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Grey's Anatomy and End of Life Ethics

Sean Micheal Swenson
University of South Florida

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Grey's Anatomy and End of Life Ethics

by

Sean Michael Swenson

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
Department of Communication
College of Arts and Sciences
University of South Florida

Co-Major Professor: Lori Roscoe, Ph.D.
Co-Major Professor: Keith Berry, Ph.D.
Aisha Durham, Ph.D.
Amy Rust, Ph.D.

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DEDICATION

This project is dedicated to my sister, Karla. Without her, it would not have been possible. You are my person.

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ABSTRACT

In this qualitative study, I analyze three episodes of the prime-time television medical drama *Grey's Anatomy* to explore how the show stages conversations of end of life. I extend the work of end of life ethicists with attention to the ways that media may/should/could be used to teach and reflect issues of dying in America. Performing a close textual analysis, I identified two modes of storytelling within the structure of these episodes: Documentary Realism and Melodrama. I argue that if we are to understand medical dramas as a tool for the dissemination of information about end of life ethics, we must understand that they speak to the audience in ways which value the perspective of the physicians, holding a torch for how emotions are played out on the faces of the protagonists, but through the bodies of the patients who are brought in to be wounded in each episode.

CHAPTER 1: INTRODUCTION

Cold Open

“It’s just like Grey’s Anatomy”!

It is less a comment and more an exultation. The true fruition of fandom. A culmination of rumors proven true. The words cut through the silence and snap me out of my wandering thoughts. The elated woman, the wife of my patient, beams at her husband laid out on the stretcher asleep. It is about 4:00 am and the three of us are parked outside a bank of elevators, awaiting one’s arrival. I reflexively smile, perhaps due to her emotional display, or in response to her television reference. I have worked as a transporter at a large community hospital since 2005, the same year Grey’s Anatomy premiered. It is a job few people recognize or even acknowledge because it carries little prestige in the hospital system. Additionally, our labor as transporters is often invisible in the medical dramas such as Grey’s Anatomy (2005-present) and ER (1994-2009) that I myself now watch as a fan, scholar, and employee of the medical industry. To explain my role, I often tell people to imagine a scene in a medical drama where the doctors are dramatically rushing a patient down the hall to some urgent destination; you hear screams, you see a blur of IV tubing, and you feel a determination to save a life. On television, viewers typically see stylish doctors and nurses leading the way and pushing the gurney. In real life, I am the one actually doing the pushing and the scene is far less glamorous.

As a transporter, in effect, I am the legs that nurses are not permitted to have in being place bound to their patients. I move patients between destinations, retrieve blood, and fetch equipment. I keep people alive when they are apart from nurses and take them away from nurses when they die. What began as a summer job out of high school has become a secondary career of sorts as well as a site of inquiry. However, I spend the majority of my time as a doctoral student of Communication. As a Critical Media scholar, I find it difficult to explain why I continue to work in the medical industry, especially given the low prestige afforded to my bottom-of-the-ladder clinical role. When I am asked by my peers, patients, and patients' families to discuss my role I feel apprehensive about delving in to the complicated nature of my relationship to health and media. That same apprehension boils up right now in front of the elevator when I realize that I have given myself away to this family member with my reaction to her comment. She reads in my smile an acknowledgment of her love, a mutual kinship to the work of Shonda Rhimes. Any hope of remaining invisible to this family member is dashed.

A wide grin spreads across her face. "Do you watch the show?" she asks.

She clearly knows the answer. It is the same smile I see on my students' faces when I mention the show during lecture, a calling card that signals one has joined the fandom of Shondaland. Not wanting to get into the complexities of my relationship to media and health I nod "yes," but nonverbally suggest that she will only get one-word answers out of me by averting my gaze. I pretend to be aloof.

She gestures to her sleeping husband in excitement, "We love it. It's so crazy!"

In the hospital, she is every bit a tourist as much as a patient/customer. Her eyes dart around the walls anthropologically in a land she has watched on television but never gotten to visit. In my opinion, there is not much to look at. I would call the wall color "parchment," but

only to fancy up the fact that the walls are stark white. If this were a medical drama it would suffer from poor set dressing. If she is this excited about the hallway, she must have been exuberant about having been in the ER these past few hours.

“Is there as much drama here as on the show?” she asks.

“You better hope not,” I say. There is a tad more sarcasm than I would have liked in my response, but she laughs at my distaste masked as humor.

The elevator dings and sideswipes open. I ease the stretcher over the bumpy tile and across the threshold of the elevator. She takes one last look around before entering behind me and says:

“Being here is just like being in the show. Except on that show everyone seems to die!”

As I push the button to launch us to the third floor, I wonder if she fully considers the gravity of her words.¹

Introduction

This dissertation is an interpretive research project which utilizes critical media analysis to understand the ways that medical dramas speak back to audiences regarding the issues of ethics and dying. I explore the use of specific filmic techniques in telling stories of health on television. I attend to issues of spectatorial positionality by reflexively writing through this analysis of my own location as a scholar, fan, and healthcare worker in a large community hospital. In this qualitative study, I analyze three episodes of the prime-time television medical drama *Grey’s Anatomy* to explore how the show relies on realism from documentaries and sentimentality from melodrama to stage conversations of end of life.

¹ Previously published in Swenson, S. (2018). Dying for the Next Episode: Living and Working within Shondaland’s Medical Universe. In R. A. Griffin & M. D. Meyer (Authors), *Adventures in Shondaland: Identity Politics and the Power of Representation*. New Brunswick: Rutgers University Press.

Through my textual analysis, I extend the work of end of life ethicists with attention to the ways that media may/should/could be used to teach and reflect issues of dying in America. A central question guides my dissertation: How is end of life produced in *Grey's Anatomy*? As a media scholar my interest is in the ways that media situates itself within the larger conversation of health communication. I take up the following research questions to attend to this concern:

1. How are genres of documentary and melodrama deployed in *Grey's Anatomy*?
2. How are narratives of end of life and ethics described in *Grey's Anatomy*?

My dissertation offers three main contributions. First, this project offers a lens of media analysis toward the field of ethics at end of life. Media has been looked at, by biomedical ethicists, as a tool to be used in the education of audiences. However, little attention has been paid to the ways in which media positions viewers to engage with the events on screen. I draw notice to the ways the current model of understanding medical dramas as a tool for educating populations, both lay and medical, ignore the influence of media texts to steer perceptions of right, wrong, desirable, and abject. This project marries concerns for both spectatorship and end of life ethics. Second, my work contributes research on medical dramas, *Grey's Anatomy* specifically, extending a tradition which has largely privileged content over production and storytelling. While *Grey's Anatomy* has been written about and discussed in academic circles, it is often through a perspective of medical accuracy, rather than by looking at how notions of truth may be constructed for audiences. Third, this qualitative study participates in embodied qualitative analysis, extending the work of such scholars as Durham (2021), Boylorn (2021), Berry (2019), and Johnson (2017). This research leans toward the idea that the positionality of a researcher and the description of experiences engaging with media, can produce more fully

engaged and complete lived accounts of what is taking place across the screens of our televisions.

Grey's Anatomy

Grey's Anatomy follows the career of Meredith Grey (Ellen Pompeo), the daughter of world-renowned general surgeon Ellis Grey (Kate Burton). Beginning on the first day of the intern class's residency at the fictional Seattle Grace Hospital, Meredith, and her fellow doctors, find themselves caught up in the interpersonal conflicts of romance, professionalism, and ethical decision-making between themselves, their superiors, and the patients they are charged with protecting. The title of the show is a playful pun of Meredith's career as a surgeon and her romantic escapades, which see her unknowingly enter into a sexual relationship with her soon to be boss the night before she begins her work.

Ethics work has been a consideration from the start of the show. We learn in the first episode that while Meredith has a bright career ahead of her, her mother Ellis is suffering from early onset Alzheimer's, a diagnosis that neither Meredith or Ellis wishes to have blight the legacy of the "Grey" name in medicine. The knowledge that Meredith, who carries the same genetic markers for the disease as her mom, may succumb to the illness hangs over her head and provides a sense of foreboding toward what decisions may need to be made in a presumptive future of Meredith's end of life. In addition, episodes have highlighted such actions as the doctors of Seattle Grace Hospital performing autopsies against the consent of families, stealing organs for patients, and performing cardiopulmonary resuscitation (CPR) on patients against their advance directives, among many other questionable acts.

Medical dramas have secured themselves as a constant presence in our lives and a presence that has great power to influence and inform. Marshall McLuhan argued fittingly that

people's curiosity with bodies, combined with the medium's passive participation, would all but assure medical dramas persist as a perennial favorite (McLuhan & Gordon, 2015). This continued obsession with voyeurism of bodily welfare has produced a multitude of shows that have traced the historical trajectory of American medicine from television's birth to the present. Along with crime dramas, the medical drama is one of the standard formats for television which have stood the test of time.

Grey's Anatomy in particular is of note because the current moment of hospital-based drama appears to privilege conversations of ethics, especially at the end of life. Currently airing its 18th season, there is little evidence to suggest that the show's popularity or influence is slowing down. *Grey's Anatomy* has undoubtedly become a lynchpin for the current historical moment in the way that *Ben Casey* (1961-1966), *Marcus Welby, MD* (1969-1976), *St. Elsewhere* (1982-1988), and *ER* (1994-2009) were for theirs. Becoming a ratings juggernaut for parent company ABC, *Grey's Anatomy* is now the longest running medical drama in primetime television history.

Despite this longevity, *Grey's Anatomy* has not been hailed critically with the same fervor it gets from its fans. In fact, the show has often been derided as overly emotional, placing its characters in a succession of mass casualty disasters which devastate both the community and the lives of the doctors too unlucky to find themselves involved. However, a reading of the show as an overwrought parade of never-ending tragedies ignores the fact that the show dwells within the tragic and yet remains a "feelgood" show. Much of this has to do with the interplay of humor and tragedy, but more credit goes to the fact that *Grey's Anatomy* privileged a cast of young surgeons who were not experts in their field from their first day. While *ER* was equally successful, it was a show of seasoned doctors dealing with a traumatic healthcare field. *Grey's*

Anatomy was able to comment on the system through an outsider perspective, one that was often unprepared to handle the difficult questions asked at end of life. Audiences grew with the show at the same pace as our protagonists. This set it apart from other shows before it and set the stage for a new viewing experience of medicine on television. The show's success is more than simply what stories are being told; it is how those stories are told which has made it a success.

Research Claims

This project operates under two assumptions which guide my analysis. First, medical dramas, *Grey's Anatomy* specifically, employ filmic techniques and narrative logics to tell their stories. These modes of storytelling transform the rational information communicated into emotional appeals for the viewers' entertainment. Second, positionality of the viewer influences the reception of these narrative techniques and how one may "read" the media text, as well as speak back to it. I absolutely adore *Grey's Anatomy* as a fan. Its storylines are fun and from the perspective of a healthcare worker, having spent 16 years as a hospital transporter, I very much enjoy pointing out the things that they get right and wrong about life in the hospital system. That being said, I also enjoy the show for the relational component. I was introduced to the show through my sister, a sonographer at the same hospital in which I work. We watched it during our lunch breaks, binging our way through seasons and interrogating what we see streamed on our laptops and smartphones. My bond with my sister was strengthened by our shared viewing. For me, those emotions are inextricable from the show. When I watch the show, I feel more than just the storyline, I feel a host of emotions from within the text and brought to it, both of who I am and what I do. This closeness to the text is one of the chief reasons why I was drawn to this as my primary text of analysis.

Henry Jenkins (2012) argues that media consumers are neither totally free from nor totally oppressed by the media in which they consume. In that space, where power is shared and meaning is created, lies a potential for fan and audience reception studies. I am methodologically positioning myself not as an ethnographic outsider but as a “Aca-fan,” an academic scholar who leans into their fandom of the show, writing more openly and reflexively about my experience without derision, suspicion, or an obligation to be defensive about what is on screen (Jenkins, 2006). I write as a scholar who feels the academy could learn just as much from the fans who privilege their experience, writing passionately about what they see and feel. The text should never be taken at purely face value, but should be interpreted by the researcher as one of many possible readings of the text. Media culture provides the tools and materials for us to forge our identities and explain who we are and why (Kellner, 2011). We must probe those materials if we are to break from the idea that certain institutions and socially constructed realities are inherent, natural, and desirable (Couldry, 2019).

Chapter Overviews

Chapter two provides a literature review situated under the auspices of health communication and media studies. I discuss the literature of medical dramas from the perspective of each research field and place my discussion of ethics into conversation with recent research on *Grey's Anatomy*.

Chapter three provides the methodology and theoretical grounding for my research. I discuss television studies and spectatorial positioning, as well as my approach to reflexivity. I provide a conversation of the media driven works of autoethnographic and reflexive writing that my work draws from and extends. I also present an overview of my episodes of analysis and provide character descriptions of the protagonists involved.

Chapter four presents my analysis of three episodes of *Grey's Anatomy*. I argue that Documentary Realism and Melodrama are used in the show to tell stories about ethics and end of life. Objectivity and sentimentality are married on screen in ways which reorient dominant conceptions of the relationship between realism and emotion in end of life ethics.

In the Conclusion, I reflect on my own position as a researcher and healthcare worker who engages with this show as a fan and scholar. I provide insight to how this project was shaped by my professional position and how the project shaped new perspectives of my professional work. I then offer future directions for this research.

CHAPTER 2: LITERATURE REVIEW

In this literature review, I discuss the medical drama and consider two specific fields of inquiry, Health Communication and Media Studies. I will define each and discuss the concerns of both fields as they pertain to *Grey's Anatomy*.

Medical Dramas & the Emergence of *Grey's Anatomy*

Medical dramas such as *Grey's Anatomy* (Rhimes, 2005-present) have become massive critical and commercial successes, yet it would be misleading to presume that the genre speaks especially to the current generation. The genre has, in fact, dominated our television screens from its inception. Having its roots in the *Dr. Kildare* series of films from the 1930s and 40s, the first televised medical drama was *City Hospital*, premiering on CBS in 1952 (Quick, 2009). Since then, a steady stream of new shows has appeared on screen, allowing the American public constant access to the fictional halls of television's healthcare spaces. Owing largely to the work of Jason Jacobs (2003), medical dramas have been understood as having transitioned through three distinct periods, reflecting the preoccupations of the age in which the doctors on screen practiced medicine in America. From the 1950s on we have the *paternal* period, characterized by doctors who are all-knowing and all-powerful healers. They represented the authority of the hospital as well as personified faith in the medical discipline (Hetsroni, 2009; Jacobs, 2003). This period was known for its affirmations of legitimacy by the American Medical Association, which took a vested interest in presenting the medical discipline as one where a compassionate doctor would routinely beat the odds to triumph over illness and save patient's lives (Hetsroni,

2009; Ostherr, 2013). Joseph Turow (2010), in mapping the portrayals of doctors on television, asserts that these physicians were portrayed as infallible heroes who rarely left the bedside of their patients and had unquestioned ethics.

From the early 1970s through the late 1980s medical dramas entered a phase marked by *conflict*, not only organizationally but interpersonally. This marked a shift from the single doctor narrative to the narrative of the healthcare team, including surgeons, nurses, and administrators (Hetsroni, 2009; Jacobs, 2003; Turow, 2010). While the medical profession was still viewed in a largely positive light, the role of the physician shifted from abiding by rules to pushing against them. In part this was a result of the spatial move away from the private clinic and into the public hospital (Jacobs, 2003). Audiences were thus introduced to the internal and external conflicts faced by members of the healthcare team at the same time that social and political conflicts regarding controversial issues such as abortion and euthanasia became present on television screens (Hetsroni, 2009; Jacobs, 2003). Regardless of this move, the advances in medical technologies allowed for increasingly more complicated yet still largely successful patient cases even in the face of the emergent emotional strain on doctors.

