MEDIA & HEALTH

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Preface

The aim of this book is to bring together the field of media studies with that of the sociology of health and illness (SHI). As a sociologist concerned with health matters, becoming interested a few years ago in media representations of illness and health-care topics, I noticed early on in my studies that SHI had not kept up with developments in media studies. For example, reviewing many small studies done on aspects of health and illness in the media, I noticed that the assumptions these made about the place of mass media in the everyday life of audiences were uninformed by the latest thinking in the field of media studies. Conversely, reading around the broad field of media studies, I noticed that there were numerous book-length treatments of certain topics – race, crime, gender, for example – but that equivalent treatments of health were rather thin on the ground and somewhat dated. At the same time, it has become increasingly clear to me that people's responses to illness, health care and health-related behaviour generally are profoundly influenced by mass media representations. This cultural aspect of experience has been inadequately recognised in numerous studies of illness experience done by sociologists relying largely on self-reports through interviews. At the broadest level, an account of media representations in this area, drawing together the studies that have been done in this field and making sense of these in terms of contemporary theories about the place of mediated experience in the everyday lives of people in late modern societies, can help illuminate the broader question (which is asked by anthropologists and historians as much as media analysts) of how cultures construct personal experiences of illness and health. An understanding of this, I am convinced, is essential for health educators, providers of health services, and students of illness behaviour. It seems to me, too, that people interested in media ought also to be concerned with the life of the body, and the place of media in influencing this, so that both fields may benefit from this work.

The first three chapters of this book outline general considerations, relevant to health and illness experience, that are helpful in understanding the role that media representations may play in everyday life experience,

the form that representations of health and illness take, and some explanations for the particular ways in which media producers behave. The difficulties experienced in the relationship between media producers on the one hand and, on the other hand, health promoters, professionals and scientists are illuminated and explained in these chapters. The chapters that follow present selective reviews of research studies in the media health field, many of which are insufficiently well known, grouped around the themes of health scares, villains and threats, victimhood, professional and lay sources of rescue, and gender differences. It will become clear that an important feature of modern times is distrust of professional authority over health matters and an elevation of ordinary, somewhat narcissistic 'consumer-heroes' to a position of considerable authority. Mass media organisations play an important part in constructing – even orchestrating – this opposition, which is made more acute by considerable investment in generating fears about disease, as well as promising a variety of rewarding pleasures.

There are gaps in this book. While I have tried to indicate where and when studies have been done and which types of media are involved, readers may wonder whether a more sustained analysis of differences between countries (US versus UK, for example), between media types (television versus newspaper or radio, tabloid versus 'serious') and over time might have produced a less generalised picture of media behaviour. I can only say in defence that this is still an emerging field, with most studies being narrow in scope and not easily comparable with similar studies done on the media of other countries, or across a variety of media genres (an exception is the media treatment of AIDS, discussed in Chapter 5). It seemed to me more important at this stage to put together an argument of reasonably general scope than to attempt the kind of nuanced account that may be possible in years to come when more evidence is available. Another gap is in the area of 'new media' and health, which has only been touched on very briefly. Although the Internet is increasingly becoming a source of health information to which people turn, good studies of people's use of this are few and far between and a review must wait until more are available.

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1 Media Health and Everyday Life

Living in the wealthy countries of the world, we nowadays experience unprecedented good health. Life expectancy is at a level higher than ever before in history, infant mortality has been reduced so far that death is largely confined to old age, and disease is subject to a host of medical interventions whose effectiveness would have appeared miraculous to earlier generations. Food is in such abundance and variety that we can all, if we choose, realistically aspire to the gluttony that once was the preserve of the privileged classes. Remedial exercise regimes and fitness programmes abound to counteract the effects of excess consumption. It is possible to imagine, for most of our early lives, that our bodies can at times be forgotten, at others can become aesthetic projects, or that even death might not exist for us.

