Chapter 1

Health and media: an overview

Clive Seale

Why should medical sociologists study the media? Accounts of the experience of illness are common in medical sociology (see, for example, recent reviews of this field by Pierret 2003 and Lawton 2003). The information these provide has been helpful over the years in re-orienting the vision of health care providers away from a biomedical and reductionist view of patienthood, towards a more holistic understanding of the meanings of illness for those who experience it. In this way many sociologists have contributed to a more widespread construction of 'patients' (passive) as being instead 'consumers' (active), promoting recognition of the psychosocial element of biopsychosocial care. Thus the medical gaze has been extended to parts of life previously hidden from view, so that a new knowledge of illness has come to dominate thinking in certain health care arenas – perhaps particularly so in primary care and in nursing (Armstrong 1983a, 1984).

In tandem with these developments has been the emergence of media and cultural studies as new disciplines. These have taken the (mass) mediated nature of personal experience to be an important topic. This can be understood as a component of the broader project of understanding what it is to be a person in late or postmodern social conditions. Thus it is very common, in these fields, to see accounts of media representations of gender, class or race (for example, Dines and Humez 2002), because these are felt to be important factors in understanding issues of identity, over which mass media have considerable influence. Personal identity is, to a great extent, a cultural construction (Rose 1999). Systems of knowledge, or discourses, are promoted in mass media and influence audiences in various ways. New media, such as the Internet, allow a new kind of experience (Castells 1996). We must, therefore, understand popular media if we are to understand experience and its rendering in narrative forms.

Yet these two fields of study – media studies and the sociology of health and illness – appear to stand at a distance from one another. There are, of course, studies of medical knowledge itself as a cultural system (Armstrong 1983b, Lupton 1994) and historical accounts may reveal the role of medical and other scientific knowledge in constructing, say, gendered subject identities (Showalter 1987). In this respect, medical sociologists draw upon the same broad theoretical perspective as many sociologists of science and technology, in so far as the truth claims of other sciences are temporarily bracketed, or held in suspense, in order to understand the role of scientific knowledge in the social construction of its subject. Yet medical sociology does not generally reveal very much about the mass mediated nature of scientific knowledge, which has largely been studied as a separate field (for example, Nelkin 1995).

COPYRIGHTED MATERIAL

To understand the potential relationship between media studies and medical sociology – at least where issues of identity and experience are concerned – we must address the issue of where experience comes from. On the whole, the discipline of psychology has a particular view of this, which many sociologists call an 'essentialist' vision of human nature. Sociologists must understand human experience differently from this, as at least in part a social construction rather than something that emanates from an inner essence. In constructing the self, modern culture makes available to individuals a great many options and resources. The resources might be understood as cultural scripts, or discourses, and modern self identity is formed in a manner that is sometimes quite reflexive (Giddens 1991), drawing on culturally available narratives, stories, scripts, discourses, systems of knowledge or, in more politically oriented analyses, ideologies.

Perhaps the greatest repository of stories in late modern societies is made up from the various organs of the mass media – television, newspapers, magazines, radio and, increasingly, the Internet. Here, people find a rich collection of resources to draw upon in telling the story of their selves. When people get sick, or make decisions about health, or visit their health service providers, or decide what to think and vote about health care policy and finance, their behaviour may be formulated in large part from resources drawn from various mass media. These can include depictions of what it is like to be sick, what causes illness, health and cure, how health care providers behave (or ought to) and the nature of health policies and their impact. Particular stories may be promoted by particular interest groups seeking to exert influence over populations.

Mass media depictions, of course, are not 'true'. At best, they are partial truths. Sometimes we may even feel they are collections of lies! The producers of mass mediated messages about health have particular agendas, and this is likely to influence what is shown. As ordinary people we must decide to trust or distrust media messages in much the same way as we decide to trust or distrust medical advice or other expertise. As sociologists interested in the experience of illness, and in health care and health policy, we ought to be interested in which stories get told and which are suppressed, and in how members of the media audience (which includes health policy makers and health care providers themselves of course) respond to mediated health messages. Because I think this is important, I have provided an overview of the media and health research field (Seale 2003). I have also edited this monograph which contains some of the best examples of media studies of health that I have been able to elicit from the research community, in a process of selection that was unusually competitive.

In this introduction, therefore, I have first discussed why I believe it to be important to bring together the fields of media studies and the sociology of health and illness. In the sections that follow I outline a general account of the media and health field, focusing first on different conceptualisations of the media audience, then on the general formal structure of popular mass

media health representations. I feel that there is now sufficient knowledge to propose a general account of representations that can guide future research studies and assist those concerned to understand the underlying logic that produces particular media health stories[1].

Following this, I outline areas of media and health studies that have been quite thoroughly investigated and others that have been less well studied. For this, I draw on my recent survey of published literature (Seale 2003) and analysis of the content of the 96 abstracts submitted by researchers internationally who applied to write a paper for this monograph. In the course of this section, I show how each of the papers in this volume fits into the field and, in most cases, how these studies offer guidance for future directions of research. I begin with a brief introduction to the structure of the media studies field.

Structure of media studies

Media studies, as it is generally taught to students, is often understood to divide into three broad areas of inquiry: production, representation and reception. Studies of production (for example, Glasgow University Media Group 1976, Schudson 1989) may concern the manner in which media producers behave, or aim to deepen understanding of the commercial environment of media organisations, or involve a 'political economy' approach to media institutions. Such studies ask, for example, about the nature of the influence exerted by governments, professional organisations and business interests on those responsible for producing various media. How do cigarette companies influence magazine editors through paying for advertising? How do the public relations activities of, say, the food industry influence what we see in the media? How do journalists relate to their sources and decide on what counts as a good story? How do health pressure groups use the web? How do government agencies and the medical profession attempt to regulate health information available on the internet?