The 1990s began to shift the narrative of television medical dramas with the arrival of the *apocalyptic* phase of televised medicine (Jacobs, 2003). Patients' roles in the dramas began to expand beyond the exam room and, for the first time, doctors started making mistakes that bore fatal consequences (Hetsroni, 2009; Jacobs, 2003). Though the large, public hospital remained the primary setting, the hospitals themselves began to resemble war zones. The patients were bloodier, the cases nastier, and the admissions never stopped (Jacobs, 2003). Art began imitating life as the dramatic shift from paternalism to a new consumer model of healthcare began to be reflected on screen (Hetsroni, 2009). Doctors began discussing with their patients their cases and

joint decisions were now being made as patients began to expect and demand care that previously would not have been discussed both on and off screen (Gordon & Edwards, 1997; Turow, 2010). The days of patients blindly accepting the advice of their doctors was over.

It is out of this context from which *Grey's Anatomy* emerges. Medical dramas, like crime procedural shows, are a fundamental genre of primetime television, owing to their ability to maintain a revolving door of storylines. However, not all of them prove to be successful at maintaining a core audience across a long airing run. I identify several reasons why *Grey's Anatomy* has remained a powerful force in the television landscape:

1. The large cast of the ensemble show has created opportunities for diverse storylines and the ability for cast to exit and enter the show without disruption to larger story arcs. It has also allowed more emotional exists, such as main character deaths without interference to the show's production or storytelling ability.
2. The shows leading actress, Ellen Pompeo, has remained on the show from the very beginning. This longevity has ensured that the show's focus has been consolidated and consistent. While changes to the show's narrative and to healthcare writ large have occurred, the show's lens has never shifted from a single, steady protagonist. This provides comfort and consistency when watching a show that could otherwise feel dark and depressing due to the content.
3. The show integrates the "real world" into the space of the television hospital. Events such as #MeToo, Black Lives Matter, and Covid-19 have become plot points for the show. This allows the narrative to feel current and grounded in reality while also portraying heightened and improbable medical scenarios.

4. Streaming services such as Netflix have allowed younger viewers to catchup with the show in ways that have not been possible until the current moment. This has refreshed the viewing audience and created opportunities to keep the conversation of characters and plot lines going. *Grey's Anatomy* has most benefitted from this, as streaming technologies emerged in the midst of its successful run.
5. Colorblind casting practices were used in the initial audition process of the show. This resulted in a more racially diverse cast than we have seen in a medical drama up to this point. This is significant for medicine on television because now racialized bodies on television are taking up space that were historically held by white, male actors. This diverse cast is now participating in discussions of ethics and end of life, even as the show participates in post-racial rhetoric's of medicine. While perhaps a better visual match for representing America today, the show is not fully addressing the underlying themes of racist medicine which still permeates hospital spaces today.

Media Studies

Media Studies, as a field, concerns itself with looking at how media, in the form of its content, effects, and production, moves the viewer at any particular moment. Media Studies is a large umbrella for the many ways that media can be examined, either anthropologically, economically, or philosophically. Medical dramas, and *Grey's Anatomy* specifically, have been popular texts of analysis for media scholars in the field of communication because they endeavor to portray very real situations in often fantastical ways. The resulting effects/affects of such a (re)presentation are noteworthy for how they reify such ideas as class, race, gender, and sexuality in addition to notions of health.

Grey's Anatomy & Media Studies

Since its premiere, scholars have been interested in *Grey's Anatomy* for its production and its portrayal of characters. Shonda Rhimes was of significant interest to the scholarship because of her many shows' successes. As a Black woman heading a major production company, people started picking apart her strategies for creating shows, often with Black female leads and colorblind casting. This representation was both praised and criticized, forming the majority of scholarly focus surrounding the show itself. One criticism was that race was not addressed at all on the show. It was seen as a missed opportunity to have such a diverse cast but to not address within the shows narrative the tensions of being Black in the healthcare system. Ralina Joseph (2018) argued against this reading, stating that this strategic ambiguity of race allows Black women in power to negotiate a tightrope of expectations and backlash. Griffin & Meyer, in their edited collection *Adventures in Shondaland: Identity Politics and the Power of Representation* (2018), argued that Rhimes' production style and shows open up avenues for exploring complicated relationships to power and representation that transcend simple, unconstructive readings. However, others such as Washington (2012) and Cramer (2016) argue that the construction of post-racial rhetoric on *Grey's Anatomy* obscures the lived reality of racism. Special attention has been given over to the characters of Miranda Bailey and Christina Yang. As the two female leads of color at the time of the show's premiere, their representation was of concern. Both were presented as tenacious, powerful women. However, the tropes of the "angry black woman" (2015) and the "dragon lady" (2011) were seen as being perpetuated despite their presence and inclusion in major storylines.

Health Communication

Health communication is a field of inquiry that is interested in the ways that different communication strategies are able to inform populations about health and analyzes how individuals and groups make sense of the concepts of health, medicine, and wellness (Lein & Wills, 2007). It presents the opportunity to use communication strategies to influence the decisions that are made in educating people about their health and hone new ways to improve upon the dissemination of healthcare information (Wanzer, Booth-Butterfield, & Gruber, 2004). From the perspective of television, health communication scholars watch media forms such as *Grey's Anatomy* to understand how messages of healthcare are being portrayed for audiences.

***Grey's Anatomy* & Health Communication**

Literature looking at *Grey's Anatomy* has largely been concerned with its portrayal of healthcare issues on the show. This is less often framed as a discussion of the show itself and more as a component of health information dissemination. For example, McClaran & Rhodes (2021) analyzed the portrayal of vaccination on *Grey's Anatomy*, in addition to several other medical dramas since 2000. The results were discussed as a reflection of the messages viewers are receiving, not as a conversation of the show's position or power. Content analyses such as this remain the most common form of study for *Grey's Anatomy* in the field of health communication, discussing a wide range of health concerns from sexual health (Kinsler et al., 2019) to diagnosis types (Meyer & Yermal, 2020).

Overall, the largest concern for the show falls under what has been termed "The Grey's Anatomy Effect." This phenomenon is where the portrayals of medicine on the show result in expectations from patients and family that do not match reality. Hoffman et al, (2017) conducted a systemic study of research regarding exposure to medical dramas and found that the majority

of cases resulted in a mixed or negative impact on knowledge and perceptions, *Grey's Anatomy* being one of the major offenders.

Freytag & Ramasubramanian (2020) conducted their own analysis, this of hospital death in medical dramas. They compared the portrayal of death on screen with responses from physicians, patients, and family members, finding that what is presented on screen does not line up with expectations/desires of the viewing public when it comes to a “good death.” Regardless of inconsistencies such as these, the research suggests that those who watch the shows have a positive association between the physicians on screen and physicians in real life, as well as the bioethics they discuss (Cambra-Badii et al, 2021).

Ethics & Health Communication

Biomedical ethics is a predominant arena for ethics within the field of healthcare. The goal of the field is to examine strategies for making “right” choices in any medical encounter, both intrapersonally and interpersonally. Biomedical ethics as practiced in modern hospitals has most often been associated with the notion of principlism, which sets as a moral and ethical guide four principles of ethics: Autonomy, Beneficence, Nonmaleficence, and Justice (Beauchamp & Childress, 2012). These four principles are to be used as guiding principles for generating the best possible outcomes in the medical setting. This approach to biomedical ethics has often been challenged as being unrealistic in practice, as the four principles often contradict each other (Huxtable, 2013). I will discuss each of the four principles and address some of the concerns that come from each.

Autonomy

Autonomy is talked about today in ways which seem to privilege it above all others (Gillon, 2003). However, the emphasis on autonomy may be misleading. Maggie Little (2016) of

Georgetown University is quick to point out that autonomy is in fact NOT the most important principle. It is very important for how it advances bioethics past the days of paternalism when doctors had the final say in a patient's care. However, the heightened discussion of autonomy is more a symptom of it being the most recent addition to bioethics; the discourse is effectively playing catch up. Autonomy emphasizes the goal of being able to self-govern oneself (Buchanan & Brock, 2004). It is both an ability, to be able to make choices about one's own life at the same time that it is a status, a right to govern oneself. Each individual has within them a jurisdiction or dominion that cannot be impressed upon (Beauchamp & Childress, 2013). Therefore, consent is something that must be given by a patient or their representative and it must be informed consent, that is, consent given when the individual understands to the best possible circumstance all options and predictions for the success or failure of said action (Beauchamp & Childress, 2013). Should a person refuse a surgery after being informed about the risks and benefits, honoring autonomy means they can refuse permission. A beneficent motive does not substitute for consent, as we saw in the case of *Schloendorff v. Society of New York Hospital*, 1914 (Mary E. Schloendorff, Appellant, v. The Society of the New York Hospital, Respondent). Mary Schloendorff was admitted to New York Hospital for stomach discomfort and was diagnosed with an unknown mass. Mary refused the surgical intervention recommended, but consented to examination under anesthesia to identify what the mass was. While under the effects of ether the mass was discovered to be a fibroid tumor, which was removed while she was open on the table against her expressed wishes. She later suffered complications from the surgery, requiring the eventual amputation of several fingers. This case is foundational for how we understand autonomy and consent as paramount within the interpersonal workings of healthcare decision making. This does not mean that practitioners have the obligation to stand idly by while patients

make decisions or submit to the demands of care from patients (Glover, 1990). It creates, instead, a relational continuum where medical professions have a responsibility to make recommendations that respect the desires of the patient while balancing evidence and stakes alongside the patient's wishes.

This of course is all presupposing the capacity to process information, project oneself into the future, as well as balance one's values and priorities. This can be easier said than done in times of trauma, time sensitive cases or in instances where power imbalances impede the ability to make consent real (Beauchamp & Childress, 2013). For example, assume a patient is told by their physician that a complex procedure is needed. The ability to give consent might be hampered by the power dynamics that cause the patient to feel that they could not say no without having some sort of consequence from the physician. What can make autonomy especially difficult is that consent is an ongoing consideration which may need to be revisited often and can be withdrawn at any point (Beauchamp & Childress, 2013). It should be noted that ethicists tend to speak in ways that discount paternalism as being in opposition to autonomy. However, a good deal of work has been done which shows that many patients desire encounters with practitioners who ascribe to a paternalistic view of medicine (Murgic, Hébert, Sovic, & Pavlekovic, 2015). Autonomy as a concept seems very personal since it privileges the status of an autonomous being, but it is in fact quite an interpersonal concept (Olick, 2001). To be sure, few of us can claim to be acting autonomously in our healthcare decisions, especially when family gets involved. Case studies show that if a family wishes for someone to pursue treatment, even when it goes against the patient's wishes, said treatment is likely to be undertaken (Roscoe & Schenck (2017).

Beneficence & Nonmaleficence

Beneficence and Nonmaleficence are two separate principles but often end up being discussed together due to the fact that they, more often than any of the other principles, are balanced in practice (Beauchamp & Childress, 2013). At the same time, they are perhaps the most deceptively simple principles. At their core, they stem from the dictums that one should do good towards their patients (Beneficence) and one should not harm their patients (Nonmaleficence). Nonmaleficence is often cast as the most basic of ethical principles largely because one does not have to act. In refraining from causing harm, you achieve this principle of biomedical ethics. To be beneficent is by definition to act so as to do good. So, they could be understood together as a single rule: if you choose to act, act to do good (Baumrucker et al., 2008; Macciocchi, 2009). Beneficence is not, however, a one-size-fits-all concept. Imagine, for example, two patients were to come into an ER in need of a kidney transplant to reverse kidney failure. The admitting physician, who is a perfect match for each of our needy patients, is not under an obligation to give up their two kidneys to save these strangers' lives. Here we distinguish between ideal and obligatory beneficence (Beauchamp & Childress, 2013). Ideal beneficence promotes the behavior which would be seen to exceed ordinary morality, such as giving a kidney to a stranger or a civilian running into a burning building to save a person from a fire. While these acts fall under the umbrella of doing good, they are considered beyond the more obligatory beneficence that healthcare practitioners are held to: providing their patients sound medical care, alleviating symptoms of illness if possible, reporting suspicion of domestic abuse in their patients, etc. (Beauchamp & Childress, 2013).

Now, the reason these principles get colluded together is because the directives of one often interfere with the desires of the other. Take a dislocated shoulder, for example. A patient

will suffer great pain by having their shoulder popped back into place. However, in weighing the options of both it is going to be a greater good to cause a patient to suffer in the short-term so that their injury could heal. The calculations can be far more complicated than this in more advanced illnesses (Muirhead, 2011). Suppose a patient with cancer will not live more than a couple of months without treatment. If an oncologist orders chemotherapy, radiation, and radical debulking of the tumor the patient could expect to live for perhaps a year or two; they may however live the rest of their life in severe pain from the treatment. Is it better to let a person have two good months or twelve bad ones?

When we connect these to the principle of autonomy, we further muddy up the water. Say the American government decides that forced procurement of organs at the point of death serves the greater good because we will be able to have access to lifesaving organs that can restore other people's quality of life. However, this would go against the notion that one has a say over how their body gets used, even after death. This justification would position organ donation under beneficence where currently we position it under the principle of autonomy. While critics will often say that these principles work to complicate morality, I would argue they keep a balance between actions where there is no value-free act (Huxtable, 2013; Turner, 2008).

Justice

Lastly, Justice as a principle is concerned with the equal and fair distribution of healthcare resources and access to healthcare (Beauchamp & Childress, 2013). For as much as people discuss autonomy, that is how little people seem to discuss justice. The three other principles are more easily applied to the dyad of the patient-physician encounter, whereas justice concerns itself with system-wide concerns. Earlier discussions of justice centered around concerns of access to scarce resources. For example, when ventilators first became available

there might only be one at an entire healthcare facility. If a person arrived to an ER following a car crash, was put on artificial ventilation, and then was declared braindead, but the family wished to have the individual remain on the ventilator, this created an issue of justice in that the next patient in need might not have access. Who then has a right to the scarce resource: the person who got to it first or the next person who would seemingly benefit more from it (Hanlon, Tesfaye, Wondimagegn, & Shibre, 2010; Zwijsen, Niemeijer, & Hertogh, 2011)? Current discussions of justice have less to do with access and more to do with cost. One can have access to the best healthcare should they have the resources to get it. As healthcare costs continue to rise many clinicians have begun to worry that doing the “right thing” towards availability of treatments is creating a new form of illness, financial toxicity (Zafar, 2015). The autonomous decision to seek out more tests, accept more treatment, and extend life as long as possible have real financial implications, and may prevent un-or under-insured patients from receiving the treatment they desire. While access to treatments can be had, it is beginning to be seen as a fairer solution to advocate for palliative care and alternative options that consider the whole of a family’s needs at end of life as well as what can be considered reasonable within a healthcare network (Kim, 2007). Holding an ICU bed for three months to futilely treat a dying woman with antibiotics is using up resources which are available but might not be used in the best way. It is both a consideration of what is fair for everyone else but also what is fair to the patient, as well as the individuals who are left behind to pay the bills (Beauchamp & Childress, 2013). A participatory model would allow for these kinds of open discussions. However, we have not done a very good job of advocating for open systems of healthcare, even as we are shown that the more closed off a system is the more likely it is to fail (Lord, 2008). Justice is increasingly becoming more patient-centered because larger considerations of minimum healthcare on an

institutional level, such as universal healthcare, have been unsuccessful in dealing with the call for equal access.

Ethics guidelines do not provide a formula for making correct decisions. In fact, many of the criticisms lobbied against a principlism view of biomedical ethics hold that it is incapable of addressing the needs of patients (Christen et al., 2014; Lee, 2010). They may work to help guide the decision-making process, reflecting on what actions may be considered “good” in a moment”

“They provide an ethical framework for making decisions under conditions that are challenging and sometimes psychologically distressing. They clarify the rights and responsibilities of each participant in the decision-making process. They can help ensure that decisions are made with appropriate knowledge, deliberation, transparency and fairness, safeguards for vulnerable patients (Berlinger, Jennings & Wolf, 2013, p.2).”