Yet, at times, we may experience minor ailments that cause troublesome limitations – coughs, colds, aches and pains – frequently dealt with by short episodes of 'taking it easy' or chemical analgesics. Rarely, we may encounter misadventure or accidents that threaten life. If we are unlucky, more serious diseases may appear on the horizon. Typically, as we get older, this can be through experience of the degenerative diseases of affluence, such as heart disease, stroke or cancer. In late middle age, we begin to notice who has 'looked after themselves' and who has not. We may start to take an increased interest in monitoring our own state of health in order to avoid the fateful moment at which the presence of a life-disrupting disease is announced. With old age our use of health services increases.

Throughout these phases of life we are exposed to many sources of information about health matters, not least of which are various kinds of media. Television, film, radio, newspapers and magazines form a constant backdrop to our lives and contain many implicit or explicit messages about health. A starting point for this book is that health messages in popular mass media are an important influence and resource in contemporary life, in addition to specialist resources available in books or

through the Internet, or the more conventional resources of professional and lay health care advice. But the media presentation of health matters is not neutral, being subject to many determining influences. Although there now exists a substantial body of information and research analysing the production, nature and influence of media health messages, I contend that health research in general has underplayed the role of popular media in constructing and influencing illness experience, and in forming expectations of health care.

An exception to this rule has been the analysis of media messages provided by health educationists and health promoters. This body of research has been important in establishing the considerable extent to which mediated images influence health experience. But, until recently, the model implicit in much health education research concerning the place of media in everyday life has been limited, in particular underestimating people's use of media for pleasurable experience rather than ascetic messages. It has also failed to investigate the full variety of audiences' readings and uses for media representations, preferring instead to concentrate on whether audiences have imbibed specific messages. After reviewing the health education perspective, and noting more recent developments in the health promotion and media advocacy fields that have attempted to address these limitations, I shall outline in this chapter an alternative vision of the place of media in constructing health experience, drawing on broad sociological theories of mediated experience and its place in the everyday lives of people in contemporary mass societies.

HEALTH EDUCATION PERSPECTIVES

The overriding aim of health educators used to be, and for many still is, to encourage individual behaviour that will result in good health. Media messages, from this perspective, are largely analysed according to whether they promote healthy behaviour by providing information and encouragement towards this goal. This has been associated, too, with a highly critical assessment of routine media coverage of health-related topics that has often (though not always) been linked with other moral or political agendas – such as feminist, environmentalist or socialist projects. As this more politicised perspective has gained ground, and the limitations of older-style health information campaigns directed at individuals have been recognised, some health educationists have shifted towards a more radical form of practice, under the rubric of health promotion, media

advocacy or community empowerment. These shifts have involved changes in the way in which audiences' relationship with the media has been conceptualised. But even while these shifts have occurred, the overriding perspective of health educators has often been that a health-promoting media ought to deliver accurate, objective information about health risks and healthy behaviour, free from any distortions of ideology, pressure from commercial interests, or obligation to entertain.

Traditional health education

A good example of this anti-entertainment, pro-accuracy, health education perspective is contained in a study by Michele Kilgore (1996) of news reporting of cancers of the female reproductive system in US newspapers between 1985 and 1993. She characterises these stories as a mixture of 'magic, moralisation and marginalization' (1996: 249). The magical category refers to the reporting of scientific developments in the diagnosis and treatment of these cancers, which, Kilgore notes, emphasises the 'amazing miracle' (1996: 252) that each of these is made to represent, using phrases like 'dawn of a new era', 'pioneering' and 'breakthrough' to excite readers with the prospects for the chosen procedure and, in Kilgore's opinion, thus raise hopes quite unrealistically. The moral elements which Kilgore finds objectionable largely relate to the stigmatisation of 'career women' (1996: 254) or the sexually promiscuous that she detects in the news reports, particularly where cervical cancer is concerned. This, she observes, reflects a highly selective focus on particular scientific studies (identifying multiple sexual partners or late childbearing as risk factors) that in actual fact are far from conclusive, but which fit a particular news agenda that imposes traditional standards of sexual morality and female behaviour. Kilgore's third complaint concerns the fact that useful medical information is often 'so embedded in extrinsic material that lay readers may not be able to conduct a successful excavation' (1996: 254). For example, too many articles, for Kilgore's taste, focused on business interests affected by government decisions about whether to license particular drugs, or diverted the reader from useful health information with irrelevant information about the lives of celebrities with these cancers. 'Generally,' Kilgore concludes, news coverage '[does] not suggest that newspapers have served as an efficient medium for transmission of medical information on [these cancers]' (1996: 255).

