor is presented may provide insight into current societal philosophies and subsequent activities. "The body may . . . operate as a metaphor for culture. From quarters as diverse as Plato to Hobbes to French feminist Luce Irigaray, an imagination of body morphology has provided a blueprint for diagnosis and/or vision of social and political life" (Bordo, 1993, p. 165).

Research and social commentary addressing the effects of televised imagery on body image and beautification is extensive. Far less evaluation, however, is focused on body care as determined from televised health information. This is surprising considering the amount of health information disseminated on television (Brubach, 2000;

Davies, 1987; Sandman, 1976; Signorielli, 1993; Wallack, 1989). According to Atkin and Arkin (1990), "Television's health-related themes are presented daily to an overwhelming majority of the population" (p. 26). The health impact is great considering the power, influence, and prevalence of media, particularly television, in the world (Fairclough, 1992). "Americans spend more time watching television than doing anything else except sleeping . . . . television's incidental health-related images and messages . . . may make critical contributions to health-related conceptions and behavior" (Gerbner, Gross, Morgan, & Signorielli, 1981, p. 901).

Due to its impact on health behavior, research in health and mass media typically focuses on using the medium to generate positive health habits (Turow & Coe, 1985; Wallack, 1989). Moreover, most of the research addressing health in the mass media focuses on specific topics such as AIDS, alcohol, and smoking (Signorielli, 1993). However, inquiry into the social and cultural aspects of health as portrayed on television is important as well. According to Lupton (1994), "The study of the ways in which medical practices and institutions are represented in the mass media and the reception of such representations by audiences is integral to interpretive scholarship attempting to understand the socio-cultural aspects of medicine and health-related knowledges and practices" (p. 17).

In addition to a focus on health-related behaviors, related research has focused on the surface, or manifest, messages (Lupton, 1995). Specific to television coverage, research focuses on spoken texts related to health topics, diagnoses, and/or treatments. For example, Turow and Coe (1985) present content analysis findings related to

television programming across day and night-time genres in depicting drugs, machines, and diagnoses.

Television Images and Patients

Research attending to manifest messages only attends to half of television's communicative process. In fact, television is a more predominantly visual than discursive medium, and part of its storytelling strategy is via images. Certainly, television images contribute to overall socialization effects (Brubach, 2000; Ganahl, Prinsen, & Netzley, 2003). But, taken alone, television images may have a significant impact in themselves. "Because TV traffics mainly scenes and images that are highly localized in time and space – and in words that must condense their messages to accommodate the medium's visual dimension and severe time constraints – it is also an essentially symbolic rather than a discursive medium" (Scheuer, 1999, p. 77). Like the adage "a picture is worth a thousand words," visual information often "overwhelms words" (Sheuer, 1999, p. 111).

Part of this power may stem from the difficulty for audiences to readily recognize and evaluate symbolism. "Images are harder to sift, edit, or analyze as we view them. It is easier to evaluate disparate or conflicting textual sources, or to dissociate elements and form an independent interpretation, than to assemble a visual picture from various images given to us [on television]. (Images seldom if ever 'conflict' in the literal sense, precisely because they are so literal)" (Scheuer, 1999, p. 111). Notably, "most people pay little attention to the nature of the images on television; television is seen as the entertainer with little thought given to how these images may influence what we know about the

world" (Signorielli, 1993, p. 1). Therefore, the health impact may be even more acute when television broadcasts health images.

In particular, images move rapidly on television, and seemingly afford less thoughtful attention or ascribed importance than language use (Signorielli, 1993). Yet, their effect is no less pronounced.

> Although recent audience studies reveal that viewers do not automatically mimic what they see on television, the imagery they observe facilitates specific forms of understanding, interpretation, and experience (Press, 1991) . . . . In social psychological terms, media images become incorporated into cognitive schema and heuristics, and are called up during processes of identity formation, self-evaluation, attrition, and social comparison (Coltrane & Messineo, 2000, p. 364).

Thus, health images may affect personal and social constructions of self and others, shape individuals' views about health, and contribute to viewers' subsequent health-seeking behaviors (Gerbner, Gross, Morgan, & Signorielli, 1981).

As paltry as research on images and health is, research specific to patient images is even less developed. Based on his enquiry of how disease is represented in the media, Gillman (1988) concludes that medical iconography shapes individuals' understanding of disease, society's image of the patient, as well as patients' internal responses to these constructions (p. 17). Independently, both Gilman and Sontag suggest that images of patients influence how patients are treated by others and how patients internalize their experiences as patients (Lupton, 1994).

Interestingly, physician images in the mass media, although not widely studied, are more prevalent than patient image studies. For example, based on a 10-year

cumulative cultural indicators data bank of dramatic television and a three-year databank of television commercials, Gerbner, Gross, Morgan, and Signorielli (1981) investigated the construction of physicians as powerful, authoritative, dominant, and controlling. The majority of these physician studies (Gerbner, Gross, Morgan, & Signorielli, 1981; McLaughlin, 1975; Pfau, Mullen, & Garrow, 1995; Turow, 1989), however, consider physician images presented in television drama rather than on television news.

A few studies do attend to patient images through analysis of broader representational categories, such as illness or healthcare. One of the most prominent scholars in this regard is Sander L. Gilman. In Disease and Representation, Gilman (1988) documents the historical representation of disease in literature, art, medical drawings, and textbooks. Patient representation is mentioned, but only in terms of the ways it constructs disease representation. For example, he documents body position in a historical comparison of male and female syphilitic patients in 15th century through 19th century art. Gilman (1988), later, identifies parallel image development in early AIDS patient representations. Similarly, Jones (1998) examined the ways the media constructs the identities of AIDS celebrities. Another study focused on AIDS patient images in a photography exhibition held at the Museum of Modern Art in New York (Crimp, 1992), and Lupton (1993) appraised Australian medical advertising in magazines for the "pictorial dismemberment of the human body" (Lupton, 1994, p. 73).

Real images used in televised news reporting offer a unique area of television inquiry. First, an image focus breaks from traditional health on television research that has tended to focus on entertainment programming. In their review of mass communication and public health, Atkin and Wallack (1990) state, "This focus [content

analyses of entertainment programming] should be broadened to measure what is being presented beyond the confines of network TV series. There is a need to chart the dimensions of these relatively neglected types of content: hard news in TV newscasts (a substantial portion of all news items related to public health . . .)" (p. 33). One of the few examples of this type of research is Nathan Stormer's (1997) "Embodying Normal Miracles" in which he examined both visual and textual elements in his rhetorical analysis of pro-life discourse in an educational video. Guided analyses, like Stormer's (1997), of mass media implications for the health care system's structure and practice (Turow & Coe, 1985) will broaden and enhance current health and media literature.

Health and the Cultural Body: A Call for Critical Research

Because issues surrounding the body and health reach far into the personal, political, and public psyches, an in-depth analysis which moves beyond description and social impact is warranted. By diversifying method and broadening focus beyond manifest messages only, this dissertation supports existing literature in health and mass communication, as well as provides needed theoretical and methodological perspectives. According to Lupton (1995), "Recent overviews of the area of health communication in the mass media (Atkin & Bractic, 1990; Rissel, 1991; Wallack, 1988) have focused upon the findings of quantitative content analyses" (p. 28). What is missing is attention to "applied cultural theory or critical analysis" (Lupton, 1995, p. 28). As Lupton (1995) writes, "I have been unable to discover many analyses which depart from the classical quantitative content analysis format . . . in news accounts of health and illness" (p. 30).

Likewise Hall (1964) contends, "We need the critical and evaluative approach precisely because the media themselves, their content and forms, are not neutral: we have to attend to how the forms within the new experiences are being presented, to discriminate between values, and to analyze our responses to them carefully" (p. 46). Similarly, Gunter (2000) notes that media output analyses should include more than the description and counting of media events in content analyses. "Instead, greater value is believed by some writers to accrue from using measures that can identify meanings conveyed by media texts (Fowler,1991; Krippendorf, 1980), or make empirically-verifiable inferences about the potential impact of media content upon individuals, groups or society as a whole (Gunter, 1985a; Hodge & Tripp, 1986)" (Gunter, 2000, p. 57).

Specific to airing footage of real patients in medical situations, this project requires use of multiple theories and methodologies. As noted by Friedman (2002):

> The limited number of scholarly writings specifically addressing television and reality should not be attributed to a lack of interest in the subject but rather to an inherent difficulty in describing and containing the ideological, economic, cultural, technological, and political influences that impact televisual representations of real events. No single methodology or theory can adequately contain the varied forms and fluctuating nature of television's relationship with reality (p. 1).

Considering literature attending to the structures and functions of news media, Van Dijk (1985) suggests, ". . . we have advocated that a new approach should be taken. This new direction of research is essentially interdisciplinary, combining linguistic, discourse

analytical, psychological, and sociological analysis of news discourse and news processes" (p. 15).

In sum, as television viewership increases (Gerbner, Gross, & Signorielli, 1986), so do its social effects. It is from television that individuals learn about themselves and society. Increasingly, this knowledge includes the definition and positioning of the body and health information. Particularly poignant is the inclusion of images of the body and health on television. Although health and mass media are frequently studied in concert, few studies focus specifically on patient images, particularly for patient images in television news reporting. Moreover, taken collectively, health and mass media research is fairly homogenous in its interest on message construction, usage, and manifest message critiques. Additional approaches to television and health research should address "broader notions about the medical institution's power to define, prevent, and treat illness in society . . . and in repeating dramatically, through news and entertainment, lessons about whom society should care for, why, when, and how" (Turow & Coe, 1985, p. 36).

CHAPTER TWO

THEORETICAL FRAMEWORK, PROBLEMS, AND SALIENT ISSUES

THEORETICAL FRAMEWORK

Although the literature review evidences a need for research attending to patient images on television and a multidisciplinary approach attending to cultural issues, how to approach this subject best requires theoretical contextualization. It is an accepted presupposition that television, particularly its images, affects society. Since this dissertation focuses on television, images of the body, and health, post-structuralist theory is a good fit because these theorists have provided the greatest attention to analyses of the body and its portrayal in the mass media (Lupton, 1994; Williams & Bendelow, 1995).

The overarching notion drawn from this theoretical perspective is that the portrayal of a body holds social significance. Because bodies are often taken for granted, however, it is easy to ignore their existence, and much less their significance (Lupton, 1994). Recently, the body has taken center stage among post-structuralist theorists. The writings of Foucault have focused attention on the body and "its role in human subjectivity and its constitution by both elite and popular discourses" (Lupton, 1994, p. 21). More specifically, Foucault argues that the body is the product of a power play constituted by the clinical gaze, and that how the public perceives the body and medicine is shaped by these power plays along prevailing modes of discourse regarding the body (Clanan & Williams, 1992).

Discourse

One of the predominant ways post-structuralist theory approaches cultural issues is by identifying, explaining, and evaluating discourses. "'Discourse'. . . is a concept

used by social theorists and analysts (e.g. Foucault 1972, Fraser, 1989) and linguists (e.g. Stubbs 1983, Van Dijk 1985)" (Fairclough, 1992, p. 54). Discourse is typically defined in two ways. From a language studies perspective, discourse is "social action and interaction, people interacting together in real social situations. The other [definition] is predominant in post-structuralist social theory (e.g. in the work of Foucault): a discourse as a social construction of reality, a form of knowledge" (Fairclough, 1992, p. 18).

Discourse, then, from a post-structuralist perspective, is a way of constructing subject-matter (Fairclough, 1992). At issue are the significant ways discourse shapes and is shaped by social structures. "Discourses are perhaps best understood as practices that systematically form the objects of which they speak" (Sarup, 1993, p. 64). In essence, critical inquiry into the construction or identity function of discourse is important in understanding society because "the ways in which societies categorize and build identities for their members is a fundamental aspect of how they work, how power relations are imposed and exercised, and how societies are reproduced and changed" (Fairclough, 1992, p. 168).

Additionally, discourses attend to the cultural aspects of health and the body called for in research. According to Clair (2003), "Discourse is not only a means to understand culture but is culture itself" (p. 15). Discourses are important to cultural analysis because they construct social identities and subject positions (identity), social relationships between people (relational), and systems of knowledge and belief (ideational) (Fairclough, 1992). In this sense, "discourses are more than ways of thinking and producing meaning. They constitute the 'nature' of the body, unconscious

and conscious mind and emotional life of the subjects which they seek to govern" (Weedon, 1997, p. 105).

In this dissertation, then, the discourse of patient images involves the myriad of cultural forces including stereotypes, production modes – both practical and ideological, involvement of 'actors' (in this case those who have agreed to have their images recorded and broadcast), and the viewers which systematically form the cultural object of what it means to be a patient.

Power, the Body, and the Mass Media

This dissertation does not include all aspects of post-structural theory, nor is that possible given the range post-structuralism encompasses. "The term 'poststructuralist' is, like all language, plural. It does not have one fixed meaning but is generally applied to a range of theoretical positions" (Weedon, 1997, p. 19). Moreover, due to the dissertation's focus, certain aspects of post-structural theory are utilized. Taken from various post-structuralist considerations of the body, the mass media, and health, the following theoretical premises are forwarded:

(1) The media reconstitute the world and include structures of domination.

(2) All signs are biased.

(3) The act of seeing is reciprocal.

(4) Power is not centrally-located or wielded unilaterally.

Using discourse as a starting point, post-structural theory provides an analytic framework which highlights the body as important in critical considerations of modern dominance structures (Weedon, 1997). Foucault argues that the body is particularly

subject to new mass mediated dominance structures. Under the new power regime, parties may have a hold over others' bodies so that they may operate as they wish with the speed and efficiency desired (Gutting, 1994).

Along with the body, a post-structural perspective isolates the mass media as information technology which reconstitutes the world and includes mechanisms of power and domination. According to Poster's explanation of Foucauldian thought (1989), the new mode of information via the media reconstitutes the world and includes structures of domination (Poster, 1989). Distinctly, the mass media structure and work from and within society in new ways. Louw (2001) explains, "A cultural resource that became especially important during the twentieth century was the media, because the media became a central site for defining social position and status. The media also became important agents for positioning people (through discourse)" (pp. 8-9).

To further this point, Hall (1964) explains that the media bring people together in new ways as an audience. "The media are not the end products of a simple technological revolution. They come at the end of a complex historical and social process, they are active agents in a new phase in the life-history of industrial society" (Hall, 1964, p. 45). Likewise, Gerbner, Gross, and Signorielli (1986) suggest:

> Thus, television neither simply creates nor reflects images, opinions, and beliefs. Rather, it is an integral aspect of a dynamic process. Institutional needs and objectives influence the creation and distribution of mass-produced messages which create, fit into, exploit, and sustain the needs, values, and ideologies of mass publics. These publics, in turn, acquire distinct identities as publics partly through exposure to the ongoing flow of messages (p. 23).

Important to understanding the various processes involved is attention to how technological structures work in discourse formulation. Poster (1989) argues that centers of discourse, such as the media, repress unwanted questions and disqualify valid objections. So, in this sense, centers of discourse work within a society not only to direct the building of identities, but also to restrict that development and hinder change by repressing the questions and objections that would afford full social evolution. According to Gutting (1994), "Human fulfillment requires an opening up of possibilities that lie beyond the limits of prevailing norms" (p. 22).

Following from Foucault's suggestion that power is not a metaphysical force existing prior to action (Rouse, 1994), it may be unrecognizable to the individuals encouraging its existence or to those on whom it has its greatest effect. This suggestion encourages studies of the workings of power and acceptance of practices deemed normal, unproblematic, necessary, and truthful when, in fact, they are arbitrary in their use and accepted as the necessary or right operational mode out of their routine acceptance.

In this sense, discourses can encompass a hegemonic viewpoint. According to Louw (2001), the mass media function hegemonically by disguising social contradictions and/or promoting the interests of a group(s) or individual(s) (p. 32). In particular, the media are "contemporary mediators of hegemony" (Van Zoonen, 1994, p. 24). "Media discourses are necessarily battled over, because such discourses serve to legitimate (or de-legitimate) particular hierarchies of positions and the incumbents of such positions" (Louw, 2001, p. 9). For this reason, Wallack (1989) critiques the growing concentration of media ownership which results in "a relatively narrow range of ideas that generally support the existing sociopolitical relationships in society" (p. 365).

True to hegemony and fitting with Foucault's notion of the interworkings of power as unrecognizable, discourses often hide the ways they further a particular set of social relationships (Louw, 2001). "A discourse will be at its most closed when it is so opaque that even its own intellectual practitioners accept its 'naturalness.' It then becomes a 'truthfulness' not open to scrutiny" (Louw, 2001, p. 32). In other words, the domination becomes invisible because it is passed off as "common sense, appearing as the natural, unpolitical state of things accepted by each and everyone" (Van Zoonen, 1994, p. 24).

The alleged objectivity of news may serve as a prime location for this naturalization to occur. As previously noted, news is a unique genre on television because it boasts objectivity and focuses on reality, yet it is confined by industry consensus and cultural mandates (Sookkyung, 2000). When health images are presented in news, TV news may suggest that the representation is truthful, real, and without alternatives for practice and representation. However, as detailed below, television image selection is never arbitrary, even if the image presentation is cloaked in the finitude of what it alleges as the totality of human experience.

Imagining the Image

To understand and address the issue of power related to the mass media and the body, many post-structuralist theorists have argued that all signs and semiotic modes are biased (Kress, 1993). Specific to the mass media, Scheuer (1999) suggests:

> Television mediates, moreover, in two subtly related ways. First, it provides a certain kind of picture of the actual experience that the camera records, subject to

> the technological and commercial limitations that comprise the medium's distinctive language. Second, it mediates in a different sense: providing a certain kind of picture of reality as a whole, and affecting the general texture of human consciousness (p. 63).

As previously noted, the use of image in this human consciousness creation is particularly powerful given human proclivity to understand the world both literally and symbolically (Scheuer, 1999), as well as images' power which defies easy analytic dissection (Coltrane & Messineo, 2000; Pfau, Mullen, & Garrow, 1995; Signorielli, 1993). In a sense, "pictures have a certain epistemic innocence: they don't lie outright; they just lie in all sorts of other ways" (Scheuer, 1999, p. 111).

Focusing on the deliberate act of mediating reality, John Berger (2002) provides the analogy of still photography in that "every time we look at photographs, we are aware, however slightly, of the photographer selecting that sight from an infinity of other possible sights. This is true even in the most casual family snapshot. The photographer's way of seeing is reflected in his [sic] choice of subject" (McQuade & McQuade, 2000, p. 210). Likewise, according to Brubach (2000):

> Differentiating between image and reality has never been easy, but the question now is whether it's even possible. Cultural commentators such as Neal Gabler argue that it isn't: "Everywhere the fabricated, the inauthentic and the theatrical have gradually driven out the natural, the genuine and the spontaneous until there is no distinction between real life and stagecraft." In fact, one could argue that the theatricalization of American life is the major cultural transformation of this century. Devoured by artifice, life is a movie. The "real" events we watch on TV

> are what the social historian Daniel Boorstin calls "pseudo-events," events that have been crafted or framed solely for media presentation - and audience reception (pp. 454-455).

According to Davies, Dickey, and Stratford (1987), "Everything the media offer us, whether news or entertainment, is channeled through people, processes, prejudices, traditions and the pressures of time, resources and competition. What is selected for exposure (and what is not), how it is edited, constructed and presented and by whom - all this is of paramount importance in structuring (and limiting) our perceptions" (p. 2).

Although cloaked in objectivity, choice of news images is no less a determined way of framing a subject. As noted earlier, newsmakers tend to maintain a status quo by making choices based on industry- and logistical-constraints. To explain further, Louw (2001) reports:

> Journalists are confronted by huge volumes of information and an enormous array of phenomena that could qualify as news. Creating news therefore involves sorting through these and selecting which will actually be allowed to reach audiences. So news-making is a process of selection, emphasis and de-emphasis . . . . Effectively, journalists are gatekeepers (White, 1950), allowing some information through the gate, but blocking other information. For anyone concerned with creating hegemonic dominance, the latter (blocking process) is of vital concern. Creating discursive dominance has as much (and possibly more) to do with what information is left out, as what is disseminated (pp. 159-160).

Newsmaking fits not only with hegemonic theory, but with constructivist notions that the news media create a specific reality (Louw, 2001). Drawing on Tuchman's

(1978) analogy, Louw (2001) suggests that journalists do not provide a window to the world as is commonly thought. Rather, journalists "break a window-sized opening through the wall, and so create a partial view of the overall panorama – that is only one portion of 'reality' is available through the window-opening" (p. 160). Fitting within a post-structuralist view of discursive formations, Louw (2001) notes that this creation of reality is not a result of conscious decision-making aimed at partiality (p. 160). "Rather, the window's position is the outcome of whatever set of practices, work routines and discourses journalists have been socialized into accepting as 'the way things are done'" (Louw, 2001, p. 160).

Lest the viewer be portrayed as a passive recipient of selected information and/or a cultural dupe, conceptualization of the seeing act develops a more reciprocal dynamic. The choice of what images to highlight, photograph, or broadcast are deliberate, so, too, is the act of seeing. Moreover, the deliberate act of seeing - the choice to look - involves identity formation. The act of seeing in infants predates using words. A child will look and recognize before he or she makes sense of spoken language or develops the ability to speak (Berger, 2000). "It is seeing which establishes our place in the surrounding world . . . we never look at one thing; we are always looking at the relation between things and ourselves. Our vision is continually holding things in a circle around itself, constituting what is present to us as we are . . . the reciprocal nature of vision is more fundamental than spoken dialogue" (Berger, 2000, pp. 211). Neatly put, "art historian Ernst Gombrich (1963) has quoted one of his colleagues as saying that 'all pictures owe more to other pictures than they do to nature' (p. 9)" (Hubbard, 1990, p. 50). Directly related to the mass media, "people are active consumers of the products of the media, bringing to bear

attitudes and values formed also by other institutions, as well as their own intelligence and judgment" (Davies, et al., 1987, p. 2).

Seeing and Power

This notion of seeing, both in the act of showing something for others' sight and the subsequent choice(s) to see, fits with a post-structuralist idea of power. Essentially, there are two predominant conceptions of power. "In the first, people are conceptualized as 'imprisoned' within a power relationship or structure . . . in the second, people have free agency – our lifewords are seen as the outcome of mutable human activity in which we make (and re-make) our own structures" (Louw, 2001, p. 9).

These different understandings of power have developed from linguistic structuralism related to the former conception, and from post-structuralism which advocates the latter conception. Following from a post-structuralist conception of power, because all signs are thought to be biased and ways of seeing are reciprocal and developed in concert with the whole of life experience, Foucault does not ascribe to the notion of individual or ideological generators of domination (Fraser, 1981; Poster, 1998; Sarup, 1993).

The conceptualization of power utilized in this dissertation is the position both Gramsci and Foucault have taken which includes human agency as well as structural and hegemonic limitations involved in "context-embedded meaning-production" (Louw, 2001, p. 11). Detailed analysis of power must not only isolate where it functions in society, but attend to the various means by which it is constructed and maintained. For example, Foucault argues that discursive practices constitute the "conditions for

existence" for other discursive practices (Gutting, 1994, p. 29). Additionally, Foucault documents how societies create institutions which develop their own sets of "practices and discourses" (Louw, 2001, p. 29). Individuals working within these institutions must conform to and demonstrate proficiency in the language, practices, discourses, and rules of these institutions (Louw, 2001). Therefore, conformity and complicity play a role in power formation.

Finally, included in discursive practices are the micropractices of everyday life in which individuals actively engage in meaning-making as well as in power relations and related interactions. This conception of power moves the discussion of domination and ideology away from a central source wielding power on individuals and pre-determined structures, and from absolving individuals of their responsibility and complicity in the making and re-making of power (Fraser, 1981; Poster, 1989; Sarup, 1993).

This theoretical position is useful in media criticism and fits with the arguments of cultivation analysis previously mentioned. According to Gerbner, Gross, Morgan, and Signorielli (1986):

> Television neither simply creates nor reflects images, opinions, and beliefs. Rather, it is an integral aspect of a dynamic process. Institutional needs and objectives influence the creation and distribution of mass-produced messages which create, fit into, exploit, and sustain the needs, values, and ideologies of mass publics. These publics, in turn, acquire distinct identities as publics partly through exposure to the ongoing flow of messages (p. 23).

The purpose of this dissertation, then, is not to speculate about generators of media portrayals (Fraser, 1981; Poster, 1989; Sarup, 1993), but to follow Foucault's

suggestion that discursive practices constitute "conditions for existence" for other discursive practices (Gutting, 1994, p. 29). Following from Nietschze's view of scientific rationality (Sarup, 1993), post-structuralist theorists argue for a focus on means rather than ends. The idea is not to look for causal agents or merely interpreting outcomes, but to ask how and why these constructions are allowed to exist or are accepted (Fraser, 1981; Gutting, 1994; Sarup, 1993). "Following Foucault, we must first abandon the idea of power as something possessed by one group and leveled against another; we must instead think of the network of practices, institutions, and technologies that sustain positions of dominance and subordination in a particular domain" (Bordo, 1993, p. 167). For example, Foucault looked at how sex moved from a physical regime to a moral matter, and how physical and public torture as a mode of discipline moved to prison confinement due to changing power centers, medical views of the body, and spiritual understanding of the soul (Flynn, 1994; Gutting, 1994; Poster, 1989; Sarup, 1993).

When applying this theoretical notion to sexual health visual discourse, the intentions of individuals and groups generating discourse, or the overall outcomes, are difficult to ascertain. But, it can be socially-instructive by describing how this discourse functions in modern society. Relatedly, a socially-significant consideration rests in how these discursive formations affect individual, societal, and governing mechanisms of truth, knowledge, relationships, and action surrounding conceptions of the body, health, privacy, and the sexes.

In essence, my purpose is not to look at who is causing domination, but to ask how and why these constructions exist and to suggest potential effects (Fraser, 1981;

Gutting, 1994; Sarup, 1993). The goal is to identify the processes of social functioning, rather than demonize one of its parts. My hope is to follow Foucault's contributions which "consist primarily of attempting to bring to our awareness the deep regularities and broad and impersonal forces that make us what we are, that define our sense of alternatives and what it makes sense to do in certain contexts in order to free us from them" (Sawicki, 1991, p. 99). The goal is decidedly post-structuralist in that it allows for human agency working within the discursive formations either in maintaining domination and hegemony or exposing it, as well as allowing for new discursive formations to emerge (Weedon, 1997).

The Problem: Private Lives, Public Portrayal

Drawing on the need for research into the socio-cultural aspects of televised patient images and post-structural theories related to the body, in this dissertation I consider the relationship between television patient images and the traditional separation between public and private. According to Scheuer (1999), there is a connection today between a television-oriented society and "boundary-oriented values: the self and the private" (p. 8). Similarly, Fairclough (1992), in Discourse and Social Change, suggests the media shift boundaries between private and public spheres, and this boundary shift provides insight into social structuring and social relations.

In particular, I apply Foucault's theory of discipline and social control via surveillance to televised images of patients in sexual health news reports. Included in this analysis are contemporary theories of image presentation related to body positioning, body touch, body dismemberment, and body penetration, and image presentation theories

specific to gender representations in the mass media. Thus, theoretically, this project is centered at the nexus of the following current and historical issues: public/private blur in television, medical surveillance, and aspects of visual medical discourse. At issue is how modern depictions of patients in the mass media are presented and to what potential social effects.

In his article "Public, private, and pseudo-private: Ethics and images in the collapse of the PTL ministry," Nothstine (1994) states, "In our culture we respect as a matter of custom the difference between public and private" (p. 239). Drawing from history, Nothstine (1994) notes the distinct separation of these entities outlined in the Greek tradition. Privacy, although usually equated with the personal, has both public and individual import. Beyond its definition, "there is something unique protected by the right to privacy" that goes beyond protection of personal property or space (Reiman, 1984, p. 28). Privacy may be an important factor in personal development. It is the "precondition of personhood. To be a person, an individual must recognize not just his [sic] actual capacity to shape his destiny by his [sic] choices, but he [sic] must also recognize that he [sic] has an exclusive moral right to shape his [sic] destiny" (Reiman, 1984, p. 39).

This moral entitlement begins with children's understanding that they are connected to their bodies, and they have exclusive moral rights over their bodies. To support this point, Reiman (1984) cites the work of Erving Goffman who identifies how removal of privacy among patients, soldiers, elderly, and criminals plays a role in destruction of self (Kupfer, 1987; Reiman, 1984), and concludes "privacy is essential to the creation and maintenance of selves" (Reiman, 1984, pp. 40-41).

Along with development of self, privacy may be crucial to individual autonomy and moral agency (Allen, 1988; Kupfer, 1987). Part of autonomy is the right of individuals to do with their bodies as they wish, and the right to control when and by whom their bodies are experienced (Kupfer, 1987; Reiman, 1984). So respected are autonomy rights, that over one hundred years ago the U. S. Supreme Court dictated, "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his [sic] own person" (Bordo, 1993, p. 72).

In the process of creating a sense of an autonomous self among others, infants must identify their connection to their bodies first (Kupfer, 1987). Later they must be able to establish autonomy and moral agency in a society which has established and respected privacy boundaries. "Autonomy entails the ability and disposition to make plans and decide for oneself what to do . . . . autonomy requires awareness of control over one's relation to others, including their access to us" (Kupfer, 1987, p. 82).

The development of an autonomous self and moral agency requires that social boundaries of individuals are respected. "Autonomy, therefore, is a social product, the result of various social practices which encourage self-determination, including those forming the institution of privacy" (Kupfer, 1987, p. 82). Reiman (1984) suggests the ability to privately hold, withhold, and share information creates relationships based on degrees of intimacy. It is through this social practice individuals learn moral entitlement. In this sense, "privacy is social practice" (Reiman, 1984, p. 38).

Therefore, the right to privacy includes the right to existence in social practice or to necessary conditions which enable the individual to think of him/herself as an entity

worthy of claiming personal and property rights (Reiman, 1984). In contrast, Susan Bordo (1993) suggests that for a slave, the body is "taken and used at will," and deemed "undeserving of privacy and [thus] undemanding of respect" (p. 11). Likewise, Allen (1988) suggests, "Privacy losses occur when a person . . . is to some degree or in some respect made more accessible than others" (p. 17). Ultimately, then, privacy is "more than just contingently good" (Kupfer, 1987, p. 81), it is necessary for self-concept development, individual autonomy, and moral agency. Moreover, it is created within the context of society and includes in its definition the degree to which privacy for some is afforded in relation to that of others.

Television: Voyeurism, Specularity, and Privacy

An obvious critique of relating privacy concerns to a television trend is whether or not the privacy issue involves anyone other than those portrayed who have likely given consent to and possibly sought the personal invasion. The issue, however, is on perceptive and societal levels as opposed to tangible and independent cases of privacy invasion. People learn about people as well as institutions through both directed and mediated experiences (Pfau, Mullen, & Garrow, 1995). "What matters in mass media is not what happens in real life, but rather the positive and negative 'messages,' prescriptions, and taboos that the spectator absorbs by means of identification with the material he [sic] is looking at" (Adorno, 1991, p. 80). Television's definitional power exists, in part, because individuals often look for and enjoy images in the interest of personally identifying with those images.

This identification is explained by specularity theory which, in turn, applies to related privacy encroachment. Developed by film scholars, specularity refers to different ways of looking at things in the world and the pleasures associated with these types of looking. In cinematic theory, also applied to television, pleasurable looking is either narcissistic or scopophilic (Brummett, 1994). Narcissistic viewing involves the pleasure in identifying with one's own image (Brummett, 1994). The same is true for images individuals deem negative. In her study of pornography, for example, Anita Allen (1988) describes how some women identify with the women portrayed publicly in pornography, and how some viewers take on the depicted women's immodesty, therefore causing the viewers to feel degradation. According to Roland Barthes, the entire cinematic process is narcissistic because individuals recognize their likeness on screen (Brummett, 1994). Others argue that narcissistic viewing occurs specifically when viewing representations of the human body or body parts (Brummett, 1994).

Based on Freud's analysis, scopophilia is enticing because it allows for the taking of others as objects and "subjecting them to a controlling and curious gaze" (Mulvey, 1989, p. 16). This scopophilic gaze can be categorized in two ways: fetishistic and voyeuristic. Fetishistic viewing derives pleasure from openly looking at an object that provides satisfaction in itself (Brummett, 1994). Fetishism usually involves fascination with a particular spectacle, many of which are commonplace, such as leather boots or the human form. By traditional definition, voyeurism involves secret and illicit looking (Brummett, 1994) commonly referred to as the peeping tom. In fetishistic viewing, the pleasure is derived from a particular object. Voyeuristic viewing, in contrast, derives

pleasure from the illicit looking process, particularly at private lives of others, such as someone undressing in a dressing room, couples engaging in sexual activity, et cetera.