Now, these four principles alone do not constitute the framework for doctors to guide their practice. It should be noted that professional ethics, too, create additional commitments to facilitate their practice (Riddick, 2003). I point this out to suggest that, like principlism, professional ethics for healthcare is a dialectical conversation of many concerns: resource conscious, morally, spiritually, and financially dependent on context at site of care. The four ethical principles protect against “undertreatment, such as failing to provide medically appropriate interventions desired by the patient, and overtreatment, in the form of interventions that are unwanted by the patient or are unduly burdensome to that patient.” (Berlinger, Jennings & Wolf, 2013, p.2). When we consider that all of these expectations also take place under the auspices of a workplace, which has its own rules, regulations, and barriers to practice, we have a intricate network of ethical considerations to satiate. These issues become all the more pressing

when we consider the ways that end of life issues intersect with questions of biomedical ethics in American healthcare.

End of Life & Health Communication

End of life as a topic of study has emerged in the medical literature as an increasingly important aspect of healthcare. At the same time, scholars and practitioners have found it progressively more difficult to entertain discussion with policy makers and participants in the field of healthcare with regard to discussing death at all. The medicalization of death has moved patients and practitioners towards an understanding of death as something from which people must be rescued (Hetzler & Dugdale, (2018). To attempt to define end of life is to understand the complexities that are inherent in such a seemingly common-sense construction of being near death and yet desiring to move away from that position. End of life as a concept is defined less by how scholars talk about it but more so by the silence that surrounds the discussion. You will be hard-pressed to find scholars defining the concept of “end of life” for their readers. Far more attention is given over to defining terms such as palliative care, hospice, or healthcare surrogates which exist as terms misunderstood even by clinicians (Inbadas, Zaman, Whitelaw, & Clark, 2017; Institute of Medicine, 2014). Definitions can be as cyclical as to define end of life care as the care that is provided at end of life. Discussions of end of life will often use vague terms which associate a closeness to death but never quantify a solid timeframe (Matlock et al., 2016). Typically, this gets understood, especially in policy, as the final six months of a person’s life. Yet this number is only known for sure retrospectively. End of life (popularly shortened to EOL in the literature) suffers from the seeming simplicity of its name. In a biomedical model of healthcare delivery, we are able to call a time of death. To be at “end of life” appears then to be close to the moment of calling death. However, death is not what it used to be.

What it means to be dead and how we die has dramatically changed over the course of the last century. Until the early twentieth century people tended to die rather quickly and outside of healthcare facilities (Gawande, 2014). Without the emergency medical services that we take for granted today, most people died of acute illness such as heart attacks, strokes, or accidents (Jones, Podolsky, & Greene, (2012). Those who developed serious infections or suffered from cancers had options for care which were largely ineffective; they tended to decline fairly quickly and often died in the comfort of their own home (Burnham, 2015). The deterioration from life to death until recently could be characterized as one of a steep descent, like falling off a cliff (Gawande, 2014). Advances in medicine have changed the way that people experience death and even changed what death means. Chronic illness has overtaken acute illness as the leading cause for hospitalization, turning once deadly diseases into manageable conditions (Armstrong, 2005). Death in many cases today is more characteristic of a slow descent down a hill, with many plateaus of maintenance in-between periods of getting worse (Gawande, 2014). At the same time, technological advances such as respirators, pacemakers, and organ donation have complicated the notion of death as being something one can easily identify. A standard medical definition of death would describe the irreversible cessation of all respiratory and circulatory systems as well as the functioning of the entire brain, including the brain stem, as the point when death has been achieved (Institute of Medicine, 2014). However, if a person is clinically braindead without the ability to maintain bodily function but the body remains “alive” due to artificial ventilation and nutrition, has the body indeed died? To be at the end of life in the 1930’s could mean the hours prior to death (Institute of Medicine, 2014). Today, a person with kidney failure could technically be only a few days away from the possibility of death if the disease took its natural course, but through the use of dialysis could survive for years.

Given all of this, how then can we define end of life? The definition that I currently find most useful comes from the Institute of Medicine's report *Dying in America* (2014). The report defined the scope of the IOM's project as examining "medical care for persons of all ages with a serious illness or medical condition who may be approaching death." In this definition, I feel one can find the best parameters for addressing end of life. Where defining end of life can become a trap is that you could theoretically extend discussions of end of life to the moment of disease or even prior. Likewise, you could define the concept so narrowly that you end up excluding individuals and families who need care but do not fall under the umbrella of being quite yet at end of life, or better still do not consider themselves to be approaching death at all (Institute of Medicine, 2014). This tension can be demonstrated through what transpired in the 1980s with outlining Medicare Hospice benefits. When the eligibility for Hospice benefits was set to a 6-month prognosis of death, healthcare providers found themselves caught between either limiting access to palliative services to those who can provide a claim to death, a very small number, versus expanding access at the risk of severe financial implications for the sites of care (Institute of Medicine, 2014). These were emerging issues back in the 1980s; today these considerations are compounded by the fact that chronic illnesses interact in overlapping ways that set different trajectories for how illness will affect the body. Too, and this cannot be diminished, the move to chronic illness management has changed the way people conceptualize themselves as individuals within the healthcare system. A person is no longer "dying" of cirrhosis but are conceived as "living" with liver failure (Institute of Medicine, 2014). By assigning a person to the category of end of life you are framing their experience through the healthcare system in ways which may not be appreciated.

From its premiere in 2005, *Grey's Anatomy* has been enmeshed within these questions of end of life and ethical decision-making. *Grey's Anatomy* premiered just four days prior to the death of Terri Schiavo (Roscoe, Osman, & Haley, (2006). Interestingly, the first episode which dealt with the removal of life-support from a braindead patient was the third episode, which aired just ten days following her death. However, high profile cases in the vein of Terri Schiavo or Karen Ann Quinlan have not been the norm (Williams, Puro, & Armstrong, 2018). These cases which can rise to national prominence are outliers that come around only so often. What we have seen though from Terri Schiavo and others is that they provide ruptures for discussion. One might expect the short-term repercussions of the Terri Schiavo case to be a backlash against the removal of life-support. However, the opposite occurred (Shepherd, 2009). The case was felt to have been mishandled by the government such that the backlash was against those who interfered rather than against Michael Schiavo or Terri's parents (Hook & Mueller, 2005). This is ironic, as it was Terri's parents who wished for the government to intervene on their daughter's behalf (Szasz, 2006). As terrible as this case was it was a moment where people were able to look at an instance where death did not seem like the worst option possible. In making Terri a spectacle, people began to discuss how they would wish to be treated in the same scenario. Until then Jack Kevorkian was the image that people had when they imagined aiding the dying process (Sanburn, 2015). Terri reshaped that narrative. We saw the same thing with Brittany Maynard in 2014 when she advocated for her own death and finally took her own life before she could begin to suffer unnecessarily from terminal brain cancer (Angell, 2014). As sensational as these cases can be they do highlight that we do not talk nearly enough about death and that becomes evident when we are faced with that reality.

While there has not been tremendous change in sensational end-of-life cases there has indeed been great change with how people interact with hospice care. From 2004 to 2011, the percentage of all deaths in the US taking place under hospice care rose from 31.5 percent to 44.6 percent. Hospice programs rose nationally from 4,700 to 5,300 from 2007-2011 (Moore & Egan Fancher, 2013). The diagnoses of people utilizing hospice services has also changed drastically. While cancer used to be the main diagnosis for people entering hospice care, by 2011 cancer diagnoses accounted for only about 38 percent of all hospice admissions (Moore & Egan Fancher, 2013). Hospice too has evolved in terms of the site of delivery. About 67 percent of all people utilizing hospice services are being provided care in their place of residence, keeping people out of hospitals at the end of life. Perhaps even more exciting is that in 2006, the American Board of Medical Specialties (ABMS) approved hospice and palliative medicine as a medical subspecialty (Moore & Egan Fancher, 2013). In just the two years following this approval, 1,271 physicians received their certification. In 2008, the Centers for Medicare & Medicaid Services (CMS) formally recognized the subspecialty, which was the first step for approving payment for service. By 2008, 81 percent of hospitals with 300 or more beds reported having their own palliative care programs (Moore & Egan Fancher, 2013). While there is still much to do in promoting palliative care as an option for care, these numbers demonstrate that there has been significant growth in the end of life industry in a very short amount of time.

With these numbers it would seem that end of life care was looking up with the arrival of the Affordable Care Act. The opposite could not have been truer. Unfortunately, the debates surrounding the proposed legislation over national healthcare utilized end of life as a point of contention as a means to destroy credibility for the entire system. Originally, the bill would have contained a provision to allow payment through Medicare so that a physician could spend time in

what was termed “advanced care planning consultations” (Moore & Egan Fancher, 2013). This meant that a physician could bill for the time needed to discuss a patient’s wishes to end of life. This piece of the legislation however was seen to be a nefarious plot for the introduction of what was popularly termed “death panels” by politician Sarah Palin. The fear was put into people’s minds that the government was going to convene a group of people to review cases and determine whether the case was worthy of the money it would cost to heal a person (Aleccia, 2017). Images of grandma being euthanized because her medication cost too much caused such a stir that the language was removed from the legislation all together. However, the damage from these discussions remained. In fact, according to polls a majority of Americans either believed the rumors about death panels or were unsure what they believed (Nyhan, 2010). The climate of fear grew so large that author and physician Atul Gawande was discouraged by fellow doctors from discussing palliative care in his writing for fear of it being used as ammunition against all physicians (Ashbrook & Gawande, 2011). In 2015, the Centers for Medicare & Medicaid Services quietly changed the rules allowing for physicians to bill Medicare for discussions of end of life care. However, as the numbers are now coming out showing that some 14,000 doctors have billed for almost \$35 million dollars in discussions of end of life care, increased fears for retaliation by conservative forces have again surfaced, including the introduced Protecting Life Until Natural Death Act in Congress which would not allow physicians to be able to charge for such discussions anymore (Aleccia, 2017).

CHAPTER 3:

METHODOLOGY

In this section I discuss the methodologies which inform my dissertation. I consider the medium of television and fan studies as a discipline, discussing how they inform my research project. I offer a description of my texts of analysis and provide character descriptions for the pertinent storylines.

Television as a Medium

Amanda Lotz (2014) articulates that television as a medium has shifted greatly from its birth. Much as cinema has been cast as a dying form since its inception, television has chased away rumors of its death for years. Lotz argues that television has shifted through several modes, each requiring its own assumptions. In the current moment, television as a medium is understood in the following ways:

1. The idea of television as a unifying experience is inaccurate for today's world. The network era of production may have allowed for such an experience but the meeting of remote controls, VCR, and multi-cable channels has segmented the audience and created a niche market of audience involvement.
2. Digitization has conflated television with the computer, granting access and mobility to the screens through which we engage our televisual experience. The television no longer situates our viewing, our viewing situates the television.

3. Specialized viewing communities create opportunities to create, distribute, and discuss television in real time and with the people who wish to engage in such dialogue.
4. Series that are produced by services such as Netflix or Amazon Prime are less bound to conventions of narrative than their predecessors. The freedom to not have to wait a week for the next episode creates a new form of storytelling which indulges rather than withholds from the audience. In some ways streaming technologies create multi-hour-long movies which have been edited like a television show.

Due to this shift, the medium of television creates hurdles and opportunities for research. Streaming allows us to watch shows in the order we desire and free from the space of archives. However, it is hard to recreate the shows in the way they were originally intended. I can speak in my research to the effects of the show as I watch it, but the medium's mode of distribution has changed. I cannot claim that *Grey's Anatomy* still functions as it once did; I may only speak to what it CAN do in this moment.

Fan Studies

Adrienne Evans and Mafalda Stasi (2014) discuss that fan studies, as a relatively new discipline, has been underdeveloped in setting out a clear methodological perspective. This is in part because fan studies attempt to intersect many methods of data collection but attempts to do so privileging the researcher. Many methods work to erase the researcher, which creates a bind for the analysis. Literary criticism often does not see fan texts as actual texts, only as intertexts in a large web of meaning. Textual analysis tends to privilege the text, allowing it to speak free from the author or audience. Psychoanalysis works for subjectivity but often pathologizes the "fan." Reflexivity, however, has the ability to highlight the power dynamics at play which tend

to privilege the position of the researcher and denigrate the subject of the fan as crazed or obsessed (Press & Livingston, 2006). In *Zankie, queerbaiting, and performative rhetorics of bisexuality*, Xavia Andromeda Publius discusses the phenomenon of Queerbaiting on the American reality show *Big Brother* (2021). Within, they acknowledge the irony of a researcher discussing the exhibition of performative sexuality on the show which is viewed through the voyeurism of the show's narrative. This kind of reflexivity plays with our conception of criticism and abject pleasure gained through such problematic texts. Martine Mussies discusses being an online gamer and autistic through what she labels "Autietnography" (2020). She argues that her neurodivergent status creates a new way of conceptualizing relationships between players, characters, and those on the other side of the screen. By writing through her experience as a fan, she opens up the possibility that other ways of knowing can exist outside of the text itself. It also encourages the researcher to produce a wide range of knowledges, in the form of traditional qualitative as well as creative works which give voice to what has been left unsaid.

Methodology

Interpretive methods are used in this project to examine the representation of ethics at end of life within three episodes of *Grey's Anatomy*. This is a media driven analysis situated within health communication. I perform a close textual reading of three episodes of *Grey's Anatomy* which privilege aesthetics, internal logic, and narratives of the documentary and melodrama genres. My writing and research operate under the assumption that an objective analysis of media texts is unlikely, as my own emotional attachment to the show creates opportunities to engage with the text that draw me closer, rather than erase me from the page. Researchers such as Asha Winfield (2020) and Max Morris (2021) use their own experiences with media to talk about issues of health, in Winfield's case living with fibroids and Morris living with a new HIV

diagnosis. By opening up as researcher, we participate in the meaning making that already occurs within our hearts and minds. Culture is not something we live with, it is something we possess, create, and influence by actively sharing in its formation. Winfield and Morris are two of many who argue that media produces opportunities for discussing health, but are far more nuanced when we may do so through the experience of the text embodied in the person whom already embodies the health concern. My work is framed by narrative vignettes which open and close the dissertation, discussing my reflections on the show from within the analysis.

My analysis of representation is thus an exploration of myself as researcher as much as it is a study of my text, since the decoding of the text must take place by/through me. In addition to the textual reading of my episodes, reflexive writing was conducted in which I returned to my positionality as a researcher within the space of academia and the halls of the hospital. To enact this kind of reflective work, I kept a writing journal through the process of my textual analysis. Before, during, and after each viewing, I would write the experience of how it felt to be seated at the screen, describing the senses I felt and how my body reacted to the scenes. Narrative writing through the process allowed me to give voice to the emotions and using thick description better articulated the emotional resonance of the show. Most narrative writing, interestingly enough, took place within the space of my hospital's workplace. The subject of *Grey's Anatomy* came up meaningfully often between staff, patients, and on the ambient screens which litter the lobbies and patient rooms. This presence kept the emotions in the present and offered new positions to consider the question of audience spectatorship. As scholar, fan, and healthcare worker, my work influences my reading and my reading, by virtue, influences my work. I return to this positionality in the conclusion of the dissertation, discussing what was learned about myself

through this process and how this reflection guided the analysis and future directions of the research.

While not an autoethnographic project, my work is indebted to the media analysis work of autoethnographers whose writings inspired this project. Autoethnography is a mode of inquiry that privileges the researcher's lived experience as embedded within the larger cultural contexts to which they are engaging (Adams, Ellis, & Jones, 2015). Autoethnography is reflexive work, requiring the researcher to continuously (re)position themselves in relation to the cultural texts, social formations, and research projects to which they are currently engaged. It presumes that the objectivity that is often sought after in social science research cannot be achieved and should not be striven for in all cases.

Scholars such as Johnson & Boylorn (2015), Griffin (2019), Manning & Adams (2015), and Atay (2020) blend media analysis and autoethnographic inquiry to explore questions of identity and media, each shaping the other. The personal becomes the entry, not the roadblock to overcome. A future project of autoethnographic inquiry is in place to expand on the issues of my role as transporter and the movement of bodies, both on screen, on the page, and in person in which I take part. For this project, I take inspiration from their example of bringing the personal to the forefront of cultural conversations within media analysis.

