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Broadcasting Health and Disease: Bodies, Markets and Television, 1950s-2000s

Jessica Borge, Tricia Close-Koenig, Sandra Schnädelbach

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Susanne Vollberg: TV Health Programmes in the FRG
and the GDR

Angela Saward: University of London's Medical
Television Lectures

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coverage of heart transplantation in France

Book Reviews, Books Received

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Introduction. The Science of Television: Television and its Importance for the History of Health and Medicine

Jessica Borge, Tricia Close-Koenig, Sandra Schnädelbach*

From the live transmission of daunting surgical operations and accounts of scandals about medicines in the 1950s and 1960s to participatory aerobic workouts and militant AIDS documentaries in the 1980s the interrelationship of the history of bodies and health on television and the history of television can be witnessed. A telling example of this is the US born aerobics movement as it was brought to TV in Europe, with shows such as *Gym Tonic* (from 1982) in France, *Enorm in Form* (from 1983) in Germany or the *Green Goddess* on BBC Breakfast Time (from 1983) in Great Britain. The 1980s aerobic movement was contemporary, similar and yet differing in national broadcast contexts. Television and its evolving formats expressed and staged bodies and health. A history of fitness or physical health, for example, could not be conducted without acknowledging and understanding the role that television played in bringing such fitness programmes into the living room. Be it health-themed magazines, reports on medical firsts and threatening illnesses in the evening or aerobic workouts in the morning, television and its role in imparting the hazards of ill-health and in presenting preventive means is a rich source of twentieth century health practices.

When public broadcasting was restructured and broadened in post-war Europe, television was still a relatively new medium. No one actually knew what its future would be. The institutions, aims, and uses of television were

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under construction: the development of content followed, sometimes as a by-product of technology and technological developments.¹ In its early days, the television set was by no means established as the home entertainment device we think of today, but was in many ways an object of experimentation. It was imagined and tested as a tool for visual telecommunications, allowing for live screenings and interactions, similar to today's video calls. It also allowed recording and closed circuit communication used for educational purposes, such as school television.² Further, the challenges and the potential of television were tested in the field of science, and more specifically, medicine and health education.

Early pre-televisual moving images from the nineteenth century were deeply entangled with the depiction (and production) of scientific knowledge.³ The use of cameras, conceived as the extension or enhancement of the human eye, proved to be especially influential in medical research and education, rendering invisible details of the human body on the screen.⁴ This began with film and micro-cinematography. Film served the aims of propaganda in the war on public health scourges such as syphilis, tuberculosis or alcoholism, battles that would deeply influence health education, conceptions of human capital, and bodily practices through to the interwar period. Continuities and differences arose as moving images progressed from the projector and large screen dispositive to broadcasting studios and television sets which, from the mid-century, could be found in research laboratories, hospitals and medical clinics.⁵ Television screens were increasingly used in classrooms⁶ and they became household fixtures, bringing medical information and health messages into the privatised, domestic sphere.

By the early twentieth century, state welfare had been established in most European countries to varying extents, for example, accident and disability insurance, such as the Bismarckian social and health insurance of late nineteenth century Germany. By the mid-twentieth century, and following two world wars, health increasingly became a state concern, especially after 1945. Public health was ever more important and state health care systems were implemented, i.e., *Sécurité Sociale* in France (1946) and the *National Health Service* in Great Britain (1948). These infrastructures were set up in an era of shifting focus of health concerns: from treating and preventing dis-

1 Williams 1974, 29.

2 Horrocks 2018, 730; Powell/Shandley 2016, 35; Hickethier 1998, 9–16; Bourdon 2014.

3 Cf. Gaycken 2015.

4 McLuhan 1964, 2001; Killen 2017; Boon 2008, for the history of television cf. pp. 184–232; Ostherr 2013.

5 Cf. Bashshur/Shannon 2009; Greene 2017.

6 Cf. Orgeron/Orgeron/Streibler 2012.

ease to ensuring and restoring individual well-being. The threat posed by infectious diseases receded, but only to be replaced by chronic conditions linked to lifestyle and individual behaviour.⁷

Parallel to these changes in concepts and practices for health in the second half of the twentieth century, television made its way into European societies. Before becoming a mass medium with increasingly individualistic consumption practices in the 1960s, educators embraced television in its early years. At the beginning of the 1950s, in the wake of nascent popular education networks, teachers and parishes set up tele-clubs; taking advantage of the advent of a leisure civilisation they provided continuing education to people of all ages.⁸ Similarly, television was welcomed in schools as a means of modernizing education. For example, in France, a dedicated structure was created under the authority of the *National Education Department* in 1951, which became *Radio-Télévision Scolaire* in 1962. In addition to supporting classroom teaching, it aimed to present current events and world realities to students.⁹

Throughout the age of television, health and body-related subjects have been presented and diffused into the public sphere through a multitude of concurrent forms: via short films in health education programmes as well as in school television, via professional training films as well as in TV ads, via documentary and reality TV shows as well as in TV news, but also as complementary VHS and similar video formats circulating in private and public spheres. Yet, television's relevance for the history of bodies and health has been little researched. As an everyday object, television has been seen as less intellectually challenging than other historical conduits, such as political history;¹⁰ television has held a backseat position as a “luxury that embellishes rather than underpins historical arguments”.¹¹ The majority of research so far accords with this sense that television sits apart from the historian's work, and has been conducted within the field of media studies.¹² Although, in recent decades scholars in the history of medicine, science, and social history have recognised the centrality of the image,¹³ and, more spe-

7 Rothstein 2003; Bonah/Cantor/Laukötter 2018.

8 Cacérés 1964, 235–236.

9 Television programmes were used as an important part of a larger pedagogical approach, for example, with students subsequently conducting their own inquiries to present to the class. Hourtic 1965; “La télévision dans les classes de transition” 1965.

10 Jordanova 2012, 23.

11 Layton-Jones 2010, 105.

12 For example in France, Mansier/Méadel/Sécaïl 2014; Mansier 2014. For Germany see, Vüllers, 2002; Brünner 2011; with regard to public health but without a historical focus: Jazbinsek 2000, especially: Appel 2000.

13 Porter 1988.

cifically, of television, to the public understanding of (and engagement in) health and healthcare cultures, the uptake has been slow. The cross-disciplinary interest in television can, however, open an important window into the history of health practices and health consumerism over the twentieth century. This has proven fruitful in cases of visual research in the examination of films on sex hygiene within the history of venereal diseases in the first half of the twentieth century¹⁴ or in the ongoing work on television and the theme of human reproduction.¹⁵

With respect to visual sources and cross-disciplinary approaches, this special issue aims to introduce the emerging field of health-related audio-visuals to medical historians by presenting case studies that identify and unpack the centrality of television for the history of medicine and health, herein bridging the gap. In doing so, we work from the premise that visuals are not conceived merely as a mirror or expression of what is observed, but should be regarded as a distinct, interactive, and performative power of mass media societies; in other words, our position is that visuals have changed body politics, healthy-self perceptions, and the practices of individuals in European market-based societies. Our objective in the assembly of this special issue is to understand the role that modern visual mass media has played in the transition from national bio-political public health paradigms to contemporary societal forms, where better and healthier life is increasingly shaped by market forces, and embodied by what is heard and seen.¹⁶

In this introduction, we offer points of entry for the combined study of TV audio-visuals and health by outlining benchmarks of television history and related archival research in Germany, Great Britain, and France, which (as we understand it) may be less familiar to historians of science and medicine at this time. In offering these frameworks, contextual details, and points of reference, we aim to broaden the discussion of relationships between television, medicine and health. This is a strand of history that, we believe and hope, will create possibilities for new findings, and new narrative pathways in twentieth century history.

14 Bonah/Laukötter 2015; Bonah 2015; Danet 2015; Laukötter 2015; Winkler 2015; Bonah/Cantor/Laukötter 2018.

15 Borge 2017; Dow 2019; Gregory 2015; Olszynko-Gryn 2017; Parry 2013.

16 This premise underpins the on-going work of our research group in the ERC funded project “The healthy self as body capital: individuals, market-based societies and body politics in visual twentieth century Europe” led by Christian Bonah (Université de Strasbourg) and Anja Laukötter (MPIHD, Berlin).

Television in Europe

Histories of television in Europe are themselves national histories, as technological processes do not prone over social processes; or according to Raymond Williams “the setting of limits and the exertion of pressures, within which variable social practices are [...] affected.”¹⁷ Prior to today’s growth of cross-national, on-demand streaming services such as Netflix, for example, broadcasting, its supporting institutions, and televisual content were historically structured upon (and reflected) defined societies, economies, and political belief systems: electronic frequencies or “bandwidth” were commoditised, redistributed, and restricted according to geographical boundaries. After experiments with TV in the first decades of the twentieth century in most European states, the years abutting the Second World War were decisive for setting up structures that still shape television landscapes today. The birth and development of national television networks and programmes were influenced by national cultural and political specificities.¹⁸

In Germany, the history of television in the second half of the twentieth century is marked by the country’s divide following the Second World War. Whereas in the socialist German Democratic Republic (GDR), television broadcasting was part of a state controlled media structure that permitted just one channel until 1969, the federally organized West (Federal Republic of Germany, FRG) provided a more complex system of regional and national public channels. And yet, in an atmosphere of political and cultural competition, both states constantly referenced each other. Whereas most East Germans could receive Western television and vice versa,¹⁹ programming produced by and for the German neighbours was of special interest.²⁰

Regular television broadcasting in the GDR began in 1952, on the symbolically charged day of 21 December, Joseph Stalin’s birthday, with two hours of daily programming. At this time watching television was a communal event: until the mid 1950s, only one in every hundred households owned a TV and broadcast content was limited to 22 hours per week. In 1956, *Deutscher Fernsehfunk* (DFF)²¹ was launched, increasing weekly output to 58 hours. In 1969, a second channel, DFF-2, was introduced together with

17 Williams 1974, 130.

18 Equally there is a history of European television, this is not explored here but that must be acknowledged. Its history traces the political specificities of Europe and an opposition to American television, for example with the *European Broadcasting Union* and Eurovision programmes. Cf. Coleman/Rollet 1997; Bourdon 2011; Bignell/Fickers 2008.

19 In the 1960s, the reception of Eastern programmes in the West ceased.

20 Dussel 2010, 123–136.

21 Renamed Fernsehen der DDR in 1972.

colour TV.²² The following decade then brought about a differentiation and diversification of television programming in East and West that allowed for innovation, even in the generally more restrictive structures of the East German broadcasters.²³

Competing with the GDR, the Western German public broadcasting service, *Arbeitsgemeinschaft der öffentlich-rechtlichen Rundfunkanstalten der Bundesrepublik Deutschland* (ARD), also started broadcasting in 1952, albeit four days later than the GDR. Founded in 1950 for radio and television programming, this federal consortium of local public broadcasting services was independent from state control and non-commercial.²⁴ Following conflicting federal and national media interests, a second channel, *Zweites Deutsches Fernsehen* (ZDF), was founded to centrally govern nationwide broadcasts in 1963. One year later regionally diverse third channels followed. It was also in this decade that television developed into a mass medium. The prevalence of TV sets and their popular usage evolved at similar rates in the West and East. In the early 1960s about a quarter of the population owned a TV: ten years later the number had risen to about three quarters. In addition to the introduction of colour TV in West Germany in 1967, a second major shift took place in 1984 when private broadcasting companies entered the scene and paved the way for a commercialized television landscape. However, following the reunification of Germany, the broadcasting system was restructured in 1992, with the West German mix of public and private broadcasting companies being applied nationwide.²⁵

In Britain, television has, for most of its history, been divided between commercial and public service broadcasting.²⁶ The *British Broadcasting Corporation* (BBC) launched the first regular (though largely experimental) television service in 1936, which was confined to around four hours per day in the London area only. Transmission was suspended during the war, resuming in 1946, when a TV licence was introduced to fund programming, although, at this stage, the BBC remained focussed on radio. The live broadcast of the coronation of Queen Elizabeth II in 1953 triggered a dramatic rise in television set ownership, which increased to about 20 per cent of households (or 81 sets per thousand population) by 1954. This put British TV ownership ahead of Europe, where the next highest proportion was Bel-

22 Steinmetz/Viehoff 2008, pp. 68–73; Schubert/Stiehler 2007, 26.

23 Cf. Steinmetz 2016, 133–154.

24 On a small scale, public television broadcasting had already begun in the late 1920s and was further developed during National Socialism.

25 Cf. Steinmetz 2016, 133–154; Dussel 2010, 136–143, 263–267.

26 For comprehensive work on this subject, see Briggs 1961–1996. See also Turnock 2007; Holmes, 2008.

gium (with 5 sets per thousand).²⁷ A second, commercial channel was introduced in 1955. This was organised as a series of separately owned regional franchises known collectively as *Independent Television (ITV)* using an advertising model for bringing in revenue and funding content. ‘Television households’ exceeded ‘radio households’ by the end of the 1950s. Increased broadcasting time per week and the considerable production costs led, by the 1960s, to the licensing and exchange of TV programmes at the international level.²⁸ Competition between TV channels and audience polls meant that American serials featured regularly on the commercial channel, although the majority of programming was produced in Britain. Regulation improved the standard of programming on both channels.

The third British television channel, BBC2, was launched in 1964, and by 1969 all three channels were transmitting in colour, although many people watched in black and white. *Channel 4* was launched in 1982 as a non-profit network with a public service remit, which nonetheless took revenue from advertising. The following decade saw a radical shift with the 1990 Broadcasting Act and subsequent legislation, which significantly deregulated British television, leading to greater competition and variety of content. Satellite television joined broadcasting institutions and was popularised through the purchase of sporting franchises, and the sale of subscriptions to consumers. *Public Service Broadcasters* have historically produced most of the visual content in Britain, and have been subject to minimum quotas and guidance on, for example, minimum amounts of news and current affairs programming, and content made by independent producers. Britain is also a significant exporter of both programmes and formats.²⁹

From its early years, television in France represented both a propaganda challenge and a field for formal and editorial experimentation; it was instructed by the State and implemented by pioneering and ambitious journalists. Although the first experimental broadcasts in France began in 1931, television was established at the end of the Second World War with the renewal of *Radiodiffusion française* in 1944 (RDF and from 1949 *Radiodiffusion-télévision française*, RTF) and had become a mass medium by the end of the 1950s.³⁰ RTF was set up by the Ministry of Information as a public

27 Tunstall 1987, 33 n.3.

28 With the goal of developing, broadcasting and exchanging programmes of a cultural nature, the International Radio Union created a film library and became the International Radio and Television Union in 1961. For more information, see <http://www.urti.org/history> (Accessed 4 September 2019).

29 House of Lords Communications Committee 2010.

30 On the history of television in France, see Brochard 1994; Sauvage/Veyrat-Masson 2012; Gaillard 2012.

body to ensure the construction of technical installations, to collect the licence fee that financed the television activity, and to produce and broadcast programmes. The success of television continued to grow over the next decade: while one million French people owned a television in 1958, by 1968 ownership topped nine million.³¹ Television created a new relationship with information and culture, especially since its capacity to produce content had rapidly increased, from a total of 2450 hours of programme time in 1958, 5580 hours in 1968, to more than 8000 hours in 1974.³² This increase can be explained in particular by the launch of the second channel (*Deuxième chaîne de l'ORTF*, from 1975 Antenne 2) in 1964 and the third channel (*Troisième chaîne de l'ORTF*, from 1975 *France Régions 3*) at the end of 1972, in the effort to structure and segment programmes in light of the social and territorial realities of the population.

However, of the three watchwords associated with television, “inform, educate, and entertain”,³³ it is the latter that has prevailed in market logic in French television, with the introduction of advertising in 1968, and privatization from the 1980s onwards (i.e., with Canal+ in 1984, La Cinq in 1986, M6 in 1987). This evolution of television, which is common to all three national contexts, brings to light the relevance of television for public communication. Over the second half of the twentieth century, it has shifted from a controlled (or one-directional) medium to an audio-visual presence capable of multi-faceted interaction with instances of moderation, guaranteed programming and as a vehicle to/for national heritage. This is what media theorist Marshall McLuhan conceptualised loosely as “hot” (one-directional) and “cool” (interactive) media, television having become, by the 1960s, “cool”.³⁴

This special issue presents national stories of health and television, collected with the understanding that television history is broadly defined along national boundaries, as described above. Yet, the significance of transnational trajectories and trends is central to a European history of health and television that we aim to promote and encourage with this issue. Aligning national with broader perspectives is no easy matter, especially considering that archiving practices relating to television have been subject to national specificities and politics.

31 In 1954, France ranked the third highest in Europe for TV set ownership after Britain and Belgium, at 3 per thousand persons. Tunstall 1987, 33 n.3.

32 Sauvage/Veyrat-Masson 2012, 66.

33 The popularization of this frequently used phrase is attributed John Reith, the first Director-General of the BBC, who used it to describe the BBC's remit in 1927. Siân 2015, 325.

34 McLuhan, 2001, 24–35; See also interview with McLuhan “Hot and cool media (1965),” <https://www.youtube.com/watch?v=J3n65fa40JM> (Accessed 4 September 2019).

In Britain, for example, the majority of early programming was not kept, or was wiped. Apart from short demonstrations, which were transferred to film, no broadcast TV from before 1947 was recorded, partially because there was no need to preserve live transmissions, and also because there was no means to tape/record it. Thereafter, recording involved a film camera taping a monitor; this was expensive and was not widely used. For all intents and purposes, broadcast television was very much a live medium until the introduction of professional videotape in the 1960s. However, video was not seen as a long-term format and tape was re-used multiple times, resulting in what has been called the “catastrophic” loss of programmes.³⁵ Accordingly, archival research is challenging. The *British Film Institute* holds a complete record of BBC output from 1990 onwards, and the BBC has a written archives centre in Caversham, Reading, that is available to researchers by appointment. At the time of writing, there is no public catalogue for BBC document sources. Excluding those that have been repeated on television or otherwise made available through, for example, DVD releases or streaming, extant BBC programmes from before 1990 are not made available for academic research.³⁶ However, the BBC, along with ITN (*Independent Television News*), have recently entered a partnership with Getty Images to manage their online content and their offline archive, meaning that although access is currently difficult (or even impossible) for academic researchers, it might improve in the near future.³⁷ Details on other current resources can also be found via the *British Universities Film and Video Council*.³⁸

In Germany, the archival situation is very different for GDR and FRG sources. As the East German state and its broadcasters no longer exist, the sources are now part of historical archives and are more easily accessible than the West German ones. The most comprehensive collection of GDR material is held at the *Deutsches Rundfunkarchiv* in Potsdam-Babelsberg. Here about 60 per cent of broadcast programming is kept and organized in a database accessible on site. In addition, for health-related material, the collection of Deutsches Hygiene Museum in Dresden offers a variety of documentaries and educational films that were aired on television.

For West Germany, the situation is much more complicated. Broadcast archives do not follow national archive regulations, but are structured for the day-to-day usage and needs of the state independent broadcasting ser-

35 Bryant 2010, 60; Dussel 2010, 165; Kavanagh/Lee 2010, 70.

36 Smart/Wrigley 2016.

37 “BBC Motion Gallery,” Getty Images, <https://www.gettyimages.co.uk/footage/bbcmotiongallery>; “ITN Source,” Getty Images, <https://www.gettyimages.co.uk/resources/itncollection>.