Theorists have argued whether or not cinematic and/or television viewing is voyeuristic. Some argue the darkness in a movie theatre creates an illusion of voyeurism. Others suggest that television, which involves controllable lighting, smaller screens, and broken stories and images due to commercial breaks, does not accommodate voyeuristic pleasure. However, portraying real life situations on television is a new and different form of television programming. Brummett (1994) notes that television criticism requires attention to the multiple types of programming because the different types afford and require different theoretical considerations. According to Anderson (1995), by watching footage of real life on television, "viewers can best be described as voyeuristic . . . viewers are invited to peep into the intimate . . . affairs of strangers" (p. 199). Ziauddin Sardar (1996) quips, "If medium is the message, then the message is voyeurism. The pandemic of voyeurism reaches its peak on television" (p. 25). The result is a "metamorphosing" of television "from a comforting electronic hearth into an aggressive probe prying into closets of ordinary folk" begging the question, "where is mainstream TV going with all this orchestrated voyeurism?" (Sheppard, 2000, p. 59).

With this discussion of voyeuristic viewing, the link to images of patients may seem loose. However, the inclusion of any televised image follows from a deliberate choice, usually with a purpose. The purpose might be to entertain, shock, persuade, inform, or provide clarity to what is orally presented. In the case of providing real footage of patients in an otherwise intimate medical setting, the question of purpose should be raised. If the image advances knowledge or clarifies understanding that the lay

audience needs or may utilize, the issue of voyeurism, then, may fall. But, since a lay audience is not expected to conduct medical procedures, the images may be provided for other purposes for which valid concern may point to voyeurism.

A counter argument could suggest that broadcasting real life heightens viewers' understanding of the world as it exists. This draws the argument back to the question of privacy in that television does not neatly reflect reality. Rather, the choices involved in placing real life footage on television arguably involves a blurring of the lines between traditional scopophilia in the mass media and privacy invasion in the sense that the actors are real people, their lines are not scripted, and the stage is everyday life. The act of this type of voyeurism appears passive, compared to traditional voyeurism which requires a degree of planning and activity, and, at times, careful engineering.

In other words, television viewers (although choosing to watch a particular program) are easily and passively involved in voyeurism allowing for a degree of detachment (Anderson, 1995), and they may identify with the individuals observed which, in turn, may contribute to self-concept development. Moreover, "with its invitation to voyeurism, TV evokes a kind of empathy for humanity's weak or abnormal that is wholly passive and risk free. At the same time, it affords us a false sense of power and control and of the world's manageability" (Scheuer, 1999, p. 36). This may be particularly pertinent with health images due to their usual focus on disease and body control, and I will discuss them more fully later in this chapter.

Finally, the new scopophilic subjects on television are private versus public figures. Legally, individuals electing to live as public figures (celebrities, politicians, et cetera) waive some of their privacy rights, and accept a more difficult burden of proof in

slander/libel cases. Moreover, the image they portray is a prepared role, not their true selves. Even though public figures have, on occasion, successfully sued individuals, magazine publishers, and television producers for excessive privacy invasions, in general privacy loss is an accepted condition for and, to some, a downside of fame (Farrar, 1997). The inclusion of formerly private medical procedures on television, however, replaces public figures with private citizens in everyday situations, thus expanding accepted privacy invasions beyond the realm of celebrity.

Surveillance: Social Control and Self Control

Another possible concern related to formerly private images publicized on television is an increase in social acceptance of surveillance strategies undermining the right to privacy originally protected in the U.S. Constitution (Anderson, 1995). "The advent of digital manipulation and image generation techniques has seriously challenged the credibility of photographic discourses. At the same time, however, we are experiencing a growing use of surveillance cameras and a form of factual television that seems to depend more heavily on the evidential force of the photographic image than any previous form . . ." (Friedman, 2002, p. 119).

Concern over surveillance was discussed before the invention of television, however. In particular, surveillance and its effects on the body are identified in ways in which the state or institutions employ surveillance in an attempt to control bodies, usually in the interest of social stability, and ways individuals respond to this surveillance by self-regulating and disciplining their bodies (Lupton, 1994).

Social control refers to ways a society "assures itself of proper respectable behavior and controls productivity of . . . its members" (Freund, 1982, p. 16). Foucault (1975) writes in Discipline and Punish: The Birth of the Prison, that public torture and capital punishment were early rulers' primary mechanisms of social discipline and control. Harsh and public punishments were more a means of displaying sovereign power and frightening the public into submission than punishing individual criminals.

Later, as monitoring and policing mass publics became easier through technological advancements, such as motorized transportation, public displays of punishment diminished, and the new mode of social control involved surveillance and subsequent self-surveillance. Sheets-Johnstone (1994) posits, "'In Discipline and Punish' Foucault shows us how punishment transposed into spectacle plays off the body. The body is the centerpiece, so to speak, of the corrective treatment. Even with the change from public torture to forced labor, for example, the body retains its focal place in that, while no longer punished by direct assault, it serves as an instrument upon which constraints and privations are applied" (p. 19).

In recent years, these constraints are applied through what Foucault calls "disciplinary institutions," such as schools, hospitals, and prisons developed in the early eighteenth century (Fraser, 1989, p. 22). According to Foucault, these institutions were the first to take on population management later employed by governments (Fraser, 1989). Mark Philip (1985) explains Foucault's historical interpretation as follows:

> The modern State is not simply the eighteenth-century State plus the practices of the human sciences, which it has seen fit to legitimate so as to extend its control over its population. On the contrary, the human sciences grew out of

> Enlightenment demands for a rational order of governance – an order founded on reason and norms of human functioning, rather than on State power and the rule of the law – and it was through the gradual growth and consolidation of their knowledge and practices that they colonized, transformed, and greatly extended the areas of State activity; with the result that State power mutated into its current disciplinary and normalizing form. It is from the human sciences that we have derived a conception of society as an organism which legitimately regulates its population and seeks out signs of disease, disturbances and deviation so that they can be treated and returned to normal functioning under the watchful eyes of other policing systems (pp. 75-76).

Thus, social management functions through a technique Foucault coined "the gaze" (Fraser, 1989, p. 22). This allows administrators to organize populations so that they can "be seen, known, surveilled [sic], and thus controlled" (Fraser, 1989, p. 22). Surveillance, as a disciplinary power, allows an anonymous power to supervise the conduct of each individual, to assess it, judge it, and calculate its qualities or merits (Gutting, 1994, p. 95). In effect, surveillance is an invasion of privacy justified on the grounds of social order. The potential drawback to establishing order in this fashion is privacy invasion, and the "value of privacy is, in part, that it can enable moral persons to be self-determining individuals" (Allen, 1988, p. 44).

Self-Surveillance

Surveillance, then, is a tool for social control. Certainly in some instances, such as public health, social control and surveillance produce positive effects. Thus, related

post-structural theorists seldom suggest that surveillance, social control, or power are inherently bad. Rather, Foucault argues that power is a productive force involving multiple players, and can produce positive and negative effects (Poster, 1993). Hence, the importance in theorizing about surveillance, social control, and power is not found in judging effects only or speculating about causal agents, but in the attempt to understand how they function in society. For example, one theoretical description of how power functions in modern society is the transference of surveillance strategies to self-policing as a behavioral control.

Although prison systems were designed primarily for punishing criminals as well as separating them from society for public protection, prison design relied on criminals' self-policing through their knowledge of an ever-present watchful warden's eye. Bentham's prison design, the panoptican, consists of a central watchtower in a series of cells. Each cell boasts a window to the outside, and one facing the tower. With the assistance of backlighting, prisoners are constantly visible from the watchtower. Although a single watchtower observer cannot monitor each inmate simultaneously, because the inmates cannot see the observer, they never know when and if they are under observation. Thus, the power of the gaze is found in its unidirectionality. The warden can view the prisoners, but not vice versa. In this way, the watchtower of the prison panoptican allows for behavior control through the created sense of perpetual observation. As described by Foucault (1977), "The major effect of the Panoptic is: to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power" (p. 201).

This state of conscious visibility extends outside prison walls. A sense of perpetual observation may incite certain behavior choices or modifications in any realm. Simply put, individuals may dress, talk, and behave differently in the privacy of their homes than in a public place. Moreover, they will likely take a more intense interest in monitoring their own behavior if attention is focused on them publicly, such as giving a public speech or performing onstage. Of concern is not actual privacy as much as the social belief in the existence of privacy (Kupfer, 1987). On the perceptive level, individuals develop self-concept, moral agency, and autonomy under the belief they are free to do so through controlling their body, thoughts, and actions (Kupfer, 1987). This can occur even if individuals are under surveillance as long as they do not realize they are under surveillance (Kupfer, 1987).

Therefore, privacy encroachment, although important in its own right, only truly affects individuals to the extent they aware of the privacy encroachment. Individuals who are being watched will not change their behavior and/or suffer losses of healthy self-development if they are unaware their privacy is invaded. A better way to understand this phenomenon is to consider it in reverse. According to Kupfer (1987), if individuals in a society are fooled into thinking they are under constant surveillance, such as through dummy surveillance cameras, spot monitoring, et cetera, even when their privacy may be completely intact, they will feel, act, and develop as if under constant surveillance. "In fact, from the standpoint of developing and maintaining autonomy they would be much worse off than their counterparts in the mirror-society in which privacy is believed but not real" (Kupfer, 1987, p. 87).

In the public realm, increasing institutional surveillance may lead to self-surveillance by the individual (Stormer, 1997). "Individuals are socialized through institutional discourses whether biological, sexual, clinical, penal, or otherwise, and produce a normal society by conformity. We all function as 'police' of sorts, continually checking our behavior against the cultural codes to which we adhere" (Stormer, 1997, p. 175). According to Gore (1993), discipline of individuals in modern society is their visibility; a sense of being seen may contribute to individuals' subjugation. Thus, excessive depiction of the body may not only function as a testament to the power of the beholder, but as a mechanism of social control through both public scrutiny and self-policing enforced through a sense of constant visibility (Poster, 1993; Rouse, 1994; Sarup, 1993). To summarize, Bartky (1988) argues that a "state of conscious and permanent visibility . . . assures the automatic functioning of power" (p. 194).

MASS MEDIATED MEDICAL SURVEILLANCE

Medicine is an institution to which social control and surveillance theories can be applied. As previously noted, Foucault identified medicine as an emergent disciplinary institution in the modern age (Fraser, 1989). In everyday practice, medicine relies on surveillance in the interest of health. From an individual health standpoint, medical surveillance is often useful. It is the fundamental principle upon which health screening is based. It is often advantageous to monitor an individual in times of health and illness to observe and describe physical changes. From a social health perspective, surveillance strategies, such as those used in epidemiology, assist in uncovering sources of disease and population-specific prevention and treatment strategies. What may be an unintended

result, particularly as medical advancements are presented in the mass media, is how individuals interpret the surveillance, and how they react to that interpretation.

Additionally, medical practitioners rely on observation and the suspension of traditional privacy and modesty conventions. Based on physician knowledge, accepted clinical practice, and the arguable necessity of physical examination as part of medical diagnosis and treatment, patients and physicians accept their respective roles and rely on the ethic of professionalism in medical practice. Usually, individuals benefit from these roles and accept what would otherwise be invasions of personal space and privacy out of necessity in maintaining health.

However, the inclusion of formerly private medical procedures on television affords an arena to study the public/private nexus and the impact these portrayals may have on individuals' health because these mediated portrayals fall outside the accepted professional roles in the medical encounter. The suspension of personal privacy deemed acceptable for various medical examinations/procedures may not be necessary for a general television audience because they will not conduct related examinations. The procedures are fully explained to patients in medical facilities but not in short television news reports, and the images do not necessarily aid in viewers' understanding of health risks.

Self-surveillance: To Help or to Harm

Whether the inclusion of medical examinations/procedures on television is necessary or not, these images may render harm. Principally, the mass media may play a role in fostering unhealthy self-surveillance in an era in which the body is subjected to an

unprecedented discipline through body surveillance (Bartky, 1988). In some cases, it is questionable whether this self-surveillance incites or hinders greater health. Cancer screening, for example, saves lives. Conventional logic might indicate that increased attention to health screening in the media may provide an impetus for increased cancer screening behaviors among viewers. However, degrees of self-policing and surrounding beliefs about health may decrease viewers' health overall due to an ensuing preoccupation with health and perceived health risks (Daly, 1990; Northrup, 1994).

In his consideration of health promotion, much of which is communicated through mass media channels, Marshall H. Becker (1986) argues that excessive communication of health promotion messages has led to unrealistic fear compared to actual risks. He contends that "the mass media, well aware that we are now a society obsessed with health matters . . . often increase our difficulties by . . . exaggerating the risks posed by putative health hazards" (Becker, 1986, p. 17). The result, according to Becker (1986), is that "reasonably content people have had their fears aroused and feel compelled to attempt significant behavioral changes, attempts at which many (if not most) will fail (10,11); some advice is subsequently considered to have actually been harmful" (p. 15).

Signorielli (1993) calls this media phenomenon "health hype," and notes ways the media frequently present health risks as far worse than they are (p. xi). For example, excessive media publicity over breast cancer has spawned disturbingly high numbers of women electing preventive mastectomies (Ehrenreich, 1999). Similarly, Payer (1996) cites U.S. media exposure of one lumpectomy study in which an investigator falsified evidence. According to Payer (1996), the media's attention was so overexaggerated

related to this one research study, "the press needlessly worried women about the operation in the face of so much other evidence" (p. xiv).

It is unlikely, however, that there is a deliberate attempt in the mass media to scare the public. Rather, Sandman (1993) argues that much of news reporting related to scientific information incites unrealistic fear and misinterpretation of risk among consumers due to reporters' and news consumers' lack of scientific education and understanding of research methods and related analyses. Additionally, the definition of news adhered to in the industry may be a contributing factor. Put simply, related to healthcare media coverage, "good news is no news. Reporting only bad news is disinformation rather than information" (Norbeck, 1994). Yet, good news is not what drives the news media nor is it expected by news consumers. The norm is not, by definition, newsworthy.

This problem is further compounded by the way the media typically approach medical issues. Wallack (1989) identifies the way media health coverage frequently reduces health causes and treatments to the individual level, often resulting in a philosophy of victim blaming. "Typical of this process, health problems are commonly reduced [in the mass media] to individual-level single factors such as 'foolish' behaviors (Will, 1987), bad habits (Knowles, 1977), or unhealthy lifestyles (U.S. Department of Health, Education and Welfare, 1979)" (Wallack, 1989, p. 355).

Granted, many diseases do have lifestyle causes (e.g. – smoking) and individuals can enhance their health and prevent some diseases through proactive behaviors. However, the media's tendency to focus on the individual as a cause and cure for disease is medically problematic.

> There is a broad consensus in the public health field that health status is largely dependent on factors external to the individual over which he or she exercises little or no control (Mechanic, 1982). One of the most resistant and predictive major factors of morbidity and mortality experience is income – persons in lower socioeconomic classes have higher rates of almost every disease (Syme & Berkman, 1981). In addition, the value of social ties and support in health promotion is supported by an impressive body of evidence (Cassel, 1976; Lindheim & Syme, 1983; Mechanic, 1982; Minkler, 1986) (Wallack, 1989, p. 360).

The media's approach, then, may be not grounded in medical science, but may be a fundamentally "conservative approach that ignores or avoids factors external to the individual" (Wallack, 1989, p. 354). In doing so, arguably, the media give the individual a disproportionately large and unrealistic responsibility for both illness and its treatment which may, in turn, lead to unnecessary preoccupation, anxiety, and victim blaming.

These concerns are particularly poignant with television images because "television is well established as a major source of observational learning (Comstock, 1979; Hamburg & Pierce, 1982)" (Wallack, 1989, p. 358). By relating visibility to privacy perception and the possible relationship with television, as more of the body is exposed and the categorization of medical norms and standards monitored publicly, the sense of the body as under surveillance may be internalized by viewers, particularly as they identify with the depicted patients. As previously noted, excessive depiction of the body may function as a mechanism of social control through both public scrutiny and self-policing enforced through patient visibility.

Finally, the media may have a strong impact on disciplining individuals not only because of its visual power and pervasiveness, but also because of its ability to naturalize and enforce rituals. This fits with discourse theories which suggest that the ultimate power of surveillance strategies is their routinization. Fairclough (1992) argues that discourse is most powerful when naturalized. Drawing on Foucault, Douglas (1980), argues that rituals concerning the body enact forms of social relations and give these relations visual expression (Douglas, 1980).

Likewise, Bordo (1993) contends, "Through routine, habitual activity, our bodies learn what is "inner" and what is "outer," which gestures are forbidden and which required, how violable or inviolable are the boundaries of our bodies, how much space around the body may be claimed, and so on. These are often far more powerful lessons than those we learn consciously, through explicit instruction . . . " (p. 16). Similarly, Goffman (1979) explains, "Ritual and ceremonial involve portraiture, involve making palpable to the sense what might otherwise remain buried and tacit in the structure of social life" (p. 10).

According to Foucault, surveillance creates rituals; a normalization process is a form of ritualization which functions as a social control mechanism (Gutting, 1994). Individuals' ability to acknowledge feelings about or question a normalized apparatus is limited because, according to Foucault, individuals have limited agency (Gore, 1993). Therefore, Foucault suggests that surveillance and its resultant rituals lead to ritualized compliance (Gutting, 1994). Once this occurs, the self-disciplining subject may not be able to question existing modes of behavior, much less envision a better way of practice (Gutting, 1994).

To apply this theory to medicine, cervical cancer screening is an example. Since its development, the Pap smear has been an effective screen for cervical cancer. However, recent practice may evidence ways a cancer screen has become routinized in ways that are unnecessary and costly. According to the American Cancer Society, Pap smears are recommended every year for women over 40, and somewhat longer intervals for younger women (http://www.cancer.org/docroot/NWS/content/NWS). In England, Pap smears are advocated every five years, and the positive effects are no less marked using longer intervals (http://www.cancer.org/docroot/NWS/content/NWS). However, in the U.S. the common practice is for women, even in their teens, to obtain Pap smears yearly, and often every six months (Payer, 1996).

In this sense, medical science facts regarding when and how often this cancer screen should be administered have been overlooked in the routine adherence to annual Pap smears. According to one California physician, "The recommendation that all women get their Pap test is even on television now. So patients come in for a test because everybody else does it. You may not be concerned with that in England, but in the United States we're stuck with doing Pap smears on many young women [needlessly]" (Payer, 1996, p. 142).

Relatedly, gynecology, the medical specialty for women's reproductive health problems, has arguably become a routinized necessity in women's lives (Daly, 1990; Ehrenreich & English, 1978). At issue is not whether gynecology is or is not beneficial. Clearly, in cases of women's reproductive illnesses it is an important medical specialty. What has received recent criticism is the degree to which women have looked to gynecology as inherently necessary to them as women; to be a woman necessitates

having a gynecologist (Daly, 1990; Ehrenreich & English, 1978; Northrup, 1994; Reagan, 1997).

Recent studies indicate that women often choose a gynecologist as a primary care physician without related reproductive illnesses or genetic risk factors justifying their decision. This may be to the patients' health detriment because they are electing a specialist as a primary care physician rather than relying on a general practice physician more equipped to deal with general health concerns. Medical experts, conversely, recommend seeing a gynecologist only when medically necessary and not as a primary care physician (Northrup, 1994; Reagan, 1997).

In a sense, then, ritualization is a form of governing because it limits "the possible field of action" (Gore, 1993, p. 52). Not only, then, does ritualization potentially limit human agency, these public routines are hegemonic in their status quo maintenance. Goffman (1979) suggests, "The traditional argument is that these enactments [referring to the visual display of ritual] function to reaffirm basic social arrangements and ultimate beliefs regarding man [sic] and nature" (p. 10).

As described in chapter one, the mass media play a large role in socially constructing reality. How the mass media have constructed gynecology and related cancer screens may have an impact on the alleged ritualization mentioned above. For example, in her historical analysis of cancer promotion, Leslie Reagan (1997) notes that mass mediated cancer screening messages for men and women are vastly different. Women have been told that cancer is their special problem, and that it is their womanly duty to get screening with little or no information about the procedures, risks, or treatments.

Mass mediated health promotion starting in the mid-1950s demanded women's compliance with screening -- no questions asked. Conversely, male cancer screening promotions were filled with information and frequently portrayed men in information-seeking interactions with physicians. Men were described as actively involved in cancer screening, whereas women were commanded to submit to screening mechanically (Reagan, 1997). This type of public health information may have created a ritual of women seeking cancer screens when not medically necessary. The same concern can be raised, for men and women, when related procedures are visually documented in television news sexual health reports.

In sum, the prison panoptican concept is transferable to the mass mediated medical theatre in that if individuals or groups witness the image of their body as visible and examined, they are more likely to obsess about that body, its normalcy, and health which leads to self-policing behaviors. For self-policing to exist, the surveyed must have a sense that they are open to scrutiny (Lupton, 1994). This sense of privacy lack may result in preoccupation. In other words, individuals may become preoccupied with themselves due to a sense of perpetual observation. Moreover, because the sense of privacy and its right in one's existence is constructed socially, if disparity exists between the types of individuals frequently depicted, their sense of privacy rights, degree of surveillance, and resultant preoccupation is heightened in relation to others not sharing the same degree of visibility.

Positioning the Patient

To this point, concerns over privacy, surveillance, and social control have centered on visibility. But, beyond a socially-constructed sense of privacy rights and self-policing which may ensue from excessive visibility, the way bodies are positioned in the televised medical context may affect health behaviors within the real medical setting. According to Lupton (1994), "The dialectic of public health is that of the freedom of individuals to behave as they wish pitted against the rights of society to control individuals' bodies in the name of health" (p. 32). With the advent of medical practice depicted on television, an interesting query is whether this inclusion erodes societal belief in the public/private split, as well as affects health, personal development, moral agency, and autonomy. Certain types of visual representations may have social and individual impact related to conceptions of the self and body. In particular, theoretical notions of medical dependency, as expressed through body positioning, body invasion, and body dismemberment, are highlighted in the following section.

Medical Dependency: Positioning the Patient as Passive and Sick

As Foucault perceived it, disciplining the body involves surveillance, which fits with current concerns over privacy. Additionally, Foucault identifies how the body is disciplined through docility. Disciplinary technologies are not primarily "repressive mechanisms" which rely on violence against or seizure of bodies or bodily processes (Sawicki, 1991, p. 83). Modern disciplinary technologies function primarily by "producing new objects and subjects of knowledge . . . and establishing bodily norms and techniques for observing, monitoring, and controlling bodily movements, processes, and

capacities. Disciplinary technologies control the body through techniques that simultaneously render it more useful . . . and more docile" (Sawicki, 1991, p. 83).

This disciplinary function, then, may be evidenced in the increasing inclusion of medical examinations on televised news programming because beyond mere body visibility and surveillance, the body as an object of medical investigation, formerly reserved for trained scientists and medical practitioners, is opened to the general public. The public takes on the role of investigating the body as a medical object, and watches themselves (via identification with real patient portrayals) as examinees. Along with the expansion of subject and investigators as intertwined groups, a mass public partakes in observing and monitoring the body. As a result, the body may become normalized as a subject of investigation. Additionally, it may be viewed as docile in this investigation and dependent on medical care. Thus, along with excessive visibility, the type of images made visible and the use of real patients in news reporting may create unhealthy medical dependency.

The concern over medical dependency is not new. Traditionally, and arguably out of necessity and the historical evolution of scientific knowledge, the medical community defined patients in relation to their illnesses rather than health. Sociologist Talcott Parsons explained this as a functionalist approach to the medical encounter which included the patient existing in a "sick role" (Lupton, 1994, p. 7). The functionalist approach to healthcare, however, has been widely criticized for typifying "patients as compliant, passive and grateful, while doctors are represented as universally beneficent, competent and altruistic (Turner, 1988: 46-7)" (Lupton, 1994, p. 7).

Reviewing Foucault's The Birth of the Clinic (1973), Lupton (1994) notes how changes in medical practice in the late eighteenth century, such as physical examination, use of the stethoscope, and surgery "all served to increasingly exert power upon the body" (p. 23). As medical practitioners exerted greater control over the body, patients, in turn, accepted a more detached and passive role. "For Foucault, the medical encounter is a supreme example of surveillance whereby the doctor investigates, questions, touches the exposed flesh of the patient, while the patient acquiesces, and confesses, with little knowledge of why the procedures are carried out" (Lupton, 1994, p. 24). According to Bordo (1993), "Since the seventeenth century, science has "owned" the study of the body and its disorders. This proprietorship has required that the body's meanings be utterly transparent and accessible to the qualified specialist (aided by appropriate methodology and technology) and utterly opaque to the patient . . . " (p. 66). In this sense, current medical practice functions as a panoptican of sorts. The patient's body is seen by a specialist; the visibility is unidirectional.

For healthcare to be efficacious, however, patients must take a responsible and active role in relation to healthcare practitioners. Shildrick (1997) notes, there is a need for patients and physicians to be self-determining, moral agents -- active participants, not passive. Control relies on coercion or the passivity of the controlled. The functionalist theory of medicine delineated the traditional sick role of the patient as one of passivity, compliance, and gratefulness compared to the powerful, paternal, and beneficent role of the physician (Lupton, 1994), and was the standard mode of medical operation in the 1950s and 1960s.

This construction contributed to a medical system formerly wrought with paternalism (Mahowold, 1993). According to Rodwin (1994), "Until very recently, medical professionals interpreted the ethical injunction to work in the interest of patients to mean that medicine was primarily a science, that doctors were experts who would know better than patients what was in their interest, and that patients had neither the interest in becoming involved in medical decision-making nor the ability to do so" (p. 148). According to Rothfield (1995):

> Medicine is sometimes described as a practice of intervention. This could be taken to suggest that there is something there, already well formed (e.g., autonomous) that is being treated. It is also possible to argue that the form of intervention is bound up with its own object, in which case the self-conception and conceptual framework of medicine, its character, is intimate with a certain kind of body and a certain notion of illness, intervention, and health. To illustrate: if the doctor is perceived by all as the expert, the one with the knowledge of the patient's body, this may pacify the patient's body as well as posit no bodily knowledge on the part of the patient. The doctor is knowledgeable and responsible, the patient is subjected to the expertise of the Other. The hierarchy of the hospital and clinic may testify to the doctor's knowing what the patient and the lay community does not. The structure, timing, and costing of the session, the provision of prescribed drug information to the doctor and not the patient – these do not just support this kind of "ignorance" but they help produce it (p. 176).

Although beneficial in some instances relating to preserving health and saving lives, "the claim of benign paternalism has until very recently been used to justify gross forms of interference with the human body . . . . the hotly debated issue of unconsented caesarian sections illustrates the extended scope of the latter consideration" (Shildrick, 1997, p. 82). Like unconsented caesarian sections, the analogs of medical history list gross abuses of paternalism including human experimentation, sterilization, unnecessary hysterectomies, overprescription of medication with related monetary kickbacks, inappropriately administered prostate therapies, and various unnecessary and potentially harmful birth interventions, to name a few (Daly, 1990; Dreifus, 1977; Ehrenreich & English, 1978; Inlander, 1994; Northrup, 1998; Relman, 1994; Rodwin, 1994; Scully, 1980).

Starting in the 1950s, the functionalist philosophy has been altered through policy changes, informed consent laws, medical experimentation guidelines, assurance of emergency medical care to all, mandates for medical record privacy, and legal remedies for mistreatment (Rodwin, 1994). With these legal and industry-induced advancements, many of the medical paternalism concerns are relegated to history books. However, as late as 1980 Shildrick (1997) reports that F. J. Inglefinger wrote in the New England Journal of Medicine, "Authoritarianism, paternalism and domination are the essence of the physician's effectiveness" (p. 67). This power was publicly questioned by the outpouring of support for obstetrician Dr. Wendy Savage who hospital authorities attempted to discipline for her insistence that birthing mothers participate in decisions relating to how they give birth and the degree to which they wanted medical intervention (Weedon, 1997).

Similarly, physician Christine Northrup's 1998 best selling Women's Bodies Women's Wisdom is just one of numerous publications focused on empowering female patients. Likewise, there is a burgeoning interest in men's health for similar reasons, all of which attest to a continued concern and interest in equalizing formally disparate power relationships within healthcare. "As a nation, we struggle to move away from a hospital-based model of acute medical care in which authority figures deliver services to sick persons, toward a holistic model of health care in which people use their own judgment, along with technical advice from a range of experts, to make decisions about their health as an integral component of their lives" (Parrott & Condit, 1996, p. 4).

Part of the concern is not over blatant cases of medical mistreatment, but in regard to the overarching philosophy undergirding healthcare. According to Shildrick (1997), the traditional medical system which objectifies the patient as a passive recipient of healthcare, does not afford patients moral status in that realm. "Many current theorists of medical ethics . . . place autonomy centre stage. The autonomy of the doctor is as ever assumed, but new impetus is given to the belief that good ethical practice will enhance, or at least respect, the autonomy of the other in any medical encounter" (p. 80).

Toward that end, communication scholars are focusing on equalizing controlling behavior in physician-patient interactions (Debrovner & Shuben-Stein, 1975; Frye & Weisberg, 1994; Kaiser & Kaiser, 1974; Todd, 1989; Weiss & Meadow, 1979), and women's advocacy groups are promoting patient information dissemination (The Boston Women's Healthcare Collective, 1998). Shildrick (1997) notes, "The move is towards conceptualizing both participants [patient and provider] as potentially self-actualising [sic] subjects. The relatively recent and growing emphasis given to counseling as an

integral feature of primary health care represents . . . a conscious attempt to render audible the voice of the patient" (p. 80).

Finally, the push to alter the traditional sick and passive patient role stems from health itself. The role of a positive attitude on health and healing is well-documented. Of lesser popularity, but possibly equal importance, is understanding and improving the health effects of medical control on individuals. Peter E. S. Freund (1982) suggests hierarchical relationships, such as those governing the medical system, are "inherently self-denigrating. Assaults on our sense of self, our competence and existential purpose may erode our 'will to live.' We are broken up and 'give up' our bodily 'control.' Defenses decline and self-healing capacities weaken" (p. 22). Thus, drawing on allopathic and holistic medical literature, Freund (1982) argues for patients' need to assume responsibility for their bodies and health. Moving away from the Cartesian mind-body split advocated early in organized medical science history, medical researchers as early as the 1960s advocated mind-body integration in health and healthcare due to health effects (Fisher & Cleveland, 1968; Jourard, 1964).

Likewise, Freund (1982) cites studies by Melzack and Wall which evidence that cognitive factors produce physiological changes in physical sensations; studies by Feuerstein and Skji (1979) which identify the effects of a sense of helplessness, anxiety, and depression on pain perception; studies by Staub, Tursky and Schwartz (1971) linking individuals' sense of personal control and pain perception; and the effects of body image on muscle activity and heart rate as identified by Fisher and Cleveland (1968). Freund further reports:

> Researchers such as Schmale (1972), Engle et al. (1969), and Seligman (1975) have argued that there is a strong but not mechanical, one-to-one connection between hopelessness-helplessness and health. A poor sense of self, a lack of ego control, a feeling that one's fate is not in one's hands, a 'dispirited' self, have been linked to depression and anxiety (Johnson & Sarason, 1978). All this, in turn, may increase susceptibility to infectious diseases (p. 88).

To summarize, the effects of self-image, a sense of personal control, and positive cognitive perceptions both prior to and during a healthcare interaction may affect, both positively and negatively, health and bodily reaction to illness. Hence, the casting of patients as sick and/or passive recipients of healthcare does not fit in recent understanding of health and wellness in terms of positive mental processing or personal autonomy.

Medical Dependency: Television's Special Public Health Problem

Although the healthcare industry has recognized and is working to include greater patient autonomy, activity, and positive attitudinal dimensions of healing, mass mediated health images have tended to maintain the older medical model. In particular, a number of radio and television programs document disparate power plays of the physician-patient relationship (Turow, 1989; Signorielli, 1993).

Based on her review of literature pertaining to televised depictions of physicians, Lupton (1994) notes:

> Analyses of the depiction of doctors on American television dramas have found that they are generally portrayed as successful, benevolent, knowledgeable and

> authoritative, with almost mystical power to dominate and control the lives of others (McLaughlin, 1975; Turow, 1989). Based on examination of television dramas, the relationship of physician to patient is one of dominance and dependence. Doctors as characters in television dramas dominate over other professional occupations . . . (Gerbner et all, 1981:902)" (p. 53).

Shown in its greatest degree, Turow (1989) observed that in television dramas physicians "are routinely depicted as 'saving' patients from themselves" (Lupton, 1994, p. 53). Also identifying this trend, Signorielli (1993) concludes, "Overall the media presents [sic] a very troublesome image of the medical world" (p. 48).