Studies of representation involve analysis of media messages themselves. Such studies may seek for ideological biases, or the discursive dominance of particular themes and constructions, or be concerned with whether messages are likely to promote or damage health. Or they may investigate the formal properties of media messages as linguistic, narrative or semiotic systems. How does a medical soap opera portray doctors as against nurses? What messages about personal versus societal responsibility for health are conveyed in the advice columns of magazines? Which political analyses of the problems of health care systems get most coverage? Is health information on the Internet at variance with medical advice?

Studies of reception involve investigations of media audiences. Once considered passive recipients (or forgetters) of information, audience 'theory' developed during the 1980s towards a conceptualisation of audiences as

much more active in relating to mediated messages. A reconceptualisation of the 'mass' audience towards a view of fragmented 'audiences', with varying motivations and competencies, has also emerged. For example, politicians are important audience members: they are highly responsive to mass media reports. Media producers themselves are also members of the media audience. What they see in the media may influence what they produce. To what extent are health policies designed to assuage a potentially hostile media? To what extent do health professionals model their behaviour on what they see on the television? How do ordinary people respond to media messages about food scares, or safe sex, or exercise, or deadly diseases? How do people use health information on the Internet? These are examples of the questions that are of interest in reception, or audience studies.

Here, we can begin to see that distinctions between producers and consumers of media are not always easy to sustain. The concept of a feedback loop in which certain audience members are also involved in production is helpful here. In studies of the Internet the blurring of the boundary between audience and producer is particularly evident. The production of web sites and contributions to other Internet forums for the discussion of health matters and the promotion of particular health related messages is within the reach of many people, no longer being confined to specialist occupational groups of media producers. Action, pressure and patient groups may form around such Internet activities.

Understanding health and the media

The existing structure of this field of study is weighted towards analyses of health representations (this point will be made more evident in the survey of abstracts that follows this section). Any general account of media and health, if it is to be based on an adequate body of evidence, must therefore take this as the primary object of analysis. But in order to understand media health representations it is necessary to know a little more about the media health audience. In the discussion that follows, little reference will be made to media production issues[1] and, reflecting the balance of existing published work, the focus will be on traditional popular 'mass' media rather than the Internet or the more specialist media read by professional groups. They are nevertheless important areas and studies of the internet, as you will see, and are included in the papers in this volume because of their importance for the future of media health research.

Understanding the media health audience

This is necessarily brief, being the bare essentials of audience theory needed to understand the account of representations that follows (a fuller account that explains the underlying rationale for this selection is in Seale 2003: Chapter 1). In my view any general account of the media health audience

should take account of the following five points, which I list together with references to works in which the particular perspective is best expressed:

1. The audience may (or may not) seek health-promoting information as a part of rational risk profiling at fateful moments. The work of Giddens (1990, 1991, 1992) and to some extent Beck (1992) outlines this vision of the modern individual's relations to expertise, though not with particular reference to media audience theory.
2. The audience seeks emotional stimulation through dramatised contrasts that have an entertaining effect; fear and anxiety, for example, may be aroused so that they are experienced as a contrast to security and pleasure. Hill's (2000) studies of 'reality television' brings this out effectively, as does Langer's (1998) account of the 'other news'.
3. Audience readings are diverse, involving 'resistance' as well as alignment with dominant ideas. The notion of the 'active audience' was designed to replace earlier conceptions of audiences as passive recipients of information, a conception often embedded in early health education studies of 'effects'. The work of Hall (1980) and Morley (1986) has been influential here, although critical responses to over-enthusiastic depictions of audiences as always active and resistant have emerged to counter this (for example Philo 1999). This perspective is particularly important in any study of audiences where political issues are of concern.
4. The audience participates in an imagined conversation with mediated ideas, and in an imagined community of other viewers, people 'like me'. Anderson (1991) is responsible for this idea, relating it to the historical emergence of daily newspapers as the first such mass mediated conversation.
5. People draw on media in order to construct themselves – the media are mirrors for narcissistic (self-regarding) experimentation with different potential selves. Abercrombie and Longhurst (1998) outline this view.

Beyond these points there is a general one – perhaps the sixth in the list – that I feel has not yet been well recognised, which concerns the nature of audience experience. This is not structured in the same way as the neat divisions of research studies require. A media analyst, in general, picks a particular issue on which to focus: BSE, for example, or depression, or HIV/AIDS, or the emergence of some new contested syndrome, and so on. Once chosen, data may be gathered about the way a range of media presents that particular issue. But audience experience is not like this – it is at once more fragmentary and in a sense more active. As we go about our lives we may at one point in the day hear a report about a health scare on a radio programme, then read about a health policy in the newspaper, then spend the evening channel hopping on the television, seeing a soap opera where characters eat a variety of health enhancing or damaging foods, a documentary where a medical breakthrough is described, finishing with reading a magazine

where readers' letters about health issues are answered. Nowhere do we decide to spend the day focusing on the way a variety of media present the topic of depression. As the result of this fragmentary experience, we learn the conventions of an overall media health story, which has certain regular features. Media audiences generally are well schooled in recognising media conventions (the discipline of media studies only formalises a tendency to critique and analyse these which we all have to a greater or lesser extent). Members of media audiences, in fact, are able actively to 'fill in the gaps' when they experience a fragment of an overall story, as Benthall (1993) has argued in relation to audience experience of disaster relief stories:

> Even when only a part of a narrative relating to disaster is shown on television – for instance, pictures of starving babies, or an aeroplane setting off from a familiar airport bringing supplies, or an ambassador thanking the public for their generosity – viewers come to recognize it as part of the total narrative convention (Benthall 1993: 188–9).