38 British Universities Film & Video Council, <http://bufvc.ac.uk/>.

vices. These archives are not open to academic researchers, but access can be requested and negotiated. Like the broadcasting landscape itself, the archives are organized regionally. The ARD material is spread over their nine regional offices, the *Landesrundfunkanstalten*, the *Westdeutscher Rundfunk* (WDR) being the biggest one with its headquarters in Cologne. For these sources, as well as for productions of the ZDF based in Mainz, the *Deutsches Rundfunkarchiv* can be a first entry point to gain information on existing archives and on how to organize research.³⁹

In France, and in contrast to Germany and Great Britain, the presence of the State and the centralized organization of the television economy, especially before the 1980s, was not only conceived to direct production and broadcasting, but also provided systematic archiving of programmes. Established in 1974, the *Institut National de l'Audiovisuel* (INA) was founded to preserve and document the productions of the public television channels. INA holds television archives from about 1940:⁴⁰ this includes audiovisual archives, as well as photographs and document archives. This was expanded in 1992, when INA became responsible for the legal deposit of radio and television productions, meaning that INA archived all productions from every channel. A digitisation plan launched in the 2000s ensured the preservation of the collections and greatly facilitated their access. Putting these digitised programmes online has made them available to the public, either directly or by obtaining approval, notably as education and research have a place in INA's mandate.⁴¹

It is clear that these national provisions contribute to the construction of collective memories of television broadcasting, simultaneously creating a socially specific sense of the “period eye”.⁴² The national collections mentioned above continue to inspire historical research initiatives, and such commentaries deepen our understanding of the physical material contained within AV archives, as well as the formal editorial decisions that created and developed the collections in the first place. Our intention in outlining the above national perspectives is to facilitate new research in these areas and to clarify the challenges of transnational research; challenges that might be perceived as barriers but which can be breached. Herein, and national boundaries notwithstanding, we must continue to ask: what are the unifying factors? Where can we find the parallel trends and comparative themes that have carried these national histories of television forward, and brought them

39 For an overview of the archives see Behmer/Bernard/Hasselbring 2014.

40 Albeit, as described above, early live programming was not recorded.

41 Institut national de l'audiovisuel, <https://institut.ina.fr/>.

42 Jordanova 2012, 121.

together whilst retaining their specific limits and pressures? Since its first demonstration on 26 January 1926, when John Logie Baird transmitted a 30-line image of his business partner, Oliver Hutchinson, to the Royal Society, television has been concerned with projecting the image of the human body in speech and action.⁴³ The technology has evolved in parallel with the provision of socialised medicine, the expansion of public health services, and the continued monetization of medical and pseudo-medical services, devices, medicines, and practices. Our answer, then, is that the staging of science, bodies, and health, provide the enduring and unifying thematic link bonding the histories of television in Europe.

Television Visuals: Staging Science, Bodies, and Health

As with all new media, the rise of television was accompanied by optimistic, even utopian ideas about its impact as well as by waves of concern and criticism regarding possible negative effects on viewers, and society in general.⁴⁴ As the papers in this issue convey, television broadcasts addressed questions of body, health and disease from its earliest days, be it in form of news reports, medical advice magazines, health education films, medical teaching films or school television – not to mention fictional productions, such as the medical soap opera. Television was discussed and used as a promotional tool, was perceived as progressive and even emancipatory to varying degrees, and at the same time it gave rise to concerns on the bodily effects and health related impacts of media (over)consumption.

As this issue aptly illustrates, the history of broadcasting health and disease and the entanglement of television, health and medicine, is more than an episode in the history of film and medicine: with its focus on live broadcasting and its potential to connect the (scientific) world with the domestic sphere, television offered a new 'dispositif', a new mode of reception as well as structuring perception, and yet could rely on an old visual tradition.⁴⁵ In the 1990s, the history and sociology of science, technology and medicine took a 'visual turn', retracing medicine's visual culture and analysing visual representations of medicine, health and health professionals.⁴⁶ This, however, resulted in the isolation of television visuals. Whereas attention to screen media as an object of historical enquiry in the service of the history of medicine,

43 Sims 2019.

44 Dant 2012.

45 On the dispositif of television see Hicketier 1998, 10–13.

46 Cf. Cartwright 1995; Pernick, 1996.

the body, society, and health has been growing in recent years, the explicit use/participation of television remains under-represented.⁴⁷ In addressing the gap, this themed issue aims to investigate how television programmes approached the subject of medical progress and its limitations, as well as the idea of healthy behaviour, as they were adapted to television formats. We ask how similar yet differing national broadcast contexts shaped and staged bodies and health in varying ways and how the evolution of televisual editing, especially its adaptation to consumer/market logic, changed health messages and practices from the 1950s to the 2000s. In using this approach, it is our aim to open dialogue between the history of medicine and health with televisual media history. Our position is that audio-visuals are not to be conceived of merely as channels of information, but that they are an active, moreover ‘interactive’ power in mass media societies. Herein, we understand histories of “broadcasting health and disease” as a central element of the reciprocal relationship between medical knowledge/practices and media.

This issue explores television and medicine in their functions for – and creations by – society. The contributions are structured by their regional focus but share thematic/analytical approaches that convey manifold interconnections and reference points which, as we shall see, cross national and cultural borders. They unfold three overarching categories: Creating Television, Creating the Viewer, and Creating Science.

Creating Television

To fully understand the role of “broadcasting health and disease” in the second half of the twentieth century, it is necessary to enquire into the medium’s preconditions: How were television programmes produced, how did technical developments enable new definitions and usages of the medium and shape new contents? How did these contexts form the ways in which bodies, health and science were presented and how did the specificities of health education and medicine contribute to creating television as we know it?

In this vein, SUSANNE VOLLBERG’s paper shows how the production process of health magazines in East and West Germany were marked by various challenges. She introduces this genre as the main format for dealing with health-related topics in East and West German television from the 1960s to the 1980s. The extremely popular magazines made use of a mix of

47 Some of the rare examples are Boon 2008; Ostherr 2013; Bonah 2020; Boon 2020; Laukötter 2020; Lury 2020.

genre elements that combined features of the traditional health education film but also added features like quizzes, an anchor person and discussion panels that gained special popularity in the context of a growing debate culture from the 1960s on. Concerning production, however, medical and media sphere were not always in agreement. This was largely due to the impact that television programmes had: doctors noted a significant raise of patient visits after health magazine broadcasts and complained about unqualified assumptions and questions. Television, Vollberg claims, created a public awareness of health issues, which developed in constant exchange with the shaping of television as a medium. West Germany's most popular magazine, for example, was discontinued when it was no longer compatible with the decentralized broadcasting landscape of the 1980s. The prior "faith in the demi-gods in white" was now seen as a relic of an overly hierarchical and lecturing media system.

In examining closed-circuit (rather than public) television, ANGELA SAWARD looks at the genesis and work of the University of London Audio-Visual Centre, which produced a large corpus of postgraduate medical educational programmes between 1971 and 1991, including such titles as *The Scientific Basis of Medicine*, *Muscle Fatigue*, and *The Causes of Obesity*. It is argued that this archive, held at Wellcome Collection, London, democratised the pedagogical experience of students engaged in medical disciplines. The corpus is also considered in respect of obsolescence and redundancy, in terms of both the content of video-lectures (which in medicine became quickly out-dated) and also in respect of video formats, which affected re-distribution to later generations of medical postgraduates. These videos are shown to pose unique challenges for the archivist specialising in both audio-visuals and the history of medicine.

To broaden our understanding of a televisual grammar, TIM BOON and JEAN-BAPTISTE GOUYON inquire into medically-themed episodes of the BBC documentary series *Horizon*, comparing them with natural history documentaries from the late 1950s to the 1980s. They analyse programme styles to explore to what extent they are responsible for establishing a distinctive relationship to the practice of medicine, which they conceptualise as the "inscribed patient". Central to the style of medical programmes is a hierarchical structure, transferring agency mainly to experts. The "inscribed patient" has been used to show viewers how to behave as patients, and as the subject of medical interventions. Yet, many kinds of documentary television, they argue, share a specific mode of address that aims to prompt the viewer to adopt certain kinds of behaviour. This finding is closely tied with the second category in this special issue: Creating the Viewer.

Creating the Viewer

Just as naturalist documentaries give a certain agency to viewers as potential participants in wildlife filmmaking, BOON and GOUYON claim, medical programmes propose the audience to engage in specific ways. Viewers are invited to identify as ‘patients’ and are provided with role models for medical interactions. Based on the “inscribed patient”, television not only contributes to the modelling of doctor-patient relationships but also actively shapes its audience. This perspective on the creation of the viewer is a second important layer of the contributions in this issue. What do we know about television reception and its (widely believed) effects? How did health programmes use knowledge about the viewer and in what ways did they transfer into new practices?

Addressing these questions through the history of cardiovascular disease prevention in the German Democratic Republic (GDR), STEFAN OFFERMANN tells us how health education looked at creating a healthy television audience that would not fall victim to excessive viewership, and herein at creating healthy socialist bodies. In this story, television is both an instrument *and* an object of health prevention. Through psycho-physiological, audience and opinion research, the effects of television on viewers were examined and then taken up in health education films. Offermann addresses the medicalization of TV usage and of the viewer.

Creating Science

Focussing on the viewer and their practices is one means through which it can be observed how television shaped the reception of, knowledge about, and implementation of health and medicine in everyday life. Further, TV proved to be a powerful ally of medicine. Making use of television’s potential in documentary narration, health-related programmes actively validated and contributed to the creation of a public image of science, and the acceptance of medical practices.

PHILIPPE CHAVOT and ANNE MASSERAN tell the story of appreciation or worth in advancements in medical practice and television. They trace an evolving/developing relationship between television media, surgeons and patient families with regard to heart transplantation in France between 1968 and 1973, a five-year period that includes two waves of heart transplant surgeries. Television not only reported on the surgeries, their successes and their stories, but brought storytelling and emotional narratives into the portrayals such that television became an influential ally in the promotion for graft med-

icine at a time when it was not wholly established. Not only did television reports support innovative work in this field of medical science, but also the reporting techniques used for them were innovative for television. In this paper, the interactions between the medical sphere and the media sphere are played out, with television effectively contributing to the on-going scientific work.

The Science of Television: Television's Entanglements with Health Beyond Information and Education

Whilst this special issue is broad in scope, it is necessarily bound by limitations. The following articles present case studies from East and West Germany, Great Britain, and France; they consider 'utility' or non-fiction productions, that is educational, public service, news-casts, talk shows and current affairs programmes (aka, magazines); their temporal scope is restricted to the late 1950s through to the early 1990s, from the establishment of television as mass media and ending before its digitalisation. The articles open questions on the multi-faceted relationship between television and health that can (and should) be pursued, expanded and complemented with further research and with more cases in these (and other) national contexts. For example, we can further explore the question of how television plays into narratives of legitimacy and how legitimacy or authority is created on medical and health issues regionally, nationally, and transnationally and with regard to cultural and political differences. As the articles in this issue demonstrate, the influences were reciprocal: television was not only an instrument that was shaped following medicine's needs but the specificities of the medium also contributed to the ways body, health, and medical science were reflected and defined in society. With its potential to bring the moving image into the domestic sphere, to bring the bodies of doctors and patients into the living room, television had the power to stabilize but also to destabilize popular evaluations of medicine and health – effects that often came as a surprise to the producers and were by no means completely under their control. Herein, we can observe that television is not only a tool or an instrument of politics or medicine, but that it shapes (and is shaped by) society, on local and global levels.

Television was an important device for the broadcast of information on health and disease, but it was more than this. As the papers presented here show, televisual technologies were part and parcel of Western health science and education trajectories of the twentieth century. Not only did they support and accompany the trajectory of change in dealing with and communicating about health and disease, but as this issue aims to explore, audio-visual media actively formed

contemporary understandings of bodily norms and, thereby, standards of treatment and concepts of medical, as well as individual, responsibility. These articles examine how spectators were invited not only to be TV consumers, but how TV programmes and TV set-ups integrated and sometimes pretended to transform the viewer into a participant of the show. In short, TV programmes spread the conviction that subjects had the ability to create their own body.

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“Because every recipient is also a potential patient” – TV Health Programmes in the FRG and the GDR, from the 1960s to the 1980s

Susanne Vollberg

Abstract

In the television programme of West Germany from the 1960s to the 1980s, health magazines like *Gesundheitsmagazin Praxis* [Practice Health Magazine] (produced by ZDF)¹ or *ARD-Ratgeber: Gesundheit* [ARD Health Advisor] played an important role in addressing health and disease as topics of public awareness. With their health magazine *Visite* [Doctor’s rounds], East German television, too relied on continuous coverage and reporting in the field. On the example of above magazines, this paper will examine the history, design and function of health communication in magazine-type formats. Before the background of the changes in media policy experienced over three decades and the different media systems in the then two Germanys, it will discuss the question of whether television was able to move health relevant topics and issues into public consciousness.

health magazine, GDR television, FRG television, Gesundheitsmagazin Praxis

Health-related programmes were, right from the early days of television, part of the common TV repertoire in both German countries but it was in the health, disease and medicine, which was well-received by the audience. The coverage of medicine and health issues in East and West German television

1 Abbreviation for *Zweites Deutsches Fernsehen* – Second German Television; public-service broadcaster.

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of that period was dominated by magazine-type formats. More extensive treatment of an issue in longer documentaries, which was characteristic for Anglo-American television, played in German programmes only a lesser role.²

However, this reporting in the mass media was met, at the same time, by a critical response by physicians and scientists, but also by the TV producers themselves, and was put under some scrutiny. One of the episodes³ of the health magazine programme called *Medizin im Dritten* [Medicine on your Regional Channel] broadcasted by *Westdeutscher Rundfunk* (WDR)⁴ started, for instance, with the following voice-over questions,

Ladies and gentlemen, how do patient and doctor react to the flood of medical information in the mass media, i.e. in the press, on the radio or on TV? Is this really providing help or is it merely making people more afraid of diseases?⁵

Based on historic materials in the archives⁶ of the respective broadcasting services or editorial offices, and based on the scientific literature on the programme history of West German and East German television,⁷ this paper explores how health and disease were addressed in magazine-type series in the two Germanies, i.e. the Federal Republic of Germany and the German Democratic Republic. The structure of this historic overview follows the partial parallels in the development of the two broadcasting systems and the emergence and diversification of health magazines from 1960 until 1980. Due to their many years of existence and their popularity with the audience, some of these programmes were important drivers of and in the societal discourse on health and disease. This examination is linked to the hypothesis that television is able to bring health relevant topics and facts into the field of public

2 Compare Floto 2003, 385.

3 The episode with the title *The pre-informed patient or The disquiet brought on by the mass media* featured three physicians, Dr Ulrich Fohrmann (science journalist), Prof J F Volrad Deneke (German Medical Association) and Prof Ludwig Demling (Erlangen University), as experts. Archived WDR material on the *Medizin im Dritten* series; episode broadcasted on 26 September 1979 on WDR.

4 *Westdeutscher Rundfunk* – West German Broadcasting Service; regional public-service-broadcaster.

5 WDR archived material (my translation).

6 *Deutsches Rundfunkarchiv Potsdam* (DRA); *Bundesarchiv Berlin*; *Unternehmensarchiv ZDF*; *RechercheDesk BR*, *Historisches Archiv WDR*.

7 The five-volume publication *Geschichte des Fernsehens in der Bundesrepublik Deutschland*, offers a good overview of the programme history of West German television, in particular volume 1. See Hieckthier 1993. The final publication of the research project on the Comparative Program History of GDR Television, funded by *Deutsche Forschungsgemeinschaft* (DFG) [German Research Foundation], provides a good overview of East German television and programme history. See Steinmetz/Viehoff 2008. Detailed information on the individual decades can be found in the anthologies by Dittmar/Vollberg 2002, 2004 and 2007.

awareness. Health related reporting and the related presentation of health-relevant behaviour can therefore influence an individual's attitude to health issues.⁸

1 Evolving into a mass medium – television in the 1960s

The beginnings of modern television go back in both German countries to the early 1950s.⁹ In close time-wise competition, the responsible authorities in both Germanys started their own public broadcasting services. The formation of *Arbeitsgemeinschaft der öffentlich-rechtlichen Rundfunkanstalten der Bundesrepublik Deutschland* (ARD) [Consortium of public broadcasters in Germany]¹⁰ in 1950 marks the beginning of joint television broadcasts on 25 December 1952. Initially, regular broadcasting in West Germany comprised only a few hours in the evening. But right from the start, TV health education was part of the programme as evidenced by the five-minute medical programme *Der Doktor hat Ihnen etwas zu sagen* [The doctor wants to tell you something], produced from 1953, which provided viewers with health-related information on Wednesday evenings right after the leading news bulletin, *Tagesschau*.

The GDR started its experimental television programme *Fernsehzentrum Berlin* [Berlin Television Centre] four days earlier, on 21 December 1952. With the start of the regular television station called *Deutscher Fernsehfunk* (DFF) [German Television Broadcaster] in 1956, East Germany's broadcasting hours also increased from approximately 22 hours per week in 1956 to about 58 hours until 1960.¹¹ Early East German television also provided its audience from the beginning with medical advice. In its first years, health and sickness were covered by a non-fictional format called *Der Arzt* [The Doctor] (1956-1957) and, after the series was dropped, the *Gesundheit für alle* [Health for Everyone] episodes (1959-1960) shown as part of the advice-oriented magazine *Sendung für die Frau* [Women's hour] continued to give airspace to physicians.¹²

8 For an extensive presentation of the scientific research in the field of medical and health communication see Rossmann/Meyer 2017.

9 Hickethier 1993, 1998; Steinmetz/Viehoff 2008.

10 The consortium was founded jointly by *Nordwestdeutscher Rundfunk* (NWDR) [North Western German Broadcasting Service], *Bayerischer Rundfunk* (BR) [Bavarian Broadcasting Service], *Hessischer Rundfunk* (HR) [Hessian Broadcasting Service], *Radio Bremen* (RB) [Bremen Radio], *Süddeutscher Rundfunk* (SDR) [Broadcasting Service for the South of Germany] and *Südwestfunk* (SWF) [Southwestern Broadcasting Service].

11 Kreuz/Löcher/Rosenstein 1998, 26; Schubert/Stiehler 2007, 26.

12 Rosenstein 1998, 379-380.

1.1 The doctor's office opens – Health information in West German television in the 1960s

Since the beginning of the 1960s, the range of available programmes expanded as the West German television system diversified. With the introduction of a second central channel, the *Zweites Deutsches Fernsehen* (ZDF) [Second German Television], on 1 April 1963, 67 percent of households owning a television set could now choose between two channels. Television in West Germany became more and more an influential mass medium due to its increasing distribution.¹³ Whereas the first channel, ARD, broadcasted an average of 7.5 hours per day, ZDF broadcasted 5.5 hours on average.¹⁴

The competition between ARD and ZDF, which was further increased by the development of ARD's regional (third) channels between 1964 and 1969, led in subsequent years to a continuous extension of daily broadcasting hours which, in turn, triggered the development of fixed programme schedules, continuous programme production based on seriality, and the establishment of fixed broadcasting slots.¹⁵ Programme planners loved magazines which, as a result, underwent increasing diversification. Their advantages lay in the format's openness for a variety of issues, high programming flexibility due to the versatility in running times (between 25 and 45 minutes), and good audience connectivity through the male, less often female, presenter. The production of magazines was also relatively cheaper and their modularity allowed to show the different aspects of a topic in a variety of audiovisual forms.

Right from the onset, the public broadcasting services, ARD and ZDF, were given the objective to ensure, and provide the people with, independent primary information, education, culture and entertainment. The provision of practical help through advice and advisory information was therefore one of the most important broadcasting objectives, as continuously emphasized by, for instance, Karl Holzamer, the then Director General of ZDF.¹⁶ With emerging organisational structures including specialized teams and departments within the broadcasting services, and continuously increasing broadcasting hours, the share of advice-focussed programmes that dealt with issues related to every-day-life, such as education, nutrition, health, school or transport, was growing.¹⁷ Service journalism, which was at the time well established in print media and radio, quickly spread to television

13 Bleicher 1993, 96-105.

14 Compare Kiefer 1999, 434.

15 Hickethier 1998, 227f.

16 Mohl 1979, 365.

17 Compare index on *Ratgebersendungen* [advice-focussed programmes] in Kreuzer 1982, 165.

and provided viewers with medially prepared insights and information on problems and possible solutions.¹⁸ This resulted in an increasing number of advice-focussed series of magazines that related concretely to the viewers' life and reality and therefore also included such issues as health and disease.