Character & Episode Overview

In this section, I present an overview of the protagonists from my three episodes of analysis: Meredith Grey, Derek Shepherd, Miranda Bailey, Ellis Grey, and Richard Webber. I then provide a brief plot synopsis for each episode's storyline concerning end of life. These episodes were chosen for their strong demonstration of storytelling modes of melodrama and documentary realism.

Character Descriptions

The following character descriptions discuss the relevant protagonists of the three episodes I analyzed. Context is provided to explain the personalities and concerns of each character as they pertain to the situations encountered in each analyzed episode.

Meredith Grey

Meredith Grey is Chief of General Surgery at Grey Sloan Memorial Hospital. Daughter of Ellis Grey, an award-winning surgeon, she had a lot to live up to. Her mother demanded perfection and never saw Meredith as capable of living up to her potential. Meredith entered into a romantic relationship with her attending physician, Derek Shepherd, the night before she began her internship as a surgeon. Cautious about allowing her personal relationships to interfere with her career aspirations, Meredith eventually agrees to begin a committed relationship with Derek. Eventually falling in love, she was devastated when Derek leaves her for his wife, an event which played on her feelings of inadequacy fostered by her mother. Meredith spends her time as an early career surgeon balancing the concerns of her mother who is suffering from early onset Alzheimer's. Meredith eventually discovers that she has multiple markers for the disease and she may possibly also succumb to the disease one day. Meredith eventually marries Derek but suffers a miscarriage in the hospital's mass shooting. Meredith and Derek ultimately adopt a daughter and have two more children before Derek dies from a car accident. Meredith eventually wins a Catherine Fox Award for surgical innovation, finally claiming her spot as a surgical phenomenon alongside her mother.

Derek Shepherd

Derek Shepherd was a neurosurgeon at Seattle Grace Hospital. Originally from New York, he left his practice to escape his wife whom he caught cheating on him with his best

friend. Invited by Richard Webber, his former teacher, he is promised the possibility of becoming Chief of Surgery upon Richard's retirement. Upon arriving to Seattle, he meets Meredith at a bar and they begin a romantic relationship before realizing the existence of their professional relationship. When they decide to make a real go at a relationship Derek's wife, Addison, comes to Seattle to fix their relationship and take him back to New York. This begins a triangle of whether to return to his former life or go after something new. He ultimately returns to his wife, leaving Meredith devastated. Derek and Addison eventually break-up permanently and Derek and Meredith reconnect, eventually marrying and becoming pregnant. In the interim, Derek becomes Chief of Surgery, a position that he loathes because it takes him away from actual surgery. While acting as Chief, Derek served on the team which took care of a woman named Alison Clark. A cancer patient, she had several complications and had to be placed on life support. As her advanced directive stated that she did not want to be placed on machines, she was removed from life support and allowed to succumb to her illness. Her husband, Gary Clark, was devastated by this and sued the hospital. However, as Derek had followed her written wishes there was no case. Grieving his loss, he went on a shooting spree at the hospital, attempting to seek revenge on physicians specifically. In the process he found and shot Derek Shepard who was injured, but not killed. Meredith, having witnessed this, suffered a miscarriage from the stress. Their processing of this loss is detailed in the documentary, *Seattle Medical: Road to Recovery*.

Miranda Bailey

Miranda Bailey is a General Surgeon and current Chief of Surgery at Grey-Sloan Memorial Hospital. Originally a timid doctor, she became fiercely protective of her patients and took on a no-nonsense policy of mentoring and leadership under the supervision of Richard

Webber. She earned the nickname “the Nazi” because of her demeanor, though she drops this moniker after performing surgery on an actual Nazi. Bailey becomes a mothering figure to her intern physicians, though they continuously push her with their actions. Her intern George O’Malley assists her during a very difficult delivery and names her son after him. When George dies from injuries sustained in a bus accident, she vows to stop caring so much, but she never does. When Gary Clark begins his shooting spree at the hospital, Miranda hides with her patient, Mary Portman, though she is found by Mr. Clark and threatened. She lies to him, telling him that she is a nurse and he spares her life. Miranda takes a long time to recover from the trauma of the experience and the subsequent death of Mary when she returns for surgery.

Ellis Grey

Ellis Grey was a world-renowned General Surgeon. Mother to Meredith, she was married to a college professor, Thatcher, whom she felt was weak. She entered into the high-pressure world of surgery, a predominantly male field, and flourished. She did, however come up against misogyny and was treated as an inferior doctor because of her sex. She found solace in the arms of Richard Webber, her fellow resident and tried to get him to leave his wife. Turning her down, her down, Ellis left Thatcher and took her daughter to Boston to begin a fellowship at Mass. General Hospital. There, she grew as a surgeon and was twice awarded the prestigious Catherine Fox Award, even having a method of surgery named after her. She remained in Boston until moving back to Seattle quietly to receive nursing care for her advancing Alzheimer’s.

Richard Webber

Richard Webber is a General Surgeon and former Chief of Surgery at Seattle Grace Hospital. Richard was a contemporary of Ellis Grey, Meredith’s mother. They were outsiders in their resident class as a woman and a Black man in the largely white male field of surgery.

Because of their isolation they entered into an affair, each of them cheating on their respective spouses. Adele, Richard's wife, was aware of the affair and Richard did not have the heart to leave her. However, he later admitted that he was also fiercely jealous of Ellis's talent as a surgeon and did not want to feel inferior to his partner. He broke off the affair with Ellis who promptly left Seattle for Massachusetts. Richard eventually rose to the rank of Chief of Surgery, becoming a teacher and mentor to multiple generations of doctors. Richard lives with an addiction to alcohol which emerged throughout his tenure as a physician in times of stress and trauma, resulting in him being suspended as Chief of Surgery. He takes on the role of father figure to Meredith, seeing her as his child and feeling partly responsible for the life she lived under her harsh and demanding mother.

Episode Synopses

The following episode synopses outline the storylines and plots relevant to my three episodes of analysis.

Into You Like a Train: (Original Air Date- October 30th, 2005)

Derek has made the decision that he will be leaving one of the two women in his life. While waiting to hear Derek's decision of whom he will be choosing, either Meredith or Addison, the interns are brought back to the hospital with news of a terrible train crash. Bonnie and Tom, a pair of passengers on the train are brought in under extraordinary conditions: while alive, they are impaled on a metal pole. It soon becomes clear that removing both of them from the pole is too dangerous, as the trauma will likely be fatal. The only way to save someone is to remove one of them from the pole, allowing enough space to work on the other. Bonnie, a young white woman is chosen as the most likely to die and is removed from the pole. This gives the doctors time to save Tom, an older Black man who pulls through the surgery. The situation of

Bonnie and Tom mirrors the situation of Meredith and Derek. Both connected, Derek chooses to leave the relationship and return to his wife, an act that leaves Meredith devastated.

These Arms of Mine: (Original Air Date- October 28th, 2010)

This episode takes the form of a documentary special within the television universe of *Grey's Anatomy*. Titled "Seattle Medical: Road to Recovery," access has been given to the hospital, chronicling the personal and spatial changes which have occurred in the six months following the mass shooting at Seattle Grace-Mercy West Hospital. Mary Portman, the young patient who hid with Miranda Bailey during the assault is returning to the hospital for a colostomy reversal, the procedure she was not able to have following the shooting. Both Mary and Miranda are anxious about the return, however there is a sense that closure will be imminent with Dr. Bailey completing the surgery. Mary has plans for children in the future and though Miranda is happy to see Mary, she finds it difficult when speaking to the camera to address the events of the shooting. It is clear that Miranda will be happy to move away from the past. The surgery occurs and Miranda gives the news to Mary's husband, who is visibly relieved. The camera's return four weeks later where the audience is shown that Mary did not wake up from surgery. Though rare, she has fallen into a coma she will not wake up from and is beginning to suffer organ failure. Mary's husband removes her from life support, an action which though reasonable for the situation is difficult for Miranda to stomach after what she went through with Mary.

Time Warp: (Original Air Date- February 18th, 2010)

Richard Webber meets with Derek about returning to his job as Chief of Surgery. Having been removed from his position due to his alcohol abuse, Richard will only be able to resume his work if the board approves his reappointment. However, Richard is not willing at this moment to

return as an attending surgeon, a mixture of pride and shame. Derek who is serving as the interim Chief asks Richard to speak at the hospital's lecture series, if nothing else to teach the audience one last time, should he decide to retire.

Richard takes the stage and tells a story of a patient encounter from 1982. Through flashback we are taken to the Seattle Grace Hospital of the past. A patient diagnosed with GRID, the antecedent to AIDS, is brought into the hospital and only Richard Webber and Ellis Grey, Meredith's mother, agree to serve on his case. With little known about transmission, the threat of acquiring the disease themselves is a concern for the young doctors. However, they both find solace that, like their patient, they are seen as outsiders within the hospital system as a Black man and a woman in the field of surgery. The patient offers them an out, saying that he is probably a lost cause and they should save themselves. However, they push the patient to not lose hope, as a cure could be just around the corner. They were able to bring their patient through surgery successfully, however he returned later with pneumonia and died, holding hands with Ellis and Richard. It was the moment Richard felt the most vulnerable and we end with the revelation that this case was the start of Richard's abuse of alcohol, coping with his own loss of direction as a person whose made it their job to help people.

CHAPTER 4:

FINDINGS

Findings

In this chapter, I offer my analysis of *Grey's Anatomy*, which revealed two distinct narrative modes that are taken up by/through the medical drama: Documentary Realism and Melodrama. I argue that these forms of narrative storytelling are not simply means for engaging with questions of end of life ethics, but function as affective technologies for the storytelling on screen. These modes do not so much filter discourse as create a site, or interface, where these episodes of ethical decision-making take place. While each of these genres position the audience in specific ways, ways which direct conversations of ethics away from that of “unbiased” case studies, I argue that something special happens when the two work together. It is in this meeting of emotionality and stylized realism that questions of end of life on screen are imbued with complexity outside of the medical facts of each case. While I agree with the majority of scholars who posit that the representation on screen is important for how we learn about ethics, I make the claim here that it is in the interface of how stories are told on screen that the meaning-making of these ethical decisions are negotiated. This space of narrative convergence is unrecognized by ethicists outside of the realm of media studies and as such is a noticeable gap in how we understand media participating in conversations of ethics at end of life. I argue that only through considering cinematic ethics in the larger conversation of biomedical ethics can we begin to understand the ways that ethics on/in film participate in the wider conversation of end of life studies.

To demonstrate this interface, I will first identify the characteristics of these prevailing themes: Documentary Realism and Melodrama. In the initial section, I will go on to classify the ways that a documentary gaze has become integrated through this medical drama. First, I will outline the tropes of documentary realism and how they serve to position spectators within the narrative conventions of the realist mode of storytelling. Using the 132nd episode of *Grey's Anatomy*, "These Arms of Mine (McKee & Cragg, 2010)," I will demonstrate the ways that documentary realism and audience identification are constructed through what has popularly been termed "the documentary episode." Taking the form of a documentary special, detailing the recovery of Seattle Grace-Mercy West Hospital in the aftermath of a hospital shooting, this otherwise narrative rupture to the more common structure of the show is important for revealing the ways that the show makes use of a documentary gaze and the audiences' reliance of "reality" on screen. While this episode would appear to be an outlier, I argue that it reveals ways that the show positions the audience in every other episode. Next, I will move on to the melodramatic mode of storytelling, discussing the ways that film philosophers have understood the affective power of this genre across the history of film to today. Aligning my analysis with Linda Williams, who sees melodrama as not so much a subgenre but as actually the prevailing storytelling mode within Hollywood, I will look at each recurring theme of melodrama and discuss how they align with the medical drama (Williams, 1998). To establish the ways that melodrama serves to narrate ethics on screen, I will use the case of Bonnie Crasnoff and Tom Maynard, two patients who appeared in the fifteenth episode of *Grey's Anatomy*, "Into You Like a Train (Vernoff & Melman, 2005)." I argue that the shows reliance on melodrama narrates the ethics on screen through emotional investment and that the decision-making taking place at the end of life gains meaning in relation to the rupture of death and the patients' interwoven ties to

the protagonists on screen. In the final section, I will put these two thematic forms into conversation using the 117th episode of *Grey's Anatomy*, “The Time Warp (Clack & Corn, 2010).” This episode, presented as a flashback to the early 1980s, discusses the choices that were made in the care of a patient in the early years of HIV. Here, I will demonstrate that these two forms of storytelling do not simply coexist, but work in complex ways to position the audience for the choices made by the physicians and patient on screen. Looking at how documentary realist and melodramatic modes interact, I will argue that these approaches to storytelling endow end of life with reality, but do so for the investment of emotion into how we feel toward the show’s protagonists. I will demonstrate, however, that rarely will the show do the same for the patients, who are wounded by the storylines and must die for the audience to learn a lesson. Such a fact may be necessary for the production of these end of life storylines, however they nonetheless situate the spectator to align with doctors and not those who suffer medically so that the story may be told.

Documentary Realism

When one considers the documentary as a form, we tend to deem it as an objective lens towards some “truth.” The camera captures on film fleeting moments that are often irreplicable. They are ephemeral snapshots sutured together into a cohesive narrative. We would think that such loyal fealty to truth would negate such necessities as editing or voiceover. However, the documentary relies on the same Hollywood magic as other genre forms to come alive in a convincing way. The difference between the realism we see employed in a documentary versus a classical narrative is that a documentary’s realism is made through the suturing, editing frames of film into a continuous story. Classical narratives rely on realism instead to make the world of the film feel like reality, as if the camera were not there. Capturing moments that are brief,

documentaries would leave us with singular moments outside of a larger narrative.

Documentaries rarely begin with a finished storyline, as they often have not yet fully taken place before the camera. Thus, the documentary develops realism through the weaving of these moments into a persuasive argument about the world (Nichols, 1991).

Scholars of the documentary form have differed over how they consider the mode of documentary realism to play itself out through the relationship of the camera, the subjects in front of the camera, and the filmmaker who manipulates the footage in relation to what has been captured. One of the leading voices of documentary scholarship is Bill Nichols. Nichols took issue with the prevailing notions of documentary categorization which held that the way to map a documentary was by what it attempted to do, either to record, persuade, analyze, or express. Nichols sought to map the HOW, as well as the WHAT, and identified six modes of documentary which are used to construct a sense of reality on film; I will discuss each of these modes in turn (Nichols, 1991). It should, however, be noted that these modes do not construct rigid categories of filmmaking, and several films may overlap into many categories at once. Criticism of these modes have hung on to this fluidity between modes. However, I appreciate that they attempt to articulate strategies of storytelling to construct reality on screen, even as genres often spill over into one another in messy ways.

Poetic Mode

The poetic mode of documentary is less interested in constructing a narrative around the images captured and focuses more on questions of tone, mood, and imagery. As there is often little in the way of a narrative structure, and therefore rarely voiceover or text, the filmmaker will usually highlight vivid imagery and stunning colors or sights that may arrest the viewer, telling a story with no need for words. It is through the juxtaposition of images that a feeling is created for

the viewer, one that may be more affectively powerful for the viewer than simply being told how one should feel. Poetic documentaries tend to be more avant-garde in style and develop a rhythm in the film which eschews continuity. The goal is to create a subjective experience to what is on the screen, rather than argue for a specific meaning. These are abstract films with no resolutions. *Sans Soleil* (Marker, 1983), the celebrated French essay film, is a great example of this mode. Sutured together using stock footage, original footage shot by Marker, and asynchronous sound, the film works to challenge our understanding of memory and how we are actually unable to access the nuances of our collective histories.

Expository Mode

The expository mode of documentary, in contrast to the more abstract poetic mode, is centered around making a clear, objective argument about its subject matter. The claim of the film is that there is a correct answer to some question and the goal of the final draft is to provide evidence to that point throughout the course of the documentary. The film will begin by setting up a specific point of view from which the film will literally speak, often through a “voice of God” narration. There is an emphasized relationship here between the visuals on screen and the commentary of the filmmaker. Stock footage, original footage, interviews, or re-enactments are used to suture the film narrative by strengthening the argument evidentially. The BBC’S *The Blue Planet* (Fothergill, 2001) falls into this of mode of logos focused filmmaking. Using the authoritative voice of David Attenborough, *The Blue Planet* makes the claim that while we understand only a minute percentage of what inhabits the world’s oceans, our behavior has serious effects on the health and welfare of one of the largest ecosystems on earth.

