1994. The question was whether in new shows the storytellers would be interested in confronting the brokenness of the health care system and maybe even exposing the rift between the public and policy views of the reasons. The answer is that both *Chicago Hope* and *ER* nodded mostly indirectly to the institutional tensions swirling around doctors and hospitals. One way they did this was to echo those tensions through a novel kind of realism, one based on gore, of accuracy of settings, and (in *ER*) speed. A more important way was to emphasize physicians' personal angst and the rarity of extended doctor-patient relationships.

Gore, Speed, Angst, Truth

Both *ER* and *Chicago Hope* made their debut during the second week of September 1994. A few days later, on September 26, Senate majority leader George Mitchell of Maine pronounced health care reform officially dead for the year; the "year" actually turned into fourteen. The juxtaposition was undoubtedly a coincidence. But in retrospect it's clear that the TV people believed with politicians that there was little to be gained by consistently engaging Americans head on with what seemed to be the scariest demons of the medical system. Instead, for their most obvious stabs at realism the creators of both *ER* and *Chicago Hope* turned to the kind of gore and frankness about illnesses that a few years before people in Hollywood had confidently stated the audience wouldn't accept. Several days before the programs aired, *USA Today* announced *Chicago Hope*'s calling card in an article headlined "Hope and Gory: Drama Aims for Realism." It underscored the first episode's depiction of brain tumors, the separation of Siamese twins, and "lots of blood and body organs."[16] A few weeks later, the *Boston Globe* noted the "inner-city realism of *ER,* where the stab wounds and adrenaline are almost as plentiful as the fluorescent lighting."[17]

The nature of realism in both series became a standard part of commentators' discussions of the programs. Close comparison of the two was almost inevitable because the programs were going head to head in a coveted time slot and because they were both based in the same city. David E. Kelly, *Chicago Hope*'s Emmy-winning writer-producer, told *USA Today* that he aimed to make the show the most realistic drama ever seen on TV. He noted that scenes in the first episode caused ad-

vertisers previewing it to squirm. But, he added, "The operation scenes, which some have considered graphic, are a necessary wake-up call to our audience. . . . This is not a hospital where everything will be aesthetically pleasing. This is a place that can be startling and wrenching."[18] The intent, he added, was to remind the audience "that this is a real hospital."

It was also a very wealthy hospital. A number of articles reported that Kelly, who was a big fan of downtrodden *St. Elsewhere,* wanted to avoid comparisons by moving the hospital from Boston to Chicago and giving it all the resources its physicians needed. The doctors too were shown as wealthy. Their apartments were classy; their civilian attire was impeccable; and in one scene two of the central physicians were seen driving golf balls in Wrigley Field, a perk they said came with the job. The conflicts in the hospital—and there were many—came from three sources: the gut-wrenching physical problems of patients, the ethical dilemmas that often rode along with those physical problems, and the interpersonal angst of the doctors and nurses that flowed from the patients and the problems they brought to the hospital.

Part of physicians' personal trauma, to Kelly, involved dealing with the law. A lawyer himself who had written sixty-seven episodes of the well-regarded series *LA Law* in the late 1980s, Kelly included the hospital attorney, Alan Birch, as a continuing character. In the first episode the focus on patients extends to persuading an HMO to allow a low-income African American patient to have an operation at *Chicago Hope* even though the HMO typically doesn't send patients to the hospital for cost reasons. Birch's scenes with the HMO executive voice the worst concerns people might have about the dangers of managed care: cost calculations above all and indifference to individual life. In the end, Birch finds a way to scare the HMO representative into believing that his hospital will lose a giant lawsuit if the *Chicago Hope* surgeon doesn't carry out the procedure.

As it turned out, though, plots that depicted managed care or other aspects of insurance were rare. Birch's role was typically to protect the *Chicago Hope* physicians from malpractice complaints brought against Hope doctors and, in at least one incident, by one doctor against another. Over the years, he sided with the physicians against outside forces—patients, companies, even government bodies such as the FDA.