Advice-focussed programmes aimed, and still aim, to awaken the audience's interest in certain topics, and to encourage viewers to take an active role themselves. The communication expert Walter Hömberg concluded in relation to the type of service journalism here involved, that, naturally, it "picks up only such issues that tend to be relevant to a mass audience. The issue must either be widespread or it must be highly probable to occur. Issues in the field of 'medicine and health' receive such overwhelming attention because every recipient is also a potential patient."¹⁹

By introducing the monthly *Gesundheitsmagazin Praxis* [Practice Health Magazine] on 3 January 1964, ZDF merged above characteristics of television as a medium in the 1960s into one: (i) concrete assistance in every-day-life or advice-orientation as general policy of public broadcasting services; (ii) the magazine format as a format of seriality and great flexibility within the structure of the overall programme; and (iii) the popularity that health topics had with the audience. *Gesundheitsmagazin Praxis* was the first prime time advice-focussed programme, even if it was only shown monthly with a total of 13 episodes per year. While the early advice-focussed broadcasts of West German television had mainly targeted female viewers, the new advice-focussed magazines with their primetime slots, such as *Gesundheitsmagazin Praxis*, now targeted all adult viewers.

Being within the responsibility of the "Health and Nature" team headed by TV journalist Hans Mohl, the magazine aimed, "to transport the most important information from the practice of medicine to the everyday practice of the audience as something that provides support in the fight against the unresolved health risks in our affluent world – lack of physical activity, obesity, alcohol, tobacco and drug abuse".²⁰ The monthly aired health magazine programme was an integral part of West German television for more than 40 years. Shown on Fridays at 9.30 pm in its first year, the 45-minute episodes moved into a new slot and were, from 1965 and the next 18 years, shown on the highly popular Monday evening slot at 8.15 pm. Mohl, who was no medical doctor himself, saw himself as an interlocutor between the world of medicine and the audience's everyday-life as expressed by the programme's credo, *More health through more information*. In order to attract

18 Compare Hömberger 2009, 8.

19 Hömberger 2009, 6 (my translation).

20 ZDF-Journal Kultur 1974, 15.

more attention from the viewers the editors convey information about first aid or healthy nutrition in the form of a quiz or a test, which got the audience involved with a question and then they explained what was the correct action and the consequences of the wrong one.²¹

The team was also paying particular attention to prevention and early detection of diseases and frequently appealed to men and women to undergo cancer screening tests. In November 1968, the programme reported on the introduction of endoscopy. For people to get a better idea, the “father of gastroenterology”,²² Prof Ludwig Demling, demonstrated live in the studio the use of an endoscope on his own body in order to show how harmless this new technology was. Time and again, the makers of the magazine took a clear stand in socio-political discussions. The documentary *Abtreibung in Deutschland* [Abortion in Germany], for instance, which was broadcasted in 1968 within the context of *Gesundheitsmagazin Praxis*, addressed the amendment of Section 218 of the West German Criminal Code at a time when abortion was illegal in West Germany. The press reaction was positive: The film manages to “educate and alert”²³ a wide audience. With Marlene Linke’s film, the magazine positioned itself in relation to a topic of great social and political relevance, and was awarded with several prizes including the Golden Camera in 1969 and the Adolf Grimme Award in gold in 1969 – one of the most renowned awards for television programmes in Germany. The jury’s decision reads,

A taboo topic has been presented in its importance with both tact and courage. The broadcast achieved a high degree of informational value and scientific consistency. It does not only show the facts and conditions but makes visible the necessity for people and society to draw the appropriate conclusions.²⁴

In July 1974, *Gesundheitsmagazin Praxis* presented a new report, this time on legal abortion as defined at the time in the Federal Republic, and on the controversial vacuum aspiration.²⁵

The programme repeatedly investigated shortcomings in the health sector and thus influenced health policies in Germany. One example was the gradual introduction of the arbitration board for medical malpractice. A test of pharmacies in 1972 discovered innumerable cases of misinformation. A

21 Compare Mohl 1979, 371-372.

22 ZDF press release 2004, 1.

23 ZDF / DV 1969, 16.

24 ZDF / DV 1969, 2 (my translation).

25 Broadcast of 1 July 1974, ZDF, 8.15 pm-9 pm. The liberal amendment that would have allowed for abortion within the first three months of pregnancy and that parliament adopted by a small majority in April 1974 was, in January 1975, ruled unlawful by the Federal Constitutional Court. In 1976, abortion was generally still illegal by law, but legislators allowed for certain exceptions.

new test some years later showed significant improvement. Another example: In 1973, a documentary in *Gesundheitsmagazin Praxis* revealed that there were serious deficiencies in psychiatric institutions, which meant that the federal government set up a commission to tackle these problems.

In addition to practical advice and disease prevention, the programme also reported on such issues as medical research and new therapies that related to important health topics. Sensational innovations in the field of heart surgery or orthopaedics and new forms of therapy received public attention, and patients now asked for intelligible information also by the mass media.²⁶ “Most ideas”, said the team in retrospect, “were the result of observations made in the medical field, or resulted from the assessment of original publications and the contact to big health organizations”.²⁷ It was not without reason that Hans Mohl was always emphasizing the close exchange with physicians and experts when preparing the reports – the relationship between members of the medical profession and members of the media in general was rather difficult. Again and again doctors complained that patients would later come into practice with the corresponding (real or supposed) complaints due to television broadcasts or newspaper articles “about certain diseases or demand treatment with the new forms of therapy shown on television – regardless of whether these are already generally available or suitable for them at all”.²⁸ But Mohl’s way of communicating information was assessed positively by the physicians: He was the first journalist to receive an honorary doctorate from the University of Erlangen-Nuremberg in 1980.

1.2 ‘Tele surgery’ – Health programmes in GDR television in the 1960s

Building the wall in August 1961 brought an end to a more liberal period in governmental policy. From now on, the communist party affirmed its leadership and dominant role in all social, political and economic spheres. When evolving into a mass medium at the end of the 1950s, East German television, *Fernsehen der DDR*, came increasingly into the focus of the political leadership of state and party. This also applied to the further development of state television, which “should mainly maintain its politically educational role in society”.²⁹ From 1957, GDR television broadcasted daily and established a regular schedule dominated by films and informational programmes. In this process, television came increasingly into a field of conflict between ideolog-

26 Compare Dernbach 2010, 163.

27 ZDF press release 2004, 1.

28 Brünner 2011, 13.

29 Rosenstein 1998, 386.

ical goals, growing expectations by the audience who wanted to be entertained, and intrinsic possibilities and conditions.³⁰

In contrast to West German television, which functioned as a media system under public law far removed from the state, East German centrally organized television was closely linked to the political ideological principles of the communist party, SED.³¹ Advice-oriented programmes conveyed, for instance, a model of child education that conformed to party ideology, the idea of collectivism in agriculture, every-day-life in socialism, or the role of women. Advice-oriented programmes were used to mitigate shortages in consumer goods *Du und Dein Garten* [You and your garden], to make better use of available resources *Der Fischkoch empfiehlt* [The fish chef recommends] and to influence consumer behaviour *Verkehrsmagazin* [Transport Magazine]. These also included the health programmes *Der Teledoktor* [The Teledoctor] (1961-1962) and *Der nächste, bitte!* [Next, please!] (1964-1970). It belonged to the economy/science segment and was a monthly 25-minute programme on medical issues and featured video clips, animated clips and expert advice by doctors as guests. First shown on Wednesday afternoons from 3.30 to 4.00 pm, the programme, which was also called “television surgery hours” or “tele surgery”³² was given a better slot in 1968, when it moved to Tuesdays, 7.00 pm. Over seven years, DFF aired a total of 107 episodes. After the programme was dropped on 15 December 1970, the service programme department started in January 1971 to produce the *Visite* [Doctor’s rounds] health magazine.³³

2 Television as ‘No 1 medium’ – television in the 1970s

Not later than by the beginning of the 1970s, when viewer consumption had reached a certain saturation, television had risen in East and West Germany to society’s No 1 medium that had replaced the radio and that, due to its huge reach, had a great impact on public opinion.³⁴ In that decade, the magazines’ share in the overall programme reached in both television systems its peak which media science refers to by such catchwords as ‘magazinities’ and ‘magazination of the programme’.³⁵ As a “classification pattern of mass media offerings”,³⁶ the magazine is regarded as a flexible form of broadcasting that is

30 See Dittmar/Vollberg 2007.

31 See Dittmar/Vollberg 2007.

32 Kreutz/Löcher/Rosenstein 1998, 117.

33 Kreutz/Löcher/Rosenstein 1998, 276.

34 Hickethier 1993, 207.

35 See Rosenstein/Kreutz, 15.

36 See Rosenstein/Kreutz, 15.

characterized by a specific history of diversification. From the 1970s, the variety of magazines included regardless of the respective media system a great diversity of genres such as political magazines, magazines for specific target groups (children's, young people's, elderly people's, women's magazines), information and advice-focussed magazines, entertainment or special interest magazines in the fields of culture, fashion, sports, music, and lifestyle. And, last but not least, the health magazines here discussed.

2.1 Health programmes on all channels – West German TV programmes in the 1970s

In the 1970s, West German television introduced a number of long-running health magazines which, alongside *Gesundheitsmagazin Praxis*, covered a wide range of health-related topics. This growth in the number of health magazines was also largely due to a change in governmental health policy. When the post-war decades until the early 1970s were characterised by the continuous development of the health care system and the furtherance of advances in medicine, cost containment became, from 1975 onwards, the most prevalent aim of West German health policy. After an expansive rise in costs which was no problem in a time of economic boom, the global economic crisis beginning in 1973/1974 and its low economic growth rates and rising unemployment led to the conviction that the health care system was too expensive and that costs had to be cut.³⁷ The concept of “cost containment policy” had had a huge impact on the health care system well into the 1990s. This meant that the discussion of the individual's responsibility for his or her own health moved to the foreground of the political discourse. Individual behaviour and avoiding sickness by proper behaviour became an important topic in the health magazines. When, in the 1960s, they had predominantly dealt with new advancements and treatment methods in modern medicine, they now focused more on self-help possibilities, alternative medicine and prevention. The following three magazines are examples to illustrate this development.

ARD-Ratgeber: Gesundheit [ARD Health Advisor]

In 1971, the joint ARD broadcaster, known to most as the First Channel, introduced a factual series under the title *ARD-Ratgeber* [ARD advisor] as a service that provided consumer information. The weekly format offered advice in a variety of segments such as health, money, technology, education/

37 Compare for an introduction into West German health policy: Alber 1992.

career or transport and was also an attempt to establish a competitive offer to ZDF's popular advice-oriented TV magazines.

After *Gesundheitsmagazin Praxis* had had a unique selling point for seven years when it came to health education, this changed when the monthly *ARD-Ratgeber: Gesundheit*³⁸ was launched. From October 1976 however, 45-minute episodes were aired on the clearly better programme slot on Saturday afternoons. The editor and presenter of many years was Winfried Göpfert, who wanted to assist his viewers in their role as, when it came to health and disease, ordinary lay people. The magazine was not about “introducing the audience uncritically to all kinds of technological developments, new devices, new methods etc.”, said Göpfert. “But instead, we wanted to strengthen the competency of each individual, their sense of their personal responsibility.”³⁹ ARD as a public broadcasting service thus followed its societal objective to inform and educate the audience. The *Ratgeber* programme also meant that the so called diseases of affluence that are based on an individual's wrong behaviour and can be reduced by minimizing risk factors moved more into the foreground of TV coverage. Through journalistic assessment of information in the magazine's items and input of experts the audience learned what behaviour was considered harmful to or beneficial for health. Göpfert judged the effect of the magazine not to lie in any prompt change of behaviour but to be a way to broaden the viewers' knowledge and strengthen their motivation, which over time could lead to a change in attitude and thus to a “whole number of very many small effects”.⁴⁰

Die Sprechstunde [Open Surgery], BR

However, health broadcasting did not remain limited to channels one and two. Already two years later, in 1973, *Bayerischer Rundfunk* [Bavarian Broadcaster] launched the magazine programme *Die Sprechstunde* on their channel and thus the first weekly health format. From 1974, the magazine was also aired by most regional channels and could thus be watched in nearly all of West Germany. In contrast to the magazines discussed above, *Die Sprechstunde* dedicated every episode to one single theme only. The 45-minute programme was presented by a medical doctor, Dr Antje-Kathrin Kühnemann. The magazine was a combination of individual films and a guest panel. Unlike the magazine's title suggests, it did not mimic a consultation by a patient

38 The magazine was initially produced by *Südwestfunk* (SWF), later by *Sender Freies Berlin* (SFB) [Free Berlin Broadcaster], and, from 1993, alternatingly by *Bayerischer Rundfunk* (BR).

39 Göpfert 1989, 316. Quoted from Appel 2000, 104 (my translation).

40 Göpfert 1994, 13. Quoted from Appel 2000, 104 (my translation).

but the presenter asked the invited experts, usually a physician who specialised in the medical problem the programme dealt with, questions about certain diseases, aiming to share information with the audience.

Aired in the evening programme at approximately 9.00 pm, the magazine targeted men as well as women. It centred on the presentation of current medical topics, but the team also wanted to provide “basic information on the fundamental vital functions of the human body”.⁴¹ One speciality of the weekly aired magazine was the monthly mini-series within the magazine which followed its various topics⁴² consistently over the year.

Medizin im Dritten [Medicine on your regional channel], WDR

Two years later, in 1975, another Third Programme implemented its own health series. The WDR launched with *Medizin im Dritten* a new series that, in 45-minute episodes, aimed to explore as many aspects of medical issues of general interest as possible. The monthly programme was produced by the science team. The topics were chosen along two criteria: the number of sufferers and/or a lack of media attention. The programme was not moderated and was monothematically oriented.

These new magazines as well as *Gesundheitsmagazin Praxis* focussed from now on more on information for preventing the most important widespread diseases like cancer, diabetes or cardiovascular diseases. Health communication now aimed stronger on changing people’s behaviour and attitudes. Reporting centred not only merely on treatment but most of all on the prevention of lifestyle-induced diseases. The individual person became therefore responsible for his or her own health and was asked to act, or to abstain from certain behaviour.

Providing the viewer with information and orientation continued to be a key objective in the field of health programmes too, as they aimed to strengthen viewer competence in health issues. In the following years, *Gesundheitsmagazin Praxis* provided such help with concrete campaigns: In 1977 the magazine started a campaign called *I.d.R: Iss das Richtige* [Eat the right stuff] to provide viewers with advice on proper diet and behaviour to motivate them to lose weight. For this purpose, they ran a six month food campaign that followed ten people on their way towards a healthier body-weight. There were recipes in every episode from the then very popular TV

41 Bayerischer Rundfunk, winter programme 1973/1974, 171.

42 E.g. *Die ersten 365 Tage im Leben eines Kindes* [The first 365 days in a baby’s life], or *Was geschieht mit meinem Sohn bei der Bundeswehr?* [What happens with my son in the army?] Bayerischer Rundfunk 1973/1974, 171. The mini-series *Die Gesundheitsküche* [The healthy kitchen] dealt with issues in modern nutritional science. Bayerischer Rundfunk 1980, 164.

chef Max Inzinger. Half a year later, Mohl, supported by German showbiz celebrities like Udo Jürgens, Luise Ullrich and Dieter Hallervorden, presented the results of the six month slimming campaign. Another six months later in the show of 9 January 1978, Mohl gave an update on the original ten people's weight and health to illustrate the long-time effects of the Eat-the-right-stuff campaign. The integration of well-known television stars and live demonstrations, for example of new treatment methods during the programme, increased the credibility of the programme for many viewers.

Particularly loved by the audience – in its first ten years, the programme's viewing rate averaged at 30 percent (12 million viewers) – were the tests and quizzes that allowed the audience in front of the TV to test their fitness, safety, knowledge about health issues, their eye vision etc. By using such entertaining formats, the editors were able to appeal directly to the audience and to activate their viewers to, for instance, join in the quiz or to reflect their own behaviour, while they were still watching the programme. And this direct involvement was indeed very popular with the audience: The episode with a fitness test called *Check your shape*, for instance, proved, with a 45 percent viewing rate, to have been particularly popular.⁴³

2.2 Health in a magazine-type format – East Germany's *Visite* in the 1970s

The continuous expansion of daily broadcasting hours and the introduction of a second channel⁴⁴ in 1969 led in East German television too to continuous programme production, fixed broadcasting slots and an expansion of magazine formats into numerous genres. A large-scale programme reform was brought on by the much-quoted criticism voiced by the new leader of the state and party, Erich Honecker, who had mentioned “a certain boredom of GDR television”.⁴⁵ The reform aimed to create viewer loyalty for their own programmes by offering a greater share of entertainment programmes without undermining the leading role of the communist party. GDR television's management headed by Heinz Adameck also started to pay more attention to viewer preferences. Advice-oriented programmes were seen as suitable formats to meet viewer requests and, by directly appealing to their viewers, to also get closer to the audience. They therefore held polls at regular intervals, asking viewers about their daily routines, viewing behaviour and programme preferences. The results of such a poll from September 1971 showed

43 Compare *ZDF Journal Kultur* 1974, 15.

44 For a comprehensive account of the history of the second channel, compare Vollberg 2002, 147-182.

45 Dittmar/Vollberg 2002, 7 (my translation).

an elementary interest in medical advice (46.1 percent of participants) and in advice on a healthy lifestyle (36.2 percent).⁴⁶ In order to live up to the claim of a greater focus on viewers, the programme makers, within the course of the programme reform of 1972, set up a 7.00 pm advice-focussed slot on the first channel, which ushered in the evening programme on workdays. The health magazine-type programme *Visite* [Doctor's visit], first launched in 1971 in channel two's evening programme, was later also moved into that slot. While *Der nächste, bitte!* had been assigned to the economy/science team, *Visite* now belonged to the advice division.⁴⁷

In contrast to the pluralistically structured broadcasting service system of the Federal Republic where ARD, ZDF and regional channels competed to win over viewers also in the field of health communication, which had led to a certain variety of health magazines, GDR television had with *Visite* only one health magazine. Other than its predecessor, *Der nächste, bitte!*, whose main focus had been on common diseases, the *Visite* team no longer wanted to restrict themselves to the giving of medical advice but wanted to encourage behaviour that would be of benefit to an individual's fitness and well-being. "Information was embedded in their health-educational overall objective, and dealt with diseases and looked on how to get better, or on how to prevent them."⁴⁸ The programme's time of 45 minutes corresponded to that of *Gesundheitsmagazin Praxis*. *Visite* was also aired monthly which from 1981 onwards became twice a month.

The *Visite* team worked with a large team of experts organized in an advisory board that, besides including representatives of the state health system, was also made up of scientists and physicians from a variety of disciplines. That some of those physicians also acted as presenters, had a positive effect on reception. The audience's trust was expressed in numerous, often very personal, letters to the team. Answering these letters together with their experts was a responsibility that the team took very seriously.⁴⁹ The team also participated frequently in so-called audience forums and frequent

46 Rosenstein 1998, 390.

47 GDR television had a strongly hierarchical structure of so called *Hauptabteilungen* (HA) or central departments which, in turn and for their share in the programme, were reporting to the State Television Committee and the General Directorate. Besides the HA for advice-oriented programmes, there were also HA's for sports, youth and education, entertainment, programme management, programme exchange, or economy/science, for instance. See Schubert/Stiehler 2007.