It is in the context of this learned capacity of audiences to recognise narrative conventions (which media producers themselves may recognise and exploit) that we can understand media health representations.

Understanding media health representations

One of the many insights of narrative analysts (for example Propp 1968, Labov 1973) is that stories often work by creating and then exploiting oppositions. These are common in the overall story of media health. To list just a few classic oppositions, such stories contain heroes and villains, pleasure and pain, safety and danger, disaster and repair, the beautiful and the ugly, the normal and the freak, cleanliness and dirt, female and male, lay and professional, orthodox and alternative. Perhaps most importantly, media health stories often oppose life with the threat, or the actuality, of death. This last opposition explains, for Turow (1989), the enduring appeal of TV medical soaps, as well as the reason for the overriding focus on doctors rather than nurses or other health care workers in such dramas. Doctors can be more easily depicted making life or death decisions. This means that medical soaps – perhaps like all media health stories at some level – explore the most fundamental anxiety that we all face as embodied, finite beings.

A perennial complaint of scientists considering media reporting of scientific discoveries is that journalists sensationalise their findings, thus introducing inaccuracies (Nelkin 1995). For example, a new drug is either a miracle cure, or a potential Frankenstein's monster such as thalidomide. There is no room for a drug that is good in some respects but bad in others. This tendency to generate dramatic effect through extrematised oppositions is an aspect of what some have called 'tabloidisation' (Sparks and Tulloch 2000). Whether there exists an increasing tendency in Western media towards 'tabloidisation' or not (and there are those who will argue both sides

of this), opinion is also divided on whether such tendencies should be regarded as desirable. One view (seen for example in Livingstone and Lunt's (1994) analysis of daytime TV talk shows) is that tabloidisation is a route to greater democratic participation in the public sphere. It constitutes the popularisation of otherwise complex areas, thus drawing in more participants than otherwise. Others (for example, Franklin 1997) claim that the tabloid format represents a regrettable dumbing down in standards of public debate.

Clearly, popular mass media would cease to be popular if complexity were represented in a way that a scientist would find acceptable in a scientific journal. Some degree of simplification must be necessary if the dramatic oppositions that are the core device of story telling are to be created. Above and beyond this, though, the complaint of inaccuracy, with which the critique of tabloidisation is associated, reflects an inadequate understanding of the conditions of media production. People do not make TV programmes or publish newspapers solely in order to provide the public with accurate health information. The entertainment agenda (and this applies to news and current affairs as much, probably, as it does to 'fictional' products) is more dominant, and scientists, medical care providers and health educators have increasingly come to recognise this (Naidoo and Wills 2000).

Because audiences are well educated, through repeated exposure, in the standard oppositions and other forms that go to make up the media health story, they have certain expectations. But entertainment cannot be based solely on meeting expectations, otherwise the appetite for novelty suffers. Media producers know this, and through the phenomenon of the 'twitch' or the 'reversal' (Langer 1998) they play with audience expectations. This is also seen in the phenomenon of the media 'template' (Kitzinger 2000). I shall consider each of these in turn.

Kitzinger (2000) developed her idea of media templates in relation to child abuse stories. A famous case in Cleveland, UK in the 1980s involved the media-orchestrated vilification of a doctor and some social workers for removing children from families suspected of child sexual abuse, thus constructing a powerful sense of opposition between innocence and incompetence (or, even, evil). Later, events occurred in the Orkney Islands that, in the media reporting of the new case, were said to be 'another Cleveland'. The imposition of the Cleveland template on the Orkneys case meant that a ready-made set of stereotypes, judgements and interpretations could be applied. The Cleveland case had set up a 'template' so that when new cases of removal of children from families occurred, they could be understood as further examples of the original story. This operated both at the level of production (how journalists researched, wrote and conceptualised the story) and carried through to audiences. Kitzinger's focus group work showed how people used their understandings of the Cleveland-Orkney association to help remember and interpret the more recent scandal.

Karpf (1988) explains how this used to happen in stories about heart transplants:

> [Each one produces] perfect replicas of previous reports. They stress the desperation of those waiting for a heart, and the fear that time will run out. The fatal alternative is made plain. The operation is depicted as offering the chance of a new life or future, an opportunity to vanquish death. Grief and joy are voiced, and the press conference following the operation is an aria of hope (1988: 149).

We no longer see such heart transplant stories in Western media since the template that produced them has lost its currency with the proliferation and routinisation of the operation. A heart transplant story now needs an extra angle to become 'news' (for example, a dying Palestinian gives a heart to save the life of an Israeli). Templates, Kitzinger argues, can from time to time be reversed – indeed they must be when their currency begins to weaken. Thus stories of child abuse, in which adults were discovered to have committed abuse (a classic villain-victim opposition), became a tired format, the story being revived at one point by the reverse accusation of 'False Memory Syndrome', whereby the previously villainous father now became the victim, falsely accused by therapists and daughters (Kitzinger 1998).

Reversals of this sort, then, play on existing audience expectations to achieve a dramatic or entertaining effect. They confirm the existence of standard narrative conventions, their recognition by an 'active' audience, and the response to this by media producers. Langer (1998) presents some particularly subtle examples in his account of 'twitches'. Certain items become news because they disrupt expectations in an emotionally stimulating way. Langer suggests the following:

- a safety barrier impales a car driver;
- a schoolboy (rather than an engineer) builds a hovercraft;
- the Queen and Prince Philip visit a theme park and take a ride in a 'tunnel of love'.