Finally, television's version of healthcare raises a unique problem related to medical dependency. To this point, medical dependency has been critiqued based on patient disempowerment. Additionally, medical dependency is problematic for both patients and healthcare practitioners because it may create unrealistic patients' expectations of healthcare (Gaylin, 1994; Northrup, 1998; Payer, 1996; Rasell, 1994; Royko, 1994).

Media reporting of health research and practice has raised concerns in the American medical community regarding unnecessary, patient-demanded screenings and patients' expectations of definitive diagnoses and treatments (Payer, 1996; Rasell, 1994) leading to skyrocketing healthcare costs (Gaylin, 1994; Payer, 1996; Rasell, 1994). Partly due to the way health is reported (Payer, 1996) and partly due to American culture and values (Gaylin, 1994; Payer, 1996; Rasell, 1994), Americans have developed an expectation of comfortable and no risk living (Payer, 1996; Rasell, 1994), which is

allegedly ensured by immediate and complete curability in modern healthcare (Gaylin, 1994).

With this mindset, patients often expect surgical procedures or pills promising a quick fix, despite the expense, risks, and side effects these often pose compared to simpler, less expensive but more lengthy treatments. For example, Gaylin (1994) notes that U.S. hernia patients typically demand surgery rather than accept the traditional and effective treatment of wearing a truss and exercising properly, which is commonly prescribed with equal results in England. Likewise, the U.S. leads Canada, Great Britain, France, and Germany in expensive technologically- and drug-assisted aggressive treatments for most health concerns (Gaylin, 1994; Inlander, 1994; Northrup, 1998; Payer, 1996; Rasell, 1994; Schwartz, 1994), without increasing our nation's health overall. "Despite spending more on healthcare than other industrialized countries, we are not proportionally more healthy" (Rasell, 1994).

Notably, Payer (1994) documents diagnoses, treatments, medical procedures, illness incidence rates, treatment results, mortality rates, and healthcare spending in the U.S., Germany, France, and Great Britain and finds a fair degree of overall health across the nations, but vast differences in the culturally-dictated approaches to disease, health, diagnosis, and treatment. The U.S. consumer, decidedly, prefers aggressive, speedy cures to those that involve simpler, but lengthier treatments requiring patient involvement, such as exercise, relaxation therapies, and sleep. Payer (1994) concludes:

> While doctors may not realize it, they are often merely responding to the perceived or real demands of their patients. American medicine is aggressive partly because doctors are trained to be aggressive but also because many patients

> equate aggressive with better. . . . when we as patients stop demanding aggressive, quick solutions to fix the machine, our doctors will gradually stop giving them (p. 155).

Likewise, there is a correlation between this attitude and television viewership. According to Wallack (1989), "Gerbner, Gross, Morgan, and Signorielli (1981) note that heavier television viewers tend to have an unrealistic belief in the 'magic of medicine' and high confidence in the medical profession. Television may help to . . . justify 'live-for-today' attitudes; if any problem arises, the doctor will surely provide the cure (p. 904)" (p. 362). Likewise, Signorielli (1993) asserts, "On television, health care is an unlimited resource and our primary weapon against disease (Turow, 1989)," with limited reality of what patients can and should expect from healthcare (p. 27).

Thus, medical dependency is problematic on a number of levels ranging from patient disempowerment to unrealistic patient expectations.[2] Consequently, the degree of active versus passive patient positioning is an important consideration in mass media research. Granted, the mass media allow for greater information dispersion. At the same time, studies indicate that certain types of mass mediated health information create an unrealistic paranoia and sense of danger in the audience.

Likewise, with the advent of preventative healthcare, physicians and insurance companies promote preventative health screenings. In these cases, individuals are encouraged to seek medical examination in times of health and illness. However,

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[2] The raised concerns over patient expectations are not intended to promote victim-blaming. Although the literature indicates there is a link between news coverage of health and patient expectations, there are other concerns born out of health news coverage, such as promotion of the functionalist approach to medicine. Additionally, other social forces, such as economics, may influence patient and physician attitudes and behaviors regarding health and healthcare. Television, although the focus of this study, is not the only social force affecting physician and patient attitudes toward and behaviors related to health and healthcare.

depictions of individuals seeking preventative care visually contain the same trappings of illness, such as the medical gown, physical examination, et cetera. The reflected image, then, may not promote preventative behaviors because the coverage provides a flow of images which position patients in passive and sick roles.

This is not to suggest that individuals should not seek preventative measures, screen for cancer, utilize technology for fertility control, et cetera, or that the media should not report on or dramatize preventative medical procedures. The difference is the degree to which the individual is shown engaged in active, self-determined, and informed decision-making regarding her/his body and its care. For individuals to live independently, they must be allowed personal control of their essence of self – the body. In the medical encounter, active participation by the patient as well as improved physician-patient interaction are paramount to improving healthcare (DiMatteo, 1994; Kreps, O'Hair, & Clowers, 1994; Smith-Dupre & Beck, 1996).

It follows, then, that mass mediated portrayals of medicine should include depictions of active and empowered patients. Created medical dependency and accompanying public visibility of that dependency may induce an acquiescence to medical control devoid of empowered decision-making. An overarching concern in this dissertation, then, is whether mass mediated representations of patients mirror the new trend in healthcare – the consumerist model – or continue to play the older, more functionalist scripts. These functionalist scripts are identified to the degree to which patients are relegated to passive roles in their healthcare.

Body Positions

To assess how patient images in televised news sexual health reports may or may not contribute to medical dependency, literature involving the body in the mass media provides useful categories for analysis. Related to patients' active versus passive roles, basic body position is important because it may provide a visual representation of medical dependency and social hierarchical positioning. How bodies are positioned, particularly in relation to others, exhibits and affects social beliefs about the displayed individual and/or groups. "Spatial positioning . . . is a natural marker of power relations . . . . why one's physical standing along a vertical axis can be indicative of social status, and why where one stands in relation to another along that axis is neither a capricious nor trivial matter" (Sheets-Johnstone, 1994, p. 46).

Visual representations of passivity and helplessness, for example, are characterized by a prostrate position. Likewise, body language of individuals low on the hierarchy scale includes restricted motility, comportment, tension, and constriction. Additionally, higher status individuals strike looser, more relaxed poses, and touch more than they are touched (Bartky, 1988). "What is announced in the comportment of superiors is confidence and ease, especially ease of access to the Other" (Bartky, 1988, p. 187).

Additionally, some of the most commonly-known elements of body positioning include spatial positioning and frontal versus rear positioning (Goffman, 1979). The evolutionary benefits of physical size are readily recognized. However, in human relations "size is not merely a measure of comparative bulk and/or height; it is central to a relational invariant in the spatial semantics of intercorporeal life, an invariant carrying for

each individual a specific spatial valence depending upon the particular position each individual holds with reference to the other" (Sheets-Johnstone, 1994, p. 44). For example, positioning one's body beneath another demarcates an inaccessibility to defense resources and evokes a submissive stance (Sheets-Johnstone, 1994). Finally, the built-in meanings of submissiveness and vulnerability in primates involve face-on, front-end defensive and aggressive posturing, versus the hind-end positioning denoting vulnerability to another (Sheets-Johnstone, 1994).

Regardless of setting or context, body positioning often speaks of social status, power, and control (Goffman, 1979). Specific to healthcare, certain body positions hold additional meaning. Body position is cited as an issue in patient satisfaction and control (Billings & Stoeckle, 1977; Debrovner & Shubin-Stein, 1975; Domar, 1986; Frye & Weisberg, 1994; Northrup, 1998). For example, women have expressed extreme dissatisfaction with the lithotomy position due to its submissive stance. Frye and Weisberg (1994) cite a number of authors who suggest that allowing the patient to maintain a semi-sitting position would afford women a greater sense of control in gynecologic examinations.

Although certain body positions are necessary in the healthcare setting, body positioning and portrayal in the media are never arbitrary; they are a choice. According to Goffman (1979), "Public pictures are those designed to catch a wider audience – an anonymous aggregate of individuals unconnected to one another by social relationship and social interaction, although falling within the same market or the same political jurisdiction, the same outreaches of appeal" (p. 10). Therefore, in a general sense, communication, art criticism, film criticism, and sociology literature scrutinize body

position in terms of objectification, domination, and social positioning (Berger, 1983; Dijkstra, 1986; Gammon & Marshment, 1989; Mulvey, 1988; Young, 1998).

In the mass media, in particular, the way bodies are positioned has been critiqued. In his work Gender Advertisements, Erving Goffman (1979) provided a detailed analysis of gender and racial differences in body positioning presented in advertisements. He outlined recurring body position categories in advertisements such as relative size, function ranking, and subordination. Goffman (1979) argues for a focus on body positioning in the mass media because individuals' bodily displays are telling of social identity (p. 1).

Applying the biological and sociological considerations of body position to mass mediated portrayals of medical intervention, Lupton (1994) notes the frequency with which the media depict patients in television dramas as passively lying on a bed or connected to life-saving machinery (Lupton, 1994). The visual impact is one of suggested passivity. "To be prostrate is to be helpless" (Turner, 1992, p. 235), so lying down is suggestive not only of passivity, but helplessness.

Body Invasion

Along with body visibility, patient passivity, and body positioning, I consider body invasion in this dissertation. Advancements in medical technology have meant increases in internal body examinations and invasive procedures. The concern is the effect increased body invasions have on a collective sense of body boundaries, as well as individuals' sense of self.

According to Freund (1982), "Fisher and Cleveland were the first researchers to systematically examine the relationship between perception of body boundaries and disease" (p. 47). The findings, later corroborated, show that an individual's sense of body boundary strength in a given area may affect whether that individual will develop a disease in that area. Likewise, Cassell (1965) investigated body boundary perception and symptoms in localized areas. In pain studies, notes Freund (1982), individuals with stronger senses of body boundaries had a higher tolerance for pain in experimental studies. Moreover, "perceived firmness of body boundaries has also been linked to physiological reactivity" (Freund, 1982, p. 49). For example, Fisher and Cleveland (1968) found that boundary differences, which were measured as "barrier" or "penetration" scores, covaried with patients exhibiting interior versus exterior diseases.

Concern does not end with self-definition and illness. Body invasion is conceived by some as the ultimate example of social control of the body. In early days of practice, medical science was deductive. With the advent of autopsy, surgery, and ensuing penetrating technologies, medicine became more fixated on the clinical gaze, and with lessening degrees on physical boundaries. Experimentation replaced deduction, and bodily interiors were made externally observable, calculable, and regulative (Lash, 1991).

> In the present context of a body turned inside out by ultrasound, x-rays, and electron microscopy, I would argue it is now a working assumption within our culture that anatomical knowledge is synonymous with our interior (Kroker & Kroker). In that regard, the anatomy lesson is a central example of the displacement of the unruly corporeal body and the embodiment of the disciplined normal one (Stormer, 1997, p. 179).

Although invasive medical procedures are good, to a degree, some loss of personal agency is inherent. Granted, scientific observation is often necessary for effective diagnosis. But the degree to which the body is opened up to expose what is normally invisible, even to the patient, has been discussed in terms of the ability of some to view what is hidden, how body boundaries vary across certain groups, and, in the case of the mass media, what is acceptable to portray in terms of body invasions. Lupton (1994) suggests, "These images vividly render the internal body as a form of 'inner space,' colonized and busy with the violent activities of foreign bodies engaged in warlike activities, destabilizing the sense of perspective people have about their bodies as a self-contained, knowable part of Self" (Lupton, 1994, p. 75). In sum, Turner (1984) notes that "discourse determinism" denies subjectivity and embodiment. He emphasizes the importance of human agency and consciousness in the ability to take ownership of the body and related healthcare (Turner, 1984).

Body Dismemberment

Like body positioning and invasion, whether the body is depicted wholly or in parts is important socially. From a social perspective, body dismemberment has traditionally indicated humiliation and objectification. "Unlike the last two centuries, dissection was formerly science and punishment. Certain criminals, as part of their sentence [sic], were to be dissected as a last humiliation" (Stormer, 1997, p. 183). This tactic was documented in Rembrandt's painting of the anatomy lesson which depicts a criminal body taken off the scaffold and dissected on an operating table (Turner, 1987). According to Turner (1987), "The anatomical theatre was part of the same drama of

public humiliation which had started on the scaffold . . . the body of the surgeons was taking a form of revenge on the body of the criminal in the interests of public authority. The body of the criminal was being slowly destroyed as part of the legal system of revenge" (p. 35).

Later, criminal dissections were replaced by autopsies and surgeries. Few would argue that the scientific benefits of autopsy and modern surgery are problematic. Moreover, donating one's body posthumously for scientific dissection and organ donation is considered a morally-conscious decision today rather than a humiliating sentence as previously thought. What is of interest in this dissertation is how popular representations of scientific and medical advancements are packaged and interpreted for the general population. As previously noted, a discourse is informed by cultural interpretations and simultaneously creates culture.

The popular representations of dissection and surgery during its development functioned as a cultural discourse. Alongside advancements in medical surgery, medical illustrations and early modern art of the seventeenth century evidenced a growing interest in publicly dissecting the body. For example, Shildrick (1997) describes the Vesalian drawings in the "Epitome" of De Humani Corporis Fabrica in which the body is progressively stripped of skin and muscle. The ease with which medical dissection entered mainstream art fits with the thought of that time in which the self and the physical body were believed separate. In the Vesalian drawings, for example, the depicted body assists in its own dissection.

Placing this consideration in a historical context, Turner (1987) speaks to the social forces working in concert during the seventeenth century's advent of dissection.

> The advancement of anatomical dissections appears to be associated with the decline of religious prohibitions on public dissection and with the growth of empirical science under the general cultural influence of Puritanism. The public dissection was always performed on a criminal body and the public anatomy lesson therefore was part of a juridical punishment of the criminal. Furthermore, these public dissections continued to have a moral and religious purpose indicating the frailty and finitude of human mortal flesh (Turner, 1987, p. 34).

With the advent of dissection, arguably, the body became increasingly a manipulable object, which, in turn, gave rise to a longstanding mechanistic view of the body. "At the end of the twentieth century, the body is [sic] regarded as something to be managed and maintained" (Brumberg, 1997, p. xxi). In a normal functioning form, the biomedical assumption is that "the body is merely an appendage to the self" (Diprose, 1995, p. 210). This division fit with the then popular Cartesian mind/body split which splintered the whole of experience into corporeal and spirit-related parts.

In medical practice, this reductionist concentration may, in turn, dehumanize patients by lowering them to machine status (Shildrick, 1997). "By attending to the body as if it were a thing rather than attending to its rehabilitation, medicine risks doubling the objectification and alienation of the body . . . . In this, the body, and therefore the self, remains a stranger" (Diprose, 1995, p. 210). For the medical institution, according to Shildrick (1997), "Once the body has been constructed as ontologically and structurally differentiated in this way, then the division into discrete systems and parts grounds a reductive approach to medical practice" (p. 19).

Additionally, this may have an increasing and, at times, problematic and imbalanced medical specialization approach in the United States which far exceeds that of other developed countries (Enthoven, 1994; Payer, 1996; Rasell, 1994; Schroeder, 1994). In the last decade, the American medical institution has sought to balance this perspective by reinstating the value of general practice as a first healthcare step for patients (Northrup, 1994), similar to approaches in Great Britain and Canada (Payer, 1996). This is not to suggest that medical specialization or attention to one body part is inherently bad; it is often medically advantageous. The concern lies in the degree to which the system focuses on parts, rather than on -the whole person.

Issues related to self-development and embodiment within the medical institution, and possibly because of it, have remained within the confines of existing medical practice. These concerns are now applicable to television if body reductionism is included in television medical portrayals. The concern is greater with popular representations of a reductionist approach than actual and, at times, necessary reductionism in clinical medical practice. Whereas medical practitioners are trained to deal with the scientific and emotional ramifications of necessary body reductionism and invasion, a mass audience may not be.

Increasingly, the news media routinely show only portions of the body. In a study of patient representations in Australian advertisements, "it was found that common to several medical advertisements was the pictorial dismemberment of the human body, featuring 'sawn-off' bits of bodies" (Lupton, 1994, p. 73). Likewise, in documenting pathology, patients' faces are rarely shown; rather, body parts are depicted (Lupton, 1994, p. 72). From an individual perspective, "the body as machine without a mind or

soul has become almost familiar, but the body without the integrity of even its parts will necessarily lead to many readjustments in our conceptions of the self, and the shape that will emerge is far from clear" (Martin, 1987, p. 20).

Lupton (1994) asserts, "The effect of such fragmented representations is to dehumanize the doctor-patient relationship by rendering patients' bodies as distinct from their individuality. When only one part of the patient's body is depicted without a face, the result is dehumanizing and promotes anonymity" (p. 73). This, in turn, may affect physicians and patients negatively. For example, Sheets-Johnstone (1994) suggests that reducing a person to a specific part(s) is a way to privilege and de-privilege "pieces of the body, to valorize them, to make them rather than the person her-himself the source of meaning" (p. 126).

Likewise, the choice not to include a patient's face in television sexual health news reports may be necessary in the interest of protecting a depicted patient's identity, or because of a depicted patient's request. Similarly, a choice not to include a patient's face in the portrayal of intimate medical examinations may, in fact, be preferable in that it may decrease sexualization of the procedure and may afford greater generalizability. For example, a choice to include a young, physically-attractive female patient's face during a digital breast examination could not only raise questions about sexualizing a health screen on television news reports, but it could also suggest that a certain age demographic is more susceptible to a particular disease or in need of a certain medical procedure than other age groups.

The concerns related to this ontological paradox rest on the ways it affects patients' sense of self and subsequent healthcare interactions. Like the dissection

discourse of the seventeenth century, socio-cultural forces may interpret medical science and practice in ways that both shape and are shaped by culture.

GENDER AND THE MEDIA: HEALTH, PRIVACY, AND BODY PORTRAYALS

So far this chapter has presented the problem of privacy, surveillance, social control, and salient issues related to body positioning, health, and medical dependency as theoretical frames through which patient images in television news sexual health reports may be analyzed. Included in this review is the way these issues are constructed respective to male and female patient images. Since image portrayal involves a particular way of constructing the seen and the way audiences see, questions of uniformity versus group differences in this act of seeing logically follow.

Of concern is the degree to which a disciplinary system does not impose visibility uniformly. "In practice, our legal tradition divides the human world as Descartes divided all of reality: into conscious subjects and mere bodies (res extensa). And in the social expression of that duality, some groups have clearly been accorded subject-status and its protections, while others have regularly been denied those protections, becoming for all medical and legal purposes pure res extensa bodies stripped of their animating, dignifying, and humanizing 'subject-ivity'" (Bordo, 1993, p. 73). In terms of privacy, as previously quoted, Allen (1988) alleges, "Privacy losses occur when a person . . . is to some degree or in some respect more accessible than others" (Allen, 1988, p. 17).

Related to disciplinary power, Foucault (1975), posits that disciplinary power "imposes on those whom it subjects a principle of compulsory visibility . . . it is the subjects who have to be seen . . . the fact of being constantly seen . . . maintains the

disciplined individual" (p. 187). Surveillance, then, is particularly powerful when focused on specific groups to the exclusion of others.

Sex Comparisons

To investigate possible differences in visibility across groups, in this dissertation I delineate between male and female patient images. The social impact of the body as patient is not limited to a homogeneous consideration. Foucault suggests that surveillance is not always rendered in a uniform fashion, and particular attention is often paid to specific groups over that of other groups (Lupton, 1994). Related to medical surveillance, Foucault documents how the shift of illness was moved from the individual body to the social body (Lupton, 1994) as medical scientists focused their scrutiny on targeted groups, such as homosexuals, believed to be aberrations and/or threats to social health (Foucault, 1973), more so than other groups.

In terms of privacy, there is evidence that some groups have received greater or lesser rights of privacy than other groups. As previously noted, in this sense, "privacy is social practice" (Reiman, 1984, p. 38) in that the right to privacy includes the right to existence in social practice or to necessary conditions which enable the individual to think of him/herself as an entity worthy of claiming personal and property rights (Reiman, 1984). In her depiction of slavery, for example, Susan Bordo (1993) suggests the treatment of a human body as property suggests that a slave's body is treated as an animal allowed to be "taken and used at will," and is "undeserving of privacy and [thus] undemanding of respect" (p. 11).

Therefore, in this dissertation I consider how patient images are portrayed in relation to group distinctions. Certainly, a number of groups (racial, sexual orientation, class, et cetera) could be analyzed for image differences. This study, however, includes sex comparison due in large part to a call for this kind of research and a theoretical basis for sex differences in television portrayals.

Mass media research and feminist theory directly isolate ways the female body, particularly the body-as-patient, has been constructed differently than the male body. "Sex differences are socially constructed because being raised as a girl or a boy produces biological as well as social differences. Society defines the sex-appropriate behavior to which each of us learns to conform, and our behavior affects our bones, muscles, sense organs, nerves, brain, lungs, circulation, everything. In this way, society constructs us biologically, as well as socially, gendered people" (Hubbard, 1990, p. 138). In particular, the media provide "models of behavior" and gender roles along with pressure to maintain the role "to be a perfect mother, lover, wife, homemaker, glamorous accessory, secretary - whatever best suits the needs of the system" (Davies, Dickey, & Stratford, 1987, p. 4). Likewise, although not as prevalent, there are concerns about male socialization in the media, particularly related to violence (Teelucksingh, 2003).

The difference that makes a difference to the sexes in a social sense is not actual biology, but the socially-constructed views of masculinity and femininity that make up our definitions of gender (Harre, 1998; Sookkyung, 2000). This idea of sex identity is "not as a fixed property of individuals, but as part of an ongoing process by which subjects are constituted, often in paradoxical ways" (Van Zoonen, 1994, p. 33), and fits the notion of gender "as a discursive construct and is inspired by poststructuralist thought

as expressed, among others, in the work of French philosopher Michel Foucault" (Van Zoonen, 1994, p. 32).

Gender and the Media

The media have been identified as a predominant modern technology constructing gender (Sookkyung, 2000; Weedon, 1997). According to Van Zoonen (1994), "De Lauretis (1987: 2) proposes that gender should be thought of as 'the product of various social technologies, such as cinema, and of institutionalized discourses, epistemologies and critical (social) technologies of gender, accommodating, modifying, reconstructing and producing disciplining and contradictory cultural outlooks of sexual difference" (p. 41). McQuade and McQuade (2000) write, "Magazine and advertising headlines insistently proclaim that men and women are different. Indeed, representations of these differences can be seen everywhere in popular culture . . . We 'know' these things to be true because we read them and see such statements everywhere – and clearly many people still believe that anatomy is destiny" (p. 261).

Television's socialization effects are most pronounced with gender representations (Ganahl, Prinsen, & Netzley, 2003). Specifically, Ganahl, Prinsen, and Netzley (2003) cite a study by Murphy (1988) which "showed how culturally shared gender . . . stereotypes were created and reinforced [on television] until stereotypes . . . cued consistent interpretations in unrelated media events" (p. 546). Likewise, based on her findings, Gallagher (2001) states, "These findings, and those of countless other studies, illustrate clearly that . . . media content still reflects a masculine voice of the world and of what is important " (p. 11).

However, despite the importance of considering gender and the media, literature pertaining to media representations and gender is fairly homogenous in media genre focus. In my review of the literature, most documents pertaining to media, gender, and image focus on entertainment and advertising, with few specific to television news. This conclusion is supported by other reviews of media and gender literature. Although Feminist media criticism is voluminous (Gallagher, 2001; Lumby, 1997; Mayne, 2003), most studies focus on mediated entertainment (Sookkyung, 2000) and advertisements (Lont, 1993), with some of the more recent literature focusing on changes in the industry due to women's increasing purchasing power (Ganahl, Prinsen, & Netzley, 2003; Vranica, 2003).

With a large portion of the attention on gender representation focused on advertisements and entertainment, this dissertation's focus on television news is fairly unique in its consideration of gender. Whereas "gendered and sexual images of ads are well documented (Bretl & Cantor, 1988; Goffman, 1979; Gunter, 1995; Joliffe, 1989; Reichert, Lambiase, Morgan, Carstarphen, & Zavoina, 1999)" (Rouner, Slater, & Domenech-Rodriguez, 2003, p. 435), few studies address television news. Moreover, literature addressing gender portrayals in news focus on print media predominantly, or on a lack of women in lead broadcast journalism positions.

Gender portrayals in television news do, however, matter. Gender portrayal concerns may be as pronounced, but less identifiable in television news than other media genres. As noted in chapter one, news as a genre is of unique interest related to cultural effects due to its acceptance as an objective source of reality, its believed credibility and

reliance on expert opinion, and industry-related constraints. Specific to TV news and gender, Sookkyung (2000) writes:

> Especially, gender representations in TV news influence a person's perception, because it claims to present gender discrimination with a certain degree of societal objectivity . . . . However, in terms of their relative importance and in the method of presenting women, it is common sense that the fixed ideas of gender discrimination are tacitly included. Gender representations contain fixed ideas of gender. Nevertheless these are claimed to be social reality, regardless of the content of the gender representations of TV news, because they are ideologically effective as part of the so-called objectivity of TV news (p. 243).

Having established the importance of media and gender research in general and to television news specifically, in this dissertation I investigate an important aspect of media and gender representation research related to health and patient images. As indicated in chapter one, medical patient portrayals have been of little interest to researchers, and, when considered, pertain to televised dramas almost exclusively. Research describing images of the male and female body as patient is not extensive. Yet, both men and women submit to intimate medical examinations, particularly involving sexual health. But, because women seek medical care for sexual health more often than men, the number of sexual health news stories are likely greater for women than for men. Regardless of story frequency, the way patients are presented can be analyzed relative to percentages of image portrayals of men and women respectively.

Therefore, consideration of traditional media criticism in conjunction with the previously noted theoretical problem and related salient issues affords an important

research area in media and gender specific to patient images in television sexual health news reports. In doing so, this dissertation contributes to existing gender and media research in a unique way. Moreover, it will address the cultural implications of body representation from a gender perspective. In the introduction to The Body, editor Donn Welton acknowledges that, "conspicuously missing from the analysis of the body thus far, are the questions of language and gender" (Welton, 1999, p. 6).

Seeing the Female

Although not specific to sex differences in patient images in sexual health news reports, mass media research and theories have long attested to sex differences in media representation in general. According to Brubach (2000), "Our contemporary images of women are descended from a centuries-old tradition and, inevitably, they are seen in its light" (McQuade & McQuade, 2000, p. 414). In 1995, at the Fourth World Conference on Women, the United Nations Platform for Action identified the media as a critical area in addressing gender equality, and called for "the promotion of a balanced and non-stereotypical portrayal of women in the media" (Women's International Network, 1999).

Drawing on writing and research ranging from feminist theory to film criticism, the problem of privacy, social control, and self-surveillance is more prominent in media representations of women than men. Moreover, the issues previously described (medical dependency, body positioning, body invasion, and body dismemberment) have a theoretical basis for hypothesizing that the female body-as-patient may suffer greater domination in its portrayal on television than the male body-as-patient. Related to this

dissertation's focus, the following issues are clearly connected: the male gaze, visibility, passivity, the medical film genre, and female bodily reductionism.

The Male Gaze: An Issue of Power and Privacy

Like beauty, power is in the eyes of the beholder. As delineated earlier, the process through which modern power works involves visibility, surveillance, and resultant self-surveillance. Although this idea, first identified by Foucault, speaks to society in a general sense, acknowledgement that isolating groups for excessive visibility exists (Lupton, 1994). Although not related to the surveillance ideas directly, media studies argue that excessive body visibility has been the plight of women, and the power to gaze on women the right of men (Berger, 1983; Van Zoonen, 1994).

Critics have argued the female body holds a greater degree and different kind of visibility than the male body (Berger, 1983; Brubach, 2000; Gammon & Marshment, 1989; Penley, 1988). According to Gamman and Marshment (1989), "In most popular representations it seems that men look and women are looked at. In film, on television, and in popular narratives men are shown to be in control of the gaze, women are controlled by it" (p. 1). To watch is to act, to be watched is to be acted upon. The active role of the watcher is traditionally reserved for men, while the passive role of the watched relegated to women. As Berger (1983) notes:

> One might simplify this by saying: men act and women appear. Men look at women. Women watch themselves being looked at. This determines not only most relations between men and women but also the relation of women to themselves. The surveyor of woman in herself is male: the surveyed female.

> Thus she turns herself into an object – and most particularly an object of vision: sight (p. 47).

Reviewing media studies literature reveals differences in interest, visibility, and censorship surrounding male and female body exposure (Davies, 1987). Inherent in these discussions is the issue of privacy. Allen (1988) states, "Women have not always had adequate opportunities for personal privacy, neither in the private sphere of the home, marriage, and family, nor in the public sphere" (p. 2). Others concur that not only are women less often afforded private space than men, the female body is seemingly of greater interest and less worthy of privacy and personal dignity than the male body (Daly, 1990; Ehrenreich & English, 1978; Lerner, 1993).

In art, for example, invasion of privacy seems to haunt the female more than the male form. Drawing on the dignity of privacy in suffering and appropriation of the sick female, Dijkstra (1986) highlights Hermann Moest's "The Fate of beauty" and Paul-Albert Besnard's "The Dead woman" and "The Dying woman" as representative of an artistic genre in which female suffering is appropriated for aesthetic pleasure. "Under the guise of documentary concern, Besnard," argues Dijkstra, robs the woman depicted in his series "of even the dignity of privacy on her death bed" (p. 54).

Likewise, privacy in the western tradition includes concealing genitalia aptly colloquialized as private parts. Discussions of visibility of male and female parts for their sexual and/or aesthetic pleasure in entertainment is highly-developed (Davies, 1987; Lumby, 1997; Van Zoonen, 1994). However, at issue here is the overall sense of individuals' right to privacy in real and intimate medical situations broadcast in television

news programming. The inclusion of real patients in news segments offers a unique genre to consider issues of privacy, social control, and gender differences.

Women's Visibility: Simultaneous Invisibility and Overexposure

Drawing on feminist critiques of the mass media, a number of issues related to visibility are evident. At first, the critiques may seem contradictory in that there is complaint over lack of inclusion of women as subjects and their interests, as well as critiques over disproportionate displays of the female body.

First, gender and the media studies have highlighted ways the "media reflect society's dominant social values and symbolically denigrate women, either by not showing them at all, or by depicting them in stereotypical roles" (Van Zoonen, 1994, p. 17). For example, many gender and media studies focus on "representation of central characters" (Ganahl, Prinsen, & Netzley, 2003, p. 546) which leads to "ways in which media images render women invisible" (p. 49).

Based on various reviews of media criticism, the following visibility issues are isolated: Men are represented both as characters and in voice overs on television more than women; men are used in advertisements more than women; men's character roles are more diverse and less stereotypic than women's character roles in television dramas; women have fewer major roles in television and movies; men are depicted as experts more than women (Bartsch, Burnett, Diller, & Rankin-Williams, 2000; Blaine & McElroy, 2002; Brown, 1998; Coltrane & Messineo, 2000; Davis et al., 1987; Furnham & Mak, 1999; Lont, 1993). Particular to news, Gallagher (2001) notes that "only 17 percent of the world's news subjects (e.g. news-makers or interviewees in news stories)

were women (MediaWatch 1995)" (p. 11). In terms of presenting the news, Cann and Mohr (2001) found that on the five Australian networks men were over-represented as presenters, reporters, and experts compared to women.

At the same time, one of the most common critiques of the mass media is its disparate focus on women's appearance compared to men's appearance; women have a huge cultural mandate to be beautiful (Brubach, 2000). "In terms of appearance, the pressure finds expression in the media chiefly as fashion, beauty, and health features . . . " (Davies, et al., 1987, p. 4). The push for women to maintain physical perfection, as predominantly presented in the mass media, is cited as a cause for eating disorders, election of dangerous cosmetic surgeries, and low self-esteem in women (Bordo, 1993; Davies, et al., 1987; Van Zoonen, 1994; Wolf, 1990).

The push for physical perfection is not only a problem in its own right, but the reason behind this push is problematic. A predominant critique of mass mediated portrayals of women is the reduction of women to sexual objects predominantly as women fit sexually into a male fantasy (Davies, et al., 1987; Harre, 1998; Irigaray, 1999; Van Zoonen, 1994). "The way they [the mass media] do this is to present women constantly as glamorous, alluring and available. This results in women being viewed as objects, to be used for the pleasure and profit of men" (Davies, et al., 1987, p. 72).

This is accomplished through a predominance of mass mediated images of women shown naked, semi-naked, and available (Davies, et al., 1987; Rouner, Slater, & Domenech-Rodriguez, 2003). The multi-billion dollar pornography industry (Davies, et al., 1987; Van Zoonen, 1994) is a mass media case study in point. The focus on women's physical appearance is not reserved for the pornography industry alone. In their content

analysis of prime time television between 1999-2000, Lauzen and Dozier (2002) found that female characters are twice as likely as male characters to receive comments on their physical appearance.