48 Rosenstein 1998, 391.

49 Audience research was right from the start important to GDR television. Television producers were particularly interested in the audience's motives for using the TV, their concrete watching of individual contents, their leisure activities and daily routines. For capturing information, researchers used most of all the letters sent by viewers but also print items

discussions with the members of a working team acting as non-professional critics.⁵⁰

In two to four short films per episode, *Visite* covered new medical research results as well as treatment and operating methods. A central aspect was also the provision of information on healthy living and a healthy diet as important to the prevention of diseases, whereby the provision of such information accorded, as Doris Rosenstein argues in her study of advice programmes on GDR television, with “the GDR’s socio-political goals of health education and health propaganda”.⁵¹ *Visite* was predominantly watched by viewers who already had or anticipated health problems and who most of all expected detailed information and concrete advice on preventing, mitigating or eliminating disease. The often politically and ideologically motivated provision of information was often at odds with these viewer expectations.

3 Times of change – television in the 1980s

The introduction of the dual broadcasting system consisting of public and private broadcasters and the ensuing increase of commercial channels in the mid-1980s brought huge changes to West German television which strongly altered broadcasting strategies, competition and programme dynamics. Still, health coverage formats remained surprisingly intact.⁵² Although WDR ceased their *Medizin im Dritten* in 1985, *Gesundheitsmagazin Praxis* kept its good prime time slot and was produced until 2004. *ARD-Ratgeber: Gesundheit* remained until 2014 a permanent magazine in ARD’s advice-focussed weekend programme, and the regional magazine *Die Sprechstunde* broadcasted on the Bavarian channel was aired weekly until 2007, meaning that there were altogether 1,530 surgery hours aired by Dr Kühnemann and her guests.

The GDR’s television also responded to the changes in West Germany with far reaching programme restructuring in the wake of the 2nd programme reform in 1983. Under the header “Introduction of an Alternative Programme Structure”, the GDR’s 1st and 2nd channel underwent comprehensive changes. The official reason given was to better the GDR’s own channels in order to

or various viewers’ forums as, for instance, in state institutions and companies. Compare Steinmetz/Viehoff 2008, 53-55.

50 Compare Rosenstein 1998, 391.

51 Rosenstein 1998, 391.

52 Competition with the private broadcasters increased the number of entertainment programmes in the public channels, which were tailored to the needs of a broad mass of viewers (e.g. game shows and series), while the proportion of informative and cultural programmes was reduced. See Bleicher 1993, 117.

meet the audience's demand for entertainment whereas the option to choose a West German public or private channel instead was never mentioned.⁵³ In East German television, *Visite* too was able to uphold its position as *the* health magazine programme with a reference on everyday life and sometimes reached rates of 20 percent, which was, for GDR TV, very high. After the fall of the Berlin wall in 1989, *Visite* was one of the few shows that made it into the ARD programme. Since 1992, the series is produced and broadcasted by NDR.

4 “For information about risks and side-effects, please consult your doctor or pharmacist” – The question of effect

The effectiveness and sustainability of this approach of health education and communication in the media was already under discussion by medical doctors and television editors in the 1970s. Most journalistic articles and studies about or on *Gesundheitsmagazin Praxis* hawk on the “morbus Mohl” phenomenon, which was a term used by doctors to describe that, the day after the show was aired, their waiting rooms were visibly more crowded than usual, even more than on Mondays.

In 1978, the German Medical Women's Association held a conference on “Medicine and the Mass Media” that critically looked at the often tense relationship between doctors and journalists. Being convinced that medicine would continue to feature in the media, they acknowledged that there was a great demand for information on the part of the audience as shown by the high viewing rates in Germany for prime-time programmes like *Gesundheitsmagazin Praxis*. The majority of physicians agreed that television, due to its wide reach, had a high potential for pushing topics and, if information was given responsibly, was able to make a contribution to the early detection of diseases. Heuser concludes accordingly, “most early diagnosis and screening campaigns in recent years have only been so successful because the media had provided proper coverage. People's health awareness has never been as sustainably influenced as by television.”⁵⁴

The potential the magazines discussed had for health communication is, even today, to be rated rather low. Although the magazines generated stable viewing figures and had for a long time been part of the West – and East – German television, their effect remained limited for a number of reasons. Firstly, the magazines usually attracted only those viewers who already had

53 For a more detailed description of this programme reform see Dittmar/Vollberg 2004.

54 Heuser 1982, 23 (my translation).

a general interest in the issue or had a specific need for information because they were ill. New, specific target groups were therefore impossible to reach. Secondly, the magazine format, which consists of several shorter elements, made it difficult to convey extensive or detailed information. The magazines *Die Sprechstunde* and *Gesundheit im Dritten* tried to compensate for this by monotypical 45-minute episodes. The audience had, thirdly and except by writing letters, no possibility of interaction if they had, for instance, problems with comprehension. Fourthly, the formats here discussed were not about communication between physician and patient even if their titles suggested otherwise. Instead, two or more actants – the presenter and the expert(s) – were engaged in a discourse that aimed to feed the audience with information. And even beyond the studio discussion there were mainly experts speaking also in videos or films. Less space was given to the experience of those affected. This only changed in the late 1970s when there was an increased involvement also of support groups. This mode of education however meant that it was not any individual illness or patient that or who was in the foreground, but rather sickness and disease as abstract phenomena.

In her study of health and disease concepts in relevant information and advice programmes, Andrea Appel concludes, “Since health (or rather illness, that is) was most of all seen as a case for the medical field, it was the medical experts who were playing the lead role.”⁵⁵ The 44 analysed broadcasts by Appel taken from ten regularly aired health broadcasts or magazines including *ARD-Ratgeber: Gesundheit*, *Gesundheitsmagazin Praxis* and *Die Sprechstunde*, had 132 experts, 103 thereof being medical experts, speaking to the audience. This amounts to three experts per topic on average whereas of the people affected, there were on average only two who could have their say. Their share of speaking time was also significantly smaller than that given to experts or presenters.⁵⁶

5 Conclusion

Since the 1970s, coverage of health and disease issues in magazine-type formats was spreading significantly in West Germany. For television producers and broadcasters, television had a special role in the provision of practical advice, so that service journalism gained a strong position in relation to health. The magazine format’s modular nature allowed to mix topics and to set pri-

55 Appel 2000, 105 (my translation).

56 Appel 2000, 105 (my translation).

orities, and to combine various genre elements such as animated or film clips, quizzes, expert interviews, presented contents or discussions with guests or people affected. At the same time, however, the format was prone to certain limitations in terms of the length and depth of their elements. In these formats, their presenters of many years enjoyed the trust of the viewers on whose behalf they asked their questions on medical topics or demanded explanations. Coverage was largely within the line of advice-oriented journalism and offered concrete tips and information.

This provided viewers in West Germany with a number of frequent programmes in the field, which were spread out over the week and time slots. In East German television, the choice of magazine-type formats was significantly smaller but the health magazine *Visite* was, with on average 20 percent, nevertheless able to achieve a viewing rate that was impressive for GDR television, and that remained stable until the end of the East German programme. It should also be noted that, with the exception of some very few areas (e.g. in the greater Dresden area), West German television was available across the whole of the GDR and was intensely watched by large proportions of the GDR populace.⁵⁷ It can therefore be assumed that the West German magazines here discussed were also watched in the GDR.

The example of the historic development of various West and East German health magazines shows the change in the understanding of health communication through television. While, in the early years, reporting mainly featured achievements in modern medicine and presenters regarded themselves as interlocutors between medical experts and an audience of laypeople, broadcasters in the late 1960s and 1970s addressed increasingly so called diseases of affluence. This meant that the audience was predominantly given information on risk factors, and individual behaviour became an important variable in the health equation. A person's responsibility for his or her own health acquired a new weight. In this phase too, editors relied on the power of persuasion as exerted by experts (medical scientists, nutritionists, physicians etc.) who explained on TV what things were harmful or beneficial to a person's health. At the same time, however, the people affected also had their say, either in discussion panels in the studio, or in the stories themselves. Television, as some exemplary topics here have shown, was well able to bring about public awareness of health-relevant issues. Fundamental changes in behaviour triggered by those shows were, however, rare or one-off occurrences at the most. The creators of these programmes took themselves a critical view on the potential effects of these magazines.

57 See Steinmetz/Viehoff 2008, Dittmar/Vollberg 2002.

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Television programmes

FRG

- ARD-Ratgeber: Gesundheit* [ARD Health Advisor]; produced by ARD between 1971-2004 (30 minutes)
- Der Doktor hat Ihnen etwas zu sagen* [The doctor wants to tell you something], produced by NWDR in 1953 (5 minutes)

Die Sprechstunde [Open Surgery]; produced by BR between 1973-2007 (45 minutes)
Gesundheitsmagazin Praxis [Practice Health Magazine], produced by ZDF between
1964-2004 (45 minutes)
Medizin im Dritten [Medicine on your regional channel]; produced by WDR between
1975-1985 (45 minutes)

GDR

Der Arzt [The Doctor]; produced by DFF 1 between 1956-1957 (30 minutes)
Der nächste, bitte! [Next, please!]; produced by DFF 1 between 1964-1970 (25 minutes,
since 1970 30 minutes)
Der Teledoktor [The Teledoctor]; produced by DFF 1 between 1961-1962 (30 minutes)
Gesundheit für alle [Health for Everyone]; produced by DFF 1 between 1959-1960,
episodes in *Sendung für die Frau* [Women's hour] (30 minutes)
Visite [Doctor's rounds]; produced by DFF 1 between 1971-1991 (45 minutes)



‘Television Discourses’: how the University of London’s Audio-Visual Centre professionalised and democratised the televisual lecture for postgraduate medical students*

Angela Saward

Abstract

The focus of this article is on a discrete group of videos that are, for the most part, held at Wellcome Collection in the United Kingdom. It is a case study of a ‘hidden’ archive – one that was almost lost, and certainly overlooked, of the closed-circuit television output from a university department. This department, the University of London Audio-Visual Centre, produced a large corpus of postgraduate medical educational video programmes from 1971–1991. The article looks at the initial technological optimism, the ‘ideology’ and passion behind this endeavour through the lenses of an influential governmental report and those archives relating to this department. These documents reveal the myriad problems in meeting their original objective. The legacy of two decades of media production, represented by a small selection of videos, had long-term impacts in the educational sector and, arguably, democratised audio-visual education for postgraduate students engaged in the medical disciplines.

closed-circuit television, postgraduate education, medicine, medical humanities

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Introduction

This article investigates the physical and intellectual legacy of a university department devoted to audio-visual pedagogy and televisual media production. The sources used include 310 titles which are catalogued and available via Wellcome Collection of which 150 have been digitised, transcribed and are available online with the remainder planned to be digitised as part of a major video project run by the British Film Institute.¹ The case study is supported by extensive archival materials held at both Wellcome Collection and Special Collections, Senate House Library, University of London. The use of televisual technology was novel in the British educational sector of the early 1970s and examples of early forays into media production are little known because the video sources that survived were recorded on currently obsolescent analogue tape formats. In 2016, all analogue videotape formats were deemed obsolescent barring two (BetaSP and BetacamSX). Furthermore, no professional equipment was being manufactured (these were the conclusions of a European consortium of major audio-visual archives organisations).² Due to recent digitisation, the material is newly available for research and can now form part of the history of medical education especially in the context of mediating the body.

From its inception in 1968 to its demise in 1991, the University of London Audio-Visual Centre (ULAVC) engaged in a large-scale audio-visual post-graduate educational programme. Taking advantage of the availability of new television technology and synthesising this with pedagogy, the Centre was in part established to anticipate the demands of a rising student population, which in the 1960s in the UK had doubled in seven years to more than 50,000.³ Medical sciences and medical humanities videos, as will become clear, became by far the bulk of the Centre's output as the University represented a number of both nationally and internationally recognised centres of medical excellence. In 1975, production output was 34 television videotapes; 29 titles were medical; two examples are, 'I Want You To Take These Tablets' and 'The Microbioassay of Hormones'.⁴

For the University of London, the impetus for establishing a university department at the physical and intellectual heart of London's vibrant post-

1 Edited excerpts from the videos discussed in this article are available to view online at <https://youtu.be/gjYWwdH9K0> (accessed 6 September 2019).

2 https://kennisbank.avanet.nl/wp-content/uploads/2019/07/preservation_guide_main_preservation_guide_-_overview_of_preservation.pdf (accessed 6 September 2019).

3 Bolton 2012.

4 Michael Clarke, Document D, from a list of Productions Completed, 1975, UoL/AV/1/7 DPAV, University of London Archive, Senate House Library (hereafter UoL).

graduate educational sector dedicated to the creation of audio-visual pedagogy came from an influential report compiled by Dr Brynmor Jones.⁵ The report included a detailed survey of educational provision across the UK, France, Germany, Japan and the US, where the practice of using audio-visual tools in teaching was well-established. The significance of the report is highlighted in the archives of ULAVC and is mentioned in the unpublished memoir by a former Senior Producer who worked there.⁶ The report forms a key source for the analysis.

When the Centre was dismantled in 1991 after what had been a turbulent decade both politically and technologically, the Audio-Visual Resources Manager at the Wellcome Institute Library (now known as Wellcome Collection),⁷ negotiated the transfer of the ULAVC collection from the university. Michael J. Clark (not to be confused with Michael Clarke, former Director of the Centre) rescued a sizeable number of the videos and production materials created for postgraduate students in clinical medical and medical humanities as it appeared that most of the videos would be lost. (The rest of the collections were split between several institutions, including the British Medical Association.) Sir Henry Wellcome had been collecting audio-visual medical material from the 1910s alongside books, manuscripts and examples of visual culture such as prints, drawing and paintings. After his death, the organisation continued this activity by the creation of a library dedicated to the history of medicine and the public understanding of science (An example of audio-visual material acquired by Henry Wellcome is a sound recording from Florence Nightingale on the plight of veterans from The Crimean War, 1890). Wellcome Trust, the charity funding research into biomedicine formed as a result of Wellcome's will when he died in 1936, continues with this work and supports Wellcome Collection, the museum and library created as part of his legacy.⁸

Michael Clarke, the by then retired first director of the Centre, communicated in correspondence what he believed to be the legacy of the Centre's output:⁹

Taken together, they represent the first large-scale, systematic use of videotape in British postgraduate medical education, and certainly the largest and most varied body of medical film and video produced in any British university in the period from the mid-1960s down to

5 Jones 1965.

6 Scott 2012; revised 2017. Attached in email correspondence Trevor A. Scott to Angela Saward 20 November 2017.

7 For an account of institutional history and nomenclature: https://en.wikipedia.org/wiki/Wellcome_Library (accessed 22 June 2019).

8 James 1994, 359–60.

9 GC/170 acc. 401, Wellcome Collection.

the early 1980s. As such, the collection constitutes an audio-visual archive of considerable historical importance and a major resource for the history of twentieth-century medical sciences, whose future preservation is surely highly desirable.

Given the significance that Clarke outlines, it was important not just to rescue the collection, but also to emphasise its standing in audio-visual history of medicine in the twentieth century. Paradoxically, in 1995, in an article for the British Universities Film and Video Centre's (BUFVC) handbook, Clark surveying the twentieth century output of medical films and videos, noted the difficult task to both inform and engage the audience, deciding that the efforts of the ULAVC to put the spirit of the Brynmor Jones report into practice "were not terribly inspiring".¹⁰ By which he appears to have meant that the model of the televised lecture did not portray contemporary medical practice attractively with comparatively small (and even meagre) production budgets. He added that centralised audio-visual units in universities as advocated by Brynmor Jones were probably doomed to failure. These statements were made prior to the Centre's demise and, it's only through the passage of time, the Centre's true impact has become evident.

As a curator faced with a large volume of videos on obsolescent media formats with a limited administrative history, building a case for the historical and research value for a collection which has been mothballed for 30-odd years is challenging: these media 'texts', both words and images, have long been out of circulation and re-contextualising them requires a significant effort of research especially as medical practice evolves so rapidly. Some of the titles, on the surface, do not sound appealing ('The Properties of Mucus', no date, springs to mind). This problem is addressed by contextualising and historicising the video materials through the lens of the Centre's archives, the videos or media 'texts' themselves and the personal testimonies of the people who worked there.¹¹

Access to knowledge about our health has traditionally been held by the medical profession: television and, latterly, the internet have disrupted this paradigm. Much of the output of the Centre sits on the cusp of the acceptance of medical and 'tele-education' becoming a cultural and societal norm.¹² Also, the discourse around what is a 'healthy' and a normal body versus an 'unhealthy' and abnormal body has changed: analysing the output of the Centre provides one of the overlooked evolutionary steps in the way

10 Clark 1995, 22–29. At the time of writing the article, Clark was Audio-Visual Resources Manager at the Wellcome Centre for Medical Science and later negotiated the transfer of the ULAVC collection in 1999.

11 Michael Clarke, the first Director of the Centre, died in 2005.

12 Young 1999, 65–7.

healthy or unhealthy ‘bodies’ and behaviour were mediated in the service of postgraduate medical education before becoming the ‘norm’.

Brynmor Jones’ Report

The report published in the UK in 1965 by a committee comprising of the University Grants Committee, Department of Education and Science and Scottish Education Department, led by Dr Brynmor Jones, Vice-Chancellor of the University of Hull, was the fruition of an extensive survey of the audio-visual educational landscape around the World carried out in 1963–64. It outlined the difference in adoption of audio-visual aids, with the US significantly ahead in this pedagogical ‘arms race’:

... they have raised the efficiency of communications almost in proportion as they have increased their audiences. The skill and expertise in the presentation of some programmes rest on especial care in preparation, meticulous selection of relevant data, and on an understanding of the educational load as well as the pace required in a particular unit of communication.¹³

The report described television as “a powerful and influential medium of mass communication”, devoting a chapter solely to the medium.¹⁴ It was recognised as an increasingly popular leisure activity as domestic television set ownership had grown exponentially: in 1959 58.38% of UK domestic households owned a television set; in 1969 92.34%; in 1979 97.53%; in 2019, it is 96.11%.¹⁵ Initiatives to introduce television into the classroom in the service of education had been led by several of the broadcasters (BBC Schools and Colleges and Granada TV in particular). However, the report identified that in 1964 only 7% of British universities were using closed-circuit television and overall the practice of using audio-visual technology was still in its infancy.¹⁶ The report indicated that one of the factors behind the US developing and adopting this technology had been much larger student populations in each institution and the need for greater capacity at universities and colleges. Student numbers attending American universities were considerably larger than in the United Kingdom: The University of California had 24,000 students on campus in 1962 which was 48% of the entire student population studying first

13 Jones 1965, 3, Section 24.

14 Jones 1965, 57, Section 263.

15 Broadcasters’ Audience Research Board, “Television ownership in private domestic households 1956–2018 (millions)”. <https://www.barb.co.uk/resources/tv-ownership/> (accessed 21 June 2019). BARB commissions audience data and has historically included television ownership.

16 Jones 1965, 57, Section 265.

degrees full-time in the UK at the time.¹⁷ In the US, the approach to increases in the student population had been to create both larger lecture theatres and connect overflow theatres – rather than hiring more lecturers.