Participatory Mode

The participatory mode of documentary is marked by the presence of the filmmaker within the film. The filmmaker may be tangentially present, as in the form of a voiceover, or a direct presence, interacting with the other subjects in front of the camera. The filmmaker becomes, in many ways, the locus for the “Truth” of the documentary. While other documentary modes attempt to edit out the presence of the filmmaker to create a more objective reality on screen, the participatory mode is one that highlights the filmmaker’s relationship to the subjects and the larger topic of inquiry. Audiences get a behind the scenes view of how the movie is being constructed. The point of view is that of the filmmaker, and as such their gaze and emotional journey is the one that is often constructed as being aligned with the audience’s take on the subject. The Academy Award winning documentary, *Bowling for Columbine* (Moore, 2002), is an example of a participatory documentary. Attempting to answer the question of how America became a country where gun violence has become not an aberration, but an integrated part of the American experience, Moore interviews people within his home state of Michigan and across America. The goal, here, being to see if the problem may not be individuals or media, as is often described, but something deeper in the American psyche. Moore, as filmmaker, serves as the point of view for the audience and commentator, throughout.

Observational Mode

The observational mode of documentary is associated with the cinema vérité movement, an attempt to locate the truth of a subject by acting as a “fly on the wall.” The camera is not designed to be conspicuous into the subject’s real-world life, instead the observational documentary seeks to try to capture events as they really happen, or as they seemingly would happen if no camera crew were present to record them. Films of the observational style often

attempt to tell a story without injecting an argument, or moral message; the footage alone is thought to speak for itself. In an attempt to create a sense of immediacy and realism, you will be more likely to see actual footage, rather than reenactments. Cinematography tends to value the handheld shot, reinforcing the idea that what is staged in front of the camera arises naturally, rather than as the result of some preplanned action. Since observational documentaries will value the idea of objectivity there will not likely be a “voice of God” narration. Rather, any intrusion is out of necessity to allow cameras to be present. *Grey Gardens* (Maysles & Maysles, 1975), directed by brothers Albert and David Maysles, is one such observational documentary. Filming in the dilapidated mansion of mother and daughter “Big” Edie and “Little” Edie Beale, relatives of Jacqueline Onassis, the film documents the lives of these two society women who have been forgotten and cast off. Their eccentric lives and the interpersonal struggles of the two women are captured, portraying the daily routine of the unseen reclusive pair in East Hampton, Long Island. This documentary, though the participants directly address the camera, captures the eccentricities of a life unseen on camera, but presumably going on behind the faded walls of the once grand home of these forgotten women. This is a snapshot of what life has been and what it presumably would be once the cameras have left.

Reflexive Mode

The reflexive mode of documentary is one which focuses on the process of documentary filmmaking, rather than on an outside subject. The goal here is not to create a strong response, emotionally or evidentially, for the audience but to inspire contemplation on the documentary process. It will often feature footage shot during the process of filming, highlighting the behind-the-scenes work of filmmaking. While they both will generally feature the filmmaker, the reflexive mode will differ from the participatory mode in that the presence of the filmmaker is

not to create a subjective-centered point of view, but to create an awareness of the bias inherent to the process and have a discussion on the question of truth, and how it is created within the film. Dziga Vertov's film *Man with a Movie Camera* (1929) is an example of this integration of the filmmaking process within the documentary. This film, which documented mundane life in Soviet Ukraine, drew attention to the aspects of the filmmaking process, using editing and cinematography to play with the medium of the camera and how footage is manipulated to construct the story.

Performative Mode

The performative mode of documentary is one that holds the filmmaker's relationship with the subject as an important component of the expressed story. This form of documentary privileges the subjective experience and uses the filmmaker's positionality as a way to engage with questions of truth. The performative mode is closely related to the participatory mode. The difference between the two is that while the point of view is subjective in both, participatory wishes to create a film which could be used to answer universal questions of truth. The performative mode is more interested in privileging person truths of the filmmaker which may not be able to be replicable. Morgan Spurlock's film, *Supersize Me* (2004), is one such performative documentary. In this film, Spurlock records his experience eating nothing but McDonalds for a month, chronicling his experiences and tracking his declining health as he investigates the American experience with fast food. Audiences learn from Spurlock's experience, but it is an experience grounded in a more personal experience to the filmmaker.

Now, not all scholars have lauded Nichols' ideas about the documentary. For example, Toni de Bromhead argues the Nichols comes to the question of documentary with a bias towards rationality. She reasons that, just like classical Hollywood, documentary films create affective

responses in the viewer. His is a more journalistic approach to the information on screen, rather than a cinematic expression which may be more appropriate for a mode that seeks to persuade, and by definition create feelings of support, anger, frustration, or astonishment (De Bromhead, 1996). While I fully support this criticism, I do not want it to suggest that Nichols does not have something of value to offer. It matters less to me how a film may be categorized by strategy and more that we are recognizing the strategies themselves, those that are employed to construct the narratives which complete a story and forge an experience for the audience. In the proceeding section, I will present my first analysis of *Grey's Anatomy* and demonstrate how the techniques of documentary realism present themselves in the narrative of the episode "These Arms of Mine" (McKee & Cragg, 2010)."

"These Arms of Mine"

The episode opens visually similar to what viewers have come to expect from *Grey's Anatomy*. Through aerial shots of the Seattle skyline the audience is positioned to be transported into the world of Seattle Grace-Mercy West Hospital. However, the voiceover that should accompany these visuals, that of Meredith Grey introducing, through monologue, the overarching tensions that we will see played out over the episode, is absent. Instead, we are given over to ambulance sirens and the sound of EMS dispatch. Once the camera switches from the opening montage to inside the space of the hospital there is a noticeable shift in cinematography. Rather than the static camera that has come to be the hallmark for this single camera drama, the audience is introduced to a shaky, handheld gaze. This paired with chyron text identifying the doctors and their positions in the hospital signals a shift in the ways that we are to position the camera in relation to the events on screen. Normally the camera features as the eyes of the audience, a "fly on the wall" perspective that maintains the illusion of the fourth wall.

However, this movement towards a documentary gaze indicates to the audience that the camera is an interloper in the halls of the hospital and opens up the opportunity for the audience to see and understand the events of the episode through a different frame than the show normally allows. While the camera serves as the eyes for the audience, in the form of a documentary camera, the audience is led to gaze upon the scene in very pointed ways.

I would like to focus on one specific storyline in the episode, that of Dr. Miranda Bailey. In the episode, we are following up with the hospital six months after a mass shooting took place. The goal of the in-universe documentary is to see how the people, and the hospital, have recovered in the time since. Dr. Bailey spent the shooting hiding with a patient, Mary Portman, who was meant to undergo a colostomy reversal that day. Instead, the two of them attempted to keep alive a physician who was shot by the gunman, who ultimately succumbed to his injuries. We are reintroduced to Mary through interview footage taken as she and her husband prepare to return, the first time since the shooting, to finally have her surgery. We are given a juxtaposing account of the story by Dr. Bailey. In her confessional interview, she explains her detachment from the patient and explains that she rarely hugs her patients. However, the filmed footage of her and Mary meeting for the first time shows that they have a real connection based upon their shared trauma. At the same time, we take her words as false as viewers of the show have seen that Dr. Bailey is in fact quite emotionally attached to her patients and what befalls them, she takes with her. The documentary aspects of the episode invite the audience to challenge what is said versus what is “true.” While Dr. Bailey explains that it is good to get the surgery over with, we understand that she is referring to the lingering unfinished nature of the shooting and not Mary’s physical welfare. While the event is past, the trauma lingers across the hospital. Mary is Dr. Bailey’s reminder.

The tragedy of the episode is that while the actual surgery is successful, Mary is unable to be awakened from surgery. Tests do not give a cause, only that she is one of a small minority of people who will never be awakened from general anesthesia. The coda of the episode explains through onscreen text that Mary's husband removed her from life support when her organs began to fail. This abrupt revelation and end to Mary's storyline is responsible for two phenomena within this episode. First, it emotionally hits the audience who are not prepared to see Mary's story end in this way. Footage shows Mary's husband carrying flowers down the hall before turning into a patient room, we assume hers. He sets them down and speaks to someone off camera, still hidden from the camera's stagnant gaze. As he rounds the corner of the bed the camera lingers on him. Then, it slowly reveals a sliver of a ventilator and tubing, a warning, before the camera reveals the many other tubes, pumps, and monitors surrounding what turns out to be Mary's bed. This withholding is done specifically to blindside the audience. The second effect of this abrupt ending, a side effect of this drive to emotionally hit the audience, is that the discussion of Mary's end of life care, now being conducted through the proxy of her husband, is equally abrupt. Dr. Bailey, through an on-camera interview, explains that Mary has been in a coma since her surgery, with no brain activity, and has now become septic, moving into organ failure. The best-case scenario for her will be to awaken with severe physical and mental deficits, though the likelihood of her awakening at this point is unlikely. Footage shows her walking into Mary's room, closing the door behind her, and discussing with Mary's husband, we assume, what we have already heard her tell the camera. The camera bobs and weaves between the blinds of the patient room's window, straining to see as we cannot hear what is being said. The onscreen text indicates that he took three days to withdraw life support.

There is, in this episode, such a missed opportunity to discuss the complexities of serving as a decisionmaker for your loved one's care. We do not know if this decision is what Mary wanted, what her husband wanted for her, or what Dr. Bailey is recommending. The end of Mary's life is discussed as a point of medical fact; she is dying and the best thing to do is let her die. Studies consistently show that surrogates of decision-making often choose wrong, going against advanced directives or making decisions that they later regret effecting (Bolt et al., 2019; Bakitas et al., 2008; Klinkenberg et al., 2004). The ethics of what is the "right" choice is told through the perspective of Dr. Bailey, becoming the narrative, as well as medical, surrogate for Mary at her moment of end of life. Footage of Dr. Bailey solemnly at work backgrounds the text that indicates for the audience the Dr. Bailey declined a follow-up interview. While the documentary reality of the episode indicates the sadness involved, the gaze of the camera asks for us to investigate what is really happening. The truth of the loss rests less with her husband and more with Dr. Bailey. The catharsis of "some good" coming out of the shooting is dashed upon Mary's death.

This way of presenting the story, with a gaze towards what we are supposed to see versus what we know to be true, is important for understanding medical dramas as technologies, or frames, for interacting with questions of ethics. The audience's role in the show is to look beyond what we are being told in the documentary and understand what is really going on. We are led through this narrative structure to see the world in very specific ways. Not all representations on screen are as obvious as in this episode but the show still functions under a gaze towards reading the meaning of the text, including motivations of characters, as well as what are the right decisions to make in the healthcare setting. In this episode, the camera's intrusion into the scene has the effect of changing the behaviors of each doctor. They either act in

ways which signal their discomfort, or they profess beliefs which we hold to be false because of our longstanding relationships with them prior to this narrative rupture. The audience's role is to see this diversion enacted and create meaning from it.

The dialectic of the documentary plays out in the form of expository and observational themes. This episode purports to document the recovery of the hospital through the factual footage of the hospital in the course of the patients' treatments. Mary's surgery and her subsequent end of life create a narrative frame on which to focus the attentions of Dr. Bailey and her trauma. The film itself acts as evidence for the "truth" on screen. The editing of the footage and the addition of text creates the story of what the audience is supposed to take from this otherwise "objective" case. We align our allegiance with the facts, as presented. However, with the addition of the observational themes, the commitment to facts becomes narratively suspect. Observational themes of the documentary mode encourage the audience to search the screen, searching out the real truth. It is here, in the shaky, handheld shots and the rapid movement that we discover that we know these characters better than the show does. We disregard the "truth" of the documentary and allow it add credence to our longstanding allegiance to the surgeons.

End of Life Ethics

The documentary mode of realism encourages the audience to seek out notions of truth and, on the surface, this seems to be exactly what biomedical ethicists want from our media depictions of end of life. We want to see dialogues opening up between what we see and whether or not they are actions that we would want to enact in our own lives. However, the documentary mode of realism is one that constructs truth and presents it for the audience in ways that elicit emotional responses. These are not objective. They never can be. While they purport to be objective, they are always subject to the filmmaker and the audiences input on what is truth and

what is Hollywood magic. Whatever realism exists on the screen, it exists, narratively speaking, to create the emotion responses on the screen. What is real is what can be felt.

Melodrama

Melodrama is a mode of storytelling that has come to be synonymous with emotional excess. However, the taint against excess stems not from excessive emotion but privileging emotional representations that mirror genuine societal concerns. If a melodrama were to highlight the suffering of women as their children “leave the nest,” it is because that is a real concern for many women and deserves to be represented and interrogated. While melodrama has been a term associated with “weepy women” films of the past such as *Stella Dallas* (Vidor, 1937) or *Mildred Pierce* (Curtiz, 1945), they include such varied stories as television’s *The Wire* (Simon et al., 2002-2008) and *Shameless* (Wells et al., 2011-2021), which have attracted strong male audiences in the present day. Melodrama is not so much a genre as an expression of emotion that challenges questions of community, nostalgia, victimhood, and choice in isolated settings. That being said, the genre is still pejoratively associated with unrealistic and overwrought displays of sentimentality. When the primary audience is male, they are called dramas. When the primary audience is female, they are called melodramas (Hayward, 2017, Williams, 2014). In this section, I will discuss the melodramatic mode and look at how it emerges as a way of telling a story which privileges emotion, rather than pretending that it does not exist.

Scholar Linda Williams has become a leading voice in the reclamation of melodrama’s image in recent years. Williams is a scholar who is interested in the “body genres:” Horror, Melodrama, and Pornography. So called because they elicit individual, bodily responses from the audience, these three genres of film are much maligned by classical Hollywood (Williams,

1991). What Williams has found, as it pertains to the melodrama, is that the tropes that are enacted within the genre are indeed tropes which can be found in most drama programming on television and on our movie screens. It is not, in fact, a subgenre, but is instead the prevailing narrative style for storytelling (Williams, 2014). This disavowal of the melodramatic has the effect of creating an impression that emotion is something reserved for certain audiences, almost always female. Whereas, most scholars now feel that this privileging of emotion is what grounds films in reality, rather than isolates them as being peculiar outsiders of entertainment. While they have emerged as the primary mode of storytelling, many are not aware of how they operate to tell the story and craft meaning for the events on screen. Williams, however, identified five themes which recur within the melodramatic narrative (Williams, 1998). I will attend to each, describing how they may be enacted within the space of the melodramatic.

Melodrama Begins and Attempts to End in a Space of Innocence

Melodramas will usually begin with some level of filmic homeostasis; if things are not perfect in the setting of the film, they are at least in their proper place. The “drama” of the melodrama is created by some rupture to the perceived sense of innocence. The space of the home is commonly situated as the point of all action; so, an outsider arriving to disrupt the family unit would be a welcome framework for the melodrama. The film *Picnic* (Logan, 1955) is an example of such a framework. Outsider William Holden disrupts an idyllic Kansas town on Labor Day, resulting in a reshuffling of romantic partners and a desire to reestablish an illusionary respectability among the townsfolk at the expense of their deeper, emotional desires. Melodramas love the home because it represents a space of safety, either real or imagined. Most often, we see melodramas playing out in the present or the past, but less commonly in a future that diverges from our own social networks. The future holds possibilities of divergence from

this place of innocence, while the past harkens back to a time, real or imagined, of the “good old days.” Even if things were never how we imagine them, never really possessing innocence, we like to think we did once have everything. For this reason, nostalgia for the home, and what it represents, tends to be enacted within the melodramatic mode.