Even news is noted for its focus on female sexuality, health, and beauty (Davies, et al., 1987). The mass media, as previously noted, are major purveyors of health information. Notably, in terms of female health, there is a frequent link between health and beauty (Davies, et al., 1987). In their content analysis of primetime television commercials, Ganahl, Prinsen, and Netzley (2003) found that women were underrepresented as primary characters except for health and beauty products. Gallagher (2001) notes that whereas women were least likely to be news subjects in the areas of politics and government, they were most likely to be covered in stories related to health and social issues.

To summarize, media and gender studies suggest that women and men are portrayed differently. Speaking critically, the concern is over lack of attention to women's issues as women identify them, and lack of inclusion of women as news subjects. A related concern is the overexposure of women's bodies in terms of physical appearance, sexual objectification, and the blurring of women's health with beauty. Of particular interest to this study is the impact of visibility on the social conception of privacy and self-policing for women born out of particular type of media visibility. In the case of women, that visibility is focused predominantly on sexuality and health, with health often blurred with beauty and bodily perfection.

Passive Positioning

In addition to privacy and self-surveillance, visibility in the media relates to the theoretical notion of passive positioning. Along with the inherent difference in activity between the surveyed and the surveyor, critiques of the female object of the male gaze places women in passive positions (Van Zoonen, 1994). In early social critiques of gender discrimination, body positioning of women in art, entertainment, and advertising are often cited. Women, it is argued, are often shown beneath men and in passive stances, such as lounging or at rest, rather than active stances, such as playing sports (Goffman, 1979). Dijkstra (1986), for example, considers the history of female and male images in visual art, documenting the traditionally passive stances of female images from the arched backs of women in turn-of-the-century paintings to the floating images of the female nude. According to Dijkstra (1986), "She [the female nude in turn-of-the-century art], and her companions, and all the other endlessly repeated images of prostrate women who were seemingly unable to stand up straight . . . were a creature of the earth who lolled about, doomed to wait helplessly yet ever more eagerly for man" (p. 100).

Studies of media and gender have identified a preponderance of images of women as manipulable, submissive, and passive, whereas men appear more authoritative, powerful, and active (Rouner, Slater, & Domenech-Rodriguez, 2003; Sookkyung, 2000). In her review of media criticism, Lont (1993) found that women are depicted as more passive, dependent, and weaker than men. Particularly noted are the ways women are presented as submissive, available, and compliant in the media (Van Zoonen, 1994; Ganahl, Prinsen, & Netzley, 2003; Rouner, Slater, & Domenech-Rodriguez, 2003).

Finally, mere visibility itself may attest to passivity. Summarized by Sheets-Johnstone (1994), "Females are turned into docile bodies by keeping them at risk of exposure, that is, by keeping them under the threat – actual or potential – of male eyes. . . . Reinforcing and capitalizing on this visual liability of females, the advertising industry – in the United States if not elsewhere – echoes and re-echoes the theme of ever-present male eyes" (p. 121).

Dismembered Reduction

The sexual objectification of women in the media is most vehemently opposed when that visual focus reduces women to their body parts, particularly those related to sexuality. Fantasy taken to extreme is fetishism, a concept discussed earlier. Hall (1997) describes an early example of fetishistic reductionism in the early 1800s England where the "Hottentot Venus" was displayed as spectacle. Saartje Baartman, known as the Hottentot Venus, was an African woman taken to England to be physically displayed for the public. Of interest were her large buttocks and enlarged labia which were considered beautiful in her culture. Hall (1997) describes the animal-like way in which she was housed and publicly paraded; her body "read" like a text, and reduced to its parts, and suffering an extreme form of reductionism. "She was literally turned into a set of separate objects, into a thing - 'a collection of sexual parts'. She underwent a kind of symbolic dismantling or fragmentation" (Hall, 1997, p. 266).

Although the Hottentot Venus is one example of a trend beginning in the 1800s, which represented racism in terms of sexuality perceptions, it also fits within a history of reducing women to their body parts. Hall (1997) identifies ways the strategies employed

with Saartje Baartman are also "applied to the representation of women's bodies . . . especially in pornography" (p. 26). Frequent media analyses criticize media makers for focusing on women's body parts only (Daly, 1990; Davis et al., 1987; Jhally, 1995; Kilborne, 1999; Mulvey, 1975; Van Zoonen, 1994). According to Saladin (1993), "From the Pre-Raphaelites on, women are increasingly fetishized and objectified by a focus on particular body parts" (p. 22).

The social effects of reductionism, as widely noted, go beyond mere sexual objectification. "The pornographic convention of fragmenting the female body into close-ups of her sexual organs, reduces women to functional, depersonalized body parts for male satisfaction; and finally particular camera angles and body postures construct an image of women as powerless and submissive as objects of male desire for sexual power and dominations (Coward, 1982)" (Van Zoonen, 1994, p. 19).

Moreover, this artistic convention removes the woman from the self, and diminishes her place in society. According to Sheets-Johnstone (1994), "To reduce a person to her genitals in this way is to privilege – and de-privilege – pieces of the body, to valorize them, to make them rather than the person her-himself the source of meaning. In such a conception, a person's possibilities in the world are reduced to her or his bodily possessions . . . genitalia have been made the course of one's personal autonomy and the channel through which that autonomy is expressed" (p. 126).

The Male Gaze Meets the Medical Gaze: The Medical Film Genre

In addition to the consideration of the traditional male gaze and female objectification in the mass media, review of the medical film genre offers insight into

how traditional gender roles are portrayed within the medical institution as depicted in the mass media. Based on studies of iconographs of disease and the body in medicine, S. L. Gillman concludes, "The female body has been subjected to 'an excess of visibility' in medical and popular media representations" (Lupton, 1994, p. 74). Of concern in this dissertation is the move of a traditional medical audience into a more mass mediated theatre.

In The Clinical Eye: Medical Discourses in the 'Woman's Film' of the 1940s, Doane discusses Hollywood's interest in cinematic medical examinations of women. Doane (1986) describes a film genre interested in female problems, and which situates the woman as a medical discourse object intent on providing viewers the right of examination. According to Doane (1986) the doctor's look in the cinema penetrates the body similar to what Foucault describes as the medical glance. The audience, then, is the spectator and "the spectator's eye becomes that of a doctor and the spectator is given, by proxy, a medical or therapeutic role? the spectator knows more than the female character, is always an accomplice of the diagnosis" (p. 167).

Health and the Mass Media: Competing Gender Concerns

Moving the discussion from images of gender in the mass media, gender concerns relating to health in the mass media are presented. In direct contradiction to concern over excessive exposure of women in the media as sexual objects, the predominant viewpoint is that health issues of women receive less attention than men's health issues in the media. This focus is supported further by existing research on health and the media citing differences in media coverage of male and female health issues. "Media coverage

may also treat men and women differently, ultimately favoring male problems over those of women. In their analysis of magazine articles focusing on heart disease, Fisher et al. (1981) found considerable differences in how men and women were mentioned" (Signorielli, 1993, p. 20).

This viewpoint, however, is not universally accepted. Recently, some critiques have suggested that men's health concerns are underrepresented compared to women's health concerns. According to Coulson (2002), "The media deliberately play down men's health issues" (p. 11). In terms of visibility, subsequent critiques rest theoretically on whether disparate attention favors one group over the other in advancing public knowledge and health. On the other hand, previously noted concerns over excessive visibility and ensuing self-surveillance exist particularly when one group is highlighted.

Therefore, these contradictory arguments give rise to a concern of how both sexes are portrayed in television news sexual health reports. Foremost in this dissertation is a desire to describe whether sexual health issues and related imagery are represented similarly for male and female patients in television news sexual health reports. But, the analysis should not end with equality of representation in terms of numbers. Referring back to issues of medical dependency and empowered patient practice explicated in chapter two, an important issue is how the images of male and female patients may or may not foster empowered patient positioning in televised news sexual health reports.

Certainly, coverage (or lack thereof) of sex-specific health issues is important, and may negatively affect both men and women respectively. Yet, the analysis should go beyond a bean counting of story topic across the sexes. "For it is not only how we are portrayed, but also how we are not portrayed which is significant" (Davies, et al., 1987,

p. 5). The theoretical ideas are harder to dissect on this point regarding gender because the analysis must mete out social effects related to both equality in coverage as well as overemphasis which may incite disparate visibility and ensuing self-discipline.

Gender Difference Summary

In summary, by investigating the degree of body exposure, positioning, and examination in television news sexual health reports, I include an investigation of gender differences in portrayal of patients in sexual health news reports. Today, the private, and sometimes intimate, medical examinations historically sequestered in the medical facility are opened to the public. Along with the issues of privacy, social control (including surveillance strategies and self-surveillance), and medical dependency, an additional concern is if there are gender differences in the inclusion and portrayal of patient images undergoing private, intimate, and, at times, emotionally difficult medical examinations.

CHAPTER THREE

RESEARCH QUESTIONS AND METHODOLOGICAL FRAMEWORK

MEDICINE, SOCIETY, AND BODY VISIBILITY: THE GOOD, THE BAD, OR BOTH

Up to this point, the trajectory may seem one of fault-finding. However, the theoretical framework, related problems, and salient issues are meant to illuminate intricacies of an emergent television trend in the interest of understanding the trend and society. The overarching issues are privacy, individuals' right to personal dignity, patient empowerment and overall health, and what are considered acceptable forays into private lives portrayed on television. Relatedly, and following from the theoretical framework outlined, the purpose of this dissertation is to uncover the workings of discourse which allow for the discourse's existence and related power structures, as well as propose critical interpretations of how this discourse may affect individuals' sense of self and health practices, both positively and negatively.

A given in this dissertation is that disciplinary practices may have differing effects (Shildrick, 1997). Certainly, the importance of clinical observation and technological advancements in internal surgeries and imaging, to name a few, have the capacity to improve quality of, and extend, life. Relatedly, certain social control initiatives in healthcare, such as epidemiological studies and vaccination, are health-promoting and life-protecting. However, with more and more individuals seeking medical advice from television, at least as an initial health information source, rather than from medical practitioners, the subsequent health impact warrants critical investigation. A recent and unique shift is the moving of clinical observation and procedures from the private confines of medical facilities where they are observed and executed by trained

practitioners to a public stage on television. Of particular concern is the impact of self-surveillance as a result of the televised medical theatre.

However, lest self-surveillance is prematurely categorized as inherently bad, some behaviors incited out of self-surveillance which are criticized for negative effects, such as female pursuits of bodily perfection, produce positive effects as well. For example, Bordo (1993) notes that dieting is a process of self-surveillance which is an outcropping of current health norms and visibility which can be both harmful and self-depleting as well as healthful and self-actualizing. Likewise, Sawicki (1991) and Bordo (1993) suggest that female body builders, who may have reacted to a society in which female physical perfection is on continuous display, exceed those expectations in a way which subverts the stereotypic gender perceptions on which the initial physical perfection norms rested.

Therefore, my purpose in this dissertation is to describe the current trend of including formerly private and intimate medical examinations/procedures in television news sexual health reports. Relatedly, I identify ways this discourse may fit within a historical explanation and perspective of human interaction, and may inform current social practices. The overarching notion follows from Foucault's "formulation that everything is dangerous" (Shildrick, 1997, p. 56). In saying this, Foucault does not use the word dangerous in a pejorative sense. Rather, he suggests that discourses have potential consequences; there is always the danger of social effects. However, the effects may be positive, negative, caustic, benign, etc. In other words, discourses are not inherently good, bad, positive, or negative.

Moreover, the qualities ascribed to a discourse's effects may change over time or may be reacted to differently by different groups. Additionally, a discourse and associated social effects do not exist in a vacuum. They affect and are affected by a myriad of social forces and other discourses. Therefore, they are deemed dangerous due to the potential ways they affect, and are affected by, society. This supports critical inquiry of television images resting on the idea that television not only shapes but presents the shape of society for which its description has explanatory significance.

Toward that end, in this dissertation I placed the body at its center, while specifically addressing the content of televised images of sexual health patients. "This discursive approach toward the body . . . is often articulated in terms of bodily inscription, in which the body is socially and culturally inscribed by various discourses, and this is interiorized to produce a sense of subjectivity" (Rothfield, 1995, pp. 182-183), which, in turn, may bleed into social practice.

Historic precedence and conventional logic attest to the importance of privacy in individual self-development and autonomy and provide a check on excessive social control. Related to privacy is the role of surveillance in self-development and social control. Likewise, concern over the body as a visual discourse includes consideration of the social role of body representations, particularly with body visibility, positioning, invasion, and dismemberment. This visual discourse may affect individual and societal conceptions of privacy, self, medical dependency, and health.

Finally, sex differences in healthcare and media representation have long been cited. Drawing on these critiques, investigation of differences in portrayals of male and female patients in television news sexual health reports is important. Ultimately, visual

representation of the body, particularly the patient body, in the mass media holds import for investigation in health communication and mass media research.

RESEARCH QUESTIONS

This dissertation's objective is to examine patient images in sexual health news reports on the major U.S. networks to answer the following:

1.) In what ways are formerly private medical examinations portrayed publicly in sexual health news reporting?

2.) How do patient images in sexual health news reports promote the traditional, functionalist approach to healthcare or the newer, autonomous, and empowered patient approach?

3.) How are male and female patients portrayed in televised news segments involving normally intimate health issues?

4.) Do the networks vary in their presentation of sexual health patient images?

5.) How might historical/contextual factors account for type/style of current representations?

CRITICAL DISCOURSE ANALYSIS: THE METHODOLOGICAL FRAMEWORK

The research questions cannot be answered with one research method. Moreover, this supports the previously-supported call for research in mass communication and health to go beyond manifest messages and incorporate a multidisciplinary, multi-layered analysis. The work of critical discourse analysts, such as Norman Fairclough, Gunther Kress, and Teun A.Van Dijk, supports a multi-phasic approach to research involving

social issues. This dissertation follows the methodological pattern outlined in Critical Discourse Analysis (CDA), which includes both quantitative and critical analyses .

CDA is a hybrid method drawing on multiple methods to analyze discourse (Van Dijk, 1993). CDA's overarching schema places discourse at the center of the inquiry moving outward to consider aspects of the discourse and its production, contextualizes the discourse within history, and identifies the social practices which shape and are shaped by the discourse. Traditionally, discourse refers to written texts, but it is also used with audio-visual media (Gunter, 2000, p. 87). Media images are a type of discourse, and the study of them should be employed as part of critical textual analysis (Fairclough, 1992, p. 17).

Although relying on traditional research methods of data collection and analysis, CDA differs conceptually from other forms of discourse analysis. Traditional modes of discourse analysis often focus on how individuals use discourse and assess their attitudes about the subjects they are portraying (Fairclough, 1992). This omits the role of discourse in "constituting and constructing selves" (Fairclough, 1992, p. 168). This often-overlooked consideration is particularly important with the mass media because the mass media affect social change and socially construct reality (Fairclough, 1992). As previously explicated, the new mode of information via the media reconstitutes the world (Poster, 1989).

To address the depth of media involvement in society sufficiently, CDA typically follows three phases: (1) textual analysis, (2) discursive practice analysis, and (3) social practice analysis. The first three research questions (see p. 85) correspond to image representation (textual analysis). Critical examination of production modes (discursive

practice analysis) follows from research questions four and five. For this analysis I will draw on phase one's content analysis results to report on production differences by comparing patient image representations in the major television networks, and provide a critical interpretation of possible historical/cultural factors affecting production modes. Finally, results from phases one and two will provide the basis for future studies in phase three (social practice analysis).

Simply put, the phases I follow flow logically from describing what exists, based on a post-structuralist attention to discourse, to critical evaluation of possible explanations for how/why the discourse exists as it does. The resultant analyses from phases one and two will provide the background for future social practice analysis which should include individual effects and viewer response research studies.

Textual Analysis

First, the textual analysis is "an analysis of what is 'there'" as well as what is absent in a text (Fairclough, 1992, p. 106). Content analysis research typically describes mass media content (Sumser, 2001). This method moves a researcher from opinions regarding the mass media to a systematic inquiry designed to "identify, enumerate, and analyze occurrences of specific messages and message characteristics embedded in communication texts" (Frey, Botan, Friedman, & Kreps, 1992, p. 194). Although traditionally used to analyze spoken or written words, visual elements of media fall within the realm of content analysis research (Poindexter & McCombs, 2000; Sumser, 2001), and "a number of studies [content analyses] have explored specific categories of content in the media such as . . . health-related behavior" (Gunter, 2000, p. 61).

Discursive Analysis

Second, the discursive practice analysis involves unearthing production modes using the content analysis results and historical criticism. Included in the analysis is an investigation of existing institutional policies, practices, and norms (Fairclough, 1992). Although content analysis is purely descriptive, "content analysts can draw valid inferences about the characteristics of producers and receivers of messages and of the context in which a message is produced" (Frey, Botan, Friedman, & Kreps, 1992, p. 195).

An attention to production rests on the previously-delineated assumption that media texts constitute reality. What is selected, how images and text are edited, and ways discourses are presented are constituted versions of reality "channeled through people, processes, prejudices, traditions and the pressures of time, resources and competition" (Davis et al., 1987, p. 2). "A basic assumption is that media texts do not merely 'mirror realities' as is sometimes naively assumed; they constitute versions of reality in ways which depend on the social positions and interests and objectives of those who produce them" (Fairclough, 1992, pp. 103-104).

Content analysis can be utilized to consider what choices are made in terms of image inclusion and exclusion, explicit and implicit representation, as well as primary and secondary focuses (Fairclough, 1992). In particular, the content analysis data in this dissertation can be cross-tabulated with the network variable to detect if similarities or differences in image choices exist between networks. In doing so, assessments can be made regarding whether the major networks differ in their image choices, or if they tend to fit within the norm of television news' proclivity to rest in the status quo.

Additionally, from this vantage point, social, ideological, and institutional forces informing and/or structuring production may be ascertained by inserting history into the text. History may be inserted into a text as a way of identifying discursive practice by determining if and when there are breaks in tradition or continuation of traditional practices which may account for how and why some images may be privileged over others (Fairclough, 1992). Lupton (1994) commends a historical perspective as particularly suited to understanding why certain responses, both from and to the media, occur, and why certain types of imagery resonate in mass media news coverage. Included are historic dimensions of medical practice and education, historical views of sex relations/roles, and gendered images in art and film.

Social Practice Analysis

Finally, this dissertation will lend itself to future development particularly in the area of social practice. The combination of text and production analyses are enriched by an attention to social practice. To fulfill criteria of the social practice analysis, methodological components should assess audience interpretation. Fitting within CDA, this approach is needed in existing mass communication and health research. According to Atkin and Wallack (1990), "With a few exceptions, very little research has been conducted to assess the impact of health-related content on the public. Thus, the field is wide open for researchers who want to investigate the broad range of audience responses to various types of messages" (p. 34).

To fully address the topic of patient images in sexual health news reports, additional data collection methods specific to audience reception are required in future

studies related to this discourse. Lupton (1995) advocates a method combining health and mass media research due to interpretative methods' inability to quantify press attention on a given issue, while avoiding the confinement of research to surface meanings alone through sole reliance on content analysis. What purely descriptive analyses born out of content analysis methodology do not account for are the "potential significance of their findings . . . or impact of media content on audiences" (Gunter, 2000, p. 81).

Content analysis categories are not always perceived by viewers as the most salient attributes in a given media sample (Gunter, 2000). In field studies regarding television violence conducted by Shaw and Newell (1972) audiences identified content categories, alternative to those provided, they deemed important (Gunter, 2000). Relatedly, in media studies conducted by Gunter (1985) and Gunter and Furnham (1984), audiences often construct different analysis scales for content categories (Gunter, 2000). According to Gunter (2000), "Content analyses . . . may actually be poor indicators of audience responses to media (Ceulemans and Fauconnier, 1979; Perloff et al., 1982)" (p. 79). Therefore, although content analysis research is beneficial in describing media through objective and reliable counts, "the relevance or meaning of those items for the audience can be properly ascertained only through the perceptions of the viewers themselves" (Gunter, 2000, p. 81).

The content analysis results will provide the basis from which viewer response and related social practice (in this case how people view themselves in relation to, seek out assistance from, and interact with the health profession) analysis may stem. Results of this dissertation, then, will provide the basis for future studies that include viewer

response to the image sample and self-report survey data related to viewer response and resultant health-seeking behaviors. In sum, this dissertation fulfills the first two phases of Critical Discourse Analysis and provides a basis for future social practice analysis (phase three).

Specific Research Methods

Based on the CDA framework, the research methods included in this dissertation are: (1) content analysis of patient images in sexual health news reports, (2) consideration of production modes, including attention to how and why choices to use certain images occur by comparing image use in the four major networks along with historical/critical interpretation of content analysis results, and (3) method description for future social practice studies involving focus group and survey research.

CONTENT ANALYSIS

To describe the discourse in the textual analysis phase, I utilized a content analysis of patient images in sexual health news reports. The content categories are based on the problem and salient issues described in chapter two and answer the first three research questions pertaining to how patient images are portrayed and if there are sex differences in those portrayals. Additionally, the content analysis includes sexual health television news segments from the four major television networks (ABC, CBS, NBC, and CNN) which relates to research questions four and five. This chapter explains data collection methodology, including pilot study description, and describes coding categories.

Sample

The sample was obtained from the Vanderbilt University Television News Archives, the most comprehensive television news database in the United States. The sample contains television news stories related to sexual health. The search included the following words: prostate, testes, scrotum, penis, vagina, endometrius, uterus, ovaries, breasts, and cervix. Stories including related diseases, such as cancer, vaginitus, pelvic inflammatory disease, yeast, infections (yeast, urinary, bladder, and vaginal), and erectile dysfunction were included. Examinations commonly associated with these organs or diseases, such as mammography, rectal exam, and Pap smear were included.

Other search words included Viagra, male and female birth control methods (including sterilization, oral contraceptives, tubal ligation, vasectomy, Norplant, and Depo-Provera), all sexually transmitted diseases (including the newly-researched HPV), impotence, infertility, menstruation, premenstrual syndrome, and abortion. The search also included words pertaining to the medical specialties of obstetrics, gynecology, urology, andrology, and proctology. Finally, words related to sex, such as sex, sexual intercourse, masturbation, sexuality, and the Planned Parenthood Organization were included.

Pilot Study

A pilot study was conducted to test the workability of the coding scheme, determine if the sample fit within the study parameters, provide coder training, and assure for intercoder reliability (Poindexter & McCombs, 2000). Based on information gathered from the pilot study, segments shorter than thirty seconds were excluded from the sample

as these typically contained only reporters' head shots, were briefly mentioned as advertisements for later segments and were presented in conjunction with other bulleted news items, and/or were previews for future news programming. In other words, segments shorter than thirty seconds were not actual news stories and did not include patient images.

The sample was limited to segments aired between January, 1990 and March, 2000. The decision to include all segments from that decade rather than randomize all archived years (1968-2000) was due to increased visual representations and image clarity since 1990. Similarly, a subgroup of stories were excluded because they did not center on patient treatment. These included the Dalcon Shield lawsuit, birth rates, FDA drug approval, abortion court cases, U.S. Supreme Court decisions about abortion, the effects of birth control pills and smoking, smoking and impotence/infertility, population growth, personal/celebrity birth announcements, legislation, frozen embryos, healthcare reform, statistical reports, abortion marches, abortion demonstrations, abortion clinic bombings/violence, abortion protests, and the Viagra/birth control pill medical insurance coverage debate.

Finally, content analyses usually utilize two to three coders (Poindexter & McCombs, 2000). Because fewer coders often equates to fewer coding discrepancies (Poindexter & McCombs, 2000), only two coders coded the sample. Additionally, to reduce differences in coder viewpoints, cited by Merten (1996) as a common problem in content analyses (Gunter, 2000), the two coders worked through fifty segments not included in the sample as a way of testing uniformity in coding viewpoint, as well as testing for reasonable intercoder reliability.

Once the sample was defined and the coding sheet refined, the coders analyzed the sample (See Appendix A). Seventy-five segments from the 292 total patient containing segments were tested for intercoder reliability. Using a reliability measure of R=2M/N1 + N2, intercoder reliability calculated at .84. Segments not containing patients were excluded from the intercoder reliability test because the bulk of the coding was applicable to segments containing patients only.

Coding Categories

The purpose of content analysis is to describe what exists in a fashion which is "objective, systematic, and replicable" (Gunter, 2000, p. 60). This requires "definition of the basic units of analysis (e.g., portrayals within programs or programs themselves) and the creation of an analytical framework that will further classify attributes of content of interest in the research" (Gunter, 2000, p. 61). Specifically, this type of definition, known as operationalization, must establish criteria for judging when something is or is not (Sumser, 2001) codable as a particular unit of analysis.

In this content analysis, the coders analyzed patient images in the sample for elements related to salient issues previously described -- privacy, medical surveillance, and visual medical discourse. These issues are given visual representation in terms of patient visibility, patient body position, patient body invasion, and patient body depiction. These general issues make up the "analytical framework" (Gunter, 2000, p. 61). Additionally, the coding categories were designed to describe visual images which are indicative of the theoretical problems and concerns raised in chapter two. Principally,

these coding categories were informed by the frame analysis presented in Goffman's (1979) Gender Advertisements and literature review in chapter two.

To further classify the framework into attributes (Gunter, 2000), the following coding categories were used: depiction of a patient in a story, depiction of a physician in a story, patient clothing, unclothed sensitive body part, patient body position, procedure, patient body invasion, physician touch, physician position, procedure, body position, and chaperone.

Once the medium was identified, the sample defined, and the coding categories established, transmission dates needed documentation (Gunter, 2000). Therefore, each segment was assigned an identifying number. For each segment the network, coder, and running time were noted. Additionally, each segment was mapped by listing the scene changes within the segment. Although not coded, the mapping provided a written description of the segments as a check on the coding results for segments involving multiple patients, procedures, and physicians. In other words, mapping was included as a cross-reference for coding data.

To map the segments effectively, each coder watched the segments first and mapped the segments for scene changes before actually coding the segments. For example, a coder listed the first visual scene, such as an announcer talking, followed by any subsequent scenes, such as a visual of surgery, a patient walking into an office building, et cetera. Scene Changes were operationally defined as any change of location (announcer in a news room, patient in a waiting room, physician talking with a patient, et cetera), any change of actors within a location, or any change of action.

If a segment depicted a physician examining a series of patients, the portion of activity surrounding each patient was demarcated as a separate scene. In these instances, although the location may have remained the same, the depicted patients changed. Likewise, a Scene Change could be footage cut from a physician and patient talking in an exam room to the same physician and patient in a different location -- an office, for example. Finally, in some stories the footage remained in one location and the patients and/or physicians remain the same, but the activity drastically changed. For example, the same physician and patient were portrayed in the same examination room, but they were shown first in consultation and then engaged in a medical procedure. In these instances, each change in activity was designated a Scene Change. Any segment containing multiple scenes was demarcated as a Multiple Sequence, and each scene in the sequence was numbered. Therefore a multiple sequence segment could have contained multiple scenes each of which was coded separately.

Following the mapping process, each segment (or scenes in a multiple sequence) was coded in terms of the following units of analysis (Gunter, 2000): patient portrayal, patient sex, multiple sequence, patient clothing (gown, street clothes, drape, no shirt, unknown), unclothed sensitive body part (stomach, buttocks, pelvic region, female breast(s)), patient body position (sitting, standing, lying down, lithotomy, bending-over-front, bending-over-back, unknown), procedure (mammography, colposcopy, colonoscopy, rectal examination, digital breast examination, digital testicular examination, Norplant, unknown, other), physician shown, physician shown during procedure (front-to-front sitting, front-to-front standing, provider sitting between patient's legs, provider standing between patient's legs, front-to-front bending over,

front-to-back sitting, front to back standing, front to back bending over patient, and off-side), physician touching activity (head-to-neck, neck-to-waist region, waist-to-knee including the pelvic region, waist-to-knee including gluteus maximus, knee-to-foot, and arm), body invasion (hand or instrument, in arm, buttocks, vagina, or rectum), and chaperone.

Patient

To ensure for coder agreement, the units of analysis require specific definition (Gunter, 2000). Each segment was coded for the existence of a patient. Patients were designated as any individual receiving an examination/procedure or shown in a medical facility room. Patients walking into a medical facility or shown in a waiting room were not counted as patients. In other words, only subjects shown in conference with a healthcare worker in an examination/procedure room or waiting (sitting, standing, lying) in an examination or procedure room, as well as those patients (sitting, standing, lying) receiving an examination or procedure were coded as Patients.

Patient Sex

Patients were coded as male or female. If the patient was not recognizably male or female (due to obscurity of film or limited body exposure -- such as a close-up of an arm), patient sex was designated as Unknown.

Multiple Sequences

From the definition of scene changes as described in mapping, a segment containing more than one scene was coded as a Multiple Sequence, and the total number of scenes was indicated. Each patient-containing scene was coded individually on a separate coding form.

Patient Clothing

Patient clothing was coded for each patient. The categories were operationalized as follows:

- Gown: A medical gown with or without street clothes underneath. Patients wearing gowns but with a sheet or drape over their legs were coded in another category.
- Street Clothes: Fully clothed in street (non-medical) attire. Patients wearing street attire but had a sheet or drape over their legs were coded in another category.
- Drape: Patients wearing street clothes or a medical gown on the upper body, with lower body covered by a sheet, paper or cloth drape, were coded as Drape.
- No Shirt: Patients wearing gowns or street clothes on the lower half of the body only, such as wearing clothing from the torso down but fully unclothed on the upper torso, were coded as No Shirt. Patients wearing partially-removed medical gowns on the upper torso, common in breast examination and mammography, were not counted as No Shirt.

Unclothed Sensitive Body Part

The Unclothed Sensitive Body Part referred to showing body parts typically clothed in western society and/or are objects of sexuality. If one of the designated body parts was shown without covering, the specific body part was coded as an Unclothed Sensitive Body Part. These included the stomach, buttocks, pelvic region, or female breast(s).

Patient Body Position

Indicating the patient's primary position during a scene or segment was the Patient Body Position coding category. In cases where a patient moved in and out of position during a scene or segment, the predominant or longest held patient position was coded as the Patient Body Position. For example, if a patient was first shown sitting and later shown lying down, the stance occupying the greatest amount of time was coded only. Sitting, standing, and lying down were easily identifiable and needed no further operational definition. In addition to these three options, patients were coded in the lithotomy position, which was lying on one's back with knees bent and feet in stirrups or feet flat on an examination table/bed with knees bent and feet elevated on the table/bed extension. Two final positions, bending-over-front and bending–over-back, were operationalized as follows: bending-over-front indicated the patient was bending at the waist with the camera angle from the front; bending-over-back indicated the patient was portrayed from the rear while he/she was bending at the waist.

Body Shown

To describe how much of the patients' bodies were shown, the following Body Shown sections were coded: full body, half body, arm only, and other. The Other category indicated the portrayal of a small portion (less than half) of the body (e.g. – a leg). These incidences were coded based on the patient body position coded (position held the longest) as previously described.

Procedure

The Procedure category indicated the procedure or examination portrayed in a scene. This was a visual category, not a story content category. In other words, if a story's content was colposcopy, but a patient and physician were shown talking in an examination room, the code was None, not colposcopy as indicated by the content. The procedure categories were mammography, colposcopy, colonoscopy, rectal examination (which included any rectal probe other than a colonoscopy – digital or with a machine), digital breast examination, digital testicular examination, insertion/removal of Norplant, blood (either giving blood or having pressure taken), or gynecological examination (which indicated any gynecologic examination other than colposcopy, such as digital examination, speculum insertion, Pap smear, et cetera), body X-ray (excluding mammography), and a category for procedures which were unknown or unidentifiable.

Physician shown

The Physician Shown category referred to whether a healthcare provider was shown in a scene or segment. If more than one healthcare provider was portrayed in a scene or segment, the number of providers was documented.

Physician Position during Procedure

If a healthcare provider was shown, his/her position in relation to the patient was coded. Positions included front-to-front (of the bodies) sitting, front-to-front standing, provider sitting between patient's legs, provider standing between patient's legs, front-to-front bending over (indicating the provider was facing the patient's front while bending over the patient), provider's front to patient's back with the provider sitting, provider's front to patient's back with provider standing, provider's front to patient's back with provider bending over the patient, and provider off to the side of the patient (indicating the provider was portrayed standing or sitting away from the patient in another portion of the room). In the case of multiple providers, each provider's position was coded in a given patient-containing scene or segment.

Physician Touching Activity

If a healthcare provider was shown touching a patient, either with his/her hand or guiding an instrument touching the patient, the patient body part receiving the touch was coded. Body Parts were specified to the following regions: head-to-neck, neck-to-waist region (non-breast touch), waist-to-knee (including the pelvic region), waist-to-knee (including gluteus maximus), knee-to-foot, and arm. Additionally, the region was coded

as either posterior/anterior. Finally, whether the touch was made exclusively by the provider's hand, provider's hand guiding an instrument, or just an instrument was coded.