The report was evangelical; it was believed that media literacy would increase in emerging student cohorts who would become “picturate” and more receptive to images (rather than written text):¹⁸

The view of the controlled and disciplined utterances of film and television may lead to the realisation that these media have a significance for us comparable with that of El Greco, Titian and Michael Angelo in a less literate world.¹⁹

This has turned out to be prophetic: what we understand to be media ‘literacy’ has only happened through the paradigm shift television technology created, especially the speed between image capture, transmission and receipt, freeing media producers from the cumbersome film production process.²⁰ Television production was also revolutionised by the ability to relay images ‘live’ and in real-time on video. Two television broadcast models became possible; ‘open-circuit’ television (to the public) versus ‘closed-circuit’ television (to specific audiences). Closed-circuit television (or cctv) was defined as

[...] television which is restricted to, and can be received only by, specific audiences [...] a system of private television using a highly-directional transmission link, either in the form of a very narrow beam of radiation which can be received only by means of a highly-directional receiving system designed for the purpose, or a coaxial cable linking the camera directly to the receiver.²¹

Both models became conduits for educational programming: to begin with the ‘open-circuit’ broadcasters (BBC, ITV, Granada etc) only scheduled educational programmes for when their audiences were available (during school or late at night for adult learners) and ‘closed-circuit’ broadcasters aired their programmes to their ‘captive’ audiences, timetabled during lecture periods, for instance. Later these models merge as audiences time-shifted programmes to watch when most convenient due to the domestic video-recorder. Programmes become more like books on a library shelf available to anyone.

17 Ibid, 23, Section 23.

18 Ibid, 2–3, Section 24.

19 Ibid, 2–3, Section 21.

20 Boon 2008, 192–3.

21 Ibid, 57, Section 263.

Setting up the Centre

The report led to the re-positioning of visual aids in education across the university sector and the ULAVC became the 29th department of its kind in the UK.²² When the Centre was set up, it was alongside what was described as an ‘active department of new media’ and a Research Unit into methods of university teaching (neither of which are mentioned again in the departmental archives).²³ Clarke compared the Centre to what was considered to be the core purpose of the university by citing a comment made by Lord Annan (who was Vice-Chancellor of the University 1966–1978).²⁴ In Clarke’s words, “in a federal university the television system can help to provide the essential ‘Spielraum of scholarship’”.²⁵ By this he means that the university and, thus by extension, its television service might create scope – or a literal space – to be able to develop academic thought freely. This was a bold statement to make but was illustrative of the ‘ideology’ behind the televisual endeavour.

The documentary evidence in the department archives demonstrates the commitment and passion for the moving image within the department and a desire to proselytise about it:

... there has been a welcome tendency, by both academic contributors and producers, to exploit the illustrative and demonstrative capacities of television in greater measure, using the resources of location recording and graphic design in full measure, and the possibilities offered by videotape editing. To use television superficially demands more time in research, design and production, but a consequent increase in clarity and force.²⁶

However, there was strong resistance to tele-education and what was regarded as ‘canned’ teaching.²⁷ Concern in the University was expressed that using television technology itself could be a barrier for the student to access real bodies for their clinical experience as the approach to postgraduate medical education had traditionally been based on the “apprentice model”.²⁸ Television lecturers had to be better prepared for their broadcast lectures – they had to be conducive to lecturing in this medium *and* appropriately trained: the Centre’s archives point to 60 hours of preparation accounting for

22 Clarke 1970, 2, Section 1. UoL/AV/1/3 DPAV.

23 Clarke 1968, 2. UoL/AV/1/1 DPAV.

24 Annan chaired the Committee on the Future of Broadcasting in 1977 as well as sitting on the committee advising on the setting up of The Open University in 1966 with Dr Brynmor Jones.

25 Clarke 1971, 7–8, Section 3.3. UoL/AV/1/3 DPAV.

26 Clarke 1974, 1, Section 2. UoL/AV/1/7 DPAV.

27 Clarke 1970, 11, Section 5.6. UoL/AV/1/3 DPAV.

28 Young 1999, 57.

one hour of finished television.²⁹ In one instance, a university in the US reported 200 hours of preparation to make one hour of programming.³⁰

The first of what would be regular reports by the Academic Council and of the Collegiate Council contextualises the setting up of the department and its television capability.³¹ The University was offered shared use of a closed-circuit cable broadcast channel, Channel 7, from ILEA (Inner London Education Authority) for its college network. The line and cable channel were leased from the General Post Office (GPO) who had a monopoly on telecommunications services in the United Kingdom at the time. Fifty terminals were cabled into university lecture theatres located in Central London so they could receive television programmes.

The University of London had a federated and geographically dispersed college infrastructure particularly in relation to the dispersal of its medical departments. The idea that content/knowledge could be ‘transmitted’ around the ‘network’ rather than the students and lecturers had originated in Jones’ report:³²

Geographical separation of units in one medical school entails loss of time in travelling from one unit to another whenever students wish to attend special lectures and demonstrations in other centres. A link of this type might well improve teaching methods and save a considerable amount of travelling.

Television offered an opportunity to improve educational standards by being more scientific by standardising and systemising the pedagogical load. Quality control and modernisation of educational outputs could reduce stereotyped or dull teaching and free some of the lecturers for other work (especially in Medicine where lecturers could also be engaged in their own clinical research). Programme capture and re-transmission meant that students could be repeatedly exposed to the ‘distinguished’ lecturers in the institution in a virtuous educational circle.

Trevor A. Scott, probably one of the most prolific producers of postgraduate videos across all disciplines, in his unpublished memoir, has written a detailed account of his career at the University and played an instrumental role in the inception of the Centre – he was in post a year before the Centre was established before Michael Clarke was appointed Director. Scott already had links with Clarke who had been his former tutor and supervisor at the Royal College of Arts. Clarke was well connected professionally with founding members of the British Documentary Movement such as John Gri-

29 Clarke 1971, 1, Section 2 (i) (a). UoL/AV/1/3 DPAV.

30 Jones 1965, 12, Section 63.

31 Clarke 1968, 4, Section 8. UoL/AV/1/1 DPAV.

32 Jones 1965, 69.

erson, Paul Rotha, Edgar Anstey and Sir Arthur Elton having worked at British Transport Films and the Shell Film Unit.

In 1971 Michael Clarke and Ian Gilliland, Assistant Director of the British Postgraduate Medical Federation, published a ‘manifesto’ relating to the department.³³ There were three aims; to advance the use of audio-visual materials and methods for the furtherance of the co-ordination and research within the University of London; to establish a library of audio-visual materials; to produce films and television records and teaching programmes.³⁴

There was the ambition to extend the university’s reach beyond London to other major centres of training, to communicate the ‘benefits’ of its research too (chiefly it seems through an exchange of material), to provision an active audio-visual unit including a self-sufficient film production facility, a very small TV studio (suitable for lecture or discussion-type programme) and a mobile outside–broadcast TV Unit and, in the future, expand to a large TV studio, an ‘insert’ studio for model work, cine-microscopy and special effects.

An unexpected issue which proved initially troublesome was copyright in these media works – an entirely new sector of media production. This was a new frontier and illustrated the complexities of trying to create a parallel model of television production alongside the broadcast model. Cited in the committee’s minutes is an article, “Writing on CCTV”, by Alan Griffiths (general secretary) and N. J. Crisp (chairman) of The Writers’ Guild of Great Britain,³⁵ outlining their unease about ‘amateurs’ (i.e. The lecturers) entering the field of writing for educational television when there was already a trained (and unionised) body of professional writers available for hire. The lecturers were not (or were highly unlikely to be) members of the Guild because they were not considered to be professional writers and, therefore, were perceived to be unqualified and could financially undercut the Guild’s members for whom writing was a remunerated profession. In terms of labour relations, this potentially created conflict between the unionised versus the non-unionised sectors. Although there was an incipient threat of industrial action, labour relations appear to have remained amicable.

The selection of what subjects and lectures to produce was decided behind closed-doors at a committee attended by Clarke and Dr Iain Gilliland,

33 Clarke/Gilliland 1971, 108–9.

34 Clarke 1968. 2, Section 3. UoL/AV/1/1 DPAV.

35 The Writers’ Guild of Great Britain, established in 1959, is a trade union which represents professional writers in TV, film, theatre, radio, books, comedy, poetry, animation and videogames. It negotiates better rates of pay for its members and the media sectors in which its members operate are constantly evolving. <https://writersguild.org.uk/about/> (accessed 21 June 2019).

the former representing the University of London and the latter the British Postgraduate Medical Federation,³⁶ there was also an advisory body, chaired by Professor Norman Ashton of the Institute of Ophthalmology, which met several times a year to provide oversight for the department's activities. The role of the production team was to facilitate the transformation of these suggestions into television productions, by turning 'lectures' into recognisable television programmes, lecturers into television presenters, and their research material into comprehensible and effective visual aids (as in data, slides and graphs). Martin Hayden, a senior producer, summed up the nature of this task:

On the face of it, these might seem mere cosmetic tasks, but in fact often resolved into touchy and tricky processes, demanding a fine balance of professionalism, assertiveness, diplomacy, flattery and counselling to get anything approaching a "performance" in the end.³⁷

Concerns were raised by the University General Council Sub-committee on Educational Technology in March 1971 after a visit to the department; Michael Clarke asserted that "requests are carefully scrutinised not only for their effectiveness in the learning process but for their federal value".³⁸ A trend was emerging in the perceived bias in the completed video productions with science and medicine very well represented with the 'impoverished arts' significantly less so due to the lack of cross-departmental contributory funding as well as other difficulties relating to the costs of outside broadcasting (in the case of theatre productions).³⁹

The observation that there was an 'over'-representation of medical departments was significant; the Centre had managed to secure various grants from schools of Science and Medicine which could be leveraged towards purchasing new equipment and funding members of staff to provide production support for these disciplines. (In 1969, a grant was received from the Regional Metropolitan Hospital Boards via the BPMF for £6000 towards capital equipment and £8000 for staff, combined and adjusted for inflation, this could be worth over £160,000 in 2019.)⁴⁰ In effect, this created a virtuous circle of research, development and production. In the early years, the programmes which were made were demand-led, and arguably might well have lacked 'federal planning' in terms of being truly 'strategic' which would

36 BPMF ran from 1943–1997. For an account of the nature of support provided by BPMF for medical students engaged in advanced study: <https://www.bmj.com/content/2/5096/619.2> (accessed 21 June 2019).

37 Email from Martin Hayden to Angela Saward, 29 April 2019.

38 Clarke 1970, 4, Section 1.7. UoL/AV/1/3 DPAV.

39 Clarke 1970, 10, Section 5.3. UoL/AV/1/3 DPAV.

40 Figure arrived at using "Moneysorter", https://www.moneysorter.co.uk/calculator_inflation2.html#calculator (accessed 21 June 2019).

have led to a portfolio of programmes reflecting the University's full range of disciplines. Decision-making was doubly under suspicion because the Centre received central funding in competition with other departments and may have appeared less accountable.

Becoming more "publicity conscious" and aware that the output of the department required a higher profile both internally and externally, the Centre organised previews of some of its newer programmes (although not always in postgraduate medicine), distributed information leaflets and sent out press releases to various journals and promoted the television service which aired at regular times, just like terrestrial television, by creating and distributing provisional timetables with broadcast listings.⁴¹ The 'Television Bulletin' was a A4 document, either a photocopy or printout with a table of screenings pinned up on noticeboards outside the lecture theatres where the lectures were screened. A 'discourse' was broadcast each week of the term; it was transmitted at different times on four successive days (for example, 17:30 Mondays, 13:00 Tuesdays, 11:00 Wednesdays, 17:00 Thursdays).⁴² Other organisations assisted in the effort to promote the programmes to external institutions such as the BUFC (the British Universities Film Council as it was then) by distributing information sheets. Other medical institutions were able to borrow videotape copies and this facility was critical for some of the colleges in the Federation which were too far away to be cabled into the network (like Royal Holloway in Surrey and Westfield in Hampstead).⁴³

Professionalising Television Production

Recruiting, training and retaining personnel is a major theme in the departmental archives and this emphasis points to the legacy of the Centre in terms of its wider impact on the sector. When fully operational, the output of ULAVC was managed with a staff of 21 with five of these being producers. The lack of qualified technical staff was a problem throughout the lifespan of the department, although there was a core of established and experienced producers (the latter making up the senior levels of the production unit and many stayed until its demise) – the BBC in particular proved an attractive employer for junior technical members of the team with its structured (and unionised) pay scales and training (junior staff were often poached). Sala-

41 Clarke 1976, 5, Section 3. UoL/AV/1/8 DPAV.

42 GC/170/4/1, Wellcome Collection.

43 Originally the material was distributed on ½" video, a precursor of VHS.

ries in the Centre were graded as academic positions and were lower than in the commercial broadcast sector. Specialist training had to be provided in front and behind the camera. Addressing the issue of what to shoot and enlarge the pool of available presenters at the university, the Centre created a series of academic television workshops in 1973 when for two hours over nine Monday evenings participants devoted themselves to production. On this occasion, 24 university lecturers took part (with a small cohort of female participants). The course composition was technical, creative and critical analysis.⁴⁴

There was an awareness that educational technology training was necessary alongside the ability to deconstruct the ingredients of a successful media production. Trevor A. Scott was part of this initiative; prior to joining the ULAVC he had attended a lecture course in which one component of the teaching was the ‘Anatomy of Television’ (although no further details exist). Later in 1985, Scott wrote a report which underpinned the significance of the Centre’s “missionary role” in “clearly defined teaching and training”, advocating for teaching and training provision in educational technology, which might include workshops, training courses and summer schools.⁴⁵

Democratising Media and Medicine

Broadcast television in the 1960s had struggled with ways to articulate science to the general public and its endeavours had met with criticism.⁴⁶ In light of the University’s academic standing in science and medicine, Michael Clarke was well-placed to lead the Centre: he was an experienced writer/producer/documentarist and had made a number of films with science and technology as their focus for Shell, BP and ICI.⁴⁷ Briefly, he had worked with Paul Rotha, BBC Documentary Department 1953–1955, and also Edgar Anstey, British Transport Films.⁴⁸ The migration of many documentary leviathans into television broadcasting had opened the debate on appropriate presentation styles (whether vernacular or academic) and the nature of scientific television.⁴⁹ With this in mind, there was an ambition for the Centre to create a new style of televisual education, perhaps even a new ‘genre’ of documentary

44 Clarke 1973. UoL/AV/1/5 DPAV.

45 Scott 1985. UoL/AV/6/6.

46 Boon 2008, 225.

47 <http://bufvc.ac.uk/newsonscreen/search/index.php/person/1424> (accessed 6 September 2019).

48 <http://www.screenonline.org.uk/people/id/446796/index.html> (accessed 6 September 2019).

49 Boon 2008, 224.

production.⁵⁰ Tellingly, the subtitle of the Centre's inaugural series, *The Scientific Basis of Medicine*, was "television discourses", which appear to illustrate this desire. The history of the 'discourses' series harked back to a programme of actual lectures before their televisual iteration,

A series of reports by leading British (and sometimes) American 'authorities' on the current state of medical research intended specifically for post-graduate medical audiences, which were initiated by Sir John McMichael in the mid-1960s and continued as televisual lectures until the early 1980s.⁵¹

Arguably, it is only in medicine that ULAVC made genuine in-roads in creating a unique and distinctive production style: four titles have been selected to illustrate this and cover the medical production arc of the Centre showing how production capability evolved and matured to create televisual lectures integrating 'talking' heads, visual aids, demonstrations and drama (the 'playlet') to deliver messages about health and how the body and mind can interrelate.

As can be seen from Table 1, although there are clearly defined series, the extant productions at Wellcome largely cover the first decade of programming which was mostly in black and white. From a subset of the 150 productions which have been digitised and transcribed, four have been chosen as part of the analysis.⁵² (All programmes will be available for study across all the holding institutions in due course.) A close comparison of all the productions is not easy: as well as the patchy retention of titles (no examples of a topical series *Medicine This Week* have been retained, for example), there are many idiosyncrasies as the videos differ widely in duration with the shortest being eight minutes, the longest 58 minutes and a median duration of around 30 minutes. This is anomalous with comparable production types, where programmes are more homogenous in duration to fit around broadcast schedules. Certain medical specialities are present in number such as neurology and obstetrics/gynaecology and anecdotally, this related more to the media proficiency of individual lecturers rather than an overarching strategy. The duration of each lecture was led very much by the individual lecturer, conforming to a typical lecture unit and lending itself to the lectures being introduced and mediated. An approximation of the audience cctv viewing experience can be imagined in an illustration extrapolated from Brynmor Jones' report.

50 Boon 2008, 3.

51 M/IMA 14/5/91, Wellcome Trust.

52 The selection of videos was also made in response to how the social forms and functions of television stage health behaviour. For more examples, see ERC BodyCapital Project, http://bodycapital.unistra.fr/en/?no_cache=1 (accessed 29 September 2019).

Table 1: Wellcome Collection ULAVC Video Holdings

ULAVC Series/ Description / Sample Titles	Date Range	No. Colour	Wellcome titles held
<i>The Scientific Basis of Medicine:</i> Series of reports by leading British and American authorities on the current state of medical research intended for post-graduate medical audiences, initiated by Sir John McMichael in the mid-1960s and continued until the early 1980s. Sample titles: 'Fever'; 'Hypertension'; 'Muscle Fatigue'; 'The EMI Scanner'; 'The Biology of the Heart Muscle'.	c.1971–1977	4/80	84
<i>Uptodate:</i> Programmes on current research in half-a-dozen medical specialities, notably clinical nutrition, cardiovascular disease, obstetrics and gynaecology and respiratory diseases. Sample titles: 'Modern Management of Angina'; 'Atherosclerosis: epidemiology'; 'The Causes of Obesity'; 'Rickets'; 'Intersexual Disorders'.	c.1971–1979	0/65	65
Not noted (pending detailed cataloguing)	1971–1988	13/33	47
<i>Clinical Medicine (including Clinical Neurology, Clinical Procedures and Studies in Clinical Neurology):</i> Sample titles: 'Cardiac Arrest'; 'Alcoholism: what are the causes'; 'Severe Asthma: Assessing Severity and Monitoring Recovery'; 'Breast Feeding: practical problems of technique'.	1971–early 1980s	10/36	46
<i>GPTV: (pre-cursor of British Medical Television):</i> Sample titles: 'The Elderly Patient in General Practice'; 'I Want You To Take These Tablets'; 'The Battered Child Syndrome'; 'An Introduction to Acupuncture'.	c.1972–1982	11/33	44
<i>Current Research in Obstetrics and Gynaecology and Dialogues in Clinical Obstetrics:</i> Sample titles: 'Hormone Replacement Therapy'; 'The Management of Pre-eclampsia'.	c.1979	0/14	14
<i>Evolution of Community Medicine:</i> Sample titles: 'The Rise of the Public Health Movement'; 'Destruction and Reconstruction / From Public Health to Community'.	1984	0/7	7
n/a: test tapes and production material not for broadcast	1970s	0/22	22

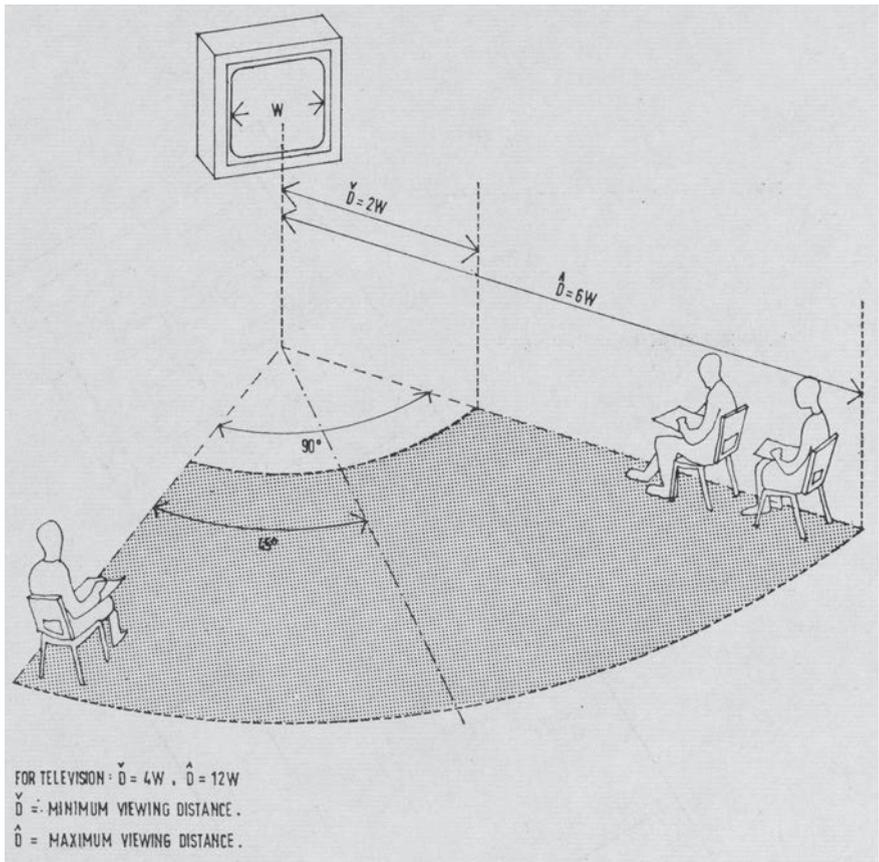


Figure A: Ideal room shape for the reception of cctv. 1965 © Crown.