How does Kilgore explain this behaviour by newspapers that, we may

imagine, she believes to be failing in their public duty to provide accurate and informative health education to women so that they may avoid these diseases, or deal with them sensibly if they get them? For this, she turns to Bell's (1991) analysis of the values that influence the selection and coverage of news. The preference of news media for events that are recent, factual and conveyed by authoritative sources explains the concentration on scientific discoveries, and the 'miracle' element of these is explained by a general preference for stories conveying superlative importance through their magnitude and significance. A preference for negativity and personal relevance explains the emphasis on personal risk; a preference for stories about elite people is behind the concentration on celebrities with cancer. Compatibility with stereotypes ('consonance' in Bell's terms) helps explain the sexism of the stories, and a focus on the unexpected means that well-known risk factors for cancer, such as age or smoking, are less likely to be included in stories. Kilgore's lament ends by concluding that health educators are up against some pretty powerful forces in their struggle to get newspapers to behave in a way that is conducive to good public health.

Clearly, Kilgore's overriding concern is with the health of women, and one can see how this incorporates also a feminist agenda as well as a hint of suspicion about capitalist interests (seen in the singling out of business coverage for criticism). I have chosen the piece not because it is particularly well known or original in its field, but because it is a typical example of a host of books, papers, reports and conference proceedings concerning media health that have emanated from health educators (and from media analysts influenced by health education goals) over the years. While such analyses reveal some undoubted truths about the way media operate in this sphere, I shall argue that they involve a limited vision of the relationship between popular media and their audiences.

The 'traditional' health education approach to the media, represented in Kilgore but shared by a host of other specialists in health communications (see, for example, Leathar et al., 1986), conceives of the public as ill-informed and devises a solution in terms of delivery of missing information. Too often, though, this model has led to disappointment. Thus Brown and Walsh-Childers (1994), in a comprehensive review of research on the effects of mass media health education campaigns, conclude that '[the] success of these campaigns has been mixed' (1994: 405). They point out that international evaluations of various campaigns to promote safer sex in the wake of AIDS, for example, were shown to be ineffective in influencing behaviour change in some countries. Some such evaluations concluded that fears about AIDS had been needlessly raised in low-risk groups, but had largely missed people engaging in high-risk practices.

Tones and Tilford (1994), in a similar review, note a poor record for alcohol abuse campaigns in encouraging moderation, though anti-smoking campaigns have had more success in a public opinion climate already primed for such messages. The consensus view is expressed by Naidoo and Wills (2000), who conclude that mass media health education campaigns can at times help raise consciousness about health issues and may change behaviour if other enabling factors are present, as they are in smoking campaigns, or if the media message is combined with other forms of health promotion. But for conveying complex health information, for teaching skills (such as the negotiation of safer sex) or for challenging strongly held beliefs, they are more likely to be ineffective. The individualistic orientation of the 'information delivery' mode of health education, where individuals are assumed to have the capacity to simply 'choose' a lifestyle as if there were no external constraints or influences to contend with, is a further limitation of this perspective.

Health educators will often, therefore, seek to persuade those who control media outlets to carry the somewhat ascetic messages that they wish to promote. Largely speaking, the 'entertainment' function of media outlets is seen to stand in opposition to the aims of health educators. One approach to this is to create specialist media outlets, often for precisely targetted audiences. This is done from time to time through the production of informative leaflets and newsletters, of the sort that one often finds lying around in health care clinics and surgery waiting rooms. These may be singularly lacking in entertainment value. Dixon-Woods (2001), in a review of studies of such materials, observes that the educational motivation behind such materials leads health educators to depict patients as 'irrational, passive, forgetful and incompetent' (2001: 3), concluding that '[it] is disappointing that such naïve, unhelpful, negative and patronising views of patients . . . dominate' (2001: 10). Jewitt (1997), in an analysis of sexual health leaflets and posters aimed at young people, notes that 'sex is represented in the context of sexual reproduction rather than pleasure' (1997: 4.28). These are hardly depictions likely to appeal to an entertainment-oriented media executive, concerned to attract an audience.