The first of these is a very common format in media health stories that involve risks to health. An everyday object turns out to be dangerous – in this case something that is supposed to promote safety. Food scares can work like this – food is an everyday object, necessary for life. Yet food can kill.

The other two twitches also work by disrupting expectations. Schoolboys are not supposed to be able to do the things that engineers do; royals are supposed to maintain their dignity by not engaging in popular pleasures. This last example reminds us that media celebrities can themselves set a media agenda by initiating twitches and reversals. Thus Princess Diana shook the hand of a person with HIV/AIDS in order to disrupt then-dominant negative stereotypes; the footballer Pele, a hero of masculinity, nevertheless advertises the benefits of Viagra; the royal family now sit uncomfortably through rock concerts trying to look as if they enjoy them, so that previous images of aloofness may be disrupted.

A meta-narrative that runs through contemporary mass media health representations, containing a series of opposed elements, arranged in a way that allows a range of sub-plots, templates, twitches and reversals to be placed, can now be described. Its five key elements are listed below, with explanations and examples of each following the list. They constitute a series of core oppositions:

1. the dangers of modern life;
2. villains and freaks;
3. victimhood;
4. professional heroes;
5. lay heroes.

The first of these is a collection of stories that generate fear, and a concomitant 'culture of safety' (Furedi 1997, Reinharz 1997) that is a marked feature of life in advanced industrialised societies with a highly developed mass media. In a variety of ways, popular mass media emphasise the dangers of modern life. Food scares (salmonella, BSE) are vehicles for such scares (as well as identifying potential villains – farmers, big business). Environmental dangers – nuclear power, acid rain, climate change, power lines and cancer – are also much emphasised in health-related scare stories, as are, from time to time, a variety of infections (for example, herpes) or 'killer bugs' (necrotising fasciitis, ebola fever). Images of medical and scientific activity gone wrong – GM foods, breast implants, tampon-induced toxic shock syndrome, contraceptive pill scares – are also important in generating a climate of insecurity.

The second of these (villains and freaks) also concerns things that can threaten health and the sense of normality with which health is nowadays associated (Petersen 1994). In this case though, the threats come from threatening kinds of people. A classic example of this, in some areas of the media, was the treatment of HIV carriers in the early stages of the emergence of this virus, whereby prostitutes, injecting drug users and gay communities were stigmatised and feared (Watney 1997). A similar level of stigmatisation can be found in the media treatment of mental illness (Philo 1996). From time to time, scientists or representatives of big business (for example, 'agribusiness', tobacco manufacturers, nuclear power station operators) may be vilified (though not often personally) if they can be associated with harmful developments. The history of depictions of people with disabilities in film is replete with negative stereotyping.

Unlike harmful objects, 'harmful' or threatening people can have their reputation defended or restored. Because of the overwhelming interest in subjectivity in media accounts, it is hard to present any person, or group of people, as irredeemably evil over a sustained period of time. Perhaps the only group whose subjectivity is largely deleted from media representations are those of child molesters, who appear to be a securely stigmatised

category of person. Most other categories, in due course, attract stigma champions (as in the case of Princess Diana and HIV/AIDS), or they organise to resist media stereotyping (as in the case of the very successful disability movement).

With threats established and continually regenerated by a steady supply of stories, we can all imagine ourselves as potential victims. Yet, from time to time, media producers like to depict victimhood and for this they tend to choose people who represent ourselves at our most vulnerable. Thus the most effective victim portrayals in contemporary media are generally of children. Much concern with safety therefore focuses on child safety. Classically, stories of child abuse have served media producers well in this respect. A less common genre, but one that is more centrally located within the media health field, is the story of the sick child. The dimensions of this story and the way in which it compares with families' reported experiences of sick children (there are many disjunctures) have been analysed in a study by Dixon-Woods *et al.* (2003).

The fourth and fifth components of the media health meta-narrative are stories about professional and lay heroes. These, in their different ways, are set up to rescue the victims threatened by danger and villainy. Yet there are important tensions between these two kinds of hero, and understanding this helps us understand why villains cannot easily be securely stigmatised – their subjectivity comes through too often, as the elevation of the lay hero involves a quite pervasive media celebration of the subjectivity of the ordinary person that has gathered pace in recent years. This in turn generates an obligation to be tolerant and inclusive of difference, something which can test the ingenuity of media producers obliged to replace old hate figures with new ones, all the time risking the alienation of important media audience constituencies, should vilification be taken 'too far'.

Sociologists of health and illness are independently interested in the changing nature of professional-lay relations. For example, the 'proletarianisation' and the 'deprofessionalisation' theses (Elston 1991) assess the argument that there is a decline in the social and cultural authority of medicine. Karpf's (1988) study of media and health took this as its theme, concluding that in spite of some knocks, medical prestige was as strong as ever on the television. Perhaps if she was writing now, her view might have changed, as it is now quite routine for media health stories to appear announcing medical authority to be bankrupt (see also Bury and Gabe 1994). For example, in Britain in recent years individual doctors have been taken to task in a variety of scandals – the Cleveland child abuse scandal mentioned earlier, the case of the murderous family doctor Harold Shipman, a scandal concerning the storage of dead children's organs at Alder Hey hospital, another involving heart surgeons (again concerning children, significantly enough) in Bristol, whose mistakes were said to have cost lives. Entwistle and Sheldon (1999) list some typical headlines: 'Patients claim they woke during surgery', 'Therapy error in cancer cases', 'Surgeon is suspended over breast

operations', 'Disease could be spread by surgical tools'. There are vestiges of the unassailable Dr Kildare in contemporary representations, though, and media health stories – particularly medical soaps – commonly contain images of doctors acting to rescue threatened victims. But in general this source of rescue is as likely to turn sour or dangerous as the villain is to turn good. Like the villain, the professional hero is no longer a secure category.