ULAVC's programmes include many televisual conventions which match our understanding of what broadcast television should be such as distinctive programme credits with music, a presenter or anchor person and closing credits. Beginning with 'talking heads' and a limited number of visual aids, the production of the earliest series reveals the craft of television being learnt. Only later did the Centre's television production output become more sophisticated and engaging.

'Fever', is an exemplar of a television discourse from 1971 of 31 minutes duration; it is one of the earliest to survive.

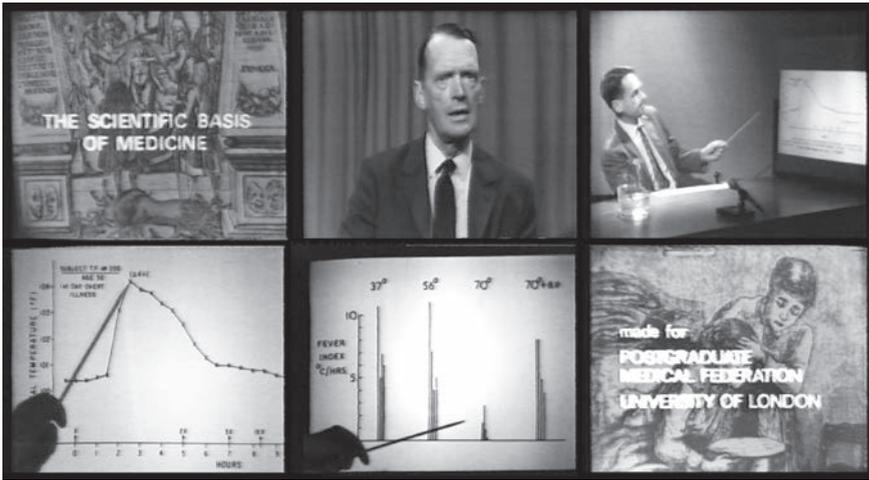


Figure B: From ‘Fever’, presented by W. I. Cranston, Professor of Medicine at St Thomas’s Hospital Medical School, London, a ‘television discourse’ from *The Scientific Basis of Medicine* series. 1971 © University of London.

Programme Summary: W. I. Cranston, Professor of Medicine at St Thomas’s Hospital Medical School, London, talks about fever. A further summary accompanying the cassette reads: The programme briefly reviews early experiments on the mechanism of production of fever. Evidence is shown that bacterial pyrogens or endotoxins are not the cause of fever in disease. The distinction is made between endotoxin and leucocyte or endogenous pyrogen. Professor Cranston discusses the production of human leucocyte pyrogen, the mechanism of production, its release by cells, its sites of action in the central nervous system and the evidence for its presence in human febrile illnesses.

Typical of each production is a short opening sequence with classical music on the soundtrack before the studio-based lecture begins (Fig. B, top left, the rostrum camerawork is from a two-dimensional work followed by an image relevant to the theme of the programme which gives it a distinct identity). There are short final credits at the end (Fig. B, bottom right), a familiar feature of broadcast programming. The ‘anchor’, Dr Ian Gilliland (Fig. B, middle top row), introduces Professor W. I. Cranston: this sequence and others in the series were recorded separately to the lecture itself. Gilliland, plays to this media convention by turning to one side of the frame before his image fades and the lecture begins. The lecture is videoed in real-time, with two cameras and in camera vision mixing edited using a shooting script (examples are held in the production archives of the Centre held at Wellcome Collection). The lecturer is videoed presenting to camera

and interacts with a variety of visual aids (Fig. B, top row right). The camera zooms in and out on the visual aids, in a restricted studio setting. Although the tone of the lecture is relatively formal, Cranston is a confident lecturer and has a clear spoken voice (with a Scottish accent), which lends him a certain degree of charisma and contributes towards ranking him somewhat highly in terms of being ‘telegenic’.

Whilst being videoed, Cranston is restless and uses the swivel and rocking mechanism of his office chair; it is not hard to imagine him delivering this lecture by pacing in front of his students, but speech and movement isn’t compatible with studio production – poise in front of the cameras is something which comes with experience and both behavioural ticks and gestures are magnified on television. Also notable is that the room is very brightly lit and there is an obvious spherical reflection of the light on the visual aids as well as brightness reflected on the presenter’s face and shirt (Fig. B, middle bottom row).

The content and pacing of the lecture itself are characteristic of material which was considered suitable for students engaged in pre-clinical studies; the educational load is quite intense requiring significant concentration on the part of the viewer. There are five graphs, a chart, an index and several diagrams, which illustrates cause and effect. The narrative arc of the lecture has a dramatic ‘punchline’ delivered at the end – that there really isn’t certainty at all about how people become febrile (feverish) and that the general ‘philosophical question’ about why people are febrile remains unanswered. On the one hand we are being given a message about how the body functioned physiologically with the predictability of a machine, and on the other sometimes it is unpredictable. The final provocation could have led to lively discussion.

This early televisual experiment contrasts with a more varied and sophisticated lecture from 1974, ‘Muscle Fatigue’.



Figure C: A lecture by Dr Richard Edwards, Wellcome Senior Research Fellow, Royal Post-graduate Medical School on ‘Muscle Fatigue’, a ‘television discourse’ from *The Scientific Basis of Medicine* series, 1974. © University of London.

Programme Summary: Dr Richard Edwards lectures on muscular fatigue in humans. This is a sustained lecture of 46 minutes duration covering the general physiology of muscle activity (in the context of neuromuscular disorders) made for the BPMF. In one scene, a human subject is used to demonstrate a small piece of technology which measures muscle force when pressing against it. This is one of a battery of tests to develop a clinical evaluation of muscle weakness. What frustrates this empirical approach (and most of the video is dedicated to this) is a lack of “voluntary effort” due to “failure of drive for psychological reasons”, which contrasts with the given fact that “athletes have better endurance, perhaps because of improved motivation” – so a disjunct between what is *felt* and what is *recorded*. This leads to the body being characterised as a ‘machine’ with measurable inputs/outputs (“myofibril measurements”) and being disembodied and physiological rather than emotional. Edwards ends his lecture to camera with “I myself have had nine biopsies”, an allusion perhaps to the long-tradition of physiologists using their own bodies as an experimental canvas. (But this also speaks to the accusation that the lecturers had to ‘perform’ and become ‘entertainers’ for the camera.)



Figure D: ‘The Causes of Obesity’ is an example from the series *Uptodate* and is presented by Dr W. P. T. James, MRC Dunn Nutrition Unit, University of Cambridge, 1977 © University of London.

Programme Summary: Dr W. P. T. James talks about the causes of obesity. He states from the outset that he is not going to look at unusual medical abnormalities associated with obesity, but at the simple, familiar types of obesity that affect ordinary people every day. He defines how obesity should be measured using weight for height criteria. As statistics show that obesity frequently starts in childhood, James looks at social factors affecting its onset as well as demographic features and studies into metabolism.

James lectures on the discourse in the medical profession about obesity. In this video, he looks at the definition of obesity by studying height versus weight, considering weight gain from childhood to adulthood. Interestingly, this video looks at the social factors which might affect the onset of obesity using an example of a public information leaflet in the format of a printed cartoon. The com-

mentary over the cartoon strip allows James to deliver a multi-dimensional ‘reading’ of the text demonstrating its explicit meaning and implicit subtext. The prevailing view, as articulated in the programme, is not dissimilar to other public health information films of the time such as the film made for parents in 1968, ‘Cruel Kindness’, with its message that “it is a cruel kindness to feed your child too much”. Reflecting the view taken by the medical profession, that it is the parents at the heart of obesity in children, James comments judgementally about people’s body types and personality traits; “fatties and thinnies” and personification as “gluttony and sloth”. He mentions “nutritionally inappropriate meals”. These charged words create a psychological distance between the material and the viewer: James’ use of idiomatic language is a shift away from the norms of medical programming when the correct medical terms are deployed, and the tone is formal. Although this clearly creates rapport between the lecturer and the viewer, it speaks to the criticism that television lacked intellectual rigour: his choice of vernacular words illustrates the shift away from medical to social reasons for behaviour which are less controllable, and perhaps less scientific. The tone of this programme is that behaviour which is unfavourable to health happens in the general population and the viewer is in a superior position of knowledge. Novel aspects of the video are that the body is healthy but flawed; belief over reality prevails (for example, people are unable to judge their frame size – choosing to believe they are large frame rather than obese) and the suggestion is that there is a breaking down of societal norms coupled with the intractability of human nature to do what is beneficial for health; “she is in fact eating at a table and that, of course, is becoming increasingly unusual”. Not eating as a family is still cited as a reason for childhood obesity;

It has long been held that the traditional practice of families eating around a table together can be enormously beneficial to children. Eating together as a family can help to teach them important social skills, while those who eat with their parents are also less likely to be truant from school and are less likely to be obese.⁵³

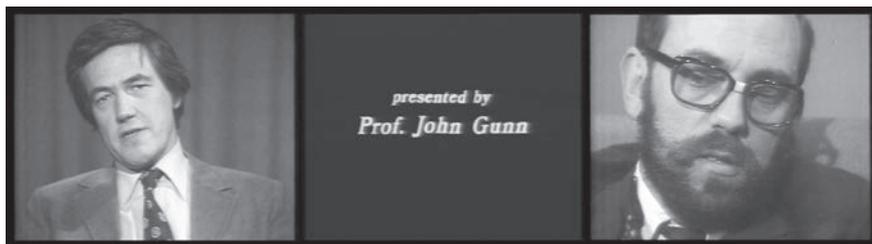


Figure E: ‘An Introduction to Forensic Psychiatry’ from the *Key Topics in Modern Psychiatry* series is presented by John Gunn, Professor of Forensic Psychiatry, Institute of Psychiatry, London, with Richard Ireson. The Medical Editor was Dr Julian Bird. 1980 © University of London.

53 Smith 2017.

Programme Summary: By means of a re-enacted interview with a patient, Professor John Gunn reviews the interrelationship between the clinical and legal roles of the psychiatrist in diagnosing mental states of alleged criminals and in their trial and disposal. By means of a re-enacted interview with a patient, Professor John Gunn reviews the interrelationship between the clinical and legal roles of the psychiatrist in diagnosing mental states of alleged criminals and in their trial and disposal. He explores the differing concepts of ‘responsibility’, and looks at the three phases where the psychiatrist’s contribution is critical: a) in the evaluation of fitness to plead, b) in the establishment of intent to commit a crime, and c) in the sentencing, choice of treatment and long-term care.

This colour video is from a sub-genre described as ‘trigger’ tapes in which a scenario is recreated for consideration and discussion. This scenario or ‘playlet’ features a case history of a patient who murdered his wife; the man (played by an actor) gradually discloses what happened and how he realised that his wife was dead. This approach was very effective; the producer, Peter Bowen, recalled an occasion when some viewers had not realised that actors had taken the parts of the patients; he received complaints about the perceived breach in patient confidentiality.⁵⁴ The inclusion of actors in this programme is foregrounded to avoid confusion. The performance is understated with appropriate pauses and hesitation, there is considerable dramatic and artistic licence used to achieve a convincing portrayal of this man – his demeanour, general appearance and clothing all combine to contribute to this.

The style of this programme is many evolutionary steps away from ‘Fever’ and ‘Muscle Fatigue’. Gunn interacts with the actor and studies the case notes as part of this discussion – lecturing as well as acting as the clinician in a version of himself. The model of the body-mind is demonstrated as complex and unpredictable; ‘responsibility’ being unreliable when the mind becomes dysfunctional especially under physical stresses caused by epilepsy, for example. The video invites the audience to be participatory; Gunn asks the audience to think about ‘our’ friends and encourages empathy. He is also aware of the boundaries of the medium of video (the use of actors, ‘jump’ cuts in the narrative) and summarises the effects of watching “this tape”. This speaks to a considerable shift in the expectations of the University viewing audience’s media literacy.

54 Email from Peter Bowen to Angela Saward, 19 May 2019.

Conflict

This section explains how the Centre's growing professional expertise and commercial activities, in the context of the internal and external pressures of the time, created a conflict of interests and, arguably, caused the Centre to over-reach its position as a University department and led to its demise. Despite the evident ambition which underpinned educational television, the acceptance of television at the University polarised views about its value. Clarke reported the following:

... cases are still known however of heads of department, in scientific subjects, forbidding their junior colleagues to use simple television techniques in practical classes.⁵⁵

This is because the perception of educational television as produced by the Centre suffered in relation to 'public' television; "the analogy with public television dies hard, where we reluctantly or avidly take what we are given".⁵⁶ Here Clarke appears to be referring to the perceived passivity of the audience and television's inherent lack of interactivity. Furthermore,

[t]his type of academic hauteur is perhaps a hangover from attitudes to public television, where a BBC Horizon programme, for instance, will properly simplify and generalise an aspect of science: many scientists and scholars in the University still seem to believe that television can only simplify and dilute; thus they ignore its real possibilities and so not read, or digest, the information circulated by the Audio-Visual Centre.⁵⁷

There was, and still is, criticism that television over simplifies and 'dumbs down' science.⁵⁸

Martin Hayden provided an insight into this disjunct between the core purpose of the department to support pedagogy and "academic hauteur" or reluctance to engage with the medium:

... the often eminent researchers and clinicians just didn't know what to make of us Scruffy Young Men, who practiced a kind of professionalism completely alien to their own. And behind it all, two particular fears. One, that we were somehow part of that PUBLIC and outside world of media business and tabloid communication. (We were not of course; we were entirely committed to their professional colleagues and closed audiences.) Two, that "televising" their "lectures" would eventually do them out of the need to give their lectures at all, and hence do them out of a job.⁵⁹

55 Clarke 1975, Appendix. 5, Section 3. UoL/AV/1/7 DPAV.

56 Clarke 1976, Appendix. Section 3, 6, Item (b) (i). UoL/AV/1/7 DPAV.

57 Clarke 1976, Appendix. Section 3, 7, Item (b) (ix). UoL/AV/1/7 DPAV.

58 The Pilkington Committee on Broadcasting (1960) was established to consider the future of broadcasting in the UK. Looking critically at the depth and breadth of science programming, it addressed the accusation that television 'trivialised' science. Boon 2008, 225–6; Burns 1977, 40.

59 Email from Martin Hayden to Angela Saward, 29 April 2019. Current university practice is that student lectures are made available in a university's virtual learning environment, per-

Noted by production staff was the pleasant, informal work culture, its “egalitarianism”, which disrupted the notion of “wearing one’s rank” and made the staff stand out against the default academic norms (and their mode of dress, favouring jeans and jumpers rather than suits and ties). It exposed them to the prejudices of their academic colleagues because these “scruffy young men,”⁶⁰ were perceived to hold significant creative and editorial power.⁶¹

The professionalisation of the production process and the way it became a ‘factory’ standardising the way programmes were made contributed to a higher standard of production. Moreover, to avoid ‘grafting on’ a lecturer as an ‘entertainer’, new modes of programming had to be developed such as the ‘trigger’ series which co-opted and integrated televisual conventions into the audience viewing experience so as not to simply append a humorous or ‘philosophical’ coda (which had been the case in earlier examples such as ‘Fever’ discussed above).

Despite the requisite investment in time, Peter Bowen,⁶² who was hired in 1970 and worked at the Centre until 1974, recounts that most lecturers-cum-presenters were reluctant to commit to spending too long in preparing the lectures: lecturers would meet prior to recording and share their teaching materials, this could be prepared for recording in advance (using the services of the inhouse designers). The next meeting was likely to be at the recording itself. The ‘heavy lifting’ in the production process was all borne by the production team at the Centre. Peter Bowen clarified this process,

I suppose you could say that we at the Centre were a bit like a factory, responding to a commission from the sponsor and working within those limits. We weren’t the originators of what we produced, and we didn’t have much contact with the consumers of the product.⁶³

The ‘factory’ approach also led to a degree of specialisation; Peter Bowen worked primarily on the medical roster of programmes having been recruited to head up the BPFM’s video programme (39 titles credited to Bowen are held at Wellcome). He recalled a phrase which Clarke used in defence of the criticism that the department was not using the televisual medium to its fullest extent: “Who writes a sonnet to the milkman?”⁶⁴ By this he means that the production aesthetic they had developed was entirely appropriate for their defined audience.

haps in response to the increase in student fees and the need to demonstrate value for money.

60 This phrase was mentioned by Pat Gulliford (former Administrative Assistant to Clarke); telephone interview with Angela Saward, 25 January 2019.

61 Burns 1977, 286. Burns interviewed production staff in 1963 and 1973 in an analysis of the BBC as a working community and an occupational milieu.

62 Email conversation Peter Bowen to Angela Saward, 06–14 May 2019.

63 Ibid.

64 Ibid.

Successes

Looking back at the financial year 1974–5, The Committee of Management reported that there were 1435 known uses of the ULAVC’s material in the London area, 541 uses in higher education elsewhere and 108 miscellaneous uses abroad or by commercial firms. Notably, Clarke mentions that not only the rate of original production was as high as in postgraduate education elsewhere in the UK, but that distribution was higher than any other university.⁶⁵

Sales figures rose too in the mid-1970s; in 1974–75, sales forecasts were £3000 versus actual sales of £4000, although there is not enough granularity to discern the most popular titles over time.⁶⁶ The Centre rapidly realised that it could increase its reach and augment its federal grant with a new revenue stream comprising of the commercial distribution of videos at cost (the mark-up of which in time increased with pressures on funding).

Overall sales figures (either loans, sales or copying) were provided in the annual reports as a key indicator of the Centre’s success.⁶⁷ There is only a broad indication of what titles were the most successful such as titles which had a clear educational brief. The *Uptodate* series on cancer research and immunology were considered good examples of the Centre’s work as they dealt in depth with a topic.⁶⁸ When the GPO withdrew the cable service which hosted Channel 7 on 31st March 1977, the impact of losing the television service was mitigated by the emergence of an alternative distribution ‘network’; the postal service itself due to the commercial sales operation which had developed for domestic sales. (There was also great potential for overseas sales to develop in the English-speaking World, although audio-visual material was routinely held up at Customs and the administration proved too burdensome).⁶⁹

During the financial year 1979–80, the department needed additional revenue to upgrade equipment (due to the shift from black and white to colour picture production) and entered into a programme distribution agreement with The Open University via its commercial arm, Open University Educational Enterprises, which became the Centre’s exclusive overseas distribu-

65 Clarke 1976, 3, Section 2. C. UoL/AV/1/7 DPAV.

66 Clarke 1975. Appendix, 2. UoL/AV/1/7 DPAV.

67 Commercialisation is a key feature of university marketing; many MOOCs (Massive Open Online Courses) free at the outset are promotional tools to engage potential students, earn fees and/or improve international student recruitment.