Bodily Probe/Invasion

If a patient's body was shown invaded, the region of the invasion was coded as follows: arm, buttocks, vagina, or rectum. Due to the number of Norplant insertions/removals shown, and to differentiate them from an IV or blood draw, Norplant insertions and removals were coded separately as Norplant.

Chaperone

For gynecologic procedures only (not including breast exams or mammography), the depiction of a Chaperone (healthcare provider or patient support person required for these procedures) was coded. The choice to include a chaperone category fits with the issue of visibility due to the inclusion of multiple healthcare professionals visually examining a patient. Number of physicians in a given segment were counted in a previous category. The choice to include the chaperone category further stemmed from the need to accurately describe what exists.

Although chaperones are only required for male providers during gynecologic examinations, they are recommended with female providers as well. Therefore sex of provider was not accounted for, and the visual portrayal of a chaperone in any gynecologic examination scene was coded. If the scene contained more than one provider, only a female was considered a chaperone, according to healthcare protocol. In

other words, a gynecologic examination requiring a chaperone did not mean a non-assisting male healthcare provider could serve as a chaperone.

For instances where more than one female healthcare provider existed in a gynecologic scene, each healthcare provider needed to be actively involved in the depicted examination/procedure to be counted in the Multiple Physician category. Otherwise, if more than one female healthcare provider were depicted in a gynecologic scene, any healthcare provider not actively assisting the attending physician was counted in the Chaperone category. This not only fits with healthcare facility protocol, this operational designation eliminated double-counting providers in both the Multiple Physician and Chaperone categories.

Finally, if a scene portrayed only partial view of the provider and/or patient, or the entire screen was filled with a portion of the physician and patient not allowing for the possibility of ascertaining the existence of a chaperone, the code was Not Applicable. Therefore, only scenes in which a chaperone should have been present and were documentable due to seeing a relatively complete expanse of examination area but clearly did not exist received a No Chaperone code.

CHAPTER FOUR

CONTENT ANALYSIS RESULTS

Phase one of Critical Discourse Analysis involves describing a visual discourse. Toward that end, the television news sexual health reports sample was textually analyzed via the content analysis method. As previously noted, the analyzed coding categories related to the theoretical notions of patient visibility, medical dependency, and body boundaries. The purpose of analyzing the sample in this way was to answer the following two research questions:

(1) In what ways are formerly private medical examinations portrayed publicly in sexual health news reporting?

(2) How do patient images in sexual health news reports promote the traditional, functionalist approach to healthcare or the newer, autonomous, and empowered patient approach?

Patient Images

There were one hundred sixty-eight segments in the sample. Of the 168 segments, 53 did not have patient images and were not coded beyond the network, time, and content categories. Of the 115 patient containing segments, 67 were multiple sequences (contained more than one coded scene). Including the single and multiple sequence scenes, there were 292 patient-containing scenes coded overall. Therefore, there were 345 segments/scenes (292 patient-containing scenes and 53 non-patient containing segments) in the total sample. The number of scenes per segment was as follows:

Table 1

Scenes per segment:	Number of scenes:
1	47
2	27
3	16
4	8
5	8
6	4
7	3
8	1
9	2

In sum, of the segment sample (168), fifty-three did not contain patient images. So, not including multiple scenes per segment, more than half of the segments (68.5%) contained patient images. Of the 115 patient-containing segments, 47 had only one scene per segment and 68 had multiple scenes per segment which created an overall patient-containing sample of 292. Overall, the majority of sexual health segments contained patient images, and many had multiple patient-containing scenes within a segment. Of the 345 scenes (total of all non-patient containing scenes and patient-containing scenes including multiple scenes per segment) coded, 292 contained patient images. Therefore, images of patients were prevalent in the sexual health news reports.

Physician Examination

Visibility, as explicated in chapter two, involves more than just a number count of patient images in the sample. Rather, degree of visibility and how the visibility is represented has theoretical implications. One aspect of visibility is positioning of the viewing audience. As explained in chapter two, part of the issue with pornography and the medical film genre, as defined in specularity theory, is the use of camera angles to

provide viewers a vantage point whereby they may watch a subject in the act of being watched by another. This concept was assessed in the visual discourse of patient images in sexual health news reports by considering how many physicians were depicted examining a patient and the existence of a chaperone in applicable scenes. Because physicians were depicted in multiple-scene segments and in some scenes there were multiple physicians, a total of 327 physicians were depicted in the 292 patient-containing scenes. Therefore, there were more physicians than patients depicted in the sample.

Additionally, a unique coding category related to patient visibility and health care practitioner visibility is the Chaperone category. As indicated earlier, the existence of a chaperone is required for gynecological examinations conducted by male physicians, and it is recommended with female physicians also. The content category Chaperone was included because it attested to the accurate depiction of gynecological examinations and the inclusion of multiple healthcare practitioners visually examining a patient. Of the sample in which a chaperone would normally be present (based on story content and/or procedure) chaperones were shown 24 times compared to 30 applicable scenes in which chaperones were not shown. Of the applicable scenes, 4 were coded as Unknown.

Unclothed Sensitive Body Parts

The sense of intimate examination at issue in the chaperone consideration was also involved in the Unclothed Sensitive Body Part category. Also, this category attended to patient visibility, medical dependency, and body boundaries. The corresponding results were as follows (percentages were rounded off to the tenth and factored based on the 292 patient-containing scenes codes):

Table 2

Unclothed Body Part	Frequency	Percentage
Stomach	12	3.5%
Female Breast	5	1.4%
Gluteus Maximus	1	0.3%
Pelvis	9	2.6%
None	65	76.8%

Here the results indicated a degree of patient empowerment and an adherence to Western norms of modesty related to showing unclothed sensitive body parts in the sample. Overall, there were 27 incidences of Unclothed Sensitive Body Parts shown compared to 265 patients portrayed without Unclothed Sensitive Body Parts. Therefore, the majority of scenes did not contain exposure of sensitive body parts.

Procedure

Along with Unclothed Sensitive Body Parts, the Procedure coding category was of interest because it not only encompassed a sense of patients under observation but also certain procedures were far more intimate than others, particularly as they involved intimate body areas. The Procedure frequencies and percentages are documented in Table 3 (percentages were rounded off to the tenth and factored based on the 292 patient-containing scenes coded).

Table 3

Procedure	Frequency	Percentage
None	31	10.6%
Mammography	72	24.7%
Colposcopy	1	0.3%
Colonoscopy	5	1.7%

(Continuation of Table 3)

Gynecological	52	17.8%
Rectal	9	3.1%
Breast Exam (digital)	1	0.3%
Testicular Exam (digital)	1	0.3%
Norplant Insertion/Removal	30	10.3%
Blood Draw or Blood Pressure	37	12.7%
Stomach (digital)	12	4.1%
Body X-Ray	8	2.7%
Other	33	11.5%
Unknown	0	0.0%

Although the lack of Unclothed Sensitive Body parts seemed to adhere to Western modesty norms, the visual depiction of intimate procedures did evidence a breaching of boundaries in medically-intimate examinations/procedures in the sexual health news sample. The two Procedure categories receiving the most visual attention in the patient-containing sample were mammography (24.7%) and gynecological procedures (17.8%). Additionally, there was one instance of vaginal colposcopy.

Body Reductionism

In addition to portraying intimate body areas and procedures, whether patients were shown as whole human beings or just in relation to a portion of their bodies was considered. How much of the patients' bodies shown was tabulated and reported in Table 4.

Table 4

Degree of Body Shown	Frequency	Percentage
Full Body	132	38.3%
Half Body	122	35.4%
Arm Only	23	6.7%
Other	15	4.3%

Percentages were rounded off to the tenth and factored based on the 292 patient-containing scenes coded

In the sample, patients' Full Bodies were shown the most which contradicted critiques of body reductionism presented in chapter two. However, the results were not strongly conclusive. Full Bodies were shown only ten times more than Half Bodies were shown. Moreover, the Other category indicated the portrayal of a small portion (less than half) of the body (e.g. – a leg). When the results of the Half Body category were collapsed with results from the Other and Arm Only categories, the total was 160 cases in which half or less than half of the body was depicted. This total exceeds the portrayal of Full Body by 28 incidences. Therefore, patients' bodies were shown partially more often than patients' full bodies.

Body Positioning

Body Positioning was coded to understand the visual discourse in relation to patient empowerment and medical dependency. Table 5 indicates the portrayed patients' Body Positions (percentages were rounded off to the tenth and factored based on the 292 patient-containing scenes coded).

Table 5

Body Position	Frequency	Percentage
Sitting	65	18.8%
Standing	72	20.9%
Lying Down	83	24.1%
Lithotomy	59	20.2%
Patient Bending (Frontal Shot)	0	0.0%
Patient Bending (Rear Shot)	0	0.0%
Other	1	0.3%
Unknown	14	4.1%

The patient Body Position results showed aspects of patient disempowerment. One of the more disempowered poses shows the patient lying down which was the most commonly-depicted patient body position. Moreover, it was visually denotative of illness.

Additionally, the Lithotomy position, although ranked third in overall depiction, is of particular interest. Arguably, as noted in chapter one, the lithotomy position is one of the most emotionally-difficult positions patients assume. Not only is it a derivative of lying down, but because patients' feet are in stirrups the visual is one of immobility. Moreover, the lithotomy's express purpose is to provide the medical practitioner access to the patients' genitals, and it has been cited as a position of extreme humiliation, vulnerability, and discomfort for patients. Yet, it accounted for 20.2% of the depicted body positions.

Finally, when the three Body Positions indicative of disempowerment (Sitting, Lying down, and Lithotomy) were collapsed, they accounted for 63.1% of the Body Positions, while Standing, the most empowered stance, was portrayed 20.9% in the patient-containing sample.

These results alone may not be universal in depicted empowerment/disempowerment. In particular, patients Standing but rendered immobile in a mammography machine were, arguably, shown in a disempowered position. Therefore, to understand better how the body positioning results related to disempowerment, Body Position results were cross-tabulated with Procedure.

Based on the cross-tabulation results, Procedure corresponded with expected Patient Positions, such as Blood Draw and Standing. Additionally, the more intimate examinations also corresponded with the more disempowered stances, such as Miscellaneous Gynecological and Lithotomy.

The one exception involves Mammography. Although Standing is the most empowered stance, that disempowerment may not be as visually strong if a patient is shown standing in a mammography machine. Standing, as documented above, was ranked the second most common patient body position. However, of the 72 standing cases, 68 (94.4% of the Standing category) were recorded in conjunction with Mammography. This cross-tabulation indicated that the sense of empowerment the Body Position results suggested may not be an accurate picture of the visual discourse.

Patient Clothing

A visual discourse of patient empowerment and the sick patient role were assessed by observing how patients were portrayed in terms of patient examination. First, Patient Clothing was considered. The clothing category results are recorded in Table 6 (percentages were rounded off to the tenth and factored based on the 292 patient-containing scenes coded):

Table 6

Clothing	Frequency	Percentage
Gown	136	39.4%
Streetclothing	69	20.0%
Drape	43	12.5%
No Shirt	27	7.8%
Unknown	17	4.9%

These results indicated that patients were depicted wearing medical gowns more than other clothing options. Additionally, patients were shown in stages of undress (street clothing/gown with drape and no shirt) 70 times. Therefore, the patients in the sample were visually defined as patients in the Clothing category.

Physician Touch

The final three coding categories which related to visual discourse of patient empowerment and medical dependency also pertained to body boundaries. First, whether a patient was or was not touched by a physician in a scene was coded. In some scenes, Physician Touching occurred more than once in a scene. In each instance of physician touch, where the touch occurred on the patients' bodies and whether it was on the posterior or anterior sides of the patients' bodies were coded. Physician Touch results are documented in Table 7. Each coding category has the resulting frequency scores listed in the table below. Beside each frequency score, the percentage of the patient-containing sample total (292) is presented in parentheses after each frequency.

Table 7

Posterior (indicated patient was lying on his/her back):

	Hand	Hand and Instrument	Instrument
Head-Neck	5 (1.5%)	1 (0.3%)	0 (0.0%)
Neck-Waist	30 (8.7%)	8 (2.3%)	4 (1.2%)
Waist-Knee	3 (0.9%)	2 (0.6%)	2 (0.6%)
Pelvis	7 (2.0%)	31 (8.1%)	8 (2.3%)
Arm	47 (13.6%)	42 (12.2%)	3 (0.9%)
Knee-Foot	4 (1.2%)	1 (0.3%)	0 (0.0%)

Anterior (indicated patient was lying on his/her front):

	Hand	Hand and Instrument	Instrument
Head-Neck	5 (1.5%)	0 (0.0%)	0 (0.0%)
Neck-Waist	32 (9.3%)	1 (0.3%)	0 (0.0%)
Waist-Knee	3 (0.9%)	0 (0.0%)	0 (0.0%)
Gluteus Maximus	3 (0.8%)	4 (1.2%)	7 (2.0%)
Knee-Foot	0 (0.0%)	0 (0.0%)	0 (0.0%)

Overall, of the patient-containing scenes, patients were shown touched by physicians 253 times compared to 70 patient image scenes in which patients were not shown touched by physicians. Touch was identified in chapter two as indicative of power; touching indicated a more powerful stance than those who are being touched.

Additionally, where touching occurred may relate to intimate body boundaries based on western norms of modesty and touching intimacy. Here the results were somewhat inconclusive in that the Arm was the most commonly touched body part, which concurred with the number of stories involving Norplant insertion/removal, which is not generally recognized as intimate based on western norms.

However, the second most commonly touched body part was the Neck-to-Waist. Generally, in Western culture, the Neck-to-Waist frontal area is intimate for women and

not intimate for men. However, when cross-tabulated with the Gender variable, the majority of the Neck-to-Waist touches occurred on female patients and corresponded to mammography stories. Finally, the third most commonly touched area was the Pelvis, which was also the most intimate body part of the available body touch categories.

Physician Position

In addition to Patient Clothing, Medical Procedure, and Physician Touch, how physicians were positioned in relation to patients can contribute to a visual discourse of patient passivity, depiction of illness, patient empowerment, as well as body visibility and body boundaries (based on how physicians were positioned in relation to patients). Because physicians were depicted in multiple scene segments and in some scenes there were multiple physicians, a total of 327 physicians were depicted in the patient-containing scenes. Table 8 documents Physician Position coding category frequencies and percentages of total physicians' depicted positions for each Physician Position category.

Table 8

First position = Physician

Second position = Patient

(Front-Front Sitting = Patient sitting with his or her front facing a seated physician's front).

	Frequency	% of Total Positions
Front-Front Sitting	25	7.7%
Front-Front Standing	72	22.0%

(Continuation of Table 8)

Sitting Between Legs	49	14.1%
Standing Between Legs	12	3.7%
Front-Front Bent Over	28	8.6%
Front-Back Sitting	2	0.6%
Front-Back Standing	24	7.3%
Front-Back Bent Over	0	0.0%
Off to Side	80	24.5%
Other	7	2.1%
Unknown	28	8.6%

The related Physician Position category results were somewhat contradictory in terms of empowerment, accessibility, and intimacy. Of the coded positions, physicians were depicted Off to the Side of the patient most, which visually indicated fairly even power dispersion between patients and physicians, and it was a non-intimate relational positioning not indicative of body accessibility.

However, the next two frequently-depicted coding categories were physician standing facing a patient (Front-to-Front Standing) followed by physicians Sitting between [patients'] Legs and Standing between [patients'] Legs. This evidenced the physicians' access to and examination of intimate areas.

In sum, although the results suggested that physicians were most often seen in an egalitarian stance (Front-Front Standing) or a detached stance (Off to Side), the frequencies of physicians Sitting between Patients' Legs (15%) and physicians Standing between Patients' Legs (3.7%) did attest to intimate positioning between physicians and patients.

Body Invasion

In addition to Physician Touching and Physician Position, the concept of body boundaries was best assessed by the content category Body Invasion. The Body Invasion categories, with related frequencies and percentages, are documented below (percentages were rounded off to the tenth and factored based on the 292 patient-containing scenes coded):

Table 9

	Frequency	Percentage
None	178	61.0%
Injection – Arm	29	9.9%
Vaginal	45	15.4%
Rectal	15	5.1%
Norplant – Arm	21	7.2%
Other	3	1%
Unknown	1	0.3%

Overall, patients' bodies were shown invaded 113 times compared to 178 times they were not invaded. However, the evaluation of the visual discourse may not sufficiently rest on whether patients' bodies were invaded fewer times than they were not. The theoretical premises presented in chapter two raised a more qualitative concern in terms of whether patients' bodies should be shown invaded at all. Furthermore, where the bodies were invaded may hold importance. The two most intimate areas, Rectal and Vaginal, were collectively invaded 60 times, which was higher than the more benign Arm invasions which occurred most often (50 times).

Patient Image Results Summary

Overall, the content analysis results may suggest that the visual discourse does support theoretical concerns raised in chapter one. Based on the Patient Image, Patient Clothing, and Procedure categories, the visual discourse contained frequent footage of patients. Additionally, patients were often shown receiving medical procedures and bodily invasions. Relatedly, patients were depicted under observation by medical practitioners. Notably, there were more physicians depicted than patients, and many patient-containing scenes included multiple physicians observing or treating a single patient. Thus, the television sexual health news visual discourse may support theoretical concerns regarding privacy, surveillance, self-surveillance, and body boundaries.

In addition to the aforementioned concerns, the results may substantiate the problem of medical dependency and medical paternalism as outlined in two. For example, the results corroborate television medical drama findings, described in chapter two, which highlight physician rather than patient portrayals. Additionally, patients were frequently shown in passive positions in relation to physicians and undergoing procedures and examinations in the television news sexual health discourse. Overall, patients were not only visible and visually-defined as patients, they were placed in passive positions, depicted under physician observation, and placed in disempowered positions.

SEX AND PATIENT PORTRAYAL RESULTS

The final aspect of the textual analysis, for which the content analysis method was utilized, involved description of gender image differences as identified in research

question three. Therefore, results documented above were cross-tabulated with patient sex to identify if there were differences between the way male and female patients were portrayed in the sample.

Sex and Patient Image Portrayal

Of the total number of patient images coded, 69 (23.6% of the patient-containing sample) were male, and 223 (76.4% of the patient-containing sample) were female. Therefore, female patients had greater visibility than male patients overall in the television sexual health news sample. Additionally, as delineated above, in at least the 24 instances where Chaperones were included in applicable gynecologic scenes, female patients were portrayed with more than one individual intimately examining them at one time. This, coupled with the greater frequency of female patients than male patients overall suggested that the theoretical concerns related to visibility, such as self-surveillance, might have greater impact with female viewers than male viewers.

Sex and Content Coverage

However, the greater visibility, it could be argued, was due to a greater number of stories specific to women's sexual health issues than men's sexual health issues in the sample. To understand how patient visibility differences might be accounted for based on what stories were aired in the sample, the Story Content frequencies and percentages (based on the 345 scenes in the sample) are presented in Table 10.

Table 10

Story Content	Frequency	Percentage of Total Sample
Prostate	86	24.9%
Breast Cancer	78	22.6%
Norplant/Depo-Provera	47	13.6%
Infertility	31	0.9%
Abortion	27	7.8%
Ovarian	26	7.5%
Other	26	7.5%
Cervical	13	3.8%
Birth Control	11	3.2%

These results addressed a number of issues raised in chapters one and two. First, was the issue of patient visibility. Female patients did have a greater visibility than male patients in the sample. But, only prostate stories were male-specific whereas six female-specific stories were coded in the sample, which may have accounted for the difference.[3] However, although prostate stories were aired more than other stories, the difference between the number of prostate stories and male patients portrayed was 17. Therefore, of the 86 stories in which a male patient could have been depicted, there were 17 scenes in which a male patient was not shown.

Conversely, female-specific stories, taken collectively, totaled 202 stories. However, there were 223 female patients included in the sample overall. This suggested

[3] The sex-specificity of story content was determined based on whether a particular story content had only one patient gender represented. For example, in Prostate Cancer stories, no female patients were portrayed, and females do not have prostates. Similarly, in the Breast Cancer stories, although men occasionally do get breast cancer, the numbers are extremely low, and in the sample only female patients were portrayed in Breast Cancer stories. For these reasons, it was classified as a Female-specific story. However, I acknowledge this is not medically-accurate in that men on rare occasion do get breast cancer. I also acknowledge that by specifying illness as sex-specific I may be furthering culturally-constructed gender classifications. However, in the interest of trying to asses whether male and female sexual health issues were represented equally, I did classify stories as sex-specific where appropriate based on either absolute sex-specificity, such as with Prostate Cancer, and/or based on high incidence rates and 100% exclusivity of patient images, such as with Breast Cancer stories.

that not only were females shown as patients more than males (by 154 cases), but also female patients were more likely to be included in female-specific stories than male patients were included in male-specific stories. In other words, regardless of story content the visual discourse clearly showed a disparity between portraying women in medical patient roles than men in medical patient roles. Additionally, based on the Story Content results, the choice to include a patient image differed across the sexes. Although there were fewer male-specific stories than female-specific stories, male patients were less likely to be shown than female patients in applicable stories.

However, there are a few caveats. First, there were 26 stories coded as Other, and whether these stories were male- or female-specific is not known. However, even if all stories in the Other category happened to be female-specific (which is unlikely based on the number of search terms used to collect the sample; see content analysis methods section in the previous chapter), the total number of female-specific stories would have totaled 228, which is still fewer stories than the number of female patient images. Additionally, because infertility problems and treatments affect both sexes, the Infertility results were not counted as either female- or male-specific in the above calculations. Hypothetically, though, if a majority of the Infertility stories were related to female-specific problems, the number of times a female patient was portrayed in female-specific stories might have been closer to the number of times a male patient was portrayed in a male-specific story.

A further issue these statistics addressed is the coverage of sex-specific health issues. As explicated in chapter two, existing research suggests that female health issues do not receive the same attention as male health issues. Based on the sexual health news

sample results, these claims were not founded. Overall, there were more stories related to female-specific sexual health stories than male-specific sexual health stories in the sample. This contradicted critiques that female health issues do not receive the same attention as male health issues. However, within the sample, the story content aired the most was Prostate.

In sum, the Story Content results did suggest that the greater degree of female visibility as patients was not merely a function of more female-specific stories in the sample. Not only did women have a greater degree of visibility as patients, patient images were more likely included in female-specific stories than male-specific stories in the sample. The Story Content results also raised questions about the legitimacy of arguments claiming disparately low coverage of female health issues compared to male health issues.

Procedure

Along with patient image, the visual discourse as it related to surveillance, self-surveillance, and medical dependency was assessed with the Procedure coding category. The Table 11 which contains Procedure results includes the frequencies of male and female patients depicted receiving the various coded Procedures. Additionally, in each Procedure category the frequencies of male patients and female patients depicted were factored into percentages of the male and female samples respectively. So, for example, the table indicates what percentage of male patient images involved a testicular exam, and what percentage of female patient images involved mammography respectively.

Additionally, Table 11 includes what percentages of patient images in each Procedure category were male images and female images respectively. Finally, the table includes percentages of male and female patient images in each Procedures category of the total patient-containing sample. For example, of the 292 patient-containing scenes in the sample, 24.7% of the patient images involved mammography.

Table 11

Procedure	Male	Female
Mammography	0	72
% of male/female samples respectively	0%	32.3%
% of Mammography procedures	0%	100.0%
% of total patient-containing scenes	0%	24.7%
Colposcopy	0	1
% of male/female samples respectively	0%	0.4%
% of Colposcopy procedures	0%	20.0%
% of total patient-containing scenes	0%	0.3%
Colonoscopy	4	1
% of male/female samples respectively	5.8%	0.4%
% of Colonoscopy procedures	80.0%	20.0%
% of total patient-containing scenes	1.4%	0.3%
Gyn.-Misc.	0	52
% of male/female samples respectively	0.0%	23.3%
% of Gyn.-Misc. procedures	0.0%	100%
% of total patient-containing scenes	0.0%	17.8%
Rectal	7	2
% of male/female samples respectively	10.1%	0.9%
% of Rectal procedures	77.8%	22.2%
% of total patient-containing scenes	2.4%	0.7%
Breast Exam	0	1
% of male/female samples respectively	0.0%	0.4%
% of Breast Exam procedures	0.0%	100%
% of total patient-containing scenes	0.0%	0.3%
Testicular	1	0
% of male/female samples respectively	1.4%	0.0%
% of Testicular procedures	100.0%	0.0%
% of total patient-containing scenes	0.3%	0.0%
Norplant	0	30
% of male/female samples respectively	0.0%	13.5%
% of Norplant procedures	0.0%	100.0%
% of total patient-containing scenes	0.0%	10.3%

(Continuation of Table 11)

Other	14	19
% of male/female samples respectively	20.3%	8.5%
% of Other procedures	42.4%	57.6%
% of total patient-containing scenes	4.8%	6.5%
None	7	24
% of male/female samples respectively	10.1%	10.8%
% of No procedures	22.6%	77.4%
% of total patient-containing scenes	2.4%	8.2%
Blood Pressure/Draw	25	12
% of male/female samples respectively	36.2%	5.4%
% of Blood procedures	67.6%	32.4%
% of total patient-containing scenes	8.6%	4.1%
Stomach	5	7
% of male/female samples respectively	7.2%	3.1%
% of Stomach procedures	41.7%	58.3%
% of total patient-containing scenes	1.7%	2.4%
Body X-Ray	6	2
% of male/female samples respectively	8.7%	0.9%
% of Body X-Ray procedures	75.0%	25.0%
% of total patient-containing scenes	2.1%	0.7%

The Procedure category results supported concerns raised in chapter two regarding medical dependency. Of note in terms of gender, there were a nearly equal percentages of male patients overall (10.1%) and (10.8%) of female patients overall that were not depicted receiving a Procedure in the coded sample.

However, some of the more intimate and emotionally-problematic examinations were depicted more often for female patients than the more benign procedures. For example, of the Procedure categories coded, Mammography and Miscellaneous Gynecologic procedures were depicted the most. In fact, nearly a quarter of all patient-containing scenes included a Mammography procedure. The Miscellaneous Gynecologic and vaginal Colposcopy accounted for 18% of the total patient-containing sample compared to only 10.3% of the total patient-containing scenes involving the more benign and less intimate Norplant insertion/removal or Blood pressure/draw (12.7%).

However, of the Colonoscopy procedures, which is a procedure given to both men and women, more male patients (4) than female patients (1) were depicted. Likewise, seven males versus two females were depicted receiving rectal examinations. However, this may be the result of the number of stories involving prostate cancer for which a rectal exam is a common screening method.

Although rectal exams are a common screening exam for prostate cancer, mammography is a common screening exam for breast cancer. However, in the majority of breast cancer stories, women were shown receiving a Mammography screen (72 procedures out of 78 breast cancer stories), whereas only seven males were shown receiving a Rectal examination out of the 80 prostate stories. Relatedly, breast examination is a common screening exam for breast cancer. In fact, unlike mammography, most often prescribed for women over forty, digital breast examinations are a standard part of yearly physical examinations for women of all ages. However, a breast exam was depicted only once in the sample.

Additionally, there were 66 female-specific stories that would likely include a gynecologic exam or related procedure (Cervical, Ovarian, and Abortion), and 53 Miscellaneous Gynecologic and vaginal Colposcopy procedures depicted. However, the number of Infertility stories (which could include male-specific stories) was 31. Depending on how many Infertility stories were female-specific, the difference in number of Gynecologic stories and depicted procedures may have been higher.

Therefore, because there were more female patients than male patients overall, female patients were depicted having medical procedures more often than male patients. However, in terms of the total number of patient images for each sex, the percentages of

male and female patients not depicted receiving a medical procedure was only a .7% difference between the male and female samples. But, the Procedure category results did indicate a greater incidence rate of female patients receiving intimate procedures, whereas male patients were most often shown receiving more benign and less intimate procedures.

Sex and Body Shown

Related to the theoretical issue of body reductionism, Table 12 documents the degree of body shown results for male and female patients. Following the same table format above, the Body Shown results table includes raw score frequencies and related percentages for male and female patients in each of the Body Shown categories.

Table 12

Body Shown	Male	Female
Full	49	83
% of male-female samples respectively	71.0%	37.2%
% of Full Bodies shown	37.1%	62.9%
% of total patient-containing scenes	16.8%	28.4%
Half	11	111
% of male-female samples respectively	15.9%	49.8%
% of Half Bodies shown	9.0%	91.0%
% of total patient-containing scenes	3.8%	38.0%
Other	2	13
% of male-female samples respectively	2.9%	5.8%
% of Other bodies shown	13.3%	86.7%
% of total patient-containing scenes	0.7%	4.5%
Arm Only	7	16
% of male-female samples respectively	10.1%	7.2%
% of Arm Only shown	30.4%	69.6%
% of total patient-containing scenes	2.4%	5.5%

These results indicated that male patients' full bodies were more often shown than their partial bodies. Conversely, female patients' bodies were more often shown partially than fully. Seventy-one percent of all male patients' bodies were shown fully compared to 37.2% of all female patients' bodies. The majority of female patients in the sample (91%) were portrayed with only half of their bodies shown.

Sex and Unclothed Sensitive Body Parts

As explained in chapter two and the previous results section, the Unclothed Sensitive Body Part category provides a visual record of patient visibility of intimate areas. To obtain a better understanding of when Unclothed Sensitive Body Parts occurred for male and female patients, Unclothed Sensitive Body Part was cross-tabulated with Patient Sex. Table 13 records frequencies, percentages of the male/female patient image samples respectively, and the percentage of the total patient-containing sample (abbreviated as "image sample" to accommodate table size) are provided for each sex.

Table 13

	Female Breast	Pelvis	Gluteus Max.	Stomach
Male	0	2	0	2
% of male sample	0.0%	2.9%	0.0%	2.9%
% of image sample	0.0%	0.7%	0.0%	0.7%
Female	12	3	1	7
% of female sample	5.4%	1.3%	0.4%	3.1%
% of image sample	4.1%	1.0%	0.3%	2.4%

The results indicated that 23 incidences of Unclothed Sensitive Body Parts occurred with female patients, and 4 incidences of Unclothed Sensitive Body Parts

occurred with male patients. Of the male patient-containing sample, 5.8% contained Unclothed Sensitive Body Parts. Of the female patient-containing sample, 10.3% contained Unclothed Sensitive Body Parts.

Physician Sex

Finally, although not part of patient visibility, the theory explicated in chapter two suggests that traditionally women have been viewed by men. This fits with the theoretical notion of specularity. Therefore, physician sex, as depicted in the sexual health news sample, was important to document. However, contrary to the theoretical notions raised, of the 327 physicians shown, 181 were female and 109 were male. The sex of 37 depicted physicians was Unknown. Therefore, the results indicated that female physicians were more often depicted than male physicians in the sample. These results contradicted critiques raised in chapter two.

Patient Image, Sex, and Clothing

Moving from patient visibility to medical dependency, patient sex and clothing were cross-tabulated. Table 14 records frequencies, percentages of the male/female patient image samples respectively, and the percentages of the total patient-containing sample (abbreviated as "image sample" to accommodate table size) for each sex.

Table 14

	Streetclothing	Gown	Drape	No Shirt	Unknown
Male	35	30	2	0	2
% of male sample	50.7%	43.5%	2.9%	0.0%	2.9%
% of image sample	12.0%	10.3%	0.7%	0.0%	0.7%
Female	34	106	41	2	15
% of female sample	15.2%	47.5%	18.4%	0.9%	6.7%
% of image sample	11.6%	36.3%	14.0%	0.7%	5.1%

Of the segments in which patients were portrayed wearing Streetclothing, male and female patients were portrayed roughly the same. However, considerably more females (106) were depicted wearing medical Gowns than males (30). Additionally, more males were shown in Streetclothing (50.7%) than the other clothing categories. Women, conversely, were shown in medical Gowns and a medical Drapes more often than in Streetclothing. Collectively (Gown and Drape), women were shown in medical clothing 147 (65.9%) times compared to 34 times (15.2%) in Streetclothing. Moreover, the two times a patient was shown without a shirt (No Shirt) the depicted patients were female. Therefore, the visual image of patients in terms of depicted Clothing clearly indicated a greater sense of medical dependency among female patients than male patients.

Finally, due to the nature of the sample, the Unknown category results were explainable by the number of stories involving Norplant insertion/removal which often showed an arm without indication of patient clothing. Likewise, the sample included stories on breast cancer accounting for the number of women shown unclothed from the waist up.

Patient Position and Sex

In addition to patient Clothing, the Patient Position category attended to issues of medical dependency. Two of the Patient Position content categories, Patient Bending Over shot from the Front and Patient Bending Over shot from the Back, were not found. The remaining categories and the number of patients portrayed in each are identified in Table 15.