Instead, emerging in media health stories with particular force in recent years is the figure of the lay hero. Powers are often conferred on this figure that are at least as 'unrealistic' as those conferred on Dr Kildare in an earlier generation. The confessional narrative has become popular over a range of media genres. In relation to cancer and terminal illness, for example, personal accounts abound in which people recount their tribulations and successes in the face of life-threatening disease (McKay and Bonner 1999). These often contain a significant anti-medical component, in which orthodox medicine is cast as unhelpful or flawed. Additionally, lay heroism possesses a significant gendered component, as my own studies of cancer stories in the news have shown (Seale 2002). Women are generally portrayed as more skilful than men in managing their own health, confirming Giddens' observation that women have pioneered the transformation of intimacy that self-identity now involves, largely through the appropriation of emotional skills so that women are 'the emotional revolutionaries of modernity' while men experience a 'lapsed emotional narrative of self' (Giddens 1992: 130). Media health representations have played an important part in this shift, which is associated with a demagogic alliance of media organisations with the supposed interests of ordinary viewers and readers, championing Everyman or woman in the risky environment of modern life. Increasingly widespread involvement by lay people in producing Internet health sites seems likely to increase this tendency.

If sociological studies of health in the media were to become more oriented to understanding production and reception issues, it is likely that a pressing concern would be to understand the consequences of the increased emphasis on lay powers. Analysts might ask, for example, how institutional and governmental interests seek to exploit this apparent 'empowerment' of ordinary people. The development in the United States of 'direct to consumer' advertising by pharmaceutical companies is an example of such commercial exploitation of lay empowerment (Yamey 2001). No longer passively following medical advice, consumers are expected by pharmaceutical companies to respond to media advertisements by demanding particular products from their doctors. The paper by Kroll-Smith in this volume also shows an important way in which mass media, including the Internet, may bypass the influence of health care interests, showing how a new syndrome has been constructed in large part by lay activists with low levels of involvement by medical authorities. The papers in this volume that relate to the Internet show, too, how active consumers may behave, potentially placing the traditional advice of health care system representatives in a less dominant

position. In this changing power relation between professional and lay interests, it is important to understand how media producers and audiences relate to health-related media messages. This is an important project for sociologists and media studies specialists alike.

Survey of abstracts and papers in this volume

In the light of this somewhat selective account of the media health studies field it is instructive to survey the actual practice of researchers to examine where current emphases lie, and where potential progress remains to be made. To do this, I shall present a brief survey of the 96 abstracts submitted by people who applied to write a paper for consideration for inclusion in the current monograph. I shall also draw on my review of the field (Seale 2003) and will show how the papers in this volume relate to the field as a whole. In many cases, they were chosen because they point to new directions for future media health research.

Media studies of health interest researchers internationally. Excluding five abstracts that turned out not to involve media topics, and based on the institutional location of the lead author, the most frequent originating country for proposals was the UK (33 abstracts), followed by Australia (19), the USA (18), and Canada (7). Other countries (Israel, France, the Netherlands, Spain, Taiwan, South Africa, Brazil, India, Singapore and Japan) produced 15 more abstracts. No doubt the bias towards English language authors and the UK reflects in part the circulation of the journal, which is edited in the UK and published in English only. In part, though, it reflects the geographical location of the relevant disciplines which is also reflected in the societies that authors have studied. For example, we do not, on the whole, know very much about how the Soviet media presented health matters and how this did or did not change with the political changes of the last 15 years. Such an omission might be considered important given the devastating impact on population health of these upheavals (Seale 2000) and the subsequent slow recovery (Shkolnikov *et al.* 1998). Nor do we know as much about African media treatments of HIV/AIDS as we do about Western media depictions (Watney 1997), there being only a few such studies (for example, Gibson 1994) in spite of the relatively more devastating impact of this disease in Africa.

The abstracts also confirm the dominance of studies of representation above those of production and reception. Of course, some studies are not easy to categorise in this way but a crude categorisation revealed that 64 of the 91 valid[2] abstracts (70%) involved analysis of representation (58 were concerned with this alone). 23 (25%) involved analysis of reception and 11 (12%) involved analysis of production (percentages add up to more than 100% since several papers combined two or more dimensions). A large proportion of studies simply referred to 'the media' as a whole as their object of study, or listed a large range of media types (23 abstracts). Of those with

a more specific focus, studies involving newspapers were most common (26), followed by magazines (15), television (12) the Internet (9), film (6) and health promotion literature (6). There was a tendency for studies focusing on magazines alone (rather than including them under the general 'print media' title) to involve investigation of gender-related issues. The division of magazines into 'men's' and 'women's' was useful for several analysts, with studies of women's magazines being more common than studies of men's. Other media studied included photographs, a theatre play, a piece of computer software, 'confessional' books in which authors told a personal story of illness, and advertisements in health professional journals.

The predominance of studies of representation and, to some extent, of written text (newspapers, magazines, etc.) over images (film, television, photos, etc.) is, in my view, related to the ease with which relevant data can be collected and analysed. Unsurprisingly, almost all of the studies employed a qualitative methodology which may be thought easier to apply to text rather than images. The material needed for studies of production and reception (transcripts of interviews and focus groups for example) are rather onerous to produce as these involve gaining access to settings, approaching and questioning or observing participants, and transcription of the talk that results. All of this is bypassed in studies of media representations, which are all around us and, in the case of many studies, are downloaded from electronic sources (for example, news archives) in electronic form amenable to analysis. The focus on representation is a notable feature in other areas of media studies, probably for the same reasons. As a result, not as much is known about issues of production and reception, with the former being particularly underdeveloped.