Edutainment, social marketing and media advocacy

A further solution has therefore been proposed, as health education has been increasingly reconceptualised as health promotion. Reflecting concern with a lack of fit between their goals and those of media personnel, health promoters have become involved in 'edutainment'. Here, there is a

more realistic squaring-up to the lack of appeal that ascetic messages are likely to have, as health promoters become involved with scriptwriters to influence the health messages of popular media products, such as soap operas. In 1994 Brown and Walsh-Childers noted a number of initiatives of this sort, including the use of anti-smoking scenes in Hollywood movies, and the use of music videos and soap operas to promote the virtues of contraception in certain countries. Popular health and fitness programmes might be regarded as an aspect of edutainment, being concerned to promote healthy behaviour as fun. Sommerland and Robbins (1997) report the collaboration between health promoters and a local radio station in England to produce a weekly soap opera containing health promotion stories, linked to various other community-based initiatives. Basil (1996), in a similar spirit, advocates the use of celebrity 'endorsers' of health-promoting behaviour, drawing on the example of Magic Johnson, whose announcement of his HIV-positive status was effective in promoting concern about safe sexual behaviour amongst young people identifying with this sports star.

Edutainment initiatives reflect a shift in the position of health educators, from complaints about the limitations of a commercially oriented media system, to a compromise with the pleasure principle that drives most mass media organisations' relationship with their audiences. Another compromise is represented by an approach known as 'social marketing', which conceives of health promotion as an attempt to 'sell' a product, along lines similar to the marketing that accompanies commercial goods (Naidoo & Wills, 2000). Good health – packaged as fitness, good looks, feelings of happiness and well-being, or whatever – is promoted as something that people want, at least as much as they may want chocolate bars, beer or cigarettes. The 'problem' for health promoters working within this scheme, though, appears to lie in the intangible nature of their product (the taste of chocolate being a more concrete realisation of pleasure than anticipation of generalised feelings of well-being) and the 'cost' of getting it, which involves sometimes lengthy periods of self-denial and effort.

The frustrations of health educators with popular mass media and with a health-damaging environment, have also generated more radical solutions, based on ideas about community activism and empowerment, using the media to highlight and change social and environmental causes of ill health. These initiatives may be fuelled by the feelings of righteous anger that have always been around in health educators' analyses. One senses this anger, for example, in vitriolic condemnations of the devious behaviour of cigarette companies in order to promote their product (see also Chapter 3). A 'direct action' element may then appear, especially if

community activists join with the health educators' cause. Thus Chesterfield-Evans and O'Connor (1986) give an account of an Australian consumer movement devoted to publicising unhealthy products by means of street graffiti – called Billboard Utilising Graffitists Against Unhealthy Promotions (BUGAUP). Wallack (1994) has called this and related developments 'media advocacy', involving attempts to generate media coverage of the health-damaging effects of commercial and sometimes governmental interests. This can, for example, involve sponsoring court cases in which smokers with lung cancer sue tobacco manufacturers. Wallack (1994) describes media campaigns in California to ban the sale of toy guns that mimic real firearms that were causing accidental deaths; Chapman and Lupton (1994a) describe media advocacy to enforce the fencing in of garden pools to prevent accidental drowning. Media advocacy in Australia has had considerable success in influencing media coverage of tobacco towards health-promoting practices (Chapman & Wakefield, 2001). These initiatives move away from an information-delivery model of media usage to one in which people are engaged in using and influencing media in a strategy of power. The key target audience may then become not the 'masses', but the relatively elite group of policy formers and lawmakers who may respond to such campaigns.

The dissatisfaction with the information-delivery model, which conceives of health messages as 'hypodermic needle' injections of information into a largely passive audience, has therefore led to alternative conceptions that imagine a much more active audience role, represented by edutainment, social marketing and media advocacy. These recognise, and attempt to address, the role of audience pleasure and the importance of commercial influences on media health. Too often, though, analyses of mass media health messages involve little more than a routine condemnation of biased media presentations that are felt by analysts to have health-damaging effects. In many studies in this field there remains an inadequate analysis of the complex relationship of mainstream media products with the everyday life experience of people in contemporary societies. This book begins from the position that the broader discipline of media studies now has much to offer health educators seeking greater sophistication in their conceptualisation of the relationship of media messages with everyday life. For example, the messages that health educators often believe to be so damaging may, in fact, receive a variety of readings, not all of which are health damaging in their consequences. To explore the potential of alternative models, then, I will now pursue an analysis of media health that draws on theories developed in the broader media studies sphere.