Table 15

Female

Sitting	Standing	Lying Down	Lithotomy	Unknown	Other
36	72	51	55	10	1

Male

Sitting	Standing	Lying Down	Lithotomy	Unknown	Other
29	0	32	4	4	0

To obtain a fuller description of how the Patient Positions were depicted for each sex out of the entire sample, the following tables provide the frequency percentages of each position for the sexes respectively.

Female

Sitting	Standing	Lying Down	Lithotomy	Unknown	Other
12.3%	24.7%	17.5%	18.8%	3.4%	0.3%

Male

Sitting	Standing	Lying Down	Lithotomy	Unknown	Other
9.9%	0.0%	10.1%	1.4%	1.4%	0.0%

In the female sample, the most frequent body position was Standing which was largely accounted for by the predominance of mammography images in breast cancer stories. The second most frequent position for the female sample was the Lithotomy position, followed by the Lying Down position. The three most frequent positions in the female sample were denotative of illness and passivity. The Sitting category typically involved patient consultation, giving blood, or Norplant insertion/removal.

In the male sample, the most frequent position was Lying Down, which was denotative of illness and passivity. The second most common male patient position was Sitting, which typically involved patient consultation or giving blood, and was not denotative of examination or procedure. Four cases of male images in the Lithotomy position were recorded and involved prostate examination/surgery.

Patient Sex and Physician Touching Activity

How often physicians touched patients addressed medical dependency and status positioning. Patient Sex and Physician Touching Activity results are documented in the following table. Table 16 records frequencies, percentages of the male/female patient image samples respectively, and the percentages of the total patient-containing sample (abbreviated as "image sample" to accommodate table size) for each sex.

Table 16

	Yes	No
Male Patient	52	17
% of male patient sample	75.4%	24.6%
% of physician touching sample	23.5%	24.3%
% of total patient-containing scenes	17.8%	5.8%

(Continuation of Table 16)

Female Patient	169	54
% of female patient sample	75.8%	24.2%
% of physician touching sample	76.5%	77.1%
% of total patient-containing scenes	57.9%	18.5%

The results indicated that female patients were shown touched by physicians more often than male patients were touched by physicians. However, the percentages of times physician touching occurred, respective to each sex sample, males and females were touched relatively the same.

Patient Sex and Bodily Invasion

Finally, to document body boundaries, Patient Sex and Bodily Invasions were cross-tabulated. Table 17 records frequencies, percentages of the male/female patient image samples respectively, and the percentages of the total patient-containing sample (abbreviated as "image sample" to accommodate table size) for each sex. Due to table size, the results were split into two parts.

Table 17

Part I

	None	Injection (Arm)	Vaginal
Male	36	20	0
% of male patient sample	52.2%	29.0%	0.0%
% of Body Invasion sample	20.2%	69.0%	0.0%
% of total patient-containing scenes	12.3%	6.8%	0.0%
Female	142	9	45
% of female patient sample	63.7%	4.0%	20.2%
% of Body Invasion sample	79.8%	31.0%	100.0%
% of total patient-containing scenes	48.6%	3.1%	15.4%

(Continuation of Table 17)

Part II

	Rectal	Norplant	Unknown	Other
Male	13	0	0	0
% of male patient sample	18.8%	0.0%	0.0%	0.0%
% of Body Invasion sample	86.7%	0.0%	0.0%	0.0%
% of total patient-containing scenes	4.5%	0.0%	0.0%	0.0%
Female	2	21	1	3
% of female patient sample	0.9%	9.4%	0.4%	1.3%
% of Body Invasion sample	13.3%	100.0%	100.0%	100.0%
% of total patient-containing scenes	0.7%	7.2%	0.3%	1.0%

Overall, female patients received more body invasions (81) than male patients (33) in the sample of patient-containing images. However, based on the total patient images for each sex respectively, male body invasions were depicted more often (47.8%) than female body invasions. So, although female patient body invasions exceeded male patient body invasions by 48, male patients were more likely to receive a body invasion when depicted than female patients due to the greater number of female patient images overall.

Relatedly, male and female patients were depicted receiving invasions in intimate areas in a fairly even degree. The most intimate Body categories were Rectal and Vaginal. Female patients received bodily invasions in the two intimate areas 47 times (21.1% of female patient images) collectively. Male patients received bodily invasions in the Rectal category 13 times (18.8% of male patient images). However, of the body invasions depicted for females there was a higher percentage (58% of female body invasions coded) than for male patients (39.4% of male body invasions coded).

In sum, the body invasion category did not evidence a high degree of difference between the sexes. Female patients were depicted receiving body invasions more often

than male patients overall, but a higher percentage of male patients received body invasions than the percentage of female patients receiving body invasions based on the respective samples. Likewise, female and male patients received similar percentages of intimate body invasions based on their male and female patient image samples respectively. But, of the invasions coded, more of the female invasions were in intimate areas than the male patient invasions respectively.

Gender Difference Results Summary

Overall, the results indicated a difference between male and female patient portrayals. In the visual discourse, female patients have a higher degree of visibility than male patients. They were shown in medical clothing, under examination, and with more unclothed sensitive body parts than male patients. Relatedy, female patients were more often shown touched by physicians. Male and female patients were depicted similarly in terms of patient position and body invasions.

Due to the degree of difference, the theoretical concerns outlined in chapters one and two, and summarized in the preceding results section, such as privacy, body boundaries, and medical dependency, may be more acute with female patient representations than male patient representations. As previously noted, a key aspect to privacy, surveillance, and self-surveillance is the degree to which an individual or group receives greater/lesser degrees of public visibility than other individuals or groups. Drawing on the notion that conceptions of privacy and body boundaries are constructed through social relations, the disparate portrayals of female and male patients in the discourse may evidence a different set of beliefs about privacy rights and body

boundaries between women and men. Similarly, these depicted differences may contribute to a disparate set of privacy rights and body boundaries between men and women, and contribute to heightened female patient anxiety and self-surveillance.

CHAPTER FIVE

DISCURSIVE ANALYSIS:

NETWORK RESULTS AND HISTORICAL/CRITICAL ANALYSIS

DISCURSIVE PRACTICE PHASE

The preceding content analysis results chapter provided textual analysis of the television sexual health news visual discourse as recommended in phase one of Critical Discourse Analysis (CDA). The content analysis addressed research questions 1-3. Moving from describing what was present in the discourse, phase two (discursive practice) focuses on production modes. This phase is divided into two sections. First, results from cross-tabulating the Network variable with the other content analysis variables are presented. These quantitative results assessed production by answering the fourth research question worded as follows: Do the networks vary in their presentation of sexual health patient images?

In Section two I move from quantitative description into interpretative analysis. In this section, I attend to the final research question worded as follows: How might historical/contextual factors account for type/style of current representations? In an attempt to provide possible answers to this question, I propose some conceivable explanations for how/why the visual discourse has been constructed as it has, and what that may mean to society.

NETWORK RESULTS

Network and Patient Images

With the exception of CNN, the major networks ran stories about sexual health in a fairly even degree. Including multiple scene sequences and non-patient containing segments (345 total sample), ABC ran the most sexual health stories (119), NBC followed (114), CBS was third (99), and CNN ran the least (13).

Table 18

ABC	NBC	CBS	CNN
40.7%	39.0%	34.0%	4.5%

Percentages of sexual health stories in the total sample by network

To obtain a better sense of how often the networks ran patient images, Table 19 indicates the total number of sexual health segments, multiple-scene segments, patient-containing scenes, and non-patient containing scenes each network ran in the total sample (345).

Table 19

	ABC	NBC	CBS	CNN
Segments	42	35	33	5
Multi-scene Segments	24	23	19	2
Patient-containing Scenes	103	98	82	9
Non patient-containing Scenes	16	16	17	4

Finally, Table 20 indicates percentages of patient-containing scenes and non-patient containing scenes for each of the networks based on the total number of scenes run on each network respectively.

Table 20

	ABC	NBC	CBS	CNN
Scenes with Patients	86.6%	85.1%	82.8%	69.2%
Scenes without Patients	13.5%	14.0%	17.2%	30.8%

As indicated in Tables 18-20, overall, the networks were fairly uniform in the inclusion of multi-scene segments, patient-containing scenes, and non patient-containing scenes as well as in their sample totals respectively.

Network and Chaperone

As described in the previous results chapter, patient visibility is further documented to the degree to which patients are depicted under observation by medical practitioners. First, the inclusion of a chaperone is considered. Table 21 documents the inclusion of a chaperone in applicable scenes across networks. Percentages within each network sample (total number of scenes on each network) and the total sample (292 patient-containing scenes) are included.

Table 21

	Chaperone	No Chaperone	Not Applicable
ABC	7	11	85
% within network	6.8%	10.7%	82.5%
NBC	5	11	82
% within network	5.1%	11.2%	83.7%
CBS	11	5	66
% within network	13.4%	6.1%	80.5%
CNN	1	3	5
% within network	11.1%	33.3%	55.6%

The results indicated that the networks varied only slightly in depiction of Chaperones in applicable scenes. Within each network sample respectively, the networks ranged from 5.1% of NBC's sample to 13.4% of CBS's sample.

Network and Physicians

Along with Chaperone, the depiction of physicians in patient-containing scenes addresses the theoretical concerns of patient visibility and medical dependency. Tables 22 and 23 indicate frequency of physician depiction, including physician sex, on the networks. Percentages listed in parentheses next to the male and female physician frequencies represent percentages of the total female (181), male (109), and unknown (37) physician samples respectively. In parentheses next to the total physician frequencies on each network (last row) are the percentages of physicians depicted on each network out of the total physician-containing sample (327).

Table 22

Physicians	ABC	NBC	CBS	CNN
Male	37 (33.9%)	40 (36.7%)	28 (25.7%)	4 (3.7%)
Female	63 (34.8%)	56 (30.9%)	58 (32.0%)	4 (3.7%)
Unknown	17 (45.9%)	9 (24.3%)	7 (18.9%)	4 (3.7%)
Total	117 (35.8%)	105 (32.1%)	93 (28.4%)	12 (3.7%)

As indicated in Table 22, the networks were fairly uniform in their inclusion of physicians. As noted in the previous chapter, the number of physicians depicted exceeded the number of patients. But, when considering physician depiction across networks, the choice to include physician images in the sample did not vary significantly across networks.

Table 23 reports percentages of physicians on each network out of total scenes on each network respectively.

Table 23

Physicians	ABC	NBC	CBS	CNN
Male	31.6%	38.1%	30.1%	33.3%
Female	53.9%	53.3%	62.4%	33.3%
Unknown	14.5%	8.6%	7.5%	33.3%

Percentage of each network's total sample

The results indicated that the networks were fairly uniform in their depiction of physician sex.

Unclothed Sensitive Body Part

Table 24 includes frequencies of Unclothed Sensitive Body Parts on each network with accompanying percentages.

Table 24

	ABC	NBC	CBS	CNN
Female Breast	3	3	6	0
% within network	2.9%	3.1%	7.3%	0.0%
% of total sample	25.0%	25.0%	50.0%	0.0%
Pelvis	2	2	1	0
% within network	1.9%	2.0%	1.2%	0.0%
% of total sample	40.0%	40.0%	20.0%	0.0%
Stomach	2	1	5	1
% within network	1.9%	1.0%	6.1%	11.1%
% of total sample	22.2%	11.1%	55.6%	11.1%
Gluteus Max	1	0	0	0
% within network	1.0%	0.0%	0.0%	0.0%
% of total sample	100.0%	0.0%	0.0%	0.00%
None	95	92	70	8
% within network	92.2%	93.9%	85.4%	88.9%
% of total sample	35.8%	34.7%	26.4%	3.0%

The networks varied only slightly in exposing sensitive body parts. The only notable difference was found on CBS which led the other networks in depicting the stomach and female breast.

Network and Story Content

Table 25 reports frequencies and related percentages of Story Content categories on each network.

Table 25

Content	ABC	NBC	CBS	CNN
Breast Cancer	24	29	23	2
% within network	20.2%	25.4%	23.2%	15.4%
% of breast c. sample	30.8%	37.2%	29.5%	2.6%
Prostate	28	27	26	5
% within network	23.5%	23.7%	26.3%	38.5%
% of prostate sample	32.6%	31.4%	30.2%	5.8%
Ovarian	7	9	7	3
% within network	5.9%	7.9%	7.1%	23.1%
% of ovarian sample	26.9%	34.6%	26.9%	11.5%
Cervical	3	9	1	0
% within network	2.5%	7.9%	1.0%	0.0%
% of cervical sample	23.1%	69.2%	7.7%	0.0%
Abortion	7	5	14	1
% within network	5.9%	4.4%	14.1%	7.7%
% of abortion sample	25.9%	18.5%	51.9%	3.7%
Birth Control	4	3	4	0
% within network	3.4%	2.6%	4.0%	0.0%
% of b. control sample	36.4%	27.3%	36.4%	0.0%
Infertility	15	6	9	0
% within network	12.6%	5.3%	9.1%	0.0%
% of infertility sample	48.4%	19.4%	29.0%	0.0%
Norplant/Depo.	19	14	14	0
% within network	16.0%	12.3%	14.1%	0.0%
% of nor./dep. sample	40.0%	29.8%	29.8%	0.0%
Other	12	12	1	1
% within network	10.1%	10.5%	1.0%	7.7%
% of other sample	46.2%	46.2%	3.8%	3.8%

These results demonstrated that network choice of which sexual health stories to run did vary. In particular, differences related to Prostate Cancer were the most pronounced. With Prostate Cancer, the leading story content area, the networks were quite uniform in the percentages of the total number of stories devoted to Prostate Cancer. However, on CNN, which made up only 3.8% of the overall study sample, 38.5% of stories run on CNN were Prostate Cancer stories -- 12.2 percentage points higher than the other networks' samples.

Additionally, CNN did not run stories on Norplant or other forms of Birth Control, but ran the second highest percentage (within each network's sample) of its stories on Abortion. CBS ran the highest percentage of Abortion stories within its sample -- a 6.4 percentage point jump over the second highest in that percentage category.

Network and Patient Clothing

Table 26 documents the frequencies and related percentages of Clothing categories on each network.

Table 26

	ABC	NBC	CBS	CNN
Gown	53	39	41	3
% within network	51.5%	39.8%	50.0%	33.3%
% of gown sample	39.0%	28.7%	30.1%	2.2%
Streetclothing	22	27	18	2
% within network	21.4%	27.6%	22.0%	22.2%
% of streetclothing sample	31.9%	39.1%	26.1%	22.2%
Drape	13	11	15	4
% within network	12.6%	11.2%	18.3%	44.4%
% of drape sample	30.2%	25.6%	34.9%	4.4%

(Continuation of Table 26)

No Shirt	7	14	6	0
% within network	6.8%	14.3%	7.3%	0.0%
% of no shirt sample	25.9%	51.9%	22.2%	0.0%
Unknown	8	7	2	0
% within network	7.8%	7.1%	2.4%	0.0%
% of unknown sample	47.1%	41.2%	11.8%	0.0%

The results indicated that the networks showed relative uniformity in the Clothing categories. The only major exception was found with CNN's depiction of Drape. Whereas the other three networks showed a patient in Drape infrequently (based on their individual samples), CNN depicted a patient in Drape more than any other Clothing category.

Network and Patient Position

Table 27 documents how the networks portrayed Patient Body Positions. The table includes frequencies and related percentages of each Body Position category by network. In the body position area, the Lithotomy position and Bending Over Front and Back were the most sexually explicit and emotionally problematic. Moreover, they are likely to involve examination of intimate areas. The Bending Over categories (front and back) were not depicted on any network and are excluded from the table.

Table 27

Patient Position	ABC	NBC	CBS	CNN
Sitting	23	26	14	2
% within network	22.3%	26.5%	17.1%	22.2%
% of sitting sample	35.4%	40.0%	21.5%	3.1%
Standing	25	27	18	2
% within network	24.3%	27.6%	22.0%	22.2%
% of standing sample	34.7%	37.5%	25.0%	2.8%

(Continuation of Table 27)

Lying Down	24	25	34	0
% within network	22.3%	25.5%	41.5%	0.0%
% of lying down sample	28.9%	30.1%	41.0%	0.0%
Lithotomy	22	15	17	5
% within network	21.4%	15.3%	20.7%	55.6%
% of lithotomy sample	37.3%	25.4%	28.8%	8.5%
Other	1	0	0	0
% within network	1.0%	0.0%	0.0%	0.0%
% of other sample	100.0%	0.0%	0.0%	0.0%
Unknown	8	5	1	0
% within network	7.8%	5.1%	1.2%	0.0%
% of unknown sample	57.1%	35.7%	7.1%	0.0%

Most of the networks were fairly similar in the Patient Position categories. However, CNN had over half of its depicted patients placed in the Lithotomy position

Procedure

Table 28 documents how the networks portrayed Procedure by frequency of each Procedure category and related percentages.

Table 28

	ABC	NBC	CBS	CNN
Mammography	25	18	27	2
% within network	24.3%	22.0%	27.6%	22.2%
% within mammo.	34.7%	25.0%	37.5%	2.8%
% of total	8.6%	6.2%	9.2%	0.7%
Colposcopy	0	0	1	0
% within network	0.0%	0.0%	1.0%	0.0%
% within colopo.	0.0%	0.0%	100.0%	0.0%
% of total	0.0%	0.0%	0.3%	0.0%
Colonoscopy	2	1	2	0
% within network	1.9%	1.2%	2.0%	0.0%
% within colonos.	40.0%	20.0%	40.0%	0.0%
% of total	0.7%	0.3%	0.7%	0.0%

(Continuation of Table 28)

Gyn.-Misc.	18	16	14	4
% within network	17.5%	19.5%	14.3%	44.4%
% within gyn-misc.	34.6%	30.8%	26.9%	7.7%
% of total	6.2%	5.5%	4.8%	1.4%
Rectal	3	1	5	0
% within network	2.9%	1.2%	5.1%	0.0%
% within rectal	33.3%	11.1%	55.6%	0.0%
% of total	1.0%	0.3%	1.7%	0.0%
Breast Exam	0	0	1	0
% within network	0.0%	0.0%	1.0%	0.0%
% within breast	0.0%	0.0%	100.0%	0.0%
% of total	0.0%	0.0%	3.0%	0.0%
Testicular	0	1	0	0
% within network	0.0%	1.2%	0.0%	0.0%
% within testicular	0.0%	100.0%	0.0%	0.0%
% of total	0.0%	0.3%	0.0%	0.0%
Norplant	12	9	9	0
% within network	11.7%	11.0%	9.2%	0.0%
% within norplant	40.0%	30.0%	30.0%	0.0%
% of total	4.1%	3.1%	3.1%	0.0%
Other	6	10	16	1
% within network	5.8%	12.2%	16.3%	11.1%
% within other	18.2%	30.3%	48.5%	3.0%
% of total	2.1%	3.4%	5.5%	0.3%
None	13	6	11	1
% within network	12.6%	7.3%	11.2%	11.1%
% within none	41.9%	19.4%	35.5%	3.2%
% of total	4.5%	2.1%	3.8%	0.3%
Blood	17	9	10	1
% within network	16.5%	11.0%	10.2%	11.1%
% within blood	45.9%	24.3%	27.0%	2.7%
% of total	5.8%	3.1%	3.4%	0.3%
Stomach	2	10	0	0
% within network	1.9%	12.2%	0.0%	0.0%
% within stomach	16.7%	83.3%	0.0%	0.0%
% of total	0.7%	3.4%	0.0%	0.0%
Body X-Ray	5	1	2	0
% within network	4.9%	1.2%	2.0%	0.0%
% within body x-ray	62.5%	12.5%	25.0%	0.0%
% of total	1.7%	0.3%	0.7%	0.0%

As with the Unclothed Sensitive Body Parts category, the networks did not vary significantly in the Procedure category.

Physician Touch

Table 29 documents Physician Touch on each network with corresponding percentages.

Table 29

Network	Physician Touching Patients
ABC	78
% within network	75.7%
% of total sample	35.3%
NBC	76
% within network	77.6%
% of total sample	34.3%
CBS	59
% within network	72.0%
% of total sample	26.7%
CNN	8
% within network	88.9%
% of total sample	3.6%

The networks were fairly uniform in their inclusion of physician touch. However, overall, CBS did have a lower frequency of physician touch overall, but due to a smaller sample size than the other two networks, CBS was only a few percentage points lower in Physician Touch than NBC and ABC. The only notable difference in Physician Touch occurred on CNN. Although having a much smaller patient-containing sample than the other three networks, CNN did have over ten percent more physician touches within its sample than the other networks.

Tables 30-33 document where Physician Touch occurred on each network.

Table 30

ABC

Posterior (indicated patient was lying on his/her back):

	Hand	Hand & Instrument	Instrument
Head-Neck	2 (1.9%)	0 (0.0%)	0 (0.0%)
Neck-Waist	10 (9.7%)	2 (1.9%)	1 (1.0%)
Waist-Knee	0 (0.0%)	1 (1.0%)	1 (1.0%)
Pelvis	1 (1.0%)	13 (12.6%)	3 (2.9%)
Arm	13 (12.6%)	20 (19.4%)	2 (1.9%)
Knee-Foot	1 (1.0%)	0 (0.0%)	0 (0.0%)

Anterior (indicated patient was lying on his/her front):

	Hand	Hand & Instrument	Instrument
Head-Neck	1 (1.0%)	0 (0.0%)	0 (0.0%)
Neck-Waist	7 (6.8%)	1 (1.0%)	0 (0.0%)
Waist-Knee	1 (1.0%)	0 (0.0%)	0 (0.0%)
Gluteus Maximus	0 (0.0%)	3 (2.9%)	2 (1.9%)
Knee-Foot	0 (0.0%)	0 (0.0%)	0 (0.0%)

Table 31

NBC

Posterior (indicated patient was lying on his/her back):

	Hand	Hand & Instrument	Instrument
Head-Neck	2 (2.0%)	0 (0.0%)	0 (0.0%)
Neck-Waist	12 (12.2%)	1 (1.0%)	1 (1.0%)
Waist-Knee	1 (1.0%)	0 (0.0%)	1 (1.0%)
Pelvis	2 (2.0%)	10 (10.2%)	3 (3.1%)
Arm	19 (19.4%)	11 (11.2%)	0 (0.0%)
Knee-Foot	1 (1.0%)	1 (1.0%)	0 (0.0%)

(Continuation of Table 31)

Anterior (indicated patient was lying on his/her front):

	Hand	Hand & Instrument	Instrument
Head-Neck	2 (2.0%)	0 (0.0%)	0 (0.0%)
Neck-Waist	14 (14.3%)	0 (0.0%)	0 (0.0%)
Waist-Knee	2 (2.0%)	0 (0.0%)	0 (0.0%)
Gluteus Maximus	2 (2.0%)	0 (0.0%)	3 (3.1%)
Knee-Foot	0 (0.0%)	0 (0.0%)	0 (0.0%)

Table 32

CBS

Posterior (indicated patient was lying on his/her back):

	Hand	Hand & Instrument	Instrument
Head-Neck	1 (1.2%)	0 (0.0%)	0 (0.0%)
Neck-Waist	7 (8.5%)	5 (6.1%)	2 (2.4%)
Waist-Knee	2 (2.4%)	1 (1.2%)	0 (0.0%)
Pelvis	3 (3.7%)	5 (6.1%)	2 (2.4%)
Arm	15 (18.3%)	10 (12.2%)	1 (1.2%)
Knee-Foot	2 (2.4%)	0 (0.0%)	0 (0.0%)

Anterior (indicated patient was lying on his/her front):

	Hand	Hand & Instrument	Instrument
Head-Neck	2 (2.4%)	0 (0.0%)	0 (0.0%)
Neck-Waist	9 (11.0%)	0 (0.0%)	0 (0.0%)
Waist-Knee	0 (0.0%)	0 (0.0%)	0 (0.0%)
Gluteus Maximus	1 (1.2%)	1 (1.2%)	1 (1.2%)
Knee-Foot	0 (0.0%)	0 (0.0%)	0 (0.0%)

Table 33

CNN

Posterior (indicated patient was lying on his/her back):

	Hand	Hand & Instrument	Instrument
Head-Neck	0 (0.0%)	0 (0.0%)	0 (0.0%)
Neck-Waist	1 (11.1%)	0 (0.0%)	0 (0.0%)
Waist-Knee	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pelvis	1 (11.1%)	3 (33.3%)	0 (0.0%)
Arm	0 (0.0%)	1 (11.1%)	0 (0.0%)
Knee-Foot	0 (0.0%)	0 (0.0%)	0 (0.0%)

Anterior (indicated patient was lying on his/her front):

	Hand	Hand & Instrument	Instrument
Head-Neck	0 (0.0%)	0 (0.0%)	0 (0.0%)
Neck-Waist	2 (22.2%)	0 (0.0%)	0 (0.0%)
Waist-Knee	0 (0.0%)	0 (0.0%)	0 (0.0%)
Gluteus Maximus	0 (0.0%)	0 (0.0%)	1 (11.1%)
Knee-Foot	0 (0.0%)	0 (0.0%)	0 (0.0%)

Overall, the networks were fairly uniform in physician touch placement on patients' bodies.

Body Invasions

The frequencies and related percentages for Body Invasion and Network are presented in Table 34.

Table 34

	ABC	NBC	CBS	CNN
None	54	65	55	4
% within network	52.4%	66.3%	67.1%	44.4%
% of total sample	30.3%	36.5%	30.9%	2.2%
Injection – Arm	14	8	7	0
% within network	13.6%	8.2%	8.5%	0.0%
% of total sample	48.3%	27.6%	24.1%	0.0%
Vaginal	17	14	10	4
% within network	16.5%	14.3%	12.2%	44.4%
% of total sample	37.8%	31.1%	22.2%	8.9%
Rectal	5	6	3	1
% within network	4.9%	6.1%	3.7%	11.1%
% of total sample	33.3%	40.0%	20.0%	6.7%
Norplant	13	4	4	0
% within network	12.6%	4.1%	4.9%	0.0%
% of total sample	61.9%	19.0%	19.0%	0.0%
Other	0	1	2	0
% within network	0.0%	1.0%	2.4%	0.0%
% of total sample	0.0%	33.3%	66.7%	0.0%
Unknown	0	0	1	0
% within network	0.0%	0.0%	1.2%	0.0%
% of total sample	0.0%	0.0%	0.3%	0.0%

The networks were fairly uniform in their depiction of Body Invasions. However, CNN did not have Norplant insertion/removal portrayals. In terms of rectal examinations, NBC and ABC differed very little. CBS came in slightly lower.

Network, Patient Image, and Sex

The networks were fairly uniform in the degree to which they showed female and male patients. The resultant frequencies and related percentages are documented in Table 35.

Table 35

	ABC	NBC	CBS	CNN
Male Patients	27	23	16	3
% within network	39.1%	33.3%	23.2%	4.3%
% of total sample	26.2%	23.5%	19.5%	33.3%
Female Patients	76	75	66	6
% within network	34.1%	33.6%	29.6%	2.7%
% of total sample	73.8%	76.5%	80.5%	66.7%

Network Results Summary

Overall, the data suggests that the networks were fairly uniform in image choices on most categories. However, the networks did vary in presentation of various patient images, procedures, and sexual health issues. In particular, CNN seemed to depart from the norm in the inclusion of intimate body positions, sensitive body portrayals, and medical clothing. Additionally, CNN, unlike the other networks, evidenced a predilection for Prostate stories and Gynecologic stories. Likewise, CNN did not include birth control stories in its sample.

Although CNN's departure from the norm in certain areas raises important questions for future study, the networks did maintain uniformity in image portrayals overall. As previously noted, this may point to reported television industry constraints which may account for status quo maintenance in television coverage.

This may support the idea presented in chapter one that broadcast journalism tends to promote a relatively stable status quo maintenance due to industry constraints and economics. As previously explicated, story content and visual footage are choices. However, the networks exhibited a high degree of uniformity among these available choices which may support the theoretical arguments involving hegemony in journalism.

At the very least, this standardization may point to a lack of diversity in reporting in the sexual health news discourse.

HISTORICAL/CONTEXTUAL ANALYSIS

Despite the lack of difference in network production choices, the image choices can be analyzed based on historical and contextual grounds in the interest of speculating on how and why the networks, as a whole, chose to depict the sexual health news visual discourse. Therefore, the final discursive analysis section involves interpretation and evaluation of sexual health news visual discourse production modes from a historical and contextual perspective. However, as previously noted, the point is not to look for individual creators of discourse or unidirectional ideologies. Rather, the intent is to consider existing production modes which, acting in concert, may contribute to the discourse's definition and presentation.

Although grounded in theory and historical data, the historical/contextual analysis is decidedly interpretive; it encompasses my ideas of potential ways the production mode can be interpreted. Just as the reading of any message may be polysemous (Ceccarelli, 1998; Cloud, 1992; Condit, 1989; Fiske, 1986), there are different ways to interpret the visual discourse results presented in chapter four. Therefore, my purpose is not to posit definitive, exhaustive, or verifiable conclusions. Rather, my intention is to suggest some, of many, critical interpretations in the interest of generating future conversations and inquiries related to the television news sexual health visual discourse. As noted by Foucault and other post-structuralists (explained in chapter two), discourse is created

through a complex system involving multiple actors as well as cultural and historical factors.

Content Analysis Results Discussion

The content analysis results suggest that the visual discourse fits with the older, functionalist model of healthcare in some of the coding categories. The television sexual health news visual discourse corroborates television medical drama findings, described in chapter two, which highlight physician rather than patient portrayals. Additionally, patients were frequently shown in passive positions in relation to physicians and undergoing procedures and examinations in the television news sexual health discourse. As previously noted, the degree and type of patient image representation may have negative social effects related to the theoretical notions of privacy, surveillance, and self-surveillance.

Granted, the depicted patient positions and related procedures are factual; they are representative of what occurs in a clinical setting. However, as explicated in chapter two, what is portrayed is a choice. For most stories, patients could be depicted just as easily walking into a medical facility or standing in consultation with physicians. Moreover, obtaining access to an examination room and necessary patient release forms requires greater effort for a journalist and camera crew than stock footage of medical facilities, laboratories, or medical devices. Therefore, the choice to include intimate examinations of patients seems unusual given that intimate examination footage is more costly in terms of time and effort than using less intimate stock footage. Potentially, then, there may be

other socio-cultural issues informing newsmakers' decisions to include patient image footage in television news reports of sexual health.

One explanation may be that television news coverage is shaped by television entertainment and advertising. As reported in chapter one, television entertainment and advertising clearly adhere to a more functionalist approach to healthcare representation.

A second explanation may rest in the theoretical premise that culture shapes and is shaped by television. American culture may have a significant impact not only on television portrayals but also on everyday medical encounters. In Medicine & Culture, Lynn Payer (1996) clearly delineates how American medical consumers differ from those in other industrialized nations. In particular, American medical institutional practitioners and patients tend to view the body as a territory under an ever-present threat of attack.

Likewise, based on war rhetoric in medical research reports, advertisements, and public health information campaigns, the American approach to health is decidedly militaristic (Keiger, 1998; Payer, 1996; Sontag, 1990). The body is a metaphoric battlefield to which illnesses pose a constant threat. The response is for individual patients and healthcare providers to utilize the most aggressive and technologically-advanced treatments to defend against and win the illness war (Keiger, 1998; Payer, 1996; Sontag, 1990).

Similarly, harkening back to a Cartesian mind/body split, the American conception of the body as machine is clearly evident, and the necessity of better machines (technology) to maintain human body functioning is a predominant American belief (Lupton, 1994; Payer, 1996). As a result, newsmakers' proclivity to show depersonalized patients through an attention to body parts, and portray the patient as a compliant

recipient of technologically- and physician-assisted body maintenance may reflect and promote prevailing American beliefs.

Additionally, a frequent American response to illness, compared to other industrialized nations, is to act with immediate, definitive strategies in most cases (Payer, 1996). This may fit within a prominent cultural history. In the United States, the rugged individual is a predominant cultural archetype (Bellah et al., 1985). The manifest destiny of individuals who tame a wild environment is a broad undercurrent in historic interpretations of national development and individuals' rights and responsibilities. The individual, according to this archetypal philosophy, has an almost moral obligation to take action against a myriad of forces working against individual advancement and self-actualization. However, when applied to medicine, as documented earlier, this may impart a sense of victim-blaming and unrealistic expectations in healthcare. Therefore, the networks' uniformity in casting the patient in a certain way may have its explanation and potential for social effects rooted in prevailing American cultural views of the body, illness, and the individual.