The biases evident in the abstracts were also true in my review of published literature. Exceptions in the health field are Karpf's (1988) British study of broadcast media, which provides an institutional analysis of media production of health stories by focusing on the history of the BBC, and Turow's (1989) account of American medical soaps in which relations between media producers and professional medical associations are charted. Miller *et al.* (1998) are notable in presenting a study investigating all three aspects, conceived as a 'circuit of mass communication', focusing on AIDS coverage. But the relative absence of media production studies means that political aspects of media health representations are inadequately understood.

Topics covered in the submitted abstracts were wide ranging, but revealed some more biases. Most notable was the relatively low number of studies investigating media and health policy issues, though this is probably the predominant focus of health news reporting. The lack of interest by media analysts in this area may parallel the rather thin level of interest shown by medical sociologists in the processes of policy making in health care (although there are some notable exceptions, for example, Strong and Robinson 1990). Although the published literature shows that there has been

some interest in media coverage of health policy (for example, Entwistle and Sheldon 1999, Miller and Reilly 1995) it is an underdeveloped area. Only five abstracts fell firmly into this category and, in line with the aim of promoting work in hitherto neglected areas, the papers emerging from three of these (Davidson *et al.*, Hodgetts and Chamberlain, Hughes and Griffiths) are published in this monograph. One of these is a study of the news reporting of particular health policy initiatives (Davidson *et al.*); another (Hodgetts and Chamberlain) is a reception study in which links with the 'lay health beliefs' literature, a long-standing area of medical sociology, are made. These two papers also make important contributions to our understanding of media involvement in the health inequalities debate, another topic that has been of considerable interest to medical sociologists. The third paper (Hughes and Griffiths) concerns production and reception issues, being part of an ethnographic study of negotiations in health management organisations, focusing on the way these involve reference to media reporting.

As we have seen, Internet studies were somewhat rare in the submitted abstracts, partly reflecting the novelty of this medium. Such studies often depicted themselves as studies of 'information' rather than representation, sometimes focusing on the use people make of health information on the Internet, so that six of the nine studies of the Internet involved 'reception' analysis of this kind. Given the interest shown by some sociologists in the cultural construction of illness in medical textbooks (for example, Martin 1989) and in medical knowledge generally, as well as the orientation of other media health analysts towards critical social constructionist analyses of media representations, it is surprising that this approach appears not to be pursued by Internet health researchers. Such an approach, of course, is not to be equated with the concern often expressed by medical authorities (Kunst *et al.* 2002) over the issue of the 'accuracy' of health information that is available on-line. Three of the Internet abstracts led to papers that appear in this volume. Henwood *et al.* report on a 'reception' study, in which the focus is not solely on how Internet-based information is used, but on the consequences of having such information for approaches to patienthood. Gillett's is a study of 'production', charting the way in which web-based representations and discussions of HIV-related issues can be understood as a part of a broader social movement in which people with a health condition forge new identities. Kroll-Smith's concerns the cultural construction of a new condition (Excessive Daytime Sleepiness) across a variety of mass media, with the Internet playing an important role in disseminating information that allows people to self diagnose and treat without recourse to orthodox medical care.

The meanings of cyber-space for individuals seeking treatment for phobias are explored in the paper by Davidson and Smith in this volume. Though not about an Internet-based virtual reality, this study shows one possible way forward for Internet studies concerned to understand how this medium may construct health matters. The authors report on the

cultural construction of 'nature' involved in such software based treatment programmes.

A significant, though quite small, group of abstracts concerned media representations of approaches to health care and health care workers. Of 13 such studies all but two were concerned with analysis of representations alone. Four of these concerned portrayals of alternative or complementary medicine; a further six concerned medical procedures or therapies that related to an interest in gender, and in particular the situation of women. These studies concerned reproductive technologies, cosmetic surgery and the oral contraceptive pill. The other three concerned medical soaps or dramas, a subject where portrayals of health professionals have been analysed in some detail (see for example, Turow 1989, Kalisch *et al.* 1983). The study by Davin in this volume is unusual in this literature in so far as it involves exploration of reception issues, comparing medical dramas with documentaries to produce a surprising result about the relative credibility accorded to these.

Health educators and promoters have a long-standing interest in the effects of health-promotion campaigns, including those mounted in the mass media. Health educators have also been at the forefront of concerns about potentially harmful effects of the incidental portrayal of health matters in mass media (for example, Gerbner *et al.* 1981, Signorielli 1993). Inevitably a proportion of abstracts (roughly 15) reflected these concerns, and these often involved reception studies. This genre of study also provided the few examples of quantitative work. Apart from studies specifically concerned with evaluating the effects of health education campaigns there were several studies that focused on the degree to which particular media forms portray healthy or unhealthy behaviour (for example, very thin female models; smoking; drinking; eating certain things). There were also some studies analysing health promotion literature, usually from a critical point of view. Critical analyses of materials involved in HIV-prevention campaigns were present in the submissions, and are very common in the published literature (for example, Watney 1997).