Melodramas Focus their Attention on Virtuous Victim-Heroes

Protagonists of the melodrama are not merely the center of action, but are presented as being morally virtuous. Those recognized as the hero of a melodrama straddle two positions: they must work to fix the suffering that has been introduced into the narrative, but they too must suffer from such a rupture into the homeostasis of the setting. The audience identification of the virtuous, “good” character is identified by the one who suffers. Likewise, it is easy to recognize who is the villain, or morally corrupt force within the narrative, as they are the one who commits or is responsible for the injuries. This is not to say that all melodramatic leads are saints. In fact, many have flaws which emerge as morally ambiguous actions throughout the storylines of a melodramatic text. However, we do not doubt within the narrative that the moral center of the character is unchanged. The only thing that changes is the suffering that is placed upon an otherwise heroic person. We can track this virtue within the emotional displays on screen. We see this identification in the film *Ali: Fear Eats the Soul* (Fassbinder, 1974). Ali, a Moroccan foreign worker, begins a relationship with Emmi, a white, German woman in her 60s. Shunned by neighbors, family, and coworkers, the strain on their relationship comes to a head when Ali collapses from a burst stomach ulcer. Doctors remark that they may repair the damage, however the ulcer is almost certain to return, as they are incredibly common in foreign workers, who must suffer the stress of living in a foreign land while facing systemic racism from many fronts. While Ali has not been a model husband to Emmi, we have seen evidence throughout that they are

made happier together, even as they face difficulties. We see his suffering as coming from forces which wish to tear him down, rather than coming from his own doing. It is this which marks him, along with his wife, as our victim-hero.

Melodrama Appears Modern by Borrowing from Realism

Melodrama is a popular form of entertainment because it speaks to real concerns and is grounded in a realistic portrayal of anxieties and societal struggles. Taking the film *Titanic* (Cameron, 1997) as an example, the character of Rose is a girl who is caught between the expectations of her family and society to maintain the appearance of wealth, at the expense of her own happiness. What makes the story work, and stay grounded in reality, is that this inter/intrapersonal conflict is taking place against the backdrop of the sinking of the Titanic ocean liner in 1912. Special effects allow us to experience this and ground the narrative as feeling real and present for the time it depicts. Told through flashbacks, we are introduced to this through the exploratory technology of 1997 which allowed researchers, and director James Cameron, to survey the actual shipwreck, adding further credibility to the film and its subject matter. The film situates an undercurrent of female autonomy, against the backdrop of domestic abuse and crushing social pressures for women to submit, as its moralizing story. We root for Rose to forge her own path, which she does, using the sinking of the Titanic as an excuse to model a new life for herself. This disavowal of the society of 1912 is all the more pertinent as the Titanic, in many ways, marked the true death of the Edwardian Era. That being said, the film uses this realism, crafting the image of the Gilded Age to attract the audience. The society that we are meant to despise is precisely the one that is so beautiful to look at. The grandeur and splendor of the foregone age is an intoxicating drug for the viewer. So, even as we may chastise

a society that might ask a teenager to give up her life to support her family, we spend three plus hours of runtime soaking it in and mourn for it as it sinks below the surface of the Atlantic.

Melodramas Involve a Give and Take of ‘Too Late’ and ‘in the Nick of Time’

Melodrama possesses a clear temporality of progressive, always moving narratives. This, in some ways, plays back to the idea of the “good old days.” The nostalgia that is bred within the melodrama is born from the way that time never stops marching forward and that the action of the narrative is often running out of control. The action of a melodrama is the emotional investment of trying to get back to the beginning before it is too late. This logic of fixing society or rectifying some mistake is privileged as always being possible, if only we can get there in time to fix it. For this reason, time is venerated and so much of the narrative is thrusting us toward a created end point where action must be halted before we arrive at this moment the audience sees coming. The science fiction film *In Time* (Niccol, 2011) plays with this dialectic of time and action quite explicitly. Set in a future where time has become a currency, a person’s remaining years of life are read as a counting clock on their forearm. Humans stop ageing at 25 years and a caste system has emerged of those who live, literally, one day at a time and those who possess enough time to live for as long as they want in leisure. Neoliberalism has, literally, tied the working classes to the timeclock. We are repeatedly reminded of our protagonists’ clocks and at several points in the film the camera lingers as they tick precariously close to “timing out.” This give and take comes to a head when our protagonist, Will (Justin Timberlake) is not able to add time to his mother’s time clock, missing her by seconds before she dies in his arms. The melodramatic mode’s use of time is a means to create stakes for the characters and for the settings that they inhabit. We stick around because we need to be sure that they get there, in the nick of time.

Melodrama Presents a Conflict Between Good and Evil

Melodrama has been attacked by what is often seen as a lack of character complexity. The melodramatic mode is one which presents a duality between heroes and villains. Lead characters are not often presented as being ambiguously good or evil, usually falling into a clearly defined role within the narrative, one way or the other. While many may be victims of circumstance, there is a clear line drawn between those who we are meant to rally behind and those we are meant to spurn our allegiance toward. The hero is one who is intuitive, seeking after justice, and will eschew less important rules/roles in service of the greater moral good. In contrast, our villains are corrupt, in service to only themselves, and are often punished for their deeds. Heroes, interestingly enough are not always elevated back to their former positions. Having suffered in their narratives, they sometimes suffer a fall in service of the restoration of the larger narrative's virtue. *The Fault in Our Stars* (Boone, 2014) plays out with this idea of good versus evil. Hazel, a teenage girl living with metastatic cancer, meets a boy, Gus, at a cancer support group. Hazel, having been depressed and lonely from her longstanding prognosis, is brought out of her isolation by Gus who, though he lost a leg to bone cancer, is in remission. The two teens fall in love against the specter of death, which is portrayed as the villain looming over our protagonists' future. Hazel mourns that she realistically does not have the time she wants to spend with Gus but must reassess her impending death when Gus' cancer returns and he dies before her, leaving her isolated once more. Hazel, with the help of her family, is able to face her loss and accept her death in light of the lessons she learned from Gus. Here, death is revealed to have been thwarted in its efforts to break Hazel, as she experiences a great love before her assured, future death. Hazel, though the hero of this melodrama, is not cured of her cancer. Instead, her suffering serves the moral of the story, which is that death does not destroy

as long as we love. The lessons of death are equally Hazel's, her parents', who are not yet ready to see her go, and the audience, who must go on living after they exit the darkened movie theater.

Like the documentary, the melodrama is a mode of storytelling which works to construct reality and create affective responses for the audience. The melodramatic mode has been identified as being constructed of several themes which allow for a narrative to privilege emotional expression, rather than inhibit an emotive reality from artistic representation. Melodrama is not excessive for excessiveness' sake: it holds emotion as being an important expression of social and individualistic experience deserving of attention, we should not hide, but instead dwell within our emotions. Williams does not produce an exhaustive list of tropes and there are exceptions for each rule. However, in recognizing that melodrama provides a solid narrative structure for dealing with real world issues in media, I hold that understanding how they work in discussing end of life issues on television is necessary for understanding the lens through which these discussions are imbued with meaning. In the proceeding section, I will present my second analysis of *Grey's Anatomy* and demonstrate how the techniques of melodramatic storytelling present themselves in the narrative of the episode "Into You Like a Train (Vernoff & Melman, 2005)."

"Into You Like a Train"

Our episode begins with Meredith, waiting at the bar across the street from the hospital. She is expecting Dr. Derek Shepherd to meet her. The two have been engaging in a burgeoning relationship which has been made complicated by the sudden reappearance of Derek's estranged wife, who wishes to reconcile their broken relationship. Derek must choose who he will be with and the answer will arrive with him at the bar. The meeting is interrupted, however, by a train derailment, which causes all of the doctors to be called back to the hospital. The train wreck is

described as being a mass casualty disaster, with several critical patients being brought in, but not many survivors.

The primary case of this event is that of Bonnie Crasnoff and Tom Maynard, two strangers who have been impaled through the torsos, fixing them together by a metal pole. Tom, is an older, Black male in his 50's who is in relatively stable condition. Bonnie, a young, white woman in her 20's is less stable. They are both alert and make small talk, even cracking jokes. However, the scene is tense. Tom's wife and Bonnie's fiancé are on their way, flying in from Vancouver to be with their loved ones. Like their significant others, they are two strangers who have been thrust together by circumstance. This is the first of several key episodes which mark big, dramatic cases outside the standard acute and chronic ailments which fill a typical episode of *Grey's Anatomy*.

The position of these two patients, and the large protruding pole, does not allow them to fit inside the CT Scan machine, so they wheel them to Xray to better assess their conditions. The results of their scans show that the pole is dangerously close to Tom's inferior vena cava and Bonnie's aorta, two important vascular structures. It is too dangerous to move the pole, for fear that they will both bleed out if either structure gets punctured. Attempting to save both patients may be the thing that could kill each of them. Instead, the safest route is to slide one of them off the pole and then slowly repair the damage of the person still on the pole as it is sawed off. Sliding one of them off the pole, however, is likely to cause irreparable damage. The argument for moving Bonnie is that, as she has suffered the most damage, it is likely she may not survive the surgery. This is compounded by the fact she appears to no longer have feeling in her legs, signaling spinal damage. The argument for moving Tom is that he is more stable, which would

give Bonnie the greatest chance to live. Meredith remarks, "So basically, whoever you move doesn't stand a chance. So how do you choose? How do you decide who gets to live?"

This case highlights the complicated interdependence of beneficence and nonmaleficence. Do good while doing no harm seem like two very easy tasks to manage. However, in the case of Bonnie and Tom, doing good, that is, saving one of them, may be the very thing that causes the other harm. The principlism approach does not offer a way to extricate the "correct" answer from the situation. At the same time, justice is difficult to distribute. A limited amount of people exist who are skilled to handle such a surgical intervention, especially when in the midst of a mass casualty disaster. Do we devote more hands to help the person more likely to need them or devote more hands to the person who will likely benefit the most? From an ethical standpoint, the physicians are morally unburdened so long as any harm is unintentional (Freeman, 1999). This is the rule of double effect, acknowledging that a bad outcome may be ethically necessary if it stops an equally bad outcome (Sulmasy, 2018). That being said, these kinds of dialectics between deciding on the course of action are not given screen time, nor are they discussed using the appropriate ethical terminology. They are, instead, presented as primarily emotional decisions, rather than decisions that are also steeped in rationality, practicality, and clinical feasibility.

After consideration, the decision is made that Tom has the greater chance to survive and so Bonnie will be moved off of the pole. Tom makes the argument that since he is older, they should move him so Bonnie, the younger woman, can live a full life. Bonnie reassures Tom that it wouldn't be fair either way, regardless of whom they choose, and it isn't anyone's fault that circumstances led to this moment. Bonnie's fiancé has not yet arrived to the hospital, but she remarks that it is better this way, as he wouldn't understand. She leaves a message with Derek to

deliver to him. As they prepare for the surgery, Bonnie accepts her inevitable death and comforts Tom, who feels guilt at being the one to live. Meredith scrubs into surgery next to Derek, who cannot make eye contact with her. It is in that moment that she realizes what Derek's answer at the bar was going to be: he is staying with his wife. Bonnie starts crashing and they quickly slide her off the pole and place her on the operating table. Her aorta is found to be shredded and she is quickly bleeding out. Unable to fix it, there is nothing left to be done. Tom's blood pressure begins to drop so everyone but Meredith leaves Bonnie to attend to him. Meredith begins to scream out, "What about her? We can't just abandon her! We have an obligation!" Dr. Miranda Bailey comes over to Meredith, says they have to let her go, and calls her time of death. Meredith stays by Bonnie's side as the other doctors work to save Tom.

Derek meets with Bonnie's fiancé and fills him in, delivering the message that Bonnie asked him to relay: "She wanted you to know that if love were enough... that she'd still be here with you." Meredith, who overhears this message, looks on, and walks away. The message is equally meant for Meredith. We later see Tom in his recovery bed, out of surgery, his wife by his side.

This episode is a thought-provoking case of end of life ethics because it asks the question of how you choose between two patients, when the life of one may mean the death of another. As an example of melodramatic storytelling, this episode plays into all of the tropes outlined by Linda Williams. I will attend to each, discussing how they reflect back to the question of ethics.

Melodrama Begins and Attempts to End in a Space of Innocence

For the medical drama, the place of innocence is always the hospital. Like the home, the hospital conjures up certain ideals, in this case recovery, rescue, and safety. The hospital is where you go when you need to get better. For the melodramatic mode of storytelling, we must

rupture such an association of innocence to advance the plot. This happens when Bonnie and Tom are brought into the hospital. There is a case that is unwinnable. Now, our residents have had patients they could not save in the past, but this is the first collection of patients whose survival is predicated on the death of another. To win is already to lose. The goal is to reclaim a sense of control, however the lesson that is learned, primarily through Meredith, is that some battles are unwinnable and they are nobody's fault when that turns out to be the case. Innocence is restored on the promise of a new day, which signals that there will be cases that may be won, this night was simply one rupture in the otherwise solid logic of rescue and recovery which marks the space of the hospital. For conversations of end of life ethics, a medical drama's hospital is a site constructed as being a safe and a neutral space in which end of life decisions may be made. However, this is not the case. The melodramatic focus on emotion is important, because it attempts to demonstrate the stakes involved. We dwell on emotions because emotions are important. However, portraying the innocence of this space creates an impression that death is an outsider to the logic of healthcare. It is a rupture to the system, and not a part of life, always around the corner. This is especially troubling as we now have many patients living with chronic illnesses that mean end of life is an ongoing conversation, not a decision that must be made when it breaks in to the innocence of life. This space of innocence that the melodramatic mode relies on, belies an ability to engage with end of life as a conversation that everyone must/should have.

Melodramas Focus their Attention on Virtuous Victim-Heroes

Meredith Grey is our victim-hero for this episode. The episode is narratively buttressed around two collisions, the train crash which brings Bonnie and Tom together, and the series of events which have thrust Meredith and Derek together. Like Bonnie and Tom, Meredith did not set out to become romantically involved, in fact she actively worked against it. However, it was

in the moment of finally giving in to love that Derek's wife returned. Bonnie becomes a placeholder for Meredith and her suffering within the story. Derek's choice is to remove himself from her, romantically. This has the effect of destroying her. This is why we see such a strong reaction from Meredith when Bonnie is forsaken on the operating table. No one is fighting for Meredith anymore and her sense of abandonment at this moment is tantamount to dying on the table. Now, we do see Meredith's virtue in fighting for her patient. She does not give up, even when Bonnie is gone. Virtue ethics holds that it is not the things that we do that signal virtue, but the inherent virtue of our moral center that determines good (Kotzee, 2017). It is not that Bonnie could be saved, but that in the trying to save her, virtue is assigned to Meredith. Most doctors are presumed to be virtuous and the profession of medicine, at least in the Western context, has worked to strengthen this ideal of virtue, holding professional ethics as maintaining a desire for beneficence and nonmaleficence (Kao, 2020). Meredith's fighting spirit thus strengthens this resolve of doctors as virtuous. Though it is not Bonnie who she fights for; she is fighting for herself. There is not, however, anyone who can help her now. In her suffering, we align ourselves with Meredith more, as we sympathize with her plight though the spectator can do nothing to bring her the catharsis she needs. It is in her pain that she is purified as our hero. For end of life ethics, this narrative device of positioning the doctor as our hero and victim is troubling. End of life ethics, as they exist today, attempt to privilege a conversation of death that is surrounding teams of stakeholders: patients, doctors, families, and policymakers. End of life is not discussed nearly enough, and to convey this story into one that demonstrates the suffering of the physician, only tells one story. Now, we cannot fault the medical drama for focusing on doctors as their protagonists. Not everyone can be the star of the show. We can, however, point out that if the doctor is to be cast as hero and victim to the conversations of end of life, we need

to mark this fact and allow it to temper the medical dramas use as an educational tool. Doctors do suffer when their patients die. However, this suffering often happens in silence, stained by that fact that a logic of rescue in healthcare marks death as a failure (Chapple, 2010). This explains why many doctors find it difficult to confront end of life discussions with their patients and may explain why gerontology is one of the hardest residencies to fill (Meiboom et al., 2015). It takes a specific kind of doctor to dedicate one's life to a population who are coming to you at the time of life when they are most vulnerable and susceptible to illness and death. As they are currently portrayed in medical dramas, doctors do not accept death as an inevitability and thus perpetuate the idea that death equals failure, an ethically problematic representation for end of life studies. This tells a very specific story about how doctors are attached to their patients and how virtuous they are in fighting for their lives. It does a disservice to the larger conversation of end of life to only present ethics as a consideration of the doctors. This may be very helpful to boosting a sense of virtue in medical students, but may take away some agency for the lay population, watching at home.