Finally, broader notions, such as capitalism, may illuminate reasons for why the discourse is constructed as it is. Certainly, the economic impetus for related involvement from the medical technology and pharmaceutical industries may affect medical research, medical practice, and related medical representations in the mass media. With the advent of technological advancements promoted through industry public relations, news may be constructed more frequently around technological advancements by virtue of its definition as "news," and because of the public information push from the economically-strong medical technology and pharmaceutical industries.

Differences in Image Representation for Male and Female Patients

An additional aspect of the visual discourse is the use of different depictions of male and female patient images. The study of difference between portrayals of male and female patients is descriptive, and some might argue a mere bean counting of mass mediated representations of physical reality. However, it is a reality that men and women are patients. It is also a reality that, at times in medical care, male patients as well as female patients must absolve control of their bodies, endure painful and/or humiliating examinations, and render themselves passive to another's scrutinizing medical gaze.

Yet, the disparity in frequency of these representations, and degree and method of portraying this reality is clearly different between the sexes as supported by the data. An appropriate question following a read of the numbers might be, so what? Answers suggesting that women go to the doctor more often than men and thus are afforded greater media attention, the media is consumer-driven, so someone, logically women, want to see these reports, or that the media needs to have interesting visuals (people doing something is the most interesting to viewers), could be rendered.

However, the visual discourse is not merely a representation. It is a production of truth and knowledge. It is not some arbitrary distinction, but a productive force which has effects. Who the agents of these differences are, their motivations and/or understandings of the role they play in the production of truth/knowledge is difficult to determine. Arguments that a central force, such as ideology, wields power on an unsuspecting or powerless group may be an oversimplification. For example, it is unreasonable to argue that newsroom producers collectively planned to portray men and women differently in sexual health news segments as a means of fulfilling some sinister

plot against a subset of humanity. Ask a group of news producers and they are likely to identify time constraints, tape availability, financial restrictions, and marketing dimensions as reasons for various news footage choices.

These explanations seem logical when considering a specific news segment, and the recorded patient image disparity is nothing more than coincidence born out of what seems to be normal, physical constraints as dictated by journalistic practices. What these arguments do not explain, however, is the glaring disparity of images based on sex when these news segments are viewed as a whole. Following from Foucault's suggestion that power is not a metaphysical force existing prior to action (Rouse, 1994), when it occurs it may be as unrecognizable or expected of the actors encouraging its existence as to those on whom it has its greatest effect. This premise encourages looking at the workings of power and acceptance of practices deemed normal, unproblematic, necessary, and truthful when, in fact, they are arbitrary in their use, and accepted as the necessary or right operational mode out of their routine acceptance.

Moreover, a socially-significant question is how these discursive formations affect individual, societal, and governing mechanisms of truth, knowledge, relationships, and action surrounding the sexes respectively. In essence, the idea is not to look at who is causing domination, but to ask how and why these constructions exist, and to offer a suggestion of potential effects (Sarup, 1993; Gutting, 1994; Fraser, 1981). Toward this end, the following interpretation is presented.

By considering the tradition of the medical gaze focusing on the sex disparity in sexual health surveillance, I suggest that televised portrayals of female patients in sexual health news reports may transfer the power of the medical gaze to the mass public,

objectify women's bodies, and propagate traditional views of women as passive and inherently ill. Through mass mediated images of women's bodies in sexual health stories, as compared to similar portrayals of men's bodies, women's bodies are placed in positions that may transfer the potential detriments of the medical gaze to a public gaze.

In essence, women's private lives may be made public discourse, and their bodies may be deemed public property. These images, taken collectively, illuminate a story of a mass mediated public panoptican that involves the continuance of age-old positioning of women as vulnerable, diseased and sexually objectified, disparity in gender boundaries of the body, and an infringement on individual female freedom.

The Medical Gaze: A Historic Viewpoint

Research addressing the male gaze and female objectification, as identified in art, literature, and entertainment is not new (Suleiman, 1986). What is lesser known is the interest science has had gazing on and into the female body. Along with an interest in the body, medical sociology and anthropology have recently moved toward providing the history of medical knowledge. A. M. Brandt argues, "In studying the history of medicine we learn about the constraints and prospects of the human condition across time and cultures" (Lupton, 1994, p. 16). Placing contemporary medical beliefs and behaviors in a historical context not only provides a sense of continuity and change, it affords insight into social issues that may otherwise go unchallenged (Lupton, 1994, p. 15).

This analysis and the content analysis results upon which it is based are largely informed by and supportive of work by Barbara Ehrenreich and Deidre English. Along with a detailed description of historical medical practices and related interpretations of

how history has informed the present, Ehrenreich and English, in their work, illuminate ways the histories of various institutions, such as religion and education, work in concert to formulate current medical practices. This process of connecting institutional histories as intertwined progenitors of present practice is also present in the feminist historical analyses of Gerder Lerner. In an attempt to pattern their style, and build on their work, I offer the following historical descriptions as possible explanations for the current sexual health news visual discourse.

Like the erotic male gaze, the medical gaze has had an historic interest in viewing the female in greater degrees than the male. This builds on Foucault's notion that the medical gaze acts as a social control mechanism through surveillance and self-surveillance. This control, according to Foucault, has been rendered in a non-uniform fashion in its particular attention to specific groups over that of other groups (Lupton, 1994). Moreover, the traditional medical gaze has been predominantly male and particularly interested in scrutinizing female sexuality (Lupton, 1994).

Although the health care industry has a long history of male dominance (Weedon, 1997), ironically the specialty for women, gynecology, "shows a record of discrimination against women practitioners," and obstetrics, which has traditionally been a female domain before the rise of medical professionalization, "has been particularly virulent in barring females" (Dreifus, 1978, p. xix). Daly (1990) notes that J. Marion Sims, in founding the Woman's Hospital in New York, "provided him with a theatre, in which he performed his [gynecologic] operations...before an audience of men" (p. 225). Citing Showalter (1990), Lupton asserts the use of penetrating surgery into women's bodies allowed the male medical profession to "know" the female completely by opening her up

and exposing her mysteries (Lupton, 1994). By contrast, Lupton asserts, "Men's bodies seemed not to hold such mystery. . . the dissection and examination of the innards of the woman was a substitute for self-knowledge, symbolizing the gaining of control over a threatening femininity" (Lupton, 1994, pp. 134-135).

This disparate interest is most notable in health issues related to sexuality. The women's health movement has argued against medical research biases against women. The majority of research on general health and organs have focused on male bodies to the exclusion of female bodies in general health, but placed an inordinate amount of attention on women's sexual health compared to men's sexual health (Northrup, 1998). In summarizing traditional feminist critiques of science, Van Zoonen (1994) states, "A third type of critique on traditional science concerns the themes, theories and methodologies which have been shown to be male-biased in the sense that women's problems have been ignored in many research agendas and that the particular experience of men has often been presented as having universal validity, overlooking the particular experiences of women" (p. 14). This medical research bias has been particularly detrimental to the extent that although more women die from heart disease than any other disease, women have rarely been included in heart disease research, and it has been framed as a *man's disease* (Northrup, 1998). What is interesting is that women suffer from the same diseases of the heart, liver, and lungs to the degree as men, yet their different systems have not been considered (Corea, 1975; Northrup, 1998).

Although complaints of inattention to women in medical science research exist, when it comes to women's sexuality, the medical profession has maintained an ever-present interest. This stands in sharp contrast to lack of male medical attention to the

reproductive organs, hormonal changes, and male testosterone rushes. In fact, the editor of the *Journal of the American Medical Association* correctly predicted that urologists desiring to develop andrology in contrast to gynecology would fail (Marieskind, 1978). To date, andrology lags behind gynecology. Jeffcoate and Sandler (1982) note medical researchers have focused a great deal on the female reproductive system and very little on the male reproductive system.

There is contemporary evidence of this continued bias and its residual effects. For example, in recent pursuits of a male birth control pill, researchers have discovered that there is a "need for further training in reproductive biology with emphasis on the male" (Zeidenstein, 1979, p. 12). Research goals toward male fertility control require a better understanding of male physiology (Jeffcoate & Sandler, 1982). "In any case, it appears mandatory to intensify basic research in andrology" (Jeffcoate & Sandler, 1982, p. 249).

Numerous authors contend that medical interest in the female reproductive organs versus the male reproductive organs stems from a male-dominated profession's desire to tinker with female sexual functioning. Because dealing with genitalia and sexual functioning is required in sexual health research, many critics claim that male researchers prefer to experiment with women's physiology over their own (Asbell, 1995; Bach, 1996; Napolitano, 1997; Kelly, 1983). For example, medical experimentation related to hormonal contraception research differs between male and female hormonal contraception research. According to Elaine Lissner, "A lot of things that wouldn't stop men from working on female bodies are stopped on male research" (Bach, 1996, p. 8). Relatedly, what are deemed acceptable side effects and risks for female hormonal

contraceptives, such as life-threatening blood clots, acne, mood swings, irritability, depression, and weight gain, are considered negative and unacceptable in related male hormonal contraceptive research (Bach, 1996; Napolitano, 1997).

The Female Invalid

Although this discussion of medical interest in sexual functioning is historical with current effects speculative, fitting it into the notion of surveillance as social control may lend a theoretical point to consider why differences in the ways male and female patients are portrayed on television related to their sexual health exist. According to Barker-Benfield (1977), "The medical attention directed at women amounted to what may have been a very effective surveillance system" (p. 52), and this surveillance seems particularly interested in women's sexuality and sexual functioning.

In particular, a disparate focus on female sexual functioning may communicate vestiges of historic definitions of women as weak and illness-prone by virtue of connecting medical investigation to female illness and weakness. This concern has been documented to the degree that overt attention to female body functions by the medical community has presented a view that normal female sexual functions are, at best, in need of monitoring and medical control, and, at worst, pathological. For example, the normal female reproductive functioning of menstruation, pregnancy, childbirth, and menopause have been defined as illnesses (Corea, 1977; Daly, 1990; Ehrenreich & English, 1978; Barker-Benfield, 1977; Northrup, 1999).

Likewise, the effects of patients adhering to a 'sick' role in the healthcare setting has held historic precedent and modern concern. Similarly, defining individuals or

groups as inherently weak or more prone to disease than others increases the illness-defined groups' preoccupation with disease, and subsequent acceptance of a medically–dependent role in their healthcare.

This bodily preoccupation is identifiable in traditional medical definition and scrutiny of the female patient. The alleged, medically-sanctioned definition of women as inherently sick, naturally, may affect physicians' treatments of female patients and societal views and treatment of women. This viewpoint, ultimately, may trickle down to affect women's behavior.

Some critics argue that the more doctors defined women as sick, the more they were able to observe and categorize women, and the more often they were called on to cure women (Barker-Benfield, 1977). According to Barker-Benfield (1977), the medical establishment effectively seduced women into their pocket books using this tactic. The more doctors treated, published their ideas, and consigned women to lives of invalidism, the more dependent on healthcare women became (Barker-Benfield, 1977).

Likewise, Daly (1990) asserts that an incessant definition of women as diseased causes preoccupation and anxiety heightened by frequent check-ups and a sense of medical dependency. The historical cult of invalidism, in which countless women were convinced inactivity and milk-only diets were the only cure for any number of minor ailments, ultimately led women into a sick, weakened, and passive state.

Although the cult of invalidism, as graphically depicted in *The Yellow Wallpaper*[3], is not practiced today, certain medical policies related to this historical bias have come under recent scrutiny. For example, the sanction that women are required to have a pelvic exam to obtain a yearly prescription of birth control pills has come under scrutiny (Donovan, 1992; Reagan, 1997). Recent criticism of this policy suggests this practice holds little logic or medical importance (personal communication, October, 1994). For example, the Rocky Mountain Planned Parenthood Association studied the impact of requiring pelvic examinations prior to the prescription of birth control pills (personal communication, April, 1997). The impetus for this research stems from the fact that, although important as a cancer screen, the pelvic examination and its results do not affect whether a woman is provided a birth control pill prescription. Moreover, requiring pelvic examinations prior to pill prescription dissemination deters many women, particularly teenagers, from obtaining a birth control pill prescription when needed (Donovan, 1992).

Thus, this medical screen requirement has caused some feminist writers to question the legitimacy of dictating a cancer screen as a mandated precursor to women's responsible contraception practice (Reagan, 1997), and resultant health effects. Considering the reverse, requiring a cancer screen for men prior to their receiving a Viagra prescription highlights the validity of this argument. This disparity may fit with arguments of historic bias in medicalized social control of women found most insidious in routinization.

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[5] *The Yellow Wallpaper* is one of the most recognized literary depictions of the created medical and societal depiction of white, middle and upper class women as inherently weak and illness-prone. In this work, author Charlotte Gillman Perkins, a physician's wife, detailed her decline into insanity as induced by the common medical practice of treating female patients as invalids.

Therefore, by considering the tradition of the medical gaze focusing on the sex disparity in sexual health surveillance, I suggest that televised portrayals of female patients in sexual health news reports may transfer the power of the medical gaze to the mass public, objectify women's bodies, and propagate traditional views of women and their bodies as passive and inherently ill. Through mass mediated images of women's bodies in sexual health news stories compared to similar portrayals of men's bodies in related news stories, women's bodies may be placed in positions that transfer the medical gaze to a public gaze. In essence, women's private lives are made public discourse.

However, drawing on social learning theory (1977), it could be argued that the frequent portrayal of female-specific sexual health issues may help alleviate the anxieties of women avoiding related examinations and procedures. Likewise, increased coverage of female diseases and related medical procedures may evidence a change from a historical disregard for women's illnesses (Apple, 1990; Dreifus, 1978; McBride, 1993).

Conversely, as presented in chapter two and the preceding interpretive analysis, the disparate coverage of female sexual health issues may raise unrealistic anxiety and foster victim-blaming for diseases. Likewise, disparate visibility of female patients compared to male patients may incite self-surveillance leading to preoccupation, anxiety, and unnecessary female patient demands related to healthcare. Finally, the female patient images depicted in the television news sexual health visual discourse, taken collectively, may illuminate a story of a mass mediated public panoptican that aids the continuance of historic positioning of women as vulnerable, diseased, and sexually objectified. Similarly, it may present gender disparity in body boundaries and an infringement on women's right to privacy.

CHAPTER SIX

CONCLUSION

SUMMARY

In this dissertation, I undertook the task of examining the recent inclusion of medical examinations that formerly were considered private as visual footage in television news sexual health reports. Drawing on a post-structuralist perspective, I identified privacy, surveillance, self-surveillance, body boundaries, patient empowerment, medical dependency, and medical paternalism as salient concerns related to the patient image discourse.

The overarching problem which gave rise to this dissertation is the right to privacy and privacy encroachment. Historically, privacy has been protected as a necessary component of individuals' development and freedom, and has, thus, held a high degree of importance in social and political theories and related legal policies. Theoretically, privacy, as a social concept, is socially-constructed so that individuals' conception of self and their right to privacy is largely formed by whether they exist in a society that ensures privacy rights, and the degree to which individuals are placed under public scrutiny compared to other individuals in society. Hence, because privacy is socially constructed, privacy boundaries portrayed in the mass media, a major factor in modern social construction of reality, are important in understanding current conceptions of privacy and related social effects.

Concerns over privacy and body visibility, particularly in the mass media, are not new and have held a high degree of prominence in related social scientific research. For example, body visibility has been discussed in mass communication research related to issues such as pornography and sexually-explicit television material. However, formerly private and intimate medical examinations and procedures have recently been included

on television giving a new stage upon which concerns over the social conception of privacy and body boundaries should be analyzed.

Historically, medical examinations and procedures often dictate a removal of patients' privacy and body boundaries in the interest of health. However, based on the work of Foucault, body examination in the medical realm draws some parallels to traditional methods of social discipline. In particular, Foucault documents how the use of surveillance and subsequent self-surveillance function as effective tools for social evaluation, delineation of social deviancy, and social control. Of particular concern, according to Foucault, is the unidirectionality of visibility and the degree to which groups are disparately positioned as objects of surveillance in various ways, including as objects of medical scientific study.

This moves the necessity of medical examination in a clinical setting to a socio-cultural construction which may have both positive and negative effects on individuals and societal views of the body, privacy, health, and medical practices. In particular, literature ranging from sociology to medical science identifies ways social constructions of medical dependency, medical paternalism, patient empowerment, the metaphoric body as illness-prone, and a mechanistic view of the body may impact health negatively, affect patient health-seeking behaviors, and limit positive advancements in medical practice.

Based on a literature review of the body, privacy, and mass communication, I identified a need to analyze theoretical concerns related to privacy in television portrayals of medicine. From this review, I concluded that mass mediated patient images may heighten the aforementioned theoretical concerns due to misrepresentation of medical scientific research. Notably, patients receive more health information from mass

mediated sources than traditional medical sources, such as physicians. Therefore, how the media report health information may impact patients' behaviors and societal views of the body, health, and medicine.

Additionally, mass mediated patient images may contribute to patients' heightened and inaccurate sense of health risks resulting in patients' paranoia and unnecessary demands for health-related screenings. Relatedly, mass mediated health information may foster unrealistic patient expectations of medical intervention efficacy, and promote a lack of patients' responsibility in their own healthcare.

Finally, based on research needs identified in the reviewed literature and the necessity for limiting this dissertation to a workable unit of analysis, I focused this dissertation on patient images in sexual health news reports on the major U.S. television networks (ABC, CBS, NBC, and CNN). The impact of imagery on television is well-documented. Visual depictions of healthcare in the mass media may impact the previously-noted concerns over privacy, surveillance, and self-surveillance to a greater extent than textual elements. Moreover, the theoretical concerns focus on the concept of visibility and, thus, necessitate an attention to visual discourse.

Additionally, the body in general, and patient images to a lesser degree, have received attention in communication literature. However, patient images in news broadcasts are relatively unexamined. Furthermore, a focus on television news is important due to the amount of health information disseminated on the news, the alleged objectivity in news reporting, and the perceived credibility of television news. Finally, my choice to focus on sexual health rested on the notion that sex and sexuality have both social and political impacts outside of health, such as privacy and gender constructions,

and because sexual health medical examinations and procedures often require a high degree of intimate examination.

Research Question and Methods Summary

The post-structural premises undergirding this examination included an acceptance that the media reconstitute the world and include structures of domination, all signs are biased, the act of seeing is reciprocal, and power is not centrally located or wielded unilaterally. Therefore, my intention was to describe a particular way of seeing and identify possible cultural forces affecting the visual production. My purpose was not to suggest individual or institutional generators of power involved in the discourse, nor to determine intentionality.

Following from the identified problems, salient issues, and theoretical premises, I attempted to answer the following research questions:

1.) In what ways are formerly private medical examinations portrayed publicly in sexual health news reporting?

2.) How do patient images in sexual health news reports promote the traditional, functionalist approach to healthcare or the newer, autonomous, and empowered patient approach?

3.) How are male and female patients portrayed in televised news segments involving normally intimate health issues?

4.) Do the networks vary in their presentation of sexual health patient images?

5.) How might historical/contextual factors account for type/style of current representations?

Based on recommendations from related literature and the research questions, inquiry into this mass mediated phenomenon required a multi-dimensional approach. Furthermore, because conceptions of the body, sexuality, gender, and health are culturally-constructed, historical and contextual interpretation was justified as part of the investigative process. Therefore, I chose Critical Discourse Analysis (CDA) as a methodology. CDA outlines a multi-phasic approach to discourse analysis which describes the discourse (Textual Analysis), examines production modes (Discursive Analysis), and identifies social effects (Social Practice Analysis). In this dissertation, I focused on the first two phases of CDA via content analysis and historical/contextual interpretation. The results of this dissertation provide the needed background to complete the final phase of CDA (Social Practice Analysis) in future research.

To describe the visual discourse of patient images in television news sexual health reports (Textual Analysis), I conducted a content analysis of patient images in sexual health news reports on ABC, CBS, NBC, and CNN. Using the Vanderbilt University Television News Archives' database, I searched for news reports which involved sexual health and sexuality issues from 1990-2000. Drawing on the theoretical concerns outlined above and Goffman's frame analysis, I developed the following coding categories: patient portrayal, patient sex, patient clothing, patient body shown, unclothed sensitive body part, patient body position, procedure, physician(s) shown, physician sex, chaperone, physician position during procedure, physician touching activity, and patient body invasion. In addition, each segment was coded for network, story content, date, and the number of scenes in multiple segments.

To train coders, test the coding mechanism, and assess the workability of the sample and method, I conducted a pilot study. Based on the pilot study results, I reduced the sample to include only segments thirty seconds and longer, and refined the coding mechanism. The trained coders then analyzed the remaining sample which contained scenes related to sexual health on the major networks between 1990 and 2000. There were 168 sexual health news segments across the four networks. Because many of the segments contained multiple scenes, the patient-containing sample included 292 scenes. The 53 segments which did not contain patient images were not coded beyond identifying information such as date, story content, et cetera. Intercoder reliability was based on 75 of the 292 patient-containing scenes and factored at .84.

The content analysis results were used to answer the first four research questions. The process of answering the first three research questions fulfilled the Textual Analysis phase of CDA and pertained to describing the visual discourse in general and isolating differences between male and female patient image portrayals.

The fourth and fifth research questions fulfilled the second phase of CDA (Discursive Practice) which involved a consideration of why the visual discourse was produced in a certain way. Drawing on the content analysis results, the network variable was cross-tabulated with the content analysis categories to assess differences in visual discourse production across networks as specified in research question four. As part of the Discursive Practice phase, the final research question was approached with a historical/contextual interpretation of why the discourse may have been constructed in the ways described in the content analysis.

Important Findings

Overall, the content analysis results supported the majority of theoretical concerns raised in chapter one. Conversely, the content analysis results contradicted the following theoretical concerns: inclusion of unclothed sensitive body parts, physician sex as predominantly male, and disparate coverage of male health issues over female health issues.

The overarching issues of privacy and surveillance were assessed by patient visibility. Of the 168 segments, 53 did not contain patient images. Moreover, of the patient-containing segments, 67 were multiple sequences. There were 292 patient-containing scenes out of 168 sexual health news segments. This supported the theoretical notion of patient portrayal of formerly private, and often intimate, medical examinations/procedures in the visual discourse.

In addition to patient visibility, the theoretical concept of surveillance was visually represented based on the inclusion of physicians and chaperones observing patients, portrayals of patients receiving medical procedures, and images of patient body invasions in the discourse. For example, congruent with reviewed research which identifies the inclusion of physicians in prominent roles in television medical dramas, more physicians than patients were portrayed in the sample. Of the 292 patient-containing scenes, 327 physicians were depicted. Furthermore, the coding apparatus did not account for physician images in the 53 non-patient containing segments. So, there may have been additional physician images in the overall sample.

These results corroborated television medical drama findings, described in chapter two, which highlight physician rather than patient portrayals. Notably, there were more

physicians depicted than patients, and many patient-containing scenes included multiple physicians observing or treating a single patient. This, in addition to the inclusion of chaperones in applicable scenes, fits with the identified concerns related to medical surveillance.

Additionally, patients were often shown receiving medical procedures and bodily invasions. In the discourse, patients' bodies were shown invaded 113 times compared to 178 times they were not invaded. Although patient bodily invasions occurred less frequently than not, the inclusion of body boundary encroachment formerly reserved for the trained clinician was portrayed to a television-viewing audience. Moreover, the two most intimate areas, Rectal and Vaginal, were collectively invaded 60 times, which was higher than the more benign Arm invasions which occurred 50 times. Thus, the television sexual health news visual discourse may support theoretical concerns regarding privacy, surveillance, self-surveillance, and body boundaries, but not to the degree indicated by Foucault and other cited authors.

In addition to the aforementioned concerns, the results from the Patient Clothing, Procedure, and Physician Touch coding categories may substantiate theoretical concerns of medical paternalism and medical dependency. For example, patients were depicted wearing medical gowns more than other clothing options, and patients were shown in stages of undress (street clothing/gown with medical drape and no shirt) 70 times. Additionally, the majority of the patient-containing scenes (261) depicted patients undergoing medical procedures compared to the 31 patient-containing scenes in which patients were not depicted undergoing medical procedures.

Similarly, patients were frequently shown in passive positions in relation to physicians, and were depicted undergoing procedures and examinations in the discourse. Likewise, patients were shown touched by physicians 253 times compared to 70 scenes in which patients were not touched by physicians.

Relatedly, portions of the patients' bodies were depicted more often than their full bodies. This related to concerns of body reductionism which may fit with the concept of the medical patient as an object of clinical study, further the traditional Cartesian notion of the mind/body split, and promote the body-as-machine metaphor often utilized in western medicine. By visually reducing patients to their body parts, the visual discourse may promote a sense of medical paternalism and dependency devoid of a holistic patient approach which includes empowered patients actively involved in their health and related healthcare.

Furthering the theoretical concerns of patient disempowerment was the Patient Body Position category. The results indicated that the most commonly-depicted patient body position was Lying down, and the Lithotomy position, which is arguably the most emotionally difficult and disempowered patient position, ranked third in Patient Body Position depiction.

Overall, in the television sexual health news discourse, patients were not only visible as patients, they were depicted under physician observation, reduced to their body parts, and placed in passive and disempowered positions. Moreover, the depiction of patients in the discourse included the trappings of illness by virtue of medical clothing, and promoted the idea of patients as medically dependent on clinical

examination/procedure rather than actively involved in related healthful behaviors, such as exercise, or in active consultation with physicians.

Taken collectively, the results indicated that the patient images presented in the television news sexual health reports on four major networks are congruent with a traditional, functionalist approach to medicine that encourages medical paternalism and dependency. Relatedly, the recent inclusion of formerly private and intimate medical examinations on television may be suggestive of a decreased adherence to body boundaries and privacy.

Conversely, the results contradicted one concern raised in the reviewed literature. The Unclothed Sensitive Body Parts category, which was developed to assess privacy loss related to Western norms of intimate body areas, was not supported by the data.[5] Overall, there were only 27 incidences of Unclothed Sensitive Body Parts shown compared to 265 patients portrayed without Unclothed Sensitive Body Parts. Furthermore, in this category, the visual discourse seemed to break from a growing trend to include nudity of intimate body areas in the mass media.

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[5] The Unclothed Sensitive Body Parts coding category was based on Western norms of intimate body areas and covering. Notably, the inclusion of this category does not suggest that presenting "intimate" body areas in a public forum is inherently bad or good. Rather, the notion is that following traditional western norms of modesty, these areas are not publicly displayed in everyday life, or without a deliberate breaking of the norm for prurient purposes. Therefore, the inclusion of Unclothed Sensitive Body Parts in television sexual health news reports may suggest aspects of privacy, surveillance, and self-surveillance portrayed and socially-constructed via this television genre. The norm, however, pertains to traditional Western modesty; It does not refer to television portrayal norms. Clearly, in televised entertainment, and more so in other mass media, the coded Unclothed Sensitive Body Parts are frequently depicted. However, television news tends to adhere to stricter norms of modesty, and boasts objectivity for which deliberate use of tantalizing visual footage solely for prurient effects would not be deemed acceptable based on industry standards.

Findings Related to Patient Sex Difference

The content analysis coding categories were cross-tabulated with patient sex to answer research question three regarding portrayal differences between female and male patients. The results evidenced a difference in the ways female and male patients were portrayed in nearly all coding categories. These results supported theoretical concerns of disparate female visibility in the media, differences in accepted body boundaries between women and men, and the depiction of women as more passive, ill, and disempowered than men. However, the results did contradict theoretical concerns involving body invasions, the inclusion of female health issues in the media, and the representation of women in socially-empowered roles, such as physicians.

Overall, female patients had greater visibility than male patients in the discourse. Female patients were shown more often than male patients because there were more female-specific stories than male-specific stories. Regardless, the overall visual impact of women as patients is greater than the visual impact of men as patients. Moreover, of the 202 female-specific stories, 223 female patients were depicted. Conversely, of the 86 male-specific stories, only 17 male patients were depicted. Therefore, female patients were not only shown more frequently than male patients, but also there was a higher likelihood that women would be shown as patients in female-specific stories than men in male-specific stories.

In addition to patient visibility, how the patients' bodies were made visible to the audience differed between male and female patients. For example, male patients' bodies were more often shown than their partial bodies, whereas female patients' bodies were

more often shown partially than fully. Likewise, female patients received more body invasions than male patients.

Additionally, the results indicated that 23 incidences of Unclothed Sensitive Body Parts occurred with female patients, and four incidences of Unclothed Sensitive Body Parts occurred with male patients. This is of particular importance given the fact that the Unclothed Sensitive Body Parts category was the only category that contradicted theoretical concerns as outlined above. However, despite the fact that Unclothed Sensitive Body Parts were not shown as often as expected based on theoretical concerns and literature reviewed in chapter two, when Unclothed Sensitive Body Parts were depicted in the sample, over half were female body parts.

Likewise, the results indicated a difference between male and female patients in coding categories pertaining to medical dependency. For example, more female patients (106) than male patients (30) were depicted in medical gowns. Furthermore, more males were shown in street clothing (50.7% of the male sample) than other clothing categories. Conversely, in the female sample, female patients were shown in medical clothing (gown and drape) 65.9% compared to 15.2% in street clothing.

Related to medical dependency and patient empowerment, female patients were shown touched by physicians more often than male patients. Similarly, of the Procedure categories there was a greater incidence of female patients receiving intimate procedures than male patients. For example, of the Procedure categories coded, Mammography and Miscellaneous Gynecologic procedures were depicted the most. Nearly a quarter of all patient-containing scenes included a Mammography procedure. Rectal exams and mammograms are common screening procedures for prostate and breast cancer

respectively. However, in the majority of breast cancer stories, women were shown receiving a mammogram (72 depicted mammogram procedures out of 78 breast cancer stories), whereas only seven males were shown receiving a rectal examination out of 80 prostate stories. Moreover, there were 66 female-specific stories that would likely include a gynecologic exam or related procedure. Of the 66 stories, 53 portrayed women receiving miscellaneous gynecologic examinations or vaginal colposcopy.

Hence, the results evidenced a difference in patient portrayals across the sexes. Overall, women were shown as patients more often than men. Because there were more female-specific stories than male-specific stories, female patients had a higher degree of depiction in nearly every coding category than male patients. Moreover, based on the sex-specific samples respectively, women were more likely to be portrayed as patients, depicted in medical clothing, and shown receiving medical procedures than male patients. Additionally, of the Unclothed Sensitive Body Parts shown, the majority was female. Therefore, the visual discourse seems to portray women as patients more often, may contribute to the theoretical concerns of disparate visibility between men and women, and may position women as ill and medically-dependent more often than men.

Finally, the results did contradict some of the theoretical concerns previously outlined. First, although female patients were touched more and received more body invasions than male patients in the discourse, when these coding categories were factored based on the sex-specific samples, male and female patients had a similar likelihood of receiving physician touch and bodily invasions. So, although the theoretical concerns that women were touched by physicians and received body invasions more often than men were supported by the data overall, the disparity in these categories was a function

of a greater number of female-specific stories than male-specific stories. Although the overall visual impact may be more pronounced in terms of physician touch and body invasion for female patients, the likelihood that a male patient in male-specific stories and a female patient in female-specific stories would be touched by a physician or receive a body invasion was fairly equal.

Secondly, the fact that there were more female-specific stories than male-specific stories counters reviewed literature citing a greater attention to male health issues than female health issues. However, within the sexual health news sample, the story content which aired the most was Prostate. So, although the results contradicted critiques that female health issues do not receive the same attention as male health issues, the most commonly-covered story was a male-specific story.

Whether this shows a bias or not is impossible to ascertain based on the content analysis results reported earlier. As previously noted, some issues may follow a life cycle (Crable & Vibbert, 1985). Prostate cancer started receiving attention in the mid-1990s. So, whether the inclusion of Prostate stories was a function of attention to a male-specific disease or due to increased medical research and public attention to a disease, regardless of type or sex-specificity, at a particular time is not determinable from the content analysis data.

Relatedly, given that more search terms for the sample involved female-specific issues may be indicative of greater medical necessity for female-specific sexual health issues by virtue of menstruation, birth, and female-dominated birth control options. Hence, the inclusion of greater female-specific stories in the sample may follow from medical necessity. Additionally, the choice to include more prostate stories than any

other story content category may still provide support for claims of gender disparity in healthcare coverage. However, the percentage of times a sex-specific story was aired in relation to actual medical incidence rates is not known. Therefore, whether the sexual health news discourse truly evidences disparity of sex-specific story representation is not conclusive.

Finally, the results indicated there were a greater number of female physicians (181) than male physicians (109) depicted in the sample. This clearly contradicted reviewed literature which critiques traditional media depiction of men in more prominent social positions than women. In particular, research studies which document the disparate portrayal of male physicians than female physicians in television entertainment did not apply to the television sexual health news discourse. In fact, the opposite was shown.