68 Clarke 1975, 2, Section 2. UoL/AV/1/7 DPAV.

69 Clarke 1976, 8. UoL/AV/1/8 DPAV.

tor.⁷⁰ The Open University typically had very small production teams and limited expertise in science programme-making (only one producer specialising in science) so this was expedient for both parties and an endorsement of excellence for the Centre's programmes and could have led to further commissions. However, fulfilling the demands of the University of London's departments was already very challenging and without more investment, this opportunity was wasted. Within the restrictive financial climate, the core production activity of the Centre just about survived. Scott, now the longest-serving and most senior producer continued his high output of productions and staff at the Centre engaged in important advocacy in the sector by representing their work at conferences.⁷¹ The expertise of the Centre was critical in providing support for the University's diverse extra-mural, part-time and continuing education portfolio of courses (unique in the sector at the time) and this shift in strategy they defined as "collaboration".⁷² This was to emphasise that production alone was no longer core to the department, instead being superseded by another and increasingly important strand of activity, "communication and instruction" or training.

Practical media training was necessary alongside the ability to deconstruct the ingredients of a successful media production. In 1985, Scott ran an introduction to educational technology as part of the department's emerging role of being a training department. In addition, reflecting the growth of interest in Television Studies as a discipline and an acceptance of television as a credible medium of study, Scott developed a Master's module on Television Drama available via the University at Royal Holloway, part of the Federation of London Universities. As part of his own research for a MPhil/PhD at the Institute of Education's Department of English and Media Studies, Scott began an investigation into the influence of production values, method and the style and effectiveness of educational TV, video and media using the work he had created for ULAVC. (Unfortunately, this research was never completed due to the pressures of work).

Michael Clarke as director of the Centre over a period of successive technological change commented in his final report (there was no annual report produced for 1983–84) that "it became unfashionable not to be a technological optimist".⁷³ His comment about technological "optimism" is charged

70 The Open University was established in 1969. <http://www.open.ac.uk/about/main/> (accessed 21 June 2019). It is the "leading university for flexible, innovative teaching and world-leading research in the United Kingdom" and is best known for supporting part-time adult distance learners by delivering teaching remotely, partly via TV programmes.

71 Clarke 1982, Document A, Agenda Item 4, p.3 Section 2. UoL/AV/1/9 DPAV.

72 Clarke 1982, 2–3 para. 23. UoL/AV/1/9 DPAV.

73 Clarke 1982, 1, Section 2. UoL/AV/1/10 DPAV.

with irony; his tenure had been characterised from the beginning by surmounting every technological shift regardless of the funding headache it presented – his investment was both professional and personal.

Upon his retirement, colleagues and industry peers collaborated on a slim publication dedicated to Clarke entitled *Continual Change* in celebration of his career. Hayden reflected on the ethos of the department and the passion behind their endeavour:⁷⁴

... we were engaged in something rather radical and challenging compared to broadcasting. We were accessible to media amateurs because we didn't have to make popular products. Productions for specialised audiences of learners did not have to contain the lowest-common-denominator features supposedly required to make subjects digestible for mass-audiences. It was not that popular invariably implied bad; more that specialised implied freedom from constraints of consensus. So we had a chance to work on selected, detailed erudite topics: to make no apology for them since audiences would be motivated (no matter whether by intellectual thirst, professional ambition or fear of examination). At the same time, we wanted to be professional – to offer the advantages of a craftsman-like approach but without the concurrent tendency to trivialise and condescend too often associated with that word 'professional'.⁷⁵

Although initially the televisual lecture format appeared limited in scope, one of the Centre's great successes was the wide appeal and distribution of these programmes in the sector – largely out of commercial necessity but providing evidence of the transferability of the subject matter and content. Martin Hayden, who produced many programmes for the ULAVC and continued his career in media production at Brighton Polytechnic as Head of Media Services (developing the 'trigger tape' videos for different professional audiences)⁷⁶ observed that regardless of the seeming out-datedness of the programmes, the organisation captured medical history in the making: how cholesterol became implicated in health and the role obesity and diabetes play in morbidity, for instance.⁷⁷

In the 1980s, several innovative productions threw a spotlight on the Centre; notable examples are an interactive videodisc and a computer-generated three-dimensional anaglyph film, 'The Structure and Function of Haemoglobin', described as "a major piece of applied research into the possibility of computer production of stereoscopic motion-pictures". Upon Michael Clarke's retirement in 1984, his deputy, David R. Clark, was appointed Director of the Centre. He repositioned the department at the cutting edge of

74 Bagshaw 1984.

75 Hayden 1984, 24.

76 'Awkward Readers', 'Awkward Libraries' and 'Awkward Colleagues', are examples of productions made for Brighton Polytechnic. Email from Martin Hayden to Angela Saward 19 May 2019.

77 A series of seven videos on atherosclerosis (a fatty build up in the arteries) was made for the *Uptodate* series, in 1975.

applied information technology (interactive laser disk technology, for instance) so the focus of activity shifted again. This was the point at which the department, arguably, achieved its greatest success but also faced the conflict of needing to create a commercial offer to support its activities, well beyond the well-established network within the University of London and its colleges, which required scaled up marketing and distribution systems to be successful. Exposure to these market forces led directly to its demise.

Challenges

Audience numbers were never collated or analysed as the Centre's clients were the departments and lecturers, so there was no formal communication with actual students. Although, in 1976, the Committee of Management reported on the findings of a newly appointed departmental Liaison Officer whose role it had been to gather feedback forms from the colleges in the federation regarding the take-up of the closed-circuit television service. There were lots of non-respondents to the questionnaire and, when followed up, a lack of enthusiasm for the cctv model emerged. Respondents indicated that the television service had been set up in the wrong places, in busy lecture theatres, for instance.⁷⁸ The upside to a centralised procurement process (how the service was rolled out to the federation) was that there was strength in numbers; the downside was individual needs of the Schools and Colleges were not addressed.

Colour television was a reality for public broadcast television from the late 1960s (BBC2 started broadcasting in colour in 1967), but in the university sector, colour video only became feasible from the mid-1970s. Shooting and broadcasting on colour video tape required all the equipment from camera to television sets to be replaced, which was a considerable expense, so there was a delay between its availability and adoption. By 1976 some post-graduate medical centres that had been using the department's production tape library refused to borrow monochrome videos (those in black and white) and so much of the earlier video material became redundant. Also colour television production proved technically challenging as the Centre used 1" IVC recording to 1" B tape, a system which was not adopted by UK broadcasters and therefore did not have industry support:

Techniques which are commonplace in monochrome production, such as videotape editing, do not always work as satisfactorily in colour, despite the claims of manufacturers; while the

78 Clarke 1975, Document C., 3, Section 4. UoL/AV/1/7 DPAV.

drop in resolution when a one-inch master recording is transferred to video-cassettes has proved more perceptible in colour programmes than in monochrome.⁷⁹

The BBC also experienced difficulties with colour television production as it required more complex equipment and more staff to operate it.⁸⁰ The Centre had been propelled into more commercial activity due to the adverse political climate under the Conservative Government led by Margaret Thatcher causing financial pressures. As a result, it became more involved in producing 'corporate' videos to promote the institution externally such as 'Not Just Another University' which broadcast on Channel 4 in 1987 to 1.8 million viewers.⁸¹ In 1976, the University of London sought to reduce the Centre's grant by 4%, representing a cut of £4800. Also, inflation and other costs which amounted to "incremental creep" were £3500 and together with a predicted deficit and a cut in the BPMF grant (due to colour production being available in an external audio-visual centre which was running under capacity),⁸² this meant that there was a large hole in the budget which was not readily resolved by cost savings, such as leaving producer posts vacant. Addressing the impact of reduced funding, the institutional consequences of this on what activities the Centre could continue to do, J. E. Webb, Chairman of the Committee of Management for the Centre argued that some of these costs were counter-productive in fulfilling the University's aim of providing a "*Spielraum*" of inter-disciplinary scholarship:⁸³

Two tendencies can be discerned in many students today: a preference for inter-disciplinary studies, which is met by the course-unit system: and a preference for applied studies, [...] but in many cases the single-subject departmental structure raises difficulties in providing some of the subject combinations for which there would be student demand.

The work of the Audio-Visual Centre, for reasons inherent in the techniques with which it deals, may well be able to help with these problems. Television, film and sound recordings can assist with the problems of numbers, distance and timing and can often be used again and again.

Later, even bigger cuts were sought. Significant technological change, problems with personnel retention and then tackling the workload were all factors in this growing tide of problems. When the Centre sought some control over its destiny by offering solutions, the University sought the advice of a city-based management consultancy who decided to dismantle the operation. The consultancy listed a catalogue of criticism; lack of clear management and direction; the absence of team approach to business development; lack of busi-

79 Clarke 1976, 10, Section 5. UoL/AV/1/8 DPAV.

80 Burns 1977, 267.

81 It was made for a budget of £28,000.

82 Clarke 1976. UoL/AV/1/8 DPAV.

83 Webb 1976, 1. UoL/AV/1/8.

ness skills and consequent failure to capitalise on opportunities for developing profitable areas of work; lack of focus in relation to market opportunities; a scattered approach to business development and underutilisation of space and facilities. This was an incredibly harsh indictment of the work carried out by the Centre of the prior decades and unfortunately mirrors the fate of similar media production units in the United Kingdom.

Legacy

‘Continual change’ was indeed a constant: together with the educational, financial and technological turmoil already outlined, the need to maintain and relocate premises on numerous occasions loomed large in the official record. The designated premises were also not always fit for purpose which impacted on the Centre’s videos: many of the tapes (One Inch IVC) became affected by mould which meant the tapes were no longer playable. Their original use had been ephemeral and the storage of the tapes in suitable environmental conditions was a luxury considering the premium placed on office and storage space in Central London. This was when the collection was at its most vulnerable and its retention was only due to the doggedness of the staff and their conviction regarding its historical value.

By the early 1990s, many of the departments who had been the Centre’s clients had obtained media production equipment to create their own video programming as technology became smaller, cheaper and easier to operate, leading to centralised video production facilities going out of favour – a phenomenon which quickly spread across the educational sector. However, with the benefit of hindsight, it can be argued that the Centre had a role in transforming educational programme production in several significant ways; by training presenters (especially scientists and medical clinicians) and by providing experience to production staff thereby distributing or ‘democratising’ expertise in front of and behind the camera across the sector. Moreover, the Centre succeeded in creating a distinct aesthetic via the televisual lecture and new sub-genres within postgraduate education.

Conclusion

A practical concern for the archivist of audio-visual material is to preserve material for what might be unknown or unforeseen audiences in the future. This challenge is becoming urgent when considering the near obsolescence

of analogue video formats: the prospects for analogue video material was summarised in 2013 as “So that’s it: going, going, gone for analogue by 2023 unless something changes. Digitise now!!”⁸⁴ Michael Clarke wrote to Wellcome in retirement with these final words:

The atmosphere during the last days of ULAVC, I gather, was not very happy, and it was fortunate that we had our meeting in May and drawn up outline plans for ‘rescuing’ the material. I suspect that if I had not written to the Principal of the University to report our discussions, the tapes and films really might have gone into a skip. As it was, preservation and continued access suddenly became the received piety, as it should have been all along [...].⁸⁵

From Clarke’s perspective, the legacy of the Centre was embodied by the video material itself. Were these videos really “not very inspiring”? Both obsolescence in terms of the video formats and the shift from monochrome images to colour made many programmes redundant because no colleges wanted to show them to their students anymore. There was no great impetus to remake any videos although at least one series was re-made when the tapes became worn out. (All 20 videos produced for The London Fortran Course, made with UCL and the London University Press, were so successful that the master tapes wore out by being repeatedly played back and they had to be re-shot).⁸⁶ There is also an inherent redundancy in much medical educational content as current practice shifts and evolves over time. The videos reflect the discourse on obesity, exercise and the dichotomy of mind-behaviour of the time and this is what makes the archive so fascinating for the scholar of medical humanities and the history of medicine because the material can speak to new audiences of researchers rather than the original intended audience. The challenge for the Collections Specialist is to take the long-term view and anticipate these future audiences and uses.

The immediate legacy of the Centre was the continuation in the educational sector of many of the producers: this meant that the educational sector was seeded by like-minded media professionals who had started at the University of London and been mentored by Michael Clarke, which by osmosis connected them to the British Documentary Movement.⁸⁷ Behind the camera, this led to the professionalisation of the craft of audio-visual media production. In front of the camera, clinicians and medical practitioners appeared in many of the Centre’s videos and, unlike today when researchers are encouraged to seek media exposure and participate in public engagement as

84 <https://www.prestocentre.org/blog/going-going-gone-prospects-analogue-audiovisual-content> (accessed 21 June 2019).

85 GC/170 acc. 401, Wellcome Collection.

86 Email from Martyn Hayden to Angela Saward 29 April 2019.

87 Boon 2008, 224.

part of their research impact statements, these videos are the only time their research can be heard in their own words. One example is, ‘The EMI Scanner’, 1975, from *The Scientific Basis of Medicine* featuring James E. Ambrose who co-developed the first Computed Tomography (CT) scanner. At the beginning of this research, the selection of lecturers appeared amorphous: the choice of lecture participants was probably highly curated (unfortunately some of the detail behind the selection is still obscure pending further archival research). The documentary evidence bears out Clarke’s claim that the Centre was “the first large-scale, systematic use of videotape in British postgraduate medical education” and “the largest and most varied body of medical film and video”. However, it is also likely due to the vicissitudes of time and the problems of preserving analogue video, that there may be little opportunity to compare similar bodies of audio-visual work as they either no longer exist or are on the brink of being lost. The “received piety” when it comes to the preservation of analogue video materials is now digitisation: alongside efforts to retain the medical-related videos at Wellcome Collection, the BFI is now playing a part in the preservation of this vulnerable video material with its major digitisation project, BFI2022.⁸⁸

ULAVC Programmes (accessed 21 June 2019):

- ‘Fever’, University of London Audio-Visual Centre on behalf of the British Postgraduate Medical Federation. Produced by Peter Bowen, 1971, B/W, <https://wellcomelibrary.org/item/b17481247#?c=0&m=0&s=0&cv=0>
- ‘Muscle Fatigue’, University of London Audio-Visual Centre on behalf of the British Postgraduate Medical Federation. Produced by Martin Hayden, 1974, B/W, <https://wellcomelibrary.org/item/b17306048#?c=0&m=0&s=0&cv=0>
- ‘The Causes of Obesity’, University of London Audio-Visual Centre. Produced by Trevor A. Scott, 1977, B/W, <https://wellcomelibrary.org/item/b17259204#?c=0&m=0&s=0&cv=0>
- ‘An Introduction to Forensic Psychiatry’, University of London Audio-Visual Centre on behalf of the British Postgraduate Medical Federation. Produced by Martin Hayden, 1980, Colour <https://wellcomecollection.org/works/tnta2bv>
- ‘I Want You To Take These Tablets’, University of London Audio-Visual Centre. 1974, B/W, <http://catalogue.wellcomelibrary.org/record=b1678689>
- ‘The Microbioassay of Hormones’, University of London Audio-Visual Centre on behalf of the British Postgraduate Medical Federation. Produced by David R. Clark. 1974, B/W, <https://wellcomelibrary.org/item/b1680353x#?c=0&m=0&s=0&cv=0>
- ‘The Properties of Mucus’, no date, <https://wellcomelibrary.org/item/b17443544#?c=0&m=0&s=0&cv=0>

88 <https://www.bfi.org.uk/2022/>(accessed 21 June 2019).

- ‘The Structure and Function of Haemoglobin’, University of London Audio Visual Centre in Association with Stichting Film en Wetenschap, Utrecht. Produced by David R. Clark, 1980, Colour,
<https://wellcomelibrary.org/item/b30011851#?c=0&m=0&s=0&cv=0>
- Uptodate*: seven programmes on atherosclerosis, University of London Audio-Visual Centre on behalf of the British Postgraduate Medical Federation. 1975, B/W
- ‘Atherosclerosis: an introduction to atherosclerosis’,
<https://wellcomelibrary.org/item/b16891715#?c=0&m=0&s=0&cv=0>
 - ‘Atherosclerosis: Lipoproteins; structure and function’,
<https://wellcomelibrary.org/item/b16769144#?c=0&m=0&s=0&cv=0>
 - ‘Atherosclerosis: families at risk’,
<https://wellcomelibrary.org/item/b16799100#?c=0&m=0&s=0&cv=0>
 - ‘Atherosclerosis: atherosclerosis and diabetes mellitus’,
<https://wellcomelibrary.org/item/b16799185#?c=0&m=0&s=0&cv=0>
 - ‘Atherosclerosis: epidemiology’,
<https://wellcomelibrary.org/item/b17271745#?c=0&m=0&s=0&cv=0>
 - ‘Atherosclerosis: treatment of hyperlipidaemia’,
<https://wellcomelibrary.org/item/b16769120#?c=0&m=0&s=0&cv=0>
 - ‘Atherosclerosis: hypolipoproteinaemia’,
<https://wellcomelibrary.org/item/b16769132#?c=0&m=0&s=0&cv=0>
- ‘The EMI Scanner’, University of London Audio-Visual Centre on behalf of the British Postgraduate Medical Federation. Produced by David R. Clark. 1975, B/W,
<https://wellcomelibrary.org/item/b16802238#?c=0&m=0&s=0&cv=0>

Full list of ULAVC titles held at Wellcome Collection:

https://search.wellcomelibrary.org/iii/encore/search/C__S%22university%20of%20london%20audiovisual%20centre%22__Ff%3Afacetmediatype%3Ag%3Ag%3AVideorecordings%3A%3A__Orightresult__U__X0?lang=eng&suite=cobalt

Related Productions:

- ‘Cruel Kindness’, British Life Assurance Trust for Health Education with the British Medical Association. Written and directed by Winifred Holmes, 1968, Colour, <https://wellcomelibrary.org/item/b16676166#?c=0&m=0&s=0&cv=0>
- ‘Not Just Another University’, University of London Audio-Visual Centre for Channel 4. Directed by Michael Orrom and produced by Trevor A. Scott, 1987, Colour, <https://www.youtube.com/watch?v=JTcnd4o4rC8>

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Doing the Work of Medicine? Medical Television Programmes and Patient Behaviour

Tim Boon, Jean-Baptiste Gouyon

Abstract

This article explores the contribution of television programmes to shaping the doctor-patient relationship in Britain in the Sixties and beyond. Our core proposition is that TV programmes on medicine ascribe a specific position as patients to viewers. This is what we call the ‘Inscribed Patient’. In this article we discuss a number of BBC programmes centred on medicine, from the 1958 ‘On Call to a Nation’; to the 1985 ‘A Prize Discovery’, to examine how television accompanied the development of desired patient behaviour during the transition to what was dubbed “Modern Medicine” in early 1970s Britain. To support our argument about the “Inscribed Patient”, we draw a comparison with natural history programmes from the early 1960s, which similarly prescribed specific agencies to viewers as potential participants in wildlife filmmaking. We conclude that a ‘patient position’ is inscribed in biomedical television programmes, which advance propositions to laypeople about how to submit themselves to medical expertise.

Inscribed patient; doctor-patient relationship; biomedical television programmes; wildlife television; documentary television; BBC Horizon

Introduction

Television programmes on medical themes, it is true, are only varieties of television programming more broadly, sharing with those others their programme styles and ‘grammar’. But they also have a distinctive relationship to the practice of medicine whenever they represent doctor and patient behaviour. This

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essay accordingly explores whether medical television departs from the rest of television specifically because of the subject position that medical programmes encode for viewers as health subjects and as potential patients. We consider whether the address to the viewer in their health identity – that is as the potential bearers of ill health – makes these films and programmes different from others that invoke the viewer in less intimate ways less coloured by the power relations of authority and supplication to authority.¹ To put it another way: given that in Britain, the decades of the establishment of televisual grammar were also those in which the nation adjusted to universal healthcare, did films and television programmes serve to provide models for people of how to behave as patients? And, did that change across the era of social revolution of the Sixties, and beyond? If so, these media would indeed have been doing the work of medicine. As Alex Mold has argued, it was in the following decade, the 1960s, that ideas of consumerism began to be applied to patients, with the formation of bodies such as the Patients Association in 1962 and the Community Health Councils from 1974, extending into the medical context the kinds of attitudes found earlier in other aspects of life with, for example, the Consumers Association from 1956.² It follows that it should be possible to see in broadcast programmes a developing range of patient roles across the examples we have selected for this essay.