Melodrama Appears Modern by Borrowing from Realism

As a medical case, this instance of an accident stretches to the very limits of medical accuracy. As with most of the sensational cases on *Grey's Anatomy*, it is possible that this sort of injury could happen, but it remains very unlikely. Likewise, the means of treatment for their injury is possible, but not very likely. By grounding this case in the medical boundaries of possibility, our emotional investment lies in the fact that there is no good option. The balance between beneficence and nonmaleficence is about maximizing the positive outcomes while minimizing harm. In the case of Bonnie and Tom, we see a give and take between these two concerns. We talk about medical dramas as being invested in representation for the point of

medical accuracy. This of course is true. It cannot, however, be denied that the medical accuracy is what allows for such emotion to play out. This case is, of course, a more sensationalized dialectic, as the patients of this case are literally tethered together. However, they are also tethered to the storyline of our protagonist, Meredith Grey. The story relies on the medicine to wound the protagonists and the physicians. The interplay for ethics is that the consideration of whether to help Bonnie or help Tom is very much the kind of thought experiment that is used to discuss limited resources and maximizing positive outcomes in the face of abysmal options. It is not, however, discussed as the kind of conversation that happens across all levels of care, even those that do not involve death. In grounding the episode in the melodramatic mode, we situate these conversations of ethics solely in the unbearable emotion of the moment, rather than an interchange of ethical considerations of balancing beneficence and nonmaleficence. It is not much of a surprise that Bonnie begins to crash at the moment that Meredith is officially dumped by Derek. The aligning of pathos toward the relationship is activated in the moment when a final choice is made. While waiting in the bar, and until Meredith can speak to Derek, their relationship lies in a Schrödinger-like paradox of being simultaneously healthy and dead. When we open it up, we see the relationship, like Bonnie, was already marked for death. The injury of Bonnie and Tom, and the medicine that backs up such sensational cases, is grounded in reality, but a reality which serves to advance emotion, not medical representation. Representation, as we see, is an important, but not primary motivation for the medical drama. From the standpoint of end of life ethics, we need to recognize that the realism that is portrayed on screen, the realism that we have worked so hard to place within the Hollywood system of medicine on film, was never just about accuracy. The truthfulness on screen allows for the sensational and emotionally fueled scenes of panic, heartbreak, and relief that are felt in every episode to be enacted. There

are consequences to such accurate representation and once that box has been opened it is difficult to get it back in. Perhaps we have been too concerned with getting things right, we did not consider how those accurate representations would make people feel, or to whom we would align those feelings toward. The passion we feel is hard fought, but that doesn't mean it is doing what we want.

Melodramas Involve a Give and Take of 'Too Late' and 'in the Nick of Time'

Much of the stress of this episode's case is that there is a ticking clock for Bonnie and Tom. Their injury is one that is fatal, possibly for both but surely for one. It is stated that the injury itself has left the two of them in shock, with their bodies not fully comprehending the injury that has befallen them. On top of that, the pole is serving to tamponade their wounds, keeping whatever injuries they have sustained closed. Whatever the state of their internal injuries and we suspect by the pole it is severe, they remain in a precariously stable position. Choices must be made quickly. The longer that doctors wait to act, the less likely the bodies will have the strength to rebound. We also know that while the decision to save one must be made, the significant others of our partners are not there and will not make it before surgery. While we hope that they will both make it through the surgery, the spectator is left with the anxious worry that the most likely case will be that we lose one of our patients, or possibly even both. The pathos of the show positions us to never rule out the possibility of a miracle, but we are always braced for disaster, especially when a patient's case appears to be tied to the emotions of a doctor. From the perspective of end of life ethics, narrating stories of end of life decision-making in this format presents a challenge. The standard medical drama is an hour long, inclusive of commercials. Stories thus need to be introduced, advanced, and concluded in the span of that time. Multi-episode story arcs are an exception, with standard episodes featuring patients who

get better or die in their one-episode appearance. Thus, the temporality of a conclusion, rapidly approaching, is always there. To temper this death drive toward the end credits, there are moments of calm coupled with the tension of the inevitable finale. In this episode, we spend a long time in relative peace with Bonnie and Tom, tension building peripherally because the enormity of their injury cannot but interject into the tranquility of the scene. We do not, however, want to only see depictions of end of life that strike like lightning and leave our agents scrambling for answers. End of life discussions are attempting to be about the give and take of life and death and the quality we can provide at each moment. However, when death must come at the end of the hour, there isn't much time for the many plateaus and declines that often characterize end of life, nor the conversations that happen along the way.

Melodrama Presents a Conflict Between Good and Evil

The medical drama, almost always, positions death as the villain to the overarching storylines of any given week. As medical dramas valorize doctors as our victim-heroes, the natural villain to those heroes is of course death, the one adversary that they cannot permanently thwart. In this episode, death comes for Bonnie and Tom, only securing Bonnie in the end. The space of the hospital is constituted to pretend like death does not exist. Hospitals operate under a logic of rescue, rarely admitting to defeat, even in times of unavoidable death. Modern innovations to healthcare have, in fact, reduced death rates to their lowest points in history. However, death does threaten, even when it is not successful. This is not to say that there are not corporeal characters who are positioned as the villain. For example, it would be easy to cast Derek's wife, Dr. Addison Forbes Montgomery, as the villain of this larger storyline, having caused the trouble for our primary protagonist, Meredith Grey. However, most doctors, within

the narrative logics of the medical drama, are seen as being noble and virtuous at heart, even when they act in ethically dubious ways.

End of Life Ethics

What this episode provides is the rupture in healthcare of an unwinnable situation. The medical establishment rarely wishes to admit defeat when it comes to illness or disease. However, there are occasions where a situation is unwinnable. This episode is a thought experience on what could be the best situation to take in such a rupture. However, as I have shown, the audience is provided a fallacious either/or situation. Those who must act in such a situation are not able to be emotionally invested in the same way that audience members may. That is why you should not operate on a family member. When the episode frames Bonnie as merely a stand-in for Meredith, the choice is not fair. This episode demonstrates that the choices we think we are making are really made for us. This does not mean it cannot be fruitful for discussion, but such a discussion must be tempered with this ethical/emotional conversation.

Documentary Realism & Melodrama: A Discussion

In the preceding sections, I discussed how documentary realism and melodrama serve as narrative modes of storytelling for discussing ethics at end of life. Alone, either of these modes privilege conversations of ethics surrounding a reliance on reality and affective displays of emotion. However, no phenomenon in the process of meaning making serves alone. In my last section of analysis, I will discuss the episode “The Time Warp (Clack & Corn, 2010),” from the sixth season of *Grey’s Anatomy*. Using this episode, I will discuss how the convergence of these two modes, and the themes they employ, amplify our understanding of ethics at end of life as being one which feeds on documentary realism and melodrama. This will lead into my

discussion, in the proceeding chapter, of how we need to use this information in an age of technological mobility of spectatorship.

“The Time Warp”

This episode is narratively framed against a hospital lecture series, where three of the physicians: Dr. Miranda Bailey, Dr. Callie Torres, and Dr. Richard Webber, are each tasked to speak about a patient case from the past and what lessons they took from that case. However, Richard is reluctant to speak. Having recently relapsed with alcohol, his position as Chief of Surgery has been suspended. He has been offered a position as an attending surgeon; however, he is not sure he wants to continue on as a practicing surgeon. Dr. Shepherd, the current, acting Chief of Surgery, asks that he give one last lecture, in the event this really is the end.

Richard’s speech flashes the audience back to 1982. Richard is a young, Black physician in the white male dominated field of surgery. Walking up to a room where a patient is crashing, a young, female surgeon performs CPR to try to resuscitate the patient. A male, surgical resident pushes to take over from her, saying that this should be a job for a doctor, not a nurse. She snaps that he should back off and that he knows full well that she is a surgeon. She is successful in bringing the patient back, after putting the surgical resident in his place. Richard reveals that this doctor was Ellis Grey, Meredith Grey’s mother. This perks up the crowd, as we have learned throughout the show that Ellis was a highly successful and venerated General Surgeon, before succumbing to early onset Alzheimer’s. This case, he tells them, would change his life.

Richard tells the crowd that this patient came in for a simple hernia repair but had gotten progressively worse and they had few clues to go on as to why. Dr. Gracie, the attending surgeon on the case, tasked the young residents with figuring out what is going on with the patient and to act fast. The gaggle of white male residents clumped up to pool resources, leaving Ellis and

Richard on the outside. Ellis and Richard had been having an affair at this point in history, a fact well-known to the *Grey's Anatomy* audience. However, now we know that this affair might have begun from their isolation within the medical field. It is here that melodrama begins to appear in our narrative. We have identified our protagonists as Ellis and Richard, marked as Other by their sex and race. Though *Grey's Anatomy* has occupied a space of colorblindness, rarely commenting on the implicit, overlapping systemic racism and sexism of the medical field, the audience is meant to align their allegiance with these outsiders, seeing their treatment as a product of the past, 1982, and something that has been largely fixed, as it no longer is demonstrated on the show outside of “very special episodes.” The audience also understands that Ellis and Richard will become leading surgeons and teachers of the field, and that their relegation to the sidelines is a reflection of the system’s failure to value difference.

Richard tells the crowd that through scut work, the unpleasant and monotonous side work of hospital diagnosis, they were able to identify that their patient, Phillip Nichols, had a rare fungus. Ellis and Richard rule out every possibility for acquiring this fungus before asking his girlfriend to step outside of the hospital room. Richard suspects that Phillip may have GRID: Gay-Related Immune Deficiency. This would, in time, be relabeled as AIDS. However, Phillip reacts aggressively to the accusation, demanding to leave the hospital and threatens to speak to their supervisors. Richard tells the crowd that in 1982, HIV was not yet isolated. There would not be a test to diagnose it until 1985 and Dr. Gracie is shown to not even be fully aware of its existence. He berates them for accusing their patient of being “a Gay.” Ellis and Richard are subsequently placed on probation. This is where audience knowledge informs our allegiance to our victim-heroes. We have, at this point, seen the kindness of Richard Webber throughout the show, and we contrast this to Dr. Gracie’s reaction. When Richard and Ellis ask his girlfriend to

step outside, they are respecting his privacy and autonomy, not accusing or slandering, but simply trying to help as best as they can.

A few months later, Ellis and Richard are paged to the emergency room where Dr. Gracie informs them that their GRID patient has returned. He is outfitted with a surgical mask and we can see that Phillip has the distinct markings of Kaposi Sarcoma, a rare form of cancer only seen in people with highly compromised immune systems. Ellis and Richard are the only doctors who will go near him. Phillip apologizes to the doctors, saying they were right about him and beg them to help him. Looking over his scans, Phillip has developed intussusception, a rare intestinal obstruction that is usually only seen in children. Dr. Gracie says they cannot operate, as there is little knowledge about how AIDS spreads and opening him up could endanger the hospital staff. Not only that, he is a “lost cause” anyway. Richard brings up the Hippocratic oath, and its dictum to help all patients in need. Richard is articulating here, though he does not say it in explicit terms, that professional ethics of medicine hold a doctor’s actions to a specific standard above what they, as individuals, may feel comfortable doing. However, Dr. Gracie snaps at Richard, telling him that Ellis and Richard wouldn’t have been allowed into the program only ten years earlier, the implication being that he does not take kindly to being told what to do by either a Black or female surgeon. What has been implicit, the secondary treatment of female and Black surgeons, is made explicit in this moment, and we now have identified our villain. Dr. Gracie represents a part of the medical industrial complex’s past, doctors who serve certain patients with disdain and who do not treat his fellow doctors with respect or care, a direct attack to the ethical code of the American Medical Association (Riddick, 2003). Once again, this is framed through a look into the past. We have not seen or heard of Dr. Gracie prior to this episode and may presume that he no longer works for Seattle Grace Hospital. He is a relic of the past, which has

been replaced with a new brand of physician: kind, reassuring, and always willing to help their patients no matter the cost.

Richard and Ellis inform Phillip about his condition and tell him that they can operate, but it will only be them, as no one else wants to take the risk. Disgusted faces look into Phillip's room from the hall, pointing and talking about him. Phillip says he doesn't blame them for being scared because he is too. Ellis offers that letting them operate will give him a chance to change his narrative. Richard adds that this will buy him time, as they do not know when a cure may come. The audience, both in the lecture hall and watching on their television screens at home, is aware that a cure will not be coming quickly and we may presume that Phillip is long dead by the time of this lecture. This pull between the pathos of wanting to help Phillip, the knowledge that he cannot be helped, and the pathos of that realization, informs the message of this act of compassion, a signal that beneficence is being enacted. Richard knows it is not likely he will survive long, but he is not willing to let Phillip give up on his own hope. Doing the most good, in this case, may be to simply try, showing that there is someone on the patient's side. Richard tells the lecture audience that they weren't noble, only arrogant with something to prove. We are not led to believe him, though. The looks of kindness between Ellis and Richard betray a level of compassion that we have seen play out across several seasons of the show. Doctors, that is, our victim-hero doctors, may be arrogant, but they are also noble. Phillip survived his surgery but returned 8 months later with pneumonia, from which he died a week later.

Richard tells the audience that he was changed by his experiences as a doctor, and asks that they remember the Declaration of Geneva, as there is too much in life that may distract from what we must be charged to do. He then recites it for the audience:

I solemnly pledge to consecrate my life to the service of humanity. I will give to my teachers the respect and gratitude that is their due. I will practice my profession with conscience and dignity. The health of my patients will be my number one consideration. I will respect the secrets that are confided in me, even after my patient has died. I will maintain by all the means in my power, the honor and the noble traditions of the medical profession. My colleagues will be my sisters and brothers. I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, race, political affiliation, nationality, sexual orientation, social standing or any other factor to intervene between my duty and my patient. I will maintain the utmost respect for human life. I will not use my medical knowledge to violate human rights and civil liberties, even under threat. I make these promises solemnly, freely and upon my honor.

Ellis and Richard are seen in flashback as he recites the declaration. Holding Phillip's hands as he dies, the camera lingering upon each of their faces on the reference to gender, race, and sexual orientation within the pledge. The audience erupts into raucous applause as Richard solemnly walks off stage. We end the episode returning to 1982 where Ellis and Richard sit in a bar, toasting to Phillip's memory. Ellis insists that Richard substitute his usually soda pop for vodka, as he is no longer a child and needs to grow up. We see that this case was the start of his history with alcohol abuse.

What this case of end of life attempts to show, from the perspective of the program, is that doctors are charged with helping their patients, no matter what. What it creates in the storytelling, however, is the assertion that there are two kinds of doctors: Those of the past who reinforced discrimination and those of the present, who actively work against it. From a documentary realism perspective, this story is told through elements of performative and

observational tropes. The framing of this story is conveyed to us through the words of Richard Webber; however, it is for the audience to search the screen to see the truth of what is really happening. We trust Richard, but we know he has not told us the full story. For example, we can be confident that he is not sharing the details of his affair with the audience, just as he has left the lecture stage by the time his flashback takes us to the bar scene coda. This creates a very specific framework for interpreting his story. We take in his feelings, how he expresses himself and the story, but the audience is left to emotionally resonate his words with the “Truth” of what we see on screen. Richards words in describing Phillip are kind and factual, but the closeup shots of Ellis and Richard’s faces, juxtaposed against the highly emotive music upon seeing his lesioned and gaunt face, do not allow the audience to interpret anything but extreme concern and compassion. The story of Philip’s end of life care is one that Richard lives and feels, and in the retelling for the lecture audience, and the reenactment on screen for the television audience, he must suffer that same loss again.