In summation, the content analysis results suggested that patient images presented in the television sexual health news reports on four major networks are congruent with a traditional, functionalist approach to medicine which may encourage medical paternalism and dependency. Relatedly, the recent inclusion of formerly private and intimate medical examinations on television may be suggestive of a decreased adherence to body boundaries and privacy. Additionally, the results indicated a difference in these boundaries and privacy rights between the male and female patients depicted, and may promote a greater degree of visual patient disempowerment and medical dependency with female than male patients. Finally, the results did show a departure from the television entertainment norm of positioning more males than females in physician roles.

Findings Related to Network Difference

The fourth research question involving network similarities was addressed by cross-tabulating the content categories with the network variable. The results indicated that the networks were fairly uniform in their depiction of patients in the sexual health news reports. This supported research which suggests there is a uniformity in news coverage.

However, there were a few noted differences in the networks. Overall, CNN varied from the other networks the most. For example, unlike the other networks, CNN did not run stories on Norplant or other forms of Birth Control, but ran the second highest percentage (based on each network's sample) of Abortion stories. Although the networks were fairly uniform in their depiction of Patient Clothing, CNN depicted a patient in a Drape more than any other Clothing category, whereas the other networks showed a patient in a Drape infrequently. Similarly, more than half of the Patient Positions on CNN were Lithotomy, whereas the other networks depicted the Lithotomy position (based on percentages within each network's samples respectively) between 15% and 21% only. CNN also led the other networks with nearly twice as many Unclothed Sensitive Body Part depictions. Likewise, CNN had a much higher percentage of Physician Touch than the other networks.

Therefore, while the networks showed high uniformity overall, CNN did vary from the other networks in a few of the coding categories. Notably, where CNN differed from the other networks, it did so to a fairly pronounced degree. This may support the theoretical concept that networks may choose from a range of options in visually constructing a news discourse, and that the choice to construct a discourse in a particular

way is indicative of a particular way of seeing. This may support the post-structural premise that signs are biased, and that they are chosen from a myriad of available options.

Interestingly, in the categories for which CNN differed from the other networks, the difference was marked in relation to male and female patient portrayals. For example, CNN differed from the other networks in its attention to birth control stories. Likewise, by cross-tabulating Network and Sex for the categories in which CNN differed from the other networks (Drape, Lithotomy, and Physician Touch), the differences were found in relation to portrayal of female versus male patients. In other words, CNN was more likely to show female patients, out of the available female patient-containing scenes, in a gynecologic Drape and in the Lithotomy position not only more often than the other networks, but also more frequently than in related male clothing and procedure options. Similarly, CNN showed a greater proclivity to depict female patients touched by physicians than male patients. The only recorded network difference category in which CNN did not show a potential gender bias was in the Unclothed Sensitive Body Part category. Therefore, although impossible to ascertain from the data alone, there may be a gender bias in CNN's production of the sexual health news discourse.

However, other explanations for CNN's divergence from the other networks in some coding categories exist. For example, of the networks analyzed, only CNN is solely a news network. Therefore, how, why, and what types of stories CNN broadcasts may differ from the other networks due to different types of audiences and advertisers. Similarly, unlike the other networks, CNN broadcasts news twenty-four hours a day, seven days a week, and may require content and visual footage that sustains regular

viewing. Related to audiences and advertisers, the on-going news dissemination process in which CNN is involved differs from the half-hour newscasts broadcast between entertainment programming on the other networks. These differences may account for the different use of visuals and story content choices on CNN compared to the other networks.

Summary of Historical/Contextual Production Mode Analysis

Moving from the content analysis results, the final research question called for analysis of the visual discourse from a historical/cultural perspective. As noted in the previous section, with the exception of CNN in a few coding categories, the networks showed relative uniformity in the visual discourse. Thus, the production mode analysis not only supported suggestions in the reviewed literature that the news media maintain a status quo, reasons given for this status quo maintenance (as described in chapter two), such as industry and economic constraints, may also serve as explanations why the discourse was constructed as it was.

Additionally, by drawing on mass media and feminist theories as well as historical information pertaining to medicine, I posited a few possible explanations for the media's choice to depict the television sexual health news discourse as described in the content analysis. Finally, I suggested alternative approaches to this visual discourse's production.

First, although cloaked in objectivity, television news finds its dissemination avenue in the predominantly entertaining purpose of television. Thus, television news coverage may be shaped by its entertaining and advertising counterparts. As delineated

in reviewed literature, television entertainment and advertising related to health adheres to the functionalist approach to healthcare. Based on the content analysis results, the tenets of this approach, such as patient passivity, medical paternalism, medical dependency, the Cartesian mind/body split, and the body-as-machine metaphor, are also fostered in the television news sexual health discourse.

Relatedly, traditional mass mediated depictions of women as more passive, illness-prone, and dependent than men were also evidenced in the sexual health news discourse. In this, the sexual health news discourse may not only show a status quo maintenance among news broadcasts, it may fit within the status quo of health and gender representations on television overall.

Second, as previously postulated, culture shapes and is shaped by television. Specific to television medical discourse, various American cultural norms, myths, and ideals may shape and find shape in the television sexual health news discourse. For example, American medical consumers and physicians exceed other industrialized nations in their expectation and use of medical technologies, invasive medical procedures, and medical interventions (Gaylin, 1994; Inlander, 1994; Northrup, 1998; Payer, 1996; Rasell, 1994; Schwarts, 1994). Likewise, based on medical research reports, advertisements, and public health information campaigns, the American approach to health is aggressive as evidenced in the frequent use of war rhetoric (Keiger, 1998). Likewise, the American approach to medicine is decidedly technologically-biased, and promotes a more mechanistic view of the body than other industrialized nation's approaches to health and healthcare (Payer, 1994). Thus, the sexual health news visual

discourse may not only fit within American cultural norms, it may also function as a culturally-normative force simultaneously.

Third, the disparate portrayals of male and female patients may mirror traditional mass mediated portrayals of men and women. Notably, as suggested in reviewed literature, the female body has held a higher degree of visibility than the male body and the boundaries of the female body, in terms of intimate portrayals and touch, are also less distinct or respected than male body boundaries. Additionally, mass mediated portrayals of women have historically positioned women as lower in social status, more passive, and weaker than male counterparts. Therefore, what is viewed as acceptable privacy and body boundary invasions in the mass media may factor into what is acceptable visual footage of patients in television news broadcasts. Similarly, various socially-constructed gender roles, such as passivity, may flow naturally into visual discourse in all mass mediated genres, such as television news.

This is not to suggest that the visual footage choices are conscious and deliberate attempts to construct gender differences or create disparate levels of privacy across the sexes. Rather, I suggest that what are normal representations on television will likely seem normal for most television genres; news not excluded. To understand this concept best, considering the reverse may be illuminating. In other words, the best question to ask may not be whether the images of female patients in the discourse seem problematic, but to ask if the visual footage would seem normal if the roles were reversed. For example, a clarifying question would be to ask if the visual footage of a man receiving a rectal or testicular examination seems as normal, on television news broadcasts, as a woman receiving a gynecologic examination or breast examination. Given the disparity

in the number of these images, the normative practice in the discourse is to show a woman receiving a gynecologic and breast examination, whereas it is unusual to show a man receiving a rectal or testicular examination.

Fourth, the history of medical research and practice evidences a disparate interest in female sexuality and sexual functioning compared to male sexuality and sexual functioning. Likewise, the analogs of medical history evidence a time when women were defined by their reproductive organs, believed to be inherently illness-prone, deemed dependent on medical care, and prescribed passive behaviors as curative measures. In this, the sexual health news discourse may represent female and male patients differently due to a historical difference in medical definition and treatment of female and male patients.[6]

Finally, along with these possible explanations for why the discourse was constructed in a particular way, I offer suggestions for alternative, and, arguably, more healthful ways of constructing the sexual health news visual discourse for all patients. For example, I propose that the visual discourse should include a greater attention to patients engaging in healthful behaviors, such as exercise, and in consultation with physicians. Similarly, less attention should be placed on visuals that reduce the body to its parts by virtue of showing only partial patient bodies or specific body parts. Likewise, patients should be portrayed in more empowered physical positions and with fewer trappings of technology than the visual discourse currently contains.

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[6] The majority of the reviewed literature pertaining to the historical differences in medical definition and treatment of male versus female patients predominantly pertains to middle an upper class, Caucasian populations. The lack of attention to all socio-economic and racial groups, although not attended to in this study, evidences additional biases in historic medical research and practice.

Consequently, I suggest that the television news sexual health visual discourse would be enhanced by a decreased attention on physicians, patients, and related medical examinations. Rather, images of people, not defined as patients by virtue of medical clothing or examination, engaging in health-enhancing behaviors may decrease potentially negative effects related to self-surveillance of the body.

Likewise, these images along with images in which patients are shown engaging in conversations with physicians may decrease a visual propagation of medical dependency. For example, as was evidenced in a few of the non-patient containing scenes I viewed during the content analysis data collection, patients in the television news sexual health visual discourse were shown engaging in healthful activities, such as exercise, rather than as patients under examination. Additionally, in many of the samples' Prostate stories men were frequently shown engaging in healthful activities, such as playing tennis. In Infertility stories parents were shown playing with infants.

So, although certain patient positions are required for medical procedures, and medical examination is necessary for health, the potential impact of including these portrayals in television news reports has been questioned in this dissertation on theoretical grounds. Collectively, the television images may imprint a sense of patient passivity and disempowerment which may be detrimental to ensuing patient attitudes and physician-patient interactions. Notably, alternative, more empowered patient images could be used in the television sexual health news reports.

Finally, in terms of patient visibility, the inclusion of a chaperone in applicable scenes increased the degree to which patients were shown under observation. However, this coding category requires additional consideration. Although the portrayal of 24

chaperones increased a sense of patients under observation in the sample, there were more applicable scenes which did not include a chaperone than those that did.

The value question is whether the visual discourse related to chaperone inclusion is positive or negative theoretically. In terms of depicting reality, as well as addressing some women's concerns about practitioner ethics related to intimate gynecologic examinations, the choice not to show chaperones where they normally would be present may give an unrealistic portrayal of gynecologic examinations. This may, in turn, increase a sense of sexualization by showing women intimately examined without a third-party advocate/monitor and deter some women from seeking necessary examinations and procedures due to reported concerns women have related to intimate examinations (Apple, 1990; Dreifus, 1978; McBride, 1993).

Therefore, the inclusion of chaperones in applicable scenes may not only accurately depict current medical policies, but also reduce anxiety some women have about the perceived sexualization of gynecologic examinations and the potential for physicians' sexual misconduct. In assessing the impact of the chaperone results, however, these potential benefits should be weighed against the possible detriments of increased patient visibility.

LIMITATIONS

In the following section, I acknowledge the limitations of the study and need for additional research and analytic development. First, the content analysis provided quantifiable description of the sexual health news visual discourse. However, the descriptive data is limited in a number of ways. One of the theoretical premises on which

this dissertation is based is that all visual forms are born out of a particular way of seeing. Notably, the content categories utilized in the content analysis are also a particular way of seeing. I chose these categories based on a post-structuralist theoretical framework and was informed, in large part, by the work of Foucault and Goffman.

In particular, the coding categories were constructed to assess the degree to which the depicted patient images may allude to various issues, such as surveillance, privacy, patient empowerment, et cetera. Certainly other theoretical frameworks and salient issues could have been chosen to inform the content analysis categories. Thus, although the content analysis did provide a description of the visual discourse, that description is bounded by the theoretical concerns, problems, and salient issues chosen for this dissertation and outlined in chapter one.

Moreover, even within the theoretical framework outlined in chapter one, additional content categories could have been chosen to describe the visual discourse in different ways. One notable exclusion was the choice to compare difference between male and female patients while other groups, such as race, sexual orientation, and age (which are important group distinctions relevant to this study's cultural perspective), were not included.

Along with the textual analysis (content analysis), the discursive practice analysis (network analysis and historical/contextual production analysis) has notable omissions and a need for future development. Specifically, the contextual analysis of production could include medical statistics to determine how the story content and image choices compare with illness and procedure frequency in medical practice. In doing so, the visual discourse could be analyzed based on the degree of factual depiction of sexual health

medical practice. Results could, in turn, attend to concerns raised in chapter one regarding journalists' tendency to overdramatize certain illnesses and underrepresent others, and more conclusively assess potential disparities in story content coverage. Crable and Vibbert's (1985) Life Cycle of an Issue theory may provide an additional theoretical perspective regarding sexual health issue news coverage and omissions.

Relatedly, both the textual and discursive practice analyses focused on sexual health stories included in the last ten years of broadcast on ABC, CBS, CNN, and NBC. However, a number of sexual health issues, originally included in the story search, were not covered by the networks. In this sense, this dissertation's greatest weakness may be in its attention to how and why the networks covered the sample stories, rather than attending to why certain sexual health issues were not covered. As noted by Burke (1935), "Any performance is discussable either from the standpoint of what it attains or what it misses" (p. 374).

Finally, the discursive practice analysis could be expanded in future studies to include greater attention to production. For example, industry producers could be interviewed regarding how and why certain story content and image footage choices were made. Relatedly, the demographic makeup of the industry decision-makers should be considered in assessing possible cultural biases in the visual discourse creation. Moreover, aside from developmental opportunities, the content analysis presented in this dissertation should be replicated before it can be presented as a conclusive description of the visual discourse.

FUTURE STUDIES

As previously noted, both the textual and discursive practice analyses afford opportunities for additional development. The need for continued research is most notable in relation to social effects. As described in chapter three, I did not conduct the final phase of critical discourse analysis (CDA) in this dissertation. The first two phases of CDA undertaken in this dissertation involved textual description and historical/contextual interpretation of the television news sexual health reports discourse. As stated earlier, this provides the foundation upon which the social practice phase can be developed in subsequent research.

The social practice phase should analyze how the visual discourse functions in everyday life by attending to audience interpretations and effects. Although the social practice analysis is not included in this dissertation, by way of evidencing the heuristic value of this dissertation I offer a brief justification for and description of two suitable social practice research methods.

Survey and Focus Group Methodologies

Two ways to learn what large groups of people think about something is through survey and focus group research (Frey, Botan, Friedman, & Kreps, 1992). By reviewing the similarities, differences, advantages, and disadvantages of survey and focus group methods, Morgan (1996) concludes there is benefit in using the two methods as complementary means of combining qualitative and quantitative data. According to Morgan (1996), a focus group/survey combination occurs in one of four ways depending

on which method holds a primary and which holds a secondary position in the overall study, and whether one serves as a preliminary or follow-up study to the other.

In this sense, I propose breaking from tradition in that the survey and focus groups could be equally weighted and occur simultaneously. This decision is justified by the following: An interest in exploring a relatively new, web-based form of survey data collection; a need to collect as much data as possible considering budget constraints; an unspecified sampling population; and an interest in two different types of data.

Web-based Survey

Survey as a method choice for this discourse follows from traditional survey rationale such as quantification of data, ability to elicit yes/no answers, avoidance of group synergy or interviewer bias, and anonymity. Additionally, the survey could be disseminated on the internet because web-based surveys allow respondents to view video footage from the sample to answer questions directly related to the visual discourse addressed in this dissertation.

Additionally, a web-based survey has financial and environmental efficiency (Schmidt, 1998; Schmidt, 2001; Stanton, 1998). Web-based surveys have a high degree of equivalency between traditional paper and pencil surveys in attitudinal or personality testing (Stanton, 1998), but web-based surveys allow for less expensive dissemination. Finally, web-based surveys have the potential to obtain data from international respondents efficiently and inexpensively (Schmidt, 1998; Schmidt, 2001; Stanton, 1998). Thus, a web-based survey is well-suited for the television news sexual health

visual discourse because the totality of television viewers is a large, demographically-undefined sample.

Focus Group Study

In addition to a web-based survey, a future social practice analysis of this discourse could include focus group research. Both the survey questions and focus group structured question formats are similar, and they can be created from the identified problems and salient issues identified in this dissertation. The intention, however, would be to obtain different information from the two methods. The survey will provide quantifiable answers from respondents. But, because surveys are "limited by the questions they ask" (Morgan, 1996, p. 132), focus group data, comparatively, provides more in-depth responses to posed questions and affords ideas/information outside the bounds of said questions.

Focus group research is a qualitative method which "uses open-ended . . . and probing questions to scratch below the surface of a small group of participants' attitudes, opinions, and behaviors to understand motivations, feelings, and reactions" (Poindexter & McCombs, 2000, p. 240), and obtains answers to how and why questions (Katcher, B. L., 1996). In addition to procuring rich texture and nuance (Poindexter & McCombs, 2000), focus group research generates new ideas (Poindexter & McCombs, 2000), and fully grasps participants' thoughts and attitudes (Berg, C. N., & Weschler, L. F., 1992; Lingua, L., Roosa, M.W., Schupak-Neuber, E., Michaels, M. L., 1992). As explicated in chapter one, because sex and sexuality encompass a wide range of cultural and individual attitudes, they are "never self-regarding and merely private. They always have both

social consequences and social dimensions" (Moskowitz, Jennings, and Callahan, 1995, p. S2). Thus, focus group research would be useful in future studies attending to the social practice dimension of television news sexual health visual discourse.

In conclusion, as identified above, this dissertation serves as a description of the television sexual health news visual discourse and a starting place for additional interpretive analysis. Limitations of the content analysis method, attention to one theoretical perspective, and the need to complete the final phase of CDA (social practice) call for future research of this discourse. In particular, I suggest that the presented content analysis should be replicated, additional groups should be looked at for image representation differences, the production mode analysis should be developed further, and the Social Practice phase (which lends itself to focus group and survey research) should be undertaken in future studies.

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APPENDIX

APPENDIX

Number: Coder:

Network: Date: Time:

Subject:

Content:

Image Mapping:

A. Patient:

1. Yes 2. No

B. Patient Gender:

1. Male 2. Female

C. Patient Clothing

1. Gown 2. Streetclothing 3. Drape 4. No Shirt 5. Unknown

D. Unclothed Sensitive Body Parts:

1. Female Breast 2. Pelvis 3. G.M. 4. Stomach 5. No

E. Body Parts Shown:

1. Full 2. Half 3. Other: _____ 4. Arm Only

F. Patient Body Position:

1. Sitting 2. Standing 3. Lying Down 4. Lithotomy

5. Bending over F 6. Bending over B 7. Other: _____ 8. Unknown

G. Procedure

1. Mammography 2. Coloscopy 3. Colonoscopy 4. Gyn-Misc.

5. Rectal 6. Breast Exam 7. Testicular 8. Norplant 9. Other

H. Physician Position Shown During Exam

1. F to F Sitting 2. F to F Standing 3. Sitting btwn legs

4. Standing btwn legs 5. F to F Bent Over 6. F to B Sitting

7. F to B Standing 8. F to B Bent Over

9. Off to Side 10. Other: _____

I. Physician Gender

1. Male 2. Female 3. Unknown

J. Physician Touching Activity

1. Yes 2. No

	Hand	Hand & Instrument	Instrument
POSTERIOR			
Head to Neck			
Neck to Waist w/Breast			
Waist to Knee			
Knee to Foot			
Arm			
Pelvis			
G.M.			

ANTERIOR			
Head to Neck			
Neck to Waist			
Waist to Knee			
Waist to Knee w/G.M.			
Knee to Foot			

K. Chaperone

1. Yes 2. No 3. N/A

L. Bodily Probe/Invasion

1. None 2. Injection (Arm) 3. Injection (G.M.) 4. Vaginal

5. Rectal 6. Norplant 7. Other

VITA

VITA

Marie Louise Dick
112 16th Avenue South
St. Cloud, MN 56301
320-202-0569 (H)
320-308-5333 (W)
marie@wheatstate.net

Education

Ph.D. Purdue University ABD; Ph.D. anticipated defense August, 2004
Major Area: Health Communication
Minor Areas: Mass Communication
Interpretative and Qualitative Methods
Dissertation Advisor: Charles Stewart

M. A. Wichita State University May 1995
Concentration: Public Communication
G.P.A.: 4.0/4.0
Major Professor: Susan Schultz Huxman

B. A. Bethel College May 1992
Major: Communication
G.P.A: 3.5/4.0

B. A. Bethel College May 1992
Major: Political Science
G.P.A.: 3.5/4.0

Second Language: Spanish

Academic Appointments

Current	Assistant Professor of Mass Communication, St. Cloud State University, St. Cloud, Mn. Responsibilities to be assigned.
2003-2004	Assistant Professor of Communication Studies, St. Cloud State University, St. Cloud, Mn. Taught four courses per semester of Introduction to Communication Studies.
2003	Visiting Professor, Texas Tech University, Lubbock, Tx. Responsible for teaching Principles of Advertising, Introduction to Mass Communication, and Public Relations Writing.
2002, August	Visiting Professor, Turan University, Almaty, Kazakhstan. Taught one-week, intensive course at the George Soros Foundation Summer Program involving social differences between developed and developing countries, and related stratification models.
1999 –2002	Assistant Professor of Speech Communication, Southwest State University, Marshall, Mn. Taught four courses per semester including Fundamentals of Public Speaking, Mass Media and Society, Introduction to Public Relations, Public Relations Writing, and Risk/Crisis Communication. Responsible for advising students and service duties.
2000	Faculty Trainer, Professional Phone Skills and Customer Service Training, Office of Distance Learning, Southwest State University, Marshall, Mn.
1999	Research Assistant, Industrial Engineering Department, Purdue University, West Lafayette, In. Conducted interviews, analyzed existing advertising campaigns, and worked with the department chair to develop program promotion materials to explain industrial engineering and promote the Purdue Industrial Engineering program to prospective undergraduate and graduate students.
1999	Production Assistant, Communication Department, Purdue University, West Lafayette, In. Assisted with page layout, design, and publication of department newsletter.
1998	Research Assistant, Purdue University, West Lafayette, In. Assistant on content analysis research of breast cancer campaigns.
1997 - 99	Graduate Teaching Assistant, Purdue University, West Lafayette, In. Responsible for teaching communication courses, and serving as an assistant for Introduction to Public Relations and Public Relations Practicum.

1993 - 95	Graduate Teaching Assistant, Wichita State University, Wichita, Ks. Responsible for teaching Basic Public Speaking, and assisting with the Communication Department's public speaking contest.
1994 - 95	Assistant to the Graduate Coordinator, Wichita State University, Wichita, Ks. Responsible for meeting with potential graduate students, and generating graduate program correspondence.
1994	Research Assistant, Wichita State University, Wichita, Ks. Assisted with physician-patient communication research.
1994	Lecturer, Wichita State University, Wichita, Ks. Responsible for teaching Basic Public Speaking.
1994	Assistant Director, Graduate Assistant Workshop, Wichita, Ks. Responsible for organizing and managing the graduate teaching assistant workshop and administrating breakout sessions.
1989 - 92	Undergraduate Teaching Assistant, Bethel College Communication Department, St. Paul, Mn. Assisted with Persuasion and the Argumentation courses, and assisted with the Forensics team coaching.
1988 - 90	Undergraduate Teaching Assistant, Bethel College Theatre Department, St. Paul, Mn. Assisted with a Creativity in the Fine Arts course.
1991	Undergraduate Teaching Assistant, Bethel College Communication Department, St, Paul, Mn. Assisted with an Organizational Communication course.

Additional Teaching Experience:

1995 - 98	Private Piano Instructor, Lafayette, In. Had private piano business, teaching 7-10 pupils weekly.
1996 - 1997	Assistant Forensics Coach, Windom Area High Schools, Windom, Mn. Coached junior high and senior high students in competitive speaking events.
1995 - 96	Secondary Education Social Studies Teacher, ICS, San Jose, Costa Rica. Taught junior high school social studies and speech, and junior/senior high school drama and music.

1995-96 ESL Instructor, ProIngles, San Jose, Costa Rica.
Taught English to business professionals.

Courses Taught:

Undergraduate Level
Fundamentals of Public Speaking
Development
Mass Media and Society
Risk/Crisis Communication
Introduction to Public Relations
Advertising Writing
Page Layout and Design
Principles of Advertising
Public Relations Writing
Journalistic Writing
Introduction to Mass Communication

Graduate Level
Intercultural Social Stratification and
Music Management and Public Relations

Secondary Level
Public Speaking
Music
American History
World History
Drama

Teaching Awards:

2002 Faculty Honor Roll, Southwest State University, Marshall, Mn.

1999 Nominee, Bruce Kendall Excellence in Teaching Award, Purdue University, West Lafayette, In.

Related Professional Appointments:

2002 Summer Independent Consultant, Minnesota Corn Processors, Marshall, Mn.
Developed, conducted, and analyzed data from focus groups regarding employment satisfaction at bulk terminal locations: Seattle, Wa., Portland, Or., Dallas, Tx., and Frazer, Pa.

2001 Independent Communication Consultant, USBancorp, Marshall, Mn.
Conducted in-house evaluation of collections department phone skills for communication training.

2001 Independent Communication Consultant, Minnesota Corn Processors, Marshall, Mn. Conducted on-site interviews to develop customized training courses in business presentation, business communication, workplace communication, crisis communication, and conflict management.

1996 - 97	News Editor, Observer/Advocate (weekly newspaper), Mt. Lake, Mn. Covered the city and education beats, wrote a weekly column and editorials, and assisted with production layout.
1995	Communication Consultant, Gaunt and Associates, Wichita, Ks. Assisted organizational communication auditing projects.
1997 - 98	Radio Voice Talent, BMA Media Consultants, Lafayette, In. Provided voice talent for radio voice-overs.
1994	Assistant to the Traffic Manager, Morris/Frey PR and Advertising Agency, Wichita, Ks. Fielded client calls and managed account traffic.
1992 - 93	Actress, national theatre tour, Refreshment Committee, St. Paul, Mn. Performed with the company on a nine-month, national tour.
1993 - 95	Voice Talent, radio/industrial videos, Perfectly Round Productions, Wichita, Ks. Recorded various radio and television commercials, and industrial video voice-overs.
1992	Marketing Research Intern and Employee, Custom Research, Inc., St. Paul, Mn. Successfully completed four-month Custom Research, Inc. Intern Training Program, and worked as a marketing research phone operator.
1988 - 89	Public Relations Representative, American Dairy Association of Minnesota, St. Paul, Mn. Attended industry meetings and conventions, served as spokesperson, wrote articles for the association's newsletter, and gave informational speeches, training workshops, and school visits.

Research:

Research Interests: My research interests are: (1) Health Communication relating to clinical practice (provider-patient communication and patient compliance) and public health concerns including behavior modification and behavior and risk predictors, particularly in areas of human sexuality; (2) Mediated health communication with a particular interest in critical analysis of mass communicated images and health campaign information; (3) Women's Health, focusing on issues related to socio-medical influences on self esteem, treatment options, and research.

Academic Grants and Awards:

2001	United States Department of Agriculture Higher Education Challenge Grant. Research on the Landscape: An Interdisciplinary Learning Experience in Tropical and SubTropical Regions for Geographically-Constrained Students. $63,000. Co-Author: Tom Dilley, Assistant Professor of Environmental Science, Southwest State University, Marshall, Mn.
2001	Faculty Improvement Grant, Southwest State University, Marshall, Mn. Rhetorical Analysis of Male Birth Control Pill Mass Communication Messages. $600.
2001	Fellowship, On-Line Curriculum Development Program, MN.INSTRUCT, Willmar, Minnesota.
2000	Faculty Improvement Grant, Southwest State University, Marshall, Mn. Content Analysis of Patient Images Televised Medical News Reporting. $400.
1999	Faculty Improvement Grant, Southwest State University, Marshall, Mn. Content Analysis of Male Birth Control Pill Mass Communication Messages. $400.
1995	Outstanding Thesis Award, Elliott School of Communication, Wichita State University, Wichita, Ks.
1994	James I. Brown Student Paper Award, Do I Hear What I am Saying?: An Overview of the Effect of Intrapersonal Listening on Self-Perception, International Listening Association.
1994	Esther Steele Hill Graduate Student Scholarship, Women in Communication, Wichita, Ks.
1994	Graduate Communication Scholarship, Elliott School of Communication, Wichita State University, Wichita, Ks.
1990	Travel Scholar, Cooperative Communicators Association, Nashville, Tn.
1988 - 92	Scholarships, Speech and Music, Bethel College, St. Paul, Mn.
1988	Speech Scholarship, Peace Festival, Gustavus Adolphus College, St. Peter, Mn.

Academic Paper Presentations and Panels:

Dick, M. L. (2004, June). Doctoring through Dialogue and Art: An Artistic Representation of Ethnographic Data Pertaining to Women's Communication about their Healthcare. Paper presented at the 2004 Women Writer's Conference, Portland, Me.

Dick, M. L. (2003, November). Gyn Talk: Women's Conversations about the Their Bodies and the Not-so Private Medical Practice. Paper presented at the 2003 National Communication Association Convention, Miami, Fl.

Dick, M. L. and Malek-Madani, T. (2002, October). Intercultural Dialogue: Intersection between Developed and Developing Democracies. Paper presented at the 25th annual Third World Studies Conference, University of Nebraska, Omaha, Ne.

Dick, M. L. (2001, August). Body Boundaries, Body Ownership, and Gender Stereotyping: Mass Mediated Portrayals of Reproductive Health. Paper presented at the national convention of the Association of Education of Journalism and Mass Communication, Washington, DC.

Rowan, R., and Dick, M. L. (2001, November). Special Teaching Series: Crisis Communication. Special session conducted at the national convention of the National Communication Association, Atlanta, Ga.

(2001, April). Panel Participant, Marianne Martinez: Feminist Muse. Music and Notes, Southwest State University, Marshall, Mn.

Dick, M. L. (1995, November). Rhetorical Criticism: Women's Use of Comedy in Steel Magnolias. Paper presented at the national convention of the National Communication Association, Minneapolis, Mn.

Dick, M. L. (1995, May). Descriptive Analysis: Steel Magnolias. Paper presented at the annual convention of the Kansas Speech Communication Association, Wichita, Ks.

Publications:

Dick, M. L. (1995). "Steel Magnolias: Descriptive Analysis." Kansas Speech Journal, 55, 10-17.

Invited Presentations and Workshops:

2001 Presenter, Communicating for Greater Health, Women's Conference, Marshall, Mn.

2001 Presenter, The Social Side of Women's Healthcare, Women's Conference, Marshall, Mn.

2001 A Prescription for Healing: Communicating with Healthcare Providers. Lecture presented at Senior College, Southwest State University, Marshall, Mn.

2001 Communication and Marketing Theory. Workshop presented at the Marketing Managers' Retreat, USBancorp Business and Office Equipment Financing Service, Marshall, Mn.

2001 Crisis Communication. Workshop presented at the USBancorp Managers Workshop, Marshall, Mn.

2001 Mass Communication and the Workplace. Seminar presented at the Leadership Training Seminar, New Ulm, Mn.

2000 Mass Communication, Society, and Ethics. Workshop presented at Network Nu Business Networking Organization, New Ulm, Mn.

1999 Guest Lecturer, Introduction to Sociology, Department of Sociology, Southwest State University, Marshall, Mn.

1994 Guest Speaker, Speech Pedagogy Workshop, Elliott School of Communication, Wichita, Ks.

1994 Opening Address, Wichita State University Graduate Teaching Assistants' Training Seminar, Wichita State University, Wichita, Ks.

1992 Commencement Address, Mt. Lake Public High School, Mt. Lake, Mn.

1990 Guest Radio/TV Correspondent, Linder Farm Network, Willmar, Mn.

1989 Keynote Address, Cenex/Land O' Lakes Annual Meeting, Minneapolis, Mn.

Service:

Academic Service:

2001 Editorial Review Board. Journal of Communication Studies.

2001 Editorial Review Board. Pesticides Program Publication, Purdue University, West Lafayette, In.

2001 Member, Instructional Technology Supervisor Search Committee, Southwest State University, Marshall, Mn.

2000 Member, Human Subjects Review Board, Southwest State University, Marshall, Mn.

1994 - 95 Graduate Council Representative, Wichita State University, Wichita, Ks.

Student Advancement:

2003 Judge, PRSSA State Student Campaign Competition, Texas Tech University, Lubbock, Tx.

1993 - 2002 Judge, Collegiate and High School Forensics Tournaments
Bethel College, St. Paul, Mn.
Windom Area Public Schools, Windom, Mn.
Wichita State University, Wichita, Ks.
Southwest State University, Marshall, Mn.

1999 - 2002 Mentor, Faculty-Student Mentorship Program, Southwest State University, Marshall, Mn.

2001 Founding Co-Director, Fundamentals of Public Speaking Contest, Southwest State University, Marshall, Mn.

2001 Faculty Founder and Supervisor, Schwan's and Southwest State University Public Relations Internship Program, Southwest State University, Marshall, Mn.

2000 Student Success Coach, Southwest State University, Marshall, Mn.

Community Service:

2001 Volunteer, Lyon County Humane Society, Marshall, Mn.

2000 – 2001 Volunteer, Marshall Public Library, Marshall, Mn.