Our contention is an extension of a previous suggestion that studying media can provide an alternative path to the cultures of bio-medicine, in the sense that study of the television programmes we consider here can provoke consideration of the history of clinical encounters beyond those internal to medical practice itself.³ Clearly, within the constraints of a short essay, it is not possible to follow all the implications of our contention into the larger literature on the history of the doctor-patient encounter.

The ‘Inscribed Patient’

Our core proposition that medical moving image media suggest a particular subject position to viewers derives from some quite old media theory.⁴ Forty years ago, film theorist Bill Nichols wrote about the ‘mode of address’ of

1 Dominance/submission or status differentials are obviously complex social phenomena that we cannot begin to address here, but for a different, dramaturgical, angle, see Johnstone 1981, 36: “I should really talk about dominance and submission [rather than status], but I’d create resistance”.

2 Mold 2015, 1.

3 Boon 2011.

4 Boon 2018.

films.⁵ For our purposes, this may be taken to describe the tone of voice in which a film speaks to its audience, which might be called the ‘cinematic voice of medicine’. More broadly, he argued that different genres of film, by using different modes of address, *assert* particular relationships to exist between the individuals seen and heard in films and the audiences watching them. Mode of address may be ‘direct’ as is found in most instructional and documentary films, where an individual – often an unseen narrator – speaks directly to people viewing. According to Nichols, in films using a fictional form, the mode of address is ‘indirect’, where the audience member ‘overhears’ the exposition between participants on screen and follows the action through identification with the film’s characters. This maps pretty well onto the old distinction between telling versus showing. Each of these modes implies a position for the viewer in relation to the film and its authors; active in the case of the direct address of the documentary, and passive in the case of the indirect address of the fiction film. This had been a commonplace of documentary theory and practice for forty years when Nichols published.⁶ Madeline Akrich, working within science and technology studies, has more recently suggested that the designers of technical artefacts inscribe a ‘script’ within an object, by which she means that the design of an object anticipates that its consumers will use it in particular ways, whether or not they do.⁷ By metaphorical extension we can say the same of films and television programmes; that the viewer is ‘inscribed’ in the programme. Where we are talking about films or programmes with specific health education aims, the metaphor with Akrich’s model holds directly because here the audience member is deliberately addressed as a potential patient. With documentaries about medicine, by contrast, the address to viewer as patient is incidental. Our argument is that television programmes that represent relations between doctors and patients also effectively make propositions about what those relations should be like, particularly about how patients are expected to behave – the subject position of the viewer-as-patient is inscribed in the programme, not as a deliberate act by the producer, but as a by-product of the programme’s grammar, including its differing modes of indirect and direct address. To be clear: we are not proposing that programme makers set out to convey models of patienthood to viewers, still less that the BBC connived with the NHS to embed such models, rather that programmes about the clinical encounter inescapably incorporate representations of patient behaviour. Furthermore, in making our proposition, we intend to encourage scholarly

5 Nichols 1976.

6 Boon 2018.

7 Akrich 2003.

reflection on how television might inform behaviour, rather than working at the close empirical level of seeking to establish whether or not this actually took place; such an analysis would require a substantial and difficult research project of its own.

The example of ‘On Call to a Nation’, a film made for BBC television by Richard Cawston, broadcast on 22 October 1958, can be used to explore this principle. This programme was an enquiry into the National Health Service (NHS) ten years after its foundation. Cawston, within a few years to become Head of BBC Documentaries, set out to make a film for television that, as he stated, ‘is in no way intended to be a technical or scientific film but will be a social documentary about people and ideas, and it will attempt to show what has happened to the public and to the doctors and what they think ought to happen next’.⁸ Coming ten years after the 1948 launch of the NHS, which for the first time provided healthcare free at the point of use to the whole British population, the programme is not in the business of explicitly demonstrating, on behalf of the state, how citizens should use the service – as they had in 1948, for example, in the memorable ‘Charley’ short films made by the animators Halas and Batchelor.⁹ The script of ‘On Call to a Nation’ proclaims, ‘That was ten years ago, and now we take it all for granted’; the purpose of the film is to investigate how it’s all going.

The structure of the programme, using patient journeys as its main structural device, enables us to interrogate these patient roles. It starts with a caption asserting ‘in the film that follows there are no actors’. In the opening sequence, we see a male GP going through his morning post with a nurse in attendance. The sequence concludes with him asking ‘now how many patients are waiting? ... Well, I’ll ring when I’m ready’. A vision cut to a waiting room follows; we hear a simple double bass melody played pizzicato; the programme’s title is superimposed. The camera tracks past the waiting patients, and a rolling caption states ‘this is about doctors – and the National Health Service as they see it, ten years after it started’. The commentary commences, giving a brief account of the foundation of the NHS over shots of five of the doctors we will meet later in the programme, before a return to the waiting patients. We hear the sound of the doctor’s buzzer (the music continues); a young woman with baby gets up; the opening commentary concludes with the question ‘but what do doctors think about it now?’ The vision cuts to the doctor’s room as this first patient enters. Cawston’s structure uses this GP’s waiting room as a device, with the bass leitmotif and GP’s

8 ER Cawston to H.T.Tel, “60 Minute Programme – Ten years of State Medicine”, T32,1,333/1, BBC Written Archives Centre, Caversham (hereafter ‘BBCWAC’).

9 Leab 2005, 234–6.

buzzer, to introduce a series of different health services by following individual patients with particular conditions into particular aspects of the NHS's functioning or into specialist services (including how GPs are paid, the administration of prescription costs, access to hospital diagnostic services and community services including ophthalmology and dentistry). The invitation to viewers of the programme is to identify with the patients in the programme just as in Nichols' theory they might identify with the participants in a fiction film; to think of themselves as being like the people in the waiting room as an imaginary path is laid out for them as people travelling into the services of the NHS. The proposition the programme makes via its mode of address to viewers is to imagine themselves playing the part of the patient, just as they see the 'real people' of Cawston's TV film provide just such performances of self.¹⁰

One of these sequences explicitly addresses the doctor-patient relationship. We see a patient, 'Mrs Radcliffe', visiting the GP, requesting a tonic on account of tiredness; the GP books her a separate, longer, appointment. The commentary voice takes over the exegesis, and we see on screen a middle-aged GP, who earlier in the programme has shown himself to be critical of younger doctors' prescribing practice. The commentator asks:

How does a GP organise his [sic] time and is his time abused? Do people call the doctor out for trivialities or flock to his surgery without good reason? In fact, has the NHS bred a nation of hypochondriacs, as was once predicted? Some GPs say there are certain patients who always waste their time, and they get to know them.

This doctor, in direct address to camera lists kinds of patients:

There is the patient who says, after you have examined her: 'ooh, whilst I'm here, doctor', and then produces a string of further unrelated symptoms. There is the patient who stops you in the street and tries to get a consultation or asks for a prescription to be left for this, that or the other. There is the patient who sends for you, and when you get there, you find not one patient, but several lined-up for examination. And there are the patients who send-in late. And it is so helpful to a doctor, in arranging his day, and the best use of his time, to have his calls sent in before he leaves the surgery in the morning.

Two succeeding doctors, also in direct address to camera, are significantly more emollient. The first, a Scottish GP, previously identified as practising at a former panel practice in a densely populated working-class district of London, explains:

I sometimes feel that a patient visit is unnecessary, and that it is frivolous, but of course there is no such thing as a frivolous visit to the doctor; the patient is bound to have some underlying anxiety or reason for his visit, and it is my business, and my duty, to reassure him and if possible, send him away happy.

10 Boon 2020.

This sequence, which goes on to explore the organisation of GPs' time, is interesting for our analysis of the patient role; the invitation to the viewer must inevitably be to consider whether they are themselves 'time wasters', or whether they have an 'underlying anxiety'. The direct address of the different doctors is also significant, as it televisually gives access to opinions about patients normally hidden from them that might also indirectly colour patient expectations of the clinical encounter. The attitude of both the doctors quoted places them hierarchically above their patients, whether the tone is more paternalistic or more critical. In both cases – patients and doctors – it is helpful to think in the terms of the sociologist Erving Goffman who, in his work on the performance of self in everyday life, distinguished between the impressions that people give consciously, and those that they 'give off' undeliberately.¹¹ Within the programme, the general practitioners (like all the doctors, never named, as was the convention at the time) give performances of easy authority, and give off impressions of varying levels of confidence ranging from considerate reflection on patient subjectivity to borderline arrogance. The patients (all named) give off a deferential impression, as was also in the case of 'Your Life in Their Hands', broadcast six months earlier.¹²

In playing their roles, Cawston allows some individual patients to transgress strict politesse, as is visible in two further examples. 'Mr Day' comes for a repeat prescription for a heart complaint. The doctor will not permit him to return to work yet. But, with his core business complete, the patient asks for an indigestion medicine for a 'Mrs Botley'. The GP gently rebuffs him: 'you tell Mrs Botley she'll have to come and ask for that herself, you see, because I don't like giving medicine to people if I don't know what's the matter with them'. This introduces a sequence on how the prescription service works. Later in the programme, the GP speaks to 'Mr Sapsford', an elderly male patient awaiting an operation for painful veins. In vision he asks pleadingly 'when could you get me into hospital, sir?' The film cuts to the GP, who explains 'You're not an urgent case, and the trouble is that the beds are used for the urgent cases first, before they can get non-urgent cases like you in. I tell you what I'll do'. The film cuts to the patient listening; the doctor continues, 'I'll ring up the hospital and I'll find what your position on the waiting list is. Is that alright?' The patient responds 'Will you tell them that I'm fed up with waiting?' The doctor answers 'yes, well I may do'. This, in its turn, introduces a sequence on hospital services and waiting lists. The point of both these patient performances is that whilst the amateur actors were

11 Goffman 1990.

12 Boon 2020.

clearly given a scenario that assists the exegesis of the film, they also present to the viewer a possible mode of patient behaviour which, while deferential, gives them a very limited degree of agency.

The years of the bedding-in of the NHS were also those of the development of televisual grammar attuned to a mass viewership. Cawston's film is interesting in that respect. This is a film shot and edited prior to broadcast, unlike the great majority of broadcast television in 1958, which was live.¹³ Despite this, by 1958, documentaries made on film for broadcast had already developed characteristics that distinguished them from what are generally thought of as 'classic' British documentaries. We see some of these in this example. The film retains the older practice of having an off-screen narrator, Colin Wills, although this is not a 'voice of God' narration telling the viewer what to think, rather Wills, voicing words written by Cawston, provides the tissue of connections between speakers and lays out factual information appropriate to each sequence.¹⁴ But much of the fine texture of the programme, especially in the statements of opinion from the doctors, is of direct address to camera, a technique rarely seen within the standard technique of older documentary films made for projection in public spaces. Camera-framing of the participants is also significant; we should pay attention to the use of close-ups that serve to reinforce the emphasis of the views they voice, for example. And we should note visual cues that tell us the extent to which the participants are speaking 'off the cuff', working from cue cards, or performing detailed scripts; most of the doctors' performances here are about half-way between these extremes: rehearsed and assisted by cues, as there is evidence of eye movement suggestive of reading. Their degree of fluency has a direct bearing on the impression they 'give off' to the viewer. And the director's choice of camera-angle and framing reinforces that effect. For a viewer today, the social attitudes encoded in the film mainly seem archaic, with paternalism and deference being the order of the day. It is harder, of course, to come to an understanding of what contemporary viewers thought of it, and that is not the point of the kind of analysis presented here.

We also need to understand that, as with very many non-fiction programmes, to get performances of the right kind for the programme, the director needed to do significant preparation, finding articulate participants, persuading them of the merits of appearing on television (which some doctors felt to be ethically questionable¹⁵), then making them feel comfortable

13 Boon 2008, e.g. 207, 219.

14 Here we concur with Stella Bruzzi's proposal that we should move away from the cliché in documentary studies that all narration is paternalistic and controlling. Bruzzi 2006.

15 Loughlin 2000.

when it came to the shoot. Unlike live TV, on film it was possible – up to a point – to do a re-take to get a better performance, but directors were obliged not to waste film; all filmmakers were constrained to work within particular ‘shooting ratios’ – between the footage used in the final programme and that not. One point worth making here is the effect of filmmaking, rather than televisual, technique on performances: individual ‘takes’ may have been quite disjointed and individually rather short – minutes or seconds, even – and the final flow was constructed after the event in the editing room employing the most usable performances from both GP and patient. With respect to the performances demanded of the participant, this needs different kinds of concentration from the participants than that required by live programmes, where all of what the participants do is seen by the camera, and the audience. But we should note a textural difference between the programme’s structural staged sequences of the GP with his patients and the opinion sequences of the selected and various doctors who appear throughout. The doctors’ opinion sequences are not unlike those that occurred in contemporary live television; they are informal and not scripted in fine detail. This is needed, not least because the interactions between GP and patients are in ‘indirect’ mode; they have something of the ‘overheard’ quality of fiction.

The examples quoted here are sufficient to make the case that, whenever television documentaries show the interactions of patients and doctors, they inscribe a role for the viewer as potential patient. Or, in this case, a variety of roles. ‘On Call to a Nation’ locates these viewer-patients explicitly in relation to the affordances and constraints of the NHS as it was responding to demand a decade after its launch.

Comparison with Natural History Television

As we argue, medical programmes share a great deal with other kinds of programmes. It makes sense then to look for evidence of whether programmes on subjects other than medicine invite viewers to assume particular roles as we have seen in the case of patients, and to play them in particular ways. We argue that many kinds of documentary television, in their mode of address, do propose kinds of action and behaviour for viewers, especially when these documentaries depict activities or occupations in which viewers could potentially take part. For example, natural history television can be said to have offered viewers a model of how they might become amateur wildlife cameramen, just as medical documentaries presented viewers with a model to be patients. Our point is not to suggest that a patient and an amateur wildlife cam-

eraman operate on the same symbolic level. In particular, the patient-doctor relationship is about how people interact within a politically charged, hierarchical setting, which would not be the case with the behaviour of an amateur naturalist in the field. Yet, this comparison is relevant because our examples were broadcast at a time when the BBC Natural History Unit (NHU) was attempting to recruit new contributors, wildlife cameramen, to provide the BBC with original film material. These films were intended to provide viewers with role-models *if they wanted to become contributors to the NHU*, which would placed them in a hierarchical setting.

The films we look at for this comparison were produced in the early 1960s, when the NHU was consistently drawing smaller audiences than their competitors, the various ITV producers of wildlife TV programmes.¹⁶ To address this issue, the NHU seized on an earlier proposal from The Nature Conservancy (a global conservation charity founded in 1951), to use their ‘immense power’ to shape the field of amateur natural history in Britain and to use the contents of their programmes to encourage people to become wildlife cameramen.¹⁷ One of their attempts involved presenting one of their contributors, Eric Ashby, as the paragon of the amateur naturalist cameraman. Ashby had come to the attention of the NHU through film reels he had sent depicting, notably, badgers filmed in full daylight and behaving naturally. At the time this was considered a feat. Ashby’s work appeared in the first filmed feature originating from Bristol, ‘The Unknown Forest’, broadcast in January 1961, which celebrated the wildlife of the New Forest in Hampshire. The film’s commentary extolled the value of blending into the landscape for anyone who wished to obtain true knowledge of wildlife. Viewers were treated to visual records of what deer, badgers, foxes or hedgehogs are up to in the forest when left alone, or if they are unaware of the presence of human observers. Following the film’s success with audiences, Ashby briefly became a wildlife personality and his work regularly featured in episodes of the natural history television series ‘Look’, the NHU’s flagship programme in the early 1960s, hosted by celebrity naturalist Peter Scott. As was usual in this series, Ashby appeared alongside Scott, to explain how he had obtained his footage. But the format of these appearances departed from the norm for the series. These can be seen as instances where the NHU, by providing viewers with a role model in the person of Eric Ashby, attempted to normalise the behaviour in the wild of would-be wildlife cameramen.

¹⁶ Gouyon, 2019.

¹⁷ E. M. Nicholson to Desmond Hawkins, personal letter, 7th July 1958, The National Archives, FT 3/541.

An example is the 1963 *Look* episode 'Forest Diaries'. This programme was filmed on location, which in the early 1960s was not uncommon at a time when the series was progressively escaping the studio.¹⁸ What is striking here is the part Ashby plays. Guest filmmakers in *Look* usually talked to Scott, explaining what it had entailed to produce the footage shown in the programme. As ornithologist James Fisher (one of Scott's regular guests on TV, and himself host of radio programmes) put it in 1959:

None of the distinguished naturalists and cinematographers whom Peter Scott has introduced talk down to their public. Indeed, they talk, not to their public, so much as to each other in the relaxed yet lucid voices that they would use in any normal discussion of their profession amongst themselves.¹⁹

Yet, in 'Forest Diaries' Ashby is only heard in a voiceover commentary. When he appears on screen, he does not interact with Scott, nor does he seem aware of the camera's presence. Instead, he is seen in the background crawling in the undergrowth, more animal than human, whilst an impassive Scott delivers his commentary, in camera, as if Ashby were absent. The scene could be taken from a sketch from the *Monty Python* comedy series. In his commentary, Scott explains that Ashby is reproducing his behaviour when filming badgers in full daylight in front of *Look*'s cameras for the benefit of viewers. The image then cuts to footage from Ashby's film on badgers, where he is seen with badgers frolicking around him, oblivious of his presence. The positioning of the camera for this footage, behind Ashby, compresses the perspective and creates the impression that the distance between the human and the animals is less than it really is. The whole sequence can be interpreted as demonstrating to viewers what results can be had if aspiring wildlife cameramen adopt the prescribed behaviour in the field.

With this example we can see television programmes working to suggest to viewers behaviours appropriate to specific circumstances. This sequence presents Ashby to audiences as an example of how would-be naturalist filmmakers should behave in the field if they want to be successful at obtaining wildlife footage valuable by the NHU. This episode of *Look* was broadcast at a time when the NHU was trying to recruit new contributors, at the same time as attempting to enforce standards of content and quality for the footage these new contributors could produce. A sequence like the one described above normalises behaviour in the field and signifies to aspiring wildlife cameramen that if they want to be able to participate in the produc-

18 Gouyon 2019.

19 Fisher 1959, 9.

tion of natural historical knowledge on the BBC they should partly become animals.

But beyond prescribing behaviour in the field, this sequence helps to establish which position aspiring wildlife cameramen could hope to occupy in the ecology of wildlife television production in the early 1960s. Their participation cannot go beyond providing programme producers with the raw footage they need to create programmes. This *Look* sequence was broadcast at a time when, as already noted, the BBC NHU was developing several outward-facing initiatives to publicly fashion its institutional identity and to encourage people to make wildlife films. These included a course for aspiring wildlife cameramen, run with the Council for Nature, and for the purpose of which the NHU produced a 'demonstration film' showing how the Bristol Unit functioned to produce wildlife television programmes.²⁰ 'Unarmed Hunters' (BBC, 1963) ascribed a very definite position in the ecology of programme production to wildlife cameramen operating in the field.

The desired stereotype was here again represented by Eric Ashby. 'Unarmed Hunters' celebrates machines, creating a very technical definition of wildlife television production, which contrasts with earlier public understandings of it as revolving around the figure of the adventurous wildlife