This approach was approved by the chief of surgery, who worked, a *Boston Globe* writer noted, "to keep all the egos in line and the hospital's eyes focused on the patients instead of the bottom line."[19]

Rather than exploring the implications of the lack of availability, for many people, of a place like *Chicago Hope, Chicago Hope* used those accessibility issues in addition to patient diseases and interpersonal matters to create emotional and interpersonal problems for the doctors. In an interview with a New Zealand newspaper, Kelly explained the causal links from patient to problem to physician: "This is the place where every surgeon wants to work, and every sick person wants to go—a very upscale hospital with the best of the best practitioners. But everybody is demanding time of these doctors and their selflessness sees them give away more time than they should. As a result, their personal lives are sometimes the casualties of their profession."[20]

The same focus on physician angst that stems from sacrifice for patients could be attributed to *ER*. In *ER,* the panorama of character types was broader, not just among the doctors but among the staff as well. A few important continuing plot lines surrounded nonphysician characters—notably a black physician assistant who develops HIV and whose attempts to cope punctuate several episodes. Most of the action, however, involved physicians. They had the central foibles and problems that extended across episodes. From the start we see Dr. Mark Greene resisting the pleas of his wife to move to an easier and more lucrative private practice; Dr. Doug Ross, a womanizer who gets drunk on his infrequent nights off; Dr. Peter Benton, "Black and ambitious, his insecurities tucked behind a gruffly serious façade";[21] Dr. John Carter, a boyish med student who isn't quite sure how to get things right; and Dr. Susan Lewis, who is clearly giving up personal relationships to carry out her medical duties. Over time, the show followed the travails of more African American physicians—male and female—as well as South Asian Indian, Chinese, and Croatian doctors. One of the central emergency room physicians also turned out to be a lesbian, and there were subplots around that topic.

The first episode pointed viewers directly toward the causal model tying patient and patient's problem to the sacrificial angst of the physician via an engaging exchange between one of the emergency room residents and a patient who comes on to her. "You're beautiful, Doc," he

assays. "Thank you," she answers. "You married?" he probes. "No. I'm a doctor," she deadpans and parries his obvious interest in carrying the conversation further.

The key point made, the scene switches, and switches quickly again, at a pace that became the signature element of the show. Reviewers comparing *ER* with *Chicago Hope* focused on what they called the former's speed and excitement. *USA Today* described it as "A trauma-rama that opens on an adrenaline rush and pretty much stays there, with timeouts for pathos and sex and dark hilarity." The two-hour pilot, it noted, introduced a "cast of instant stars and dizzying parade of needy patients from the comic (a rich hypochondriac with a hangnail, a nympho with burned thighs) to the tragic (DOAs, ODs, knife and gun victims, abused babies, and the terminally ill)." It added that "This is no slam against its Thursday night competition, CBS' *Chicago Hope* . . . But if *ER* sustains the pace of its first episodes, this will be the one commanding magazine covers with its hot young cast and blistering edge."[22]

The prediction was accurate. CBS executives quickly realized that in head-to-head combat at 10 p.m. *Chicago Hope* was losing the ratings race. (Some pundits suggested that viewers set their VCRs to record one or the other series for later watching, but taping *Hope* wouldn't help CBS because Nielsen at the time was not counting delayed viewing.) *ER*'s quick lead in tune-in numbers led several writers to speculate on the factors behind its lead. The tendency was to center on the program's pace, its cavalcade of many patients (as opposed to *Hope*'s penchant for just a few during the hour), and its "gritty" environment (as opposed to *Hope*'s elitist docs in fancy digs).

John J. O'Conner of the *New York Times* went further and tied *ER*'s rise to the Clinton health care debacle. He admitted that some of the reasons for the program's hit status could be traced to "production talent" (writer Michael Crichton, a best-selling author and physician, and John Wells, the executive producer, who had also guided *China Beach*) and "network shrewdness" (placing the series after a hit lineup that included the phenomenon *Seinfeld*). He agreed with John Wells that "audiences are tired of '80s-style exposition, going in stately cadences from A to B"—the style of *Chicago Hope* as opposed to the faster, "smoothly jumping" pace of *ER*. But he dwelled on the suggestion that *ER*'s hit status "must stem from the American public's escalating anxieties over health care in the wake of the utter confusion and helplessness in

Washington." He quoted Wells that "People are frightened about going to emergency rooms, about not being cared [for] by people who are compassionate."[23] As it turned out, compassionate did not mean predictably healed. Like Kelly, *ER*'s creators wanted people to believe in the power of modern medicine. Right from the start, though, they announced there would be no guarantees. In *ER*'s first episode, Dr. Susan Lewis sums up the basic idea to a patient who may or may not have lung cancer (we never learn whether he does): "Mr. Parker, if there's one thing you learn in my job, it's that nothing is certain. Nothing that seems very bad and nothing that seems very good. Nothing is certain. Nothing."

O'Conner speculated that "the assurances provided by *ER*" that professionals were working extraordinarily hard in a gritty environment to provide "reasonable attention . . . sometimes on short notice" accounted for its "immediate victory" over the more elite *Chicago Hope*.