THE MEDIA HEALTH AUDIENCE

Accounts of changing models of media audiences are standard fare in introductory media studies texts. A clear and recent account is given by Abercrombie and Longhurst (1998), who also present their own audience theory (for which see later in this chapter). For the present I will use an example of a particular genre of television programme to show the variety of ways in which media health audiences can be conceptualised. The terms 'reality television', 'tabloid TV' or 'reality programming' (Langer, 1998; Hill, 2000) refer to programmes like *999* or *Children's Hospital* (in the UK), *Rescue 911* (US), *Australia's Most Wanted* and a variety of European equivalents, the common factor being a focus on dramatic, often life-threatening, 'real-life' events, filmed as they happen or reconstructed for the camera, often demonstrating successful rescues by paramedics, police, fire and ambulance services, or appealing for public assistance in the case of crime shows, or showing life-preserving medical treatments. The emphasis is on the emotions of those involved, so that audiences feel anxiety, fear and sympathy, the situations subsequently resolved when rescue efforts are successful. Such programmes may contain 'public information' sections, such as safety advice, crime prevention guidance or demonstrations of elementary first-aid procedures. There are also programmes of this sort that focus on animals, following the same format of medical emergency followed by rescue and advice on appropriate pet care.

Effects model

Let us imagine the various ways such programmes might be understood by media analysts. Firstly we may consider the original 'hypodermic syringe' model of audience effects which has been influential in traditional health education. On the one hand we could expect some endorsement of the educational elements of the programmes (indeed, this educational purpose is a major way in which both the programme makers and audiences defend themselves against the charges of sensationalism and voyeurism [Hill, 2000]). However, we might also expect to see condemnation of the focus on rescue efforts in the reconstructions of, say, health care or accident scene episodes. Patients undergoing operations in hospital for life-threatening conditions; children receiving medical care for rare diseases; and people injured in bizarre or unusual ways in accidents, stuck

in lifts or mineshafts, trapped in caves awaiting the incoming tide, stranded on mountainsides – all of these, we might learn, generate fear about things which are actually quite rare, tell audiences very little about how to prevent the most common threats to health and safety (such as smoking, not wearing seatbelts), place an undue emphasis on hi-tech or institutionally based solutions to health problems, glamorise certain kinds of service worker (firefighters, doctors) at the expense of others (nurses, social workers), and in general present an inaccurate account of life's risks. It would be better for health, so this argument would go, for people to be inoculated against more important health and safety risks by a more objective and balanced approach that described statistically more prevalent threats and how to avoid them, such as the need to stop smoking, take exercise, avoid fatty foods and, for older viewers perhaps, to remember to stay warm in winter. Further, we might expect to see some moral reservations about reality TV to be aired, with eyebrows raised about the sensationalistic aspects of the programmes that appear to exploit other peoples' misfortune for public entertainment. The emphasis on success and happy endings would undoubtedly be perceived as unrealistic, misleading the audience into a false sense of security, and leaving them uninformed about the true risks of life.

What kind of research study to investigate these effects might we expect to find within this tradition? Stereotypically, we might find an experimental design in which viewers were allocated at random to view either a reality TV programme or some other 'neutral' programme, such as a documentary of space travel. All participants, before and after viewing their allocated programme, would be given a questionnaire measuring the degree to which, say, they experienced their environment as risky, trusted authority figures to protect them from danger, understood basic first-aid procedures and so on. The programme's effects, in this design, would be measured by differences in pre- and post-test scores, their magnitude being compared between treatment and control groups. Alternatively, audiences might be subjected to a cross-sectional survey in order to establish whether their views were congruent with those contained in the media messages, demonstrating the presence of a 'cultivation' effect. Perhaps, though, qualitative research would be done, to focus on the extent to which the messages gratified audiences' needs for information, and whether such information was then used and acted upon, or even to establish whether certain individuals acted as 'opinion leaders' in their local communities, relaying the messages of such programmes to acquaintances in their local community. This highly simplified account glosses over many important distinctions that exist between hypodermic, cultivation and uses/gratifications models. However, all of these

approaches in their various ways may be classed as attempts to identify direct effects, in the form of a change of attitudes or knowledge in the direction expected by the dominant media message.