This observational mode of the flashback is heightened by the changing set decoration. The modern, sleek and metallic space of the hospital has been replaced with browns and yellows of a 1970s remodel. The technology of the space has changed and while this adds to the sense of realism, it also amplifies the idea that this is taking place in another time, a time we have past and, in many ways, we should be glad to have passed. In the moment of Phillip’s death, a medium full shot of our three minoritized bodies, Ellis, Richard, and Phillip isolate the frame of compassion, compassion for others and compassion to oneself. This is what we are meant to valorize, and not what is outside that frame. That said, the realism of constructing a believable 1980s hospital space, complete with clothing and hairstyles, makes the show feel real and grounded. However, we must not forget that this worldmaking is enacted so as to create the

affective displays of revulsion to that performed past. We enjoy seeing the old days of medicine, until we see how much we have grown, and then we want to return to the present. It is a present, however, that may not match the utopia that the show constructs.

So, what then does this mean for a discussion of ethics at end of life? When we combine these two modes, we are left with stories that privilege realism, but do so as a means to elicit strong emotional reactions. These emotional reactions are thus aligned to the victim-hero doctors who become the point of view for telling our stories. This is not necessarily what practitioners and policymakers would want audiences to get from storylines containing instances of end of life. This is especially true when those episodes are being used to educate the public. In this episode, we have a story that is told to us through the voice of another. We trust Richard's words because he is cast as our victim-hero. We do not doubt his virtue and we even see proof of his actions to make the world a better place, actions that are more noble and in direct contradiction to his humble explanation of events. We see it, so we trust it. What we do not see, however, is the perspective of the person who suffers the most, Phillip Nichols. Phillip stands in as a proxy for the countless people who died of AIDS before attention or funding was made available to the pandemic which would decimate a generation of Gay men. Again, this is an example of ethical discussions of care that do not have time privileged in the episode to discuss justice. Patients with HIV infection have been present on the show; however, their narratives have never privileged HIV as being a hinderance to care. Phillip is the first whose care has been mired by the medical legacy of injustice towards those who live with HIV. But, by not addressing the question of justice, it presumes that this too is a consideration of the past. Medical professionals are burdened by this legacy of injustice, as stigma against those with an HIV positive status often prevents equal distribution of resources, compassion, and sympathy. In leaving out this

discussion of ethics, we pretend like some doctors don't still treat patient's this way, that some nurses don't still act coldly to patients living with HIV, or that funding for research and care doesn't still underperform the need. Now, this is a show about doctors, so we cannot expect the point-of-view to change with every episode, taking on one important ethical instance per airing. We accept the doctor-protagonist as the price of narrative continuity. What we should be aware of, however, is that this story is not about Phillip Nichols or end of life experiences of those with early HIV infection. It is about our victim-hero doctors. The death of Phillip serves to perpetuate the idea that doctors today are noble, because of their duty to serve. But this is done over the body, though fictional, of a minoritized person. Media ethics are equally concerned with what is being said and how it is being said. In this instance of end of life, we do not align with Phillip's suffering, we instead align with Richard's. Now, if this was a one-off occurrence, there would be little cause for alarm. But this plays out across all episodes. The realism of the medical cases is meant to ground the show in the emotional severity stakes involved. The narrative techniques of melodrama and the documentary mode serve to feed us the stories of end of life ethics in a way that never allow us to understand how the emotions affect those involved, that is the patients who must die. We cannot see these as neutral case studies because they cannot be taken out of context. The very nature of their presentation ties the case to the victim-hero doctor and tells the details in ways which manipulate our understanding of the case but make us think it was our idea for finding the evidence. We know better, because we can see the "truth" on screen. These stories, and the modes which relate said stories, are part of the larger narrative of the logic of *Grey's Anatomy*, a logic which becomes stronger and more resolute with every airing, every rerun, and every successive season.

Medical Dramas

Medical dramas work because they grant people access to a world most audiences have not had access to. The discussions of end of life are abject to our own lives but pleasurable too, when it involves others. We have control and can face those fears in safety. It is like watching a horror movie. We would not choose to be chased by a killer but the thrill is alluring when you are on the other side of the screen. What this reading shows is that a viewing position of medical dramas free from influence is illusionary. We do not really have control because so much of the emotion tied up in the cases are leading us to conclusions that do not come strictly from the medical accuracy provided by the documentary realism. The juxtaposition of melodrama and realism obscures both. We are no longer dealing with an imagined world in another place and time. Nor are we dealing with a case study that can be used to make decisions for ourselves or our patients. We are dealing with a world that looks real and feels real, though neither truly is.

CHAPTER 6:

CONCLUSION

Conclusion

In this dissertation, I analyzed end of life storylines on ABC's *Grey's Anatomy* to consider how ethics work is being portrayed and resolved in the format of the televised medical drama. Performing a close textual analysis, I identified two modes of storytelling within the structure of these episodes: Documentary Realism and Melodrama. Documentary realism is a mode of storytelling that privileges truth and positions the camera as an objective spectator to the events onscreen. The gaze of the camera invites the viewer to search the screen with a sense of urgency, as the events are played out in real time. The ephemeral nature of the events on screen are privileged for the viewer, creating a sense that looking away may lose the "truth" on screen forever. However, techniques of filmmaking such as editing and the addition of musical scores challenge the idea that a documentary could ever be considered truly objective. Such additions, though they reorganize captured images of reality, manufacture a reality that sutures the real and unreal worlds of life on and off film.

Melodrama is a mode of storytelling that has come to be synonymous with emotional excess. However, the taint against excess stems not from excessive emotion but privileging emotional representations that mirror genuine societal concerns. Melodrama is very much based in questions of good versus evil and draws clear delineations between who is the victim and who is the aggressor, or villain. While melodramas have been a term associated with "weepy women"

films of the past such as *Stella Dallas* or *Mildred Pierce*, they include such varied stories as *The Wire* and *Shameless*, which have attracted strong male audiences in the present day. Melodrama is not so much a genre but an expression of emotion that challenges questions of community, nostalgia, victimhood, and choice in isolated settings. That being said, they are still pejoratively associated with unrealistic and overwrought displays of sentimentality. When the primary audience is male, they are called dramas. When the primary audience is female, they are called melodramas.

These two modes combine to portray heightened emotions, clear distinctions between right and wrong, and a sense of truth and medical reality. Viewers are situated to experience ethical decision making as feeling real, based in medical reality, but with heightened emotions and intensified stakes for the diegetic participants, especially the physicians involved. I argue that if we are to understand medical dramas as a tool for the dissemination of information about end of life ethics, we must understand that they speak to the audience in ways which value the perspective of the physicians, holding a torch for how emotions are played out on the faces of the protagonists, but through the bodies of the patients who are brought in to be wounded in each episode.

Reflection of Writing Process

The writing of this dissertation project emerged from a desire to write about/through my experience as a hospital transporter who engages with media texts about healthcare encounters. It should be stated that my lived experience as a hospital transporter affected my lens for viewing these episodes. I am confident that nurses, physicians, and even support staff would view each episode with a different interpretive lens. Mine was informed by the fact that my position in the hospital system is situated at the bottom of the clinical ladder. I am more critical of power

dynamics between staff members than a doctor would be because I see things from the side which does not have much power. It is likely that I am more critical of bad choices that a doctor makes, however this could be offset by the affection I have for the main characters, which is cultivated exponentially over time. I speculate here, as I cannot strip my experience from my viewing. What is certain is that having worked in the hospital I was able to pick up on small details that others who have not “walked the halls” would be unable to catch.

The process of engaging with reflexivity was both satisfying and conflicting. It was satisfying in the sense that I could ask very practical questions of how I felt at any one moment and allow that to inform my writing. This is not a muscle that is encouraged in all corners of scholarship, so it was nice to lean into it. It was conflicting because the process requires the researcher to be placed in front of a mirror and ask difficult questions about complacency. It is far easier to wag a finger at a screen and say shame on you. It is harder when you stare into your own heart and ask: How are you involved in all of this?

In light of this project my understanding of my professional work has changed. I came to better understand that every role played by the hospital staff is enacting and perpetuating certain ideals of healthcare, ideals which cast some patients as good and some as bad. We talk about compliance as a good thing in healthcare. But this language really does assume that there are two choices, the right one and the wrong one. I also learned that my position as a clinical support staff member, even one who handles direct patient care, is not immune from certain assumptions of value. I have rarely felt like my labor was valued in the hospital system. Seeing that labor erased on screen and being faced with it repeatedly was difficult. Working through the Covid-19 Pandemic and seeing it enacted on screen amplified this for me. It is the doctors and nurses who are cast as heroes, not the transporters. It affects you personally but it also has an effect on the

running of the hospital. Resources are diverted to what is decided upon as being of great importance. Support is rarely seen as important and my work was affected by that. This is not to place blame or call anyone out, but to suggest that the media world and clinical world of healthcare perpetuate ideals which have existed since the founding of the profession of medicine.

Alternative Views

Due to my positionality as an Aca-fan, my positionality produced a specific observation. It is likely that mine is but one of many interpretations that may be true in several contexts. My take on this is that value exists for the ways that these shows can produce strong emotions that mirror embodied stress, fear, and relief that exist in end of life decision-making. I am also aware that such strong emotions may create undue expectations or resentments when real life situations do not mirror what is seen on screen. They are simultaneously advantageous and dangerous. I leave room for the possibility that people may not be so easily swayed by these framing devices in an educational context. I also wish to provide space for a view that would say to depict end of life on screen is an emotional manipulation which could never be seen as having educational value, since it is done in a way which plays off emotion. These are realities which may exist for individuals, institutions, or in shifting contexts. My mother, a retired nurse, does not enjoy medical dramas because it is reproducing “work” for her. That may change now that she has retired or she may harden her resolve. These observations provide only one lens that can be cast on a complicated show made of various narrative modes which collide in a beautifully complex mural of possibilities and closures.

Limitations and Directions for Future Research

I elected to conduct a qualitative analysis of the material for this dissertation project. Qualitative methods have been criticized for privileging the particular, rather than the

generalizable. In making research “personal,” some have argued that researchers are not able to remove themselves from the subject matter. However, I argue I am unable to unwind myself from the grasp of my text. I would find myself hard pressed to find a media scholar who is free from their visual texts. This is a television program that I very much care for and to which I share emotional attachments. That does not, however, mean I am not critical of it. There are several aspects of *Grey’s Anatomy* that I find to be unappealing and lacking in truth. I would, however, argue that that makes me a better scholar because I expect more from my favorite shows. My relationship to the text allows me to see subtle changes in how characters act, how a set is organized, or a choice that seems out of place after 300 plus episodes. That being said, I do acknowledge that quantifiable data is valuable and when combined with qualitative methods, can flesh out a more informed story. My experience is very specific. Feasibly, more specific than most. Yet, specific is good. If what remains a limitation in the present is that my qualitative analysis is the only window into the question of ethics on *Grey’s Anatomy*, the failing is not of my method, but of the lack of other studies to compliment my method. When others complete their own analyses, I expect they will shine light on aspects of the show that I would not have seen. And that is precisely why it is a valuable: In adding to the discussion, we make fuller the voice of the discourse. I look forward to the day where mine is but one of several asking the difficult ethical questions of medical dramas and their relationship to end of life.

Another limitation that exists in my research is that I have looked at a single medical drama, *Grey’s Anatomy*. *Grey’s Anatomy* is a show that speaks to the current moment. It is popular, present, and a cultural touchstone. However, it is not the only one. Several medical dramas currently air and even those which have been pulled off the air too soon, or whose legacy is already everlasting, deserve to be examined as well. When we add into conversation those that

came before and those in the present, we can get a fuller picture of the ethical long game being played across our television screens. The structure of medical dramas has remained largely the same from the start. I would be surprised to see that their ethical work did not follow a similar trajectory of consistency. The confines of this project did not allow me to do a comparative analysis between different texts. There is simply too much text to examine, giving each episode its due. However, such a study would be helpful to see if *Grey's Anatomy* really is as special as people privilege it to be. It is more likely, though, that these modes of storytelling are present across several television hospital sites.

Lastly, my ethical considerations were tied to instances of end of life. Ethics, as we have seen, is a wide branching tree and one that has particular concerns depending on whom the actors are in each ethical problem. Inappropriate relationships between attending physicians and interns are a separate case study than embryonic selection of a fetus to match a needed organ donation for an older child. Future study into the question of ethics in medical dramas should begin attending to what other ethical questions may be of interest to medical educators. If we are to continue using medical dramas as texts of analysis for the education of medical personal, we might want to consider what kinds of ethics are being demonstrated on screen and who is being affected.

While this dissertation lends itself to a book project, it is by no means a comprehensive study of all that medical dramas have to show us. Moving forward, I hope to continue analyzing these texts to see how audiences are positioned as spectators to the spectacle that is end of life ethics. This project taught me that bringing together seemingly disparate fields of inquiry, health communication and media studies, produces some profound insights into what assumptions we bring to the table when discussing a subject of concern. While the academic benefits of this work

are fruitful, the practical implications of tempering the use of medical dramas as educational tools with a more nuanced understanding of an audience's spectatorial power could change the way we approach medical dramas. To this point, we have assumed that audiences take in what they are given. Medical stakeholders have not yet privileged a view that holds spectators as being in control. Such a shift could change the ways we offer healthcare information and the ways in which we consider ethical decision making as a relational process. My sincerest hope would be that this research may prove a catalyst for expanding our understanding of ethics, media, and the intersection of their relationship in constituting notions of good versus bad healthcare decisions.

Post Credits Scene

"Mr. Johnson?"

I knock on the metal doorframe, though only as a formality; I have already poked my head into the doorway. I direct my eye to the patient lying on the stretcher in front of me. He acknowledges me, but only briefly; his gaze returning to the television above my head in the far corner of the room. I smile and nod but otherwise ignore the woman, I presume his wife, and the approximately 8-year-old boy, both sitting to his left. I make my way to the opposite side of his stretcher and begin my scripted spiel.

"My name is Sean; I'll be taking you upstairs, get you out of the emergency room." He raises his arm, cutting off my speech, indicating he wants me to remove his blood pressure cuff sooner, rather than later. I move swiftly around the room, nimbly popping off wires and unwrapping IV cords which have tangled themselves around every corner and handle on the back of the patient's stretcher. The last piece of paraphernalia to be moved is the remote control, which is plugged into the wall and acts as a combination volume control and call light to alert the nurse that the patient needs something. It is always wrapped several times around the

siderail so as not to be lost and tonight it has a nasty knot. I look up and see that the patient still has his eyes fixed on the screen, oblivious to my struggles. I follow his eyeline to the television and see a rerun of "Grey's Anatomy" is playing. It is from the fourth season and I can place it immediately, my mind pulling the details of the patients and drama, as if from a card catalog. The son is silently playing a game on his tablet while the wife retouches her lipstick. I am not sure who she feels will be inspecting her appearance at 1:00am, but I imagine she has little else to occupy her mind. Her husband is being admitted for observation, but seeing him laid up on the stretcher must still be distressing. Her lipliner is the one thing she can control in this moment. I finally manage to get the remote control untangled and I push off the brake with my foot, exerting some force on the well-worn stretcher. The sound of the brake being released makes the boy jump with a start and he quickly stands, as my patient's wife scoops up her husband's clothes and shoes into the green bag given to each patient when they enter the emergency room.

"Should we wait, dad? Won't you miss your show?", the boy says to his father, gesturing up to the elevated screen.

"No, don't worry, I'll just watch it on my phone upstairs."

The boy looks back at his tablet and, without a hint of irony, says, "Yeah, I'm not all about that digital life."

I suppress my laughter, but only barely. The ambient sounds of the beeping monitors hide my elevated breathing but my abdomen spasms frenetically under my scrubs. I am knocked off kilter by his declaration. Big words from such a small child, though I wonder if he knows how prophetic and poignant his words are in this moment. I slowly guide the stretcher out of the

room, taking one final look at Meredith Grey on the screen above my head. I know she'll probably be waiting when I return. Though, if she isn't, I know where to find her.

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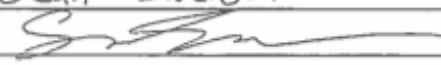
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