> For the most part . . . *E.R.* stays close to the facts of an emergency room. There are few miracles, and the stories don't always have happy endings. People do die. What with some residents sleeping on duty and at least one nurse overdosing on drugs, the series is already being criticized by medical groups, including the American Board of Emergency Medicine. Gone are the days, evidently, when the American Medical Association could oversee the content of hospital dramas. Given the current disenchantment with the health-care debate, the public is bound to applaud the caring, $36,000-a-year workaholics on *E.R.*[24]

Whether or not he was accurate about viewers' impressions, O'Conner could have been reading the minds of *ER*'s creators. "There was a great deal of disillusionment with health and the quality of medical care that was available in the United States, particularly with doctors, who were perceived to be interested in their own financial security," Wells told an Australian newspaper. "So we very consciously talked about a show about a group of residents working in an inner-urban hospital where they were underpaid. We felt that story wasn't being told."[25]

Over the years, the series darkened its vision of the emergency-room principals. As noted, one of the physician assistants developed HIV and had to contend with its implications. Mark Greene died of brain cancer, leaving a "caustic" widow, the surgeon Elizabeth Corday. Dr. Rocket Ro-

mano, a "genuinely arrogant jerk of a surgeon," had an arm sliced off by a helicopter blade, became angrier than ever, and ultimately was killed by a helicopter landing on him. These types of dramatic scenarios, which often crossed several weeks, carried only short mentions of ethical or policy issues. Beth Hoffman, a University of Pennsylvania medical student, conducted a careful analysis of several episodes from each of the first nine years of *ER*. She counted the number of patients, the time health care providers spent discussing or treating them, the time that the program spent with characters outside the emergency room, and time spent discussing health policy issues. Hoffman found that although issues around *ER* resources and insurance arose now and then, they rarely took center stage amid the medical specifics, patient stories, and story arcs involving the doctors and (less centrally) the nurses. In one typical episode, from 1995, viewers heard about 2.5 minutes of health policy or administrative issues around health care discussed:

—Mark Greene complains briefly (30 seconds) to Dr. Morgenstern about how the hospital beds are always full and so patients are not moved from the ER.
—In the hospital administration meeting there are several mentions about budget and the ER being over budget; also [a] mention [of] JACHO [Joint Accreditation Committee for Hospital Operations] inspection (1 minute total for meeting).
—In nurses[']' meeting, Carol briefly goes over re-certification requirements and some other administrative duties (1:20).[26]

Kerry Weaver, a doctor and *ER* administrator, was probably the program's most direct attempt to bring the demands of the business world to bear on the doctors' feverish work. This focus on forcing scarcity upon the emergency room didn't last long, however. As in the case of *Chicago Hope*'s Alan Birch, the writers turned the characters in other directions. As one writer noted, Weaver "began as a villain but has blossomed into one of the most original characters on television: a bureaucratic climber whose pragmatism can shift from admirable to corrupt in the course of a sentence. Kerry's gradual coming out as a lesbian was a . . . slow-building transformation that was touching without being sappy, and far too idiosyncratic to serve as any kind of lesson." The transformation didn't make her into an ideal physician—a story arc had

Kerry colluding with a closeted gay alderman to win city money for the hospital—but it did remove a plot itch around resources and saving money instead of patients.

Another element that became clear quite early in the promotion of *ER* was the show's approach to medical expertise in creating the program. The American Medical Association was no longer the direct influence over health care depiction that it had been in the 1950s and 1960s. The creators of *ER* and the programs that followed didn't seem to feel external pressure to vet the accuracy of their medical presentations, but they did do so—and they touted it proudly. In the case of *ER,* the vetting was built into the creation. Popular articles emphasized the medical pedigree of series creator and best-selling author Michael Crichton, who had written the script in 1974—around the time *M*A*S*H* came into prime time. Crichton's creation tale was that he wanted to write something based in reality with a fast pace, something "very technical, almost a quasi-documentary," but recalled that the approach was criticized for not conforming to conventional style.[27] One writer commented that "ironically, that non-conformity is seen now as one of the main reasons for *E.R.*'s success."[28]

Articles assured viewers that Crichton's pursuit of realism carried over to the program's day-to-day routines. Neil Baer, one of the show's executive producers, was a "real medical intern," who worked to ensure *ER*'s accuracy, "well beyond the sets and props." "We have doctors on the writing staff [including Lance Gentile, an emergency-room physician] who write those scenes to suit, so we really bend over backwards to be as accurate as possible." Baer admitted that he and his staff took some dramatic license. Actual hospital procedures take more time than *ER* allotted to them; for example, medical students (i.e., Carter in his early days) don't stay in the ER for an entire year, and authentic surgeons would consider the *ER* physicians' scrubbing in without masks a clear violation of hospital protocol. "But," Baer insisted to an Australian paper, "we capture something no one else has, which is the culture of medicine, down to sewing pigs' feet to practice suturing." As a reflection of this punctiliousness, he revealed, Noah Wyle, who played Dr. Carter, learned to suture a wound as well as a qualified M.D.[29]