Active audience model

But let us now consider a different view of reality TV, and of audiences' relationships to it. Here, we can draw on conceptions of media audiences as 'active' rather than 'passive' (Hall, 1980; Morley, 1986), pursuing a variety of different readings according to their particular life circumstances (for example, their social class position, their ethnic identity) or their personal preferences. A foundational assumption in this school of thought is that varieties of 'decoding' by audiences will not necessarily align with 'encoding' intentions of programme makers (Hall, 1980). Thus, we might imagine that certain members of the reality TV audience pursue 'resistant' readings, just as Morley (1980) in his study of the audience of a news and current affairs programme discovered, when he found that, for example, trades union officials were critical of news coverage of industrial disputes. Resistant readings of reality TV are easy to imagine, since health educators are not the only people who disapprove of the voyeurism and inaccuracy they involve. In addition, some people may take entirely unexpected, bizarre things from such programmes; perhaps in certain circles there is considerable interest in firemen's uniforms as fashion statements; for others, there may be sexual or sadistic pleasures in the imagery of suffering; for others, the technology of rescue machinery may be a particular fascination. Perhaps more plausibly, men, women and children may differ systematically in their 'readings': men may be excited by the chase, rescue and heroic elements; women attracted by the health and safety or the animal cruelty issues raised by the stories; children gripped by the emotional drama of abandonment and subsequent security, or the appearance of cuddly animals. Gendered or other power differentials in families may be at play in deciding whether to watch such programmes in the first place, or in the degree of focused attention that audience members may be able to direct at the screen. Thus we might imagine that diverse readings are structured by underlying social variables, such as age, gender and social class.

This more complex picture of media health would undoubtedly require a more open and exploratory research methodology for its investigation than the hypodermic model of effects outlined earlier. Typically, audience members – perhaps grouped according to their position in social

structure – are subjected to qualitative interviews or focus groups in which they are invited to surprise the media analyst with their responses to programmes. Maybe people with experience of being in similar accidents, doing similar crimes, rescuing victims, catching criminals or patching up the injured would have very divergent readings from each other, or from a group chosen at random from the general population. For all we know, just as those plotting crimes are rumoured to take tips from crime reconstruction programmes, some people could be watching medical 'docu-dramas' in order better to mimic sickness the next time they want a day off work!

Postmodern view

We have moved, then, from a linear model of direct effects to one that is concerned to explore diversity, and from a quantitative to a qualitative methodology for gathering materials to support these models. There is a third, postmodern view that has gained a degree of popularity in recent years, based on a radical deconstruction of some basic assumptions often made about the media sphere, such as the existence of an entity called 'the audience' that is separate from 'the message' or the 'producer' of the message. Instead, it may be that the 'audience is, most of all, a discursive construct produced by a particular analytic gaze' (Alasuutari, 1999: 6), and that words like the 'world', 'reception' and 'audience' ought now to be placed in inverted commas (Alasuutari, 1999: 7). This constructionist view, perhaps predictably, often ends up in an introverted pursuit of the field of media studies itself as an object for analysis and critique.

An example of the kind of research study that gets done from this point of view – although, as Alasuutari (1999) points out, empirical research may not be necessary at all to pursue constructionist ideas – is contained in Jacobs's (1996) account of producing the news in a Los Angeles television station. Drawing on an experience of participant observation, large sections of Jacobs's account are taken up with discussions of different social theories of the media. In the gaps between these discussions, Jacobs variously recounts that the TV station sometimes likes to use footage shot by 'stringers' – private camera operators who sell this to news stations; that news workers like to fit stories into a stock set of standardised narratives; that sometimes callers to the station are not dismissed as 'crackpots' but are instead taken more seriously when an unusual event (such as the Rodney King beating) has occurred; that sometimes anchor people get excited about currently 'breaking' events and read the news off

scraps of paper rather than autocues, which then probably generates excitement in viewers. From these rather mundane observations the author concludes that 'processes of cultural production, cultural reception and cultural structure are never separate in concrete practice. They are overlapping moments that must be researched and theorized as such (1996: 393).