Another significant group of studies (roughly 12) concerned health risks, such as the media presentation of food scares or infectious disease of various sorts. Some of the published literature in this area concerns the underlying politics of news reporting (for example, Miller and Reilly 1995). However, perhaps the most common category of abstract (roughly 35) concerned studies of media treatments of personal health-related experiences, these often being illnesses. These included, for example, death, sleep, obesity, birth, cancer, suicide, Gulf War Syndrome, Excessive Daytime Sleepiness, old age, genetic disease, ADHD, organ donation, mental illness, accidents, herpes and depression. Selection of studies for this monograph has been guided by criteria of overall quality and originality, focusing in particular on areas that are relatively under-studied at present. But there is also an obligation to reflect the kind of work that is most commonly done in media and health studies. In selecting an example of a study of media

representations of personal health experience we are fortunate in having the study by Kroll-Smith (mentioned earlier), which makes important new advances in understanding the medicalisation thesis (Zola 1972) and the analysis presented by Rowe *et al.* on the depiction of depression in Australian print media. This last study presents evidence that contrasts with the finding most usually reported in studies of mental health issues in the media – that these depictions overemphasise the violent and dangerous behaviour of those with mental health conditions (Philo 1996). Instead, depression is presented by media as a problem pervading the everyday lives of 'normal' people.

Evident in any review of the media and health field is the existence of some rather poor-quality studies of media representations. To paint a rather negative imaginary picture, consider the conduct of a study of the media representation of an illness condition that has attracted the attention of a researcher, perhaps through some personal experience that has generated strong feelings. The researcher decides 'the media' are responsible in some way for misinformation, and so a study is required. Rapidly, a great deal of information is collected in the form of news cuttings, tapes of broadcasts and downloaded files. What to do with this unwieldy mass of materials? The researcher is driven by the urge to discover the truth of his or her existing views rather than an interest in the theoretical problems of a parent discipline, or indeed the pragmatic concerns of health policy makers, providers and user groups. Thus the researcher bypasses the laborious business of turning such general considerations into a systematic coding scheme that will organise materials for analysis and facilitate a search for negative instances and analytic depth (Seale 1999). Instead, examples are selected anecdotally that support the analyst's views and a report emerges, that is usually strongly critical of the representations designated as 'dominant', sometimes also sprinkled with extracts from impressively worded social theory, brought in post-hoc as a kind of decoration.

In my selection of studies for this volume I have tried to avoid the publication of such material, so that the collection will serve as an example of studies that have been done to a good methodological standard, as well as showing how this important field of study may be developed in the future.

Acknowledgements

Thanks to Robert Dingwall, Jonathan Gabe, Jenny Kitzinger and Mary Dixon-Woods who all provided helpful comments on an earlier draft of this introduction. My thanks also to the many individuals who submitted abstracts and wrote papers for consideration. I was overwhelmed with the response to this special issue and am sure that many of the papers that could not be included will form excellent publications elsewhere. Numerous referees helped in assessing the papers and I am particularly grateful to referees who did this conscientiously and fairly even though their own abstracts were not accepted for the issue. Allison Pearson, the editorial

board of the journal and, once again, Jonathan Gabe and Robert Dingwall provided valuable support throughout the process. My thanks to them all.

Notes

1 A fuller account of the media production processes underlying health stories is available in Seale (2003: Chapter 3) and is only touched on here.
2 Five abstracts turned out not to involve studies of media-related topics.

References

Abercrombie, N. and Longhurst, B. (1998) *Audiences: a Sociological Theory of Performance and Imagination*. London: Sage.

Anderson, B. (1991) *Imagined Communities: Reflections on the Origin and Spread of Nationalism*. London: Verso (2nd Edition).

Armstrong, D. (1983a) The fabrication of nurse-patient relationships, *Social Science and Medicine*, 17, 8, 457–60.

Armstrong, D. (1983b) *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century*. Cambridge: Cambridge University Press.

Armstrong, D. (1984) The patients' view, *Social Science and Medicine*, 18, 9, 737–44.

Beck, U. (1992) *Risk Society: towards a New Modernity*. London: Sage.

Benthall, J. (1993) *Disasters, Relief and the Media*. London and New York: I.B. Tauris.

Bury, M. and Gabe, J. (1994) Television and medicine: medical dominance or trial by media? In Gabe, J., Kelleher, D. and Williams, G. (eds) *Challenging Medicine*. London: Routledge.

Castells, M. (1996) *The Rise of the Network Society*. Cambridge, MA: Blackwell Publishers.

Dines, G. and Humez. J.M. (eds) (2002) *Gender, Race, and Class in Media: a Text-reader* (2nd Edition). Thousand Oaks, California: Sage.

Dixon-Woods, M., Seale, C., Young, B., Findlay, M. and Heney, D. (2003) Representing childhood cancer: accounts from newspapers and parents, *Sociology of Health and Illness*, 25, 2, 143–64.

Elston, M-A. (1991) The politics of professional power: medicine in a changing health service. In Gabe, J., Calnan, M. and Bury, M. (eds) *The Sociology of the Health Service*. London: Routledge.

Entwistle, V. and Sheldon, T. (1999) The picture of health? Media coverage of the health service. In Franklin, B. (ed) *Social Policy, the Media and Misrepresentation*. London: Routledge.

Franklin, B. (1997) *Newszak and News Media*. London: Arnold.

Furedi, F. (1997) *Culture of Fear: Risk-taking and the Morality of Low Expectation*. London and NewYork: Cassell.

Gerbner, G., Gross, L., Morgan, M. and Signorielli, N. (1981) Health and medicine on television, *New England Journal of Medicine*, 305, 15, 901–4.

Gibson, M.D. (1994) AIDS and the African press, *Media Culture and Society*, 16, 349–56.

Giddens, A. (1990) *The Consequences of Modernity*. Cambridge: Polity Press.

Giddens, A. (1991) *Modernity and Self-identity: Self and Society in the Late Modern Age*. Cambridge: Polity.

Giddens, A. (1992) *The Transformation of Intimacy*. Cambridge: Polity.

Glasgow University Media Group (1976) *More Bad News*. London: Routledge and Kegan Paul.

Hall, S. (1980) Encoding/decoding. In Hall, S. (ed) *Culture, Media, Language*. London: Hutchinson.

Hill, A. (2000) Fearful and safe: audience response to British reality programming, *Television and New Media*, 1, 2, 193–213.

Kalisch, P.A., Kalisch, B.J. and Scobey, M. (1983) *Images of Nurses on Television*. New York: Springer.

Karpf, A. (1988) *Doctoring the Media: the Reporting of Health and Medicine*. London: Routledge.

Kitzinger, J. (1998) The gender-politics of news production: silenced voices and false memories. In Carter, C., Branston, G. and Allan, G. (eds) *News, Gender and Power*. London: Routledge.

Kitzinger, J. (2000) Media templates: patterns of association and the (re)construction of meaning over time. *Media Culture and Society*, 22, 1, 61–84.

Kunst, H., Groot, D., Latthe, P.M., Latthe, M. and Khan, K.S. (2002) Accuracy of information on apparently credible websites: survey of five common health topics, *British Medical Journal*, 324, 581–2.

Labov, W. (1973) *Language in the Inner City*. Philadelphia: University of Pennysylvania Press.

Langer, J. (1998) *Tabloid Television: Popular Journalism and the 'Other News'*. London: Routledge.

Lawton, J. (2003) Lay experiences of health and illness: past research and future agendas, *Sociology of Health and Illness*, 25, Silver Anniversary Issue, 23–40.

Livingstone, S. and Lunt, P. (1994) *Talk on Television: Audience Participation and Public Debate*. London: Routledge.

Lupton, D. (1994) *Medicine as Culture: Illness, Disease and the Body in Western Societies*. London: Sage.

Martin, E. (1989) *The Woman in the Body: a Cultural Analysis of Reproduction*. Buckingham: Open University Press.

McKay, S. and Bonner, F. (1999) Telling stories: breast cancer pathographies in Australian women's magazines, *Women's Studies International Forum*, 22, 5, 563–71.

Miller, D. and Reilly, J. (1995) Making an issue of food safety: the media, pressure groups and the public sphere. In Maurer, D. and Sobal, J. (eds) *Eating Agendas: Food and Nutrition as Social Problems*. New York: Aldine de Gruyter.

Miller, D., Kitzinger, J., Williams, K. and Beharrell, P. (1998) *The Circuit of Mass Communication: Media Strategies, Representation and Audience Reception in the AIDS Crisis*. London: Sage.

Morley, D. (1986) *Family Television: Cultural Power and Domestic Leisure*. London: Routledge.

Naidoo, J. and Wills, J. (2000) *Health Promotion: Foundations for Practice*. London: Balliere Tindall.

Nelkin, D. (1995) *Selling Science: how the Press Covers Science and Technology*. New York: W.H. Freeman.

Petersen, A. (1994) Governing images: media constructions of the 'normal', 'healthy' subject, *Media Information Australia*, 72, 32–40.

Philo, G. (ed) (1996) *Media and Mental Distress*. London: Longman.

Philo, G. (ed) (1999) *Message Received: Glasgow Media Group Research 1993–1998*. Harlow: Addison Wesley Longman.

Pierret, J. (2003) The illness experience: state of knowledge and perspectives for research, *Sociology of Health and Illness*, 25, Silver Anniversary Issue, 4–22.

Propp, V.I. (1968) *Morphology of the Folk Tale*. Austen: University of Texas Press.

Reinharz, S. (1997) Enough already! The pervasiveness of warnings in everyday life. In Glassner, B. and Hertz, R. (eds) *Qualitative Sociology as Everyday Life*. Thousand Oaks: Sage.

Rose, N. (1999) *Governing the Soul: the Shaping of the Private Self* (2nd Edition), London: Free Association Books.

Schudson, M. (1989) The sociology of news production, *Media, Culture and Society*, 11, 3, 263–82.

Seale, C.F. (1999) *The Quality of Qualitative Research*. London: Sage.

Seale, C.F. (2000) Changing patterns of death and dying, *Social Science and Medicine*, 51, 917–30.

Seale, C.F. (2002) Cancer heroics: a study of news reports with particular reference to gender. *Sociology*, 36, 1, 107–26.

Seale, C.F. (2003) *Media and Health*. London: Sage.

Shkolnikov, L., McKee, M. and Leon, D.A. (2001) Changes in life expectancy in Russia in the mid-1990s, *Lancet*, 357, 9260, 917–21.

Showalter, E. (1987) *The Female Malady: Women, Madness, and English Culture, 1830–1980*. London: Virago.

Signorielli, N. (1993) *Mass Media Images and Impact on Health*. Westport Connecticut: Greenwood Press.

Sparks, C. and Tulloch, J. (eds) (2000) *Tabloid Tales: Global Debates over Media Standards*. London: Rowman and Littlefield.

Strong, P. and Robinson, J. (1990) *The NHS under New Management*. Buckingham: Open University Press.

Turow, J. (1989) *Playing Doctor: Television, Storytelling, and Medical Power*. Oxford and New York: Oxford University Press.

Watney, S. (1997) *Policing Desire: Pornography, AIDS and the Media*. London: Cassell, (3rd Edition).

Yamey, G. (2001) You can always pop a pill, *British Medical Journal*, 322, 804.

Zola, I.K. (1972) Medicine as an institution of social control, *Sociological Review*, 20, 407–504.