This emphasis on the active use of physicians at the heart of the program's creativity was a shift from the historical division between Hollywood creators and their medical advisors. Although in the post-AMA

days active skirmishes around physicians' depictions were rare, one could argue that the separation of roles on the set nevertheless might eventually allow writers to have an us-against-them viewpoint on physicians in which themes questioning the profession's centrality could emerge. This concern for an independent voice reflecting on the profession was precisely the reason that Herbert Brodkin refused AMA backing on *The Nurses* back in the 1960s. A bit of that theme emerged every now and then in *M*A*S*H,* in *St. Elsewhere,* and in sitcoms such as *AES Hudson Street.* In view of the establishment orientation of network television, it happened rarely. Typically producers who were not physicians saw the profession as worth respecting, and so they didn't question it as outsiders. David Kelly, for example, told *USA Today* that "the world of medicine is a fascinating one of heroes, and we don't often get to see the heroes from behind the curtain."[30] Still, *ER* went further in ensuring the profession's legitimation by choosing writers who were themselves physicians. Neal Baer saw this trend as pathbreaking: "As far as I know, there had never been practicing physicians as writers on a television show, and this broke ground, because you got insight into the lives of doctors in a way you never had in the past," he said. "It changed the way medical series are written now."[31] While that led the writers and producers to proclaim high authenticity in environment, handling, and even emotion, it inevitably (if possibly unconsciously) reinforced the position that the medical world would be seen from within the profession's bubble, with little emotional or political challenge against physicians from outside. As a *New York Times* writer noted, "Greedy H.M.O.s and greedy insurance companies are frequent whipping boys, but greedy doctors are rarely mentioned."[32]

That didn't mean that the writers depicted physicians as near-saints, heirs to Dr. Kildare, Ben Casey, and Marcus Welby. The flaws and conflicts that doctor-writers saw in themselves came out as never before, as we'll see. But the move to integrate doctors into the writing insured the formula's continued focus primarily on the perspective of physicians rather than on other health care providers (nurses, orderlies, social workers) who might conceivably have different views on patients, health care, and the power of physicians. "Real" meant the presentation of compelling scenarios of the medical world from a physician's point of view.

By 2003, the ratings were going south; commentators proffered a va-

riety of opinions, including the lure of the Internet.[33] John Wells offered that the show's slow drift away from medical traumas into soapier personal story lines had become a creative problem.[34] But the amazing popularity of the series in its earliest years—a popularity that in 1998 led to NBC paying a license fee of over $13 million per episode—led would-be producers and programming executives to try to find elements in *ER* to package. One, Wells noted, was "the pace, the rhythm we established." He said that "hadn't been available before" and "freed up other shows" to follow it.[35] The emphasis on gore, speed, and accuracy of settings certainly affected producers with certain shows. But although Wells had volunteered that the show might have pushed too far with some of its physicians' personal issues, it turned out that these depictions and the doctors' passing relationships with most patients had even more impact on the formula.

"Marcus Welby Never Used These Terms"

The blood and guts that *ER* had used to grab and startle viewers into its new take on hospital realism became staples on several shows with physicians. Some of the shows were hospital-based programs that may not have had the hyperkinetic *ER* pulse but that nonetheless were just as serious about showing physicians working on the human body. *Grey's Anatomy, House, Nip/Tuck, Nurse Jackie,* and to a lesser extent *Gideon's Crossing* and *City of Angels* fit this description. As with *ER,* discussions in the press of the importance of verisimilitude because of doctors working on the programs also appeared. Some of the other shows picked up on the utility of physicians as writers. "With the success of realistic medical and forensic science programs like *ER, CSI,* and *Scrubs,*" a *San Jose Mercury News* article noted, "many doctors and researchers have been jumping at the chance to serve as consultants to Hollywood script writers." The article contended that "Savvy fans have . . . fueled the accuracy trend," quoting Syracuse University's Robert Thompson that "Our vocabulary has gotten very good. We know what intubate means. Or a lidocaine drip. Marcus Welby never used these terms."[36]

Many papers pointed to David Foster, M.D., a writer on *Gideon's Crossing, House,* and *Law and Order: SVU.* "The stories in *House* may seem out-of-this-world," stated a piece from Canwest News Service, "but Fos-