The attempt from within this third view to deconstruct divides between production representation and reception has been subjected to thoroughgoing critique by representatives of the second view (Philo, 1999; Kitzinger, 1999a), who argue that claims about limitless polysemy are based in a relative neglect of – or disdain for – empirical work on audiences. Additionally, the determining influence of socio-economic forces on audience experience is neglected in a social constructionist perspective that insists on seeing class and ethnic identity as endlessly mutable. Extreme constructionism, for Philo and others, consigns media studies to a drift into irrelevance because of a failure to address issues of power, since the view that representations may be biased or ideological cannot be sustained without a commitment to some form of philosophical realism (see also Seale, 1999, for a discussion of the implications of this debate for the practice of social research).

MEDIA HEALTH, SELF-IDENTITY AND COMMUNITY

The argument that runs through the rest of this book relies on a particular view of the part that health concerns play in peoples' lives in late modernity, and of the place which media representations of health issues may occupy within these, attempting to overcome some of the limitations of audience theories reviewed so far. These issues involve quite basic existential matters that must preoccupy us all, but which manifest themselves in particular forms in the social conditions of late modernity. In proposing this argument I draw in particular on earlier sociological work I have done on mortality in late modernity (Seale, 1998), as well as more general ideas that sociologists have proposed to explore the consequences of modernity, including developments in mediated communications, for self-identity.

We may draw first on Giddens's account of the conditions we face in late modernity (Giddens, 1990, 1991, 1992), which he contrasts with pre-modern social organisation. Nowadays, so this argument goes, we no longer have a strong sense of local community, in which a person's place

in the world is largely determined at birth by their place in the kinship system and social hierarchy; where a sense of duty and obligation is based on respect for authority and tradition; where interaction is face-to-face and travel to distant lands is unusual; and where the world is safely divided into 'us' and 'them', with enemies who are safe to hate. Instead, we must negotiate our place in the world, puzzle out our identities in a process of reflexive self-awareness, in which the self and its story becomes a worked-on project. We perceive that a variety of 'authorities' and 'experts' exist, and that they do not always agree, so that leaps of faith and trust are required if we are to commit ourselves to becoming even temporary followers of any particular one. We have an increasingly cosmopolitan view of human variety, being aware that at some level we are part of a global 'human race' who, underneath surface features of skin colour, language and cultural difference, are 'the same as us'. Thus 'humankind becomes a "we", facing problems and opportunities where there are no "others"' (Giddens, 1991: 27). The virtues of tolerance and respect for difference become a part of official morality. This is coupled with a state monopolisation of the means of violence by means of warfare or punishment systems, so that interpersonal acts of violence to solve disputes are stigmatised in favour of talking things through. Elias's (1978, 1982) work on the civilising process, suggesting a progressive pacification of civil society, marries well with Giddens's analysis at this point.

Medicine, as an expert system to which we may turn at fateful moments, has nowadays to work harder to generate trust. Medical authority is no longer what it was, and system representatives may need to make particular efforts to adjust their demeanour in order to get clients on their side. Thus we see a plethora of training courses for health-care staff in 'communications skills', and a premium placed on what Maura Hunt (1991) has called 'professional friendliness'. In this respect, professional–client relationships mirror more intimate relationships, where commitment (to a marriage, for example) must now be generated and expressed through the display of emotional warmth, rather than relying on God-given ties of duty. Trust, Giddens argues, 'demands the opening out of the individual to the other' (1990: 121) and the philosophy of patient-centredness is precisely constituted in this way, so that it may be perceived as a 'meeting between experts' (Tuckett et al., 1985) whereby both doctor and patient co-operatively work together on the illness problem by sharing ideas. Correspondingly, relations between health-care workers in this scheme of things become increasingly democratised, so that concepts of teamwork and multi-disciplinarity hold sway, and the special expertise of nurses in the area of emotional labour is asserted (James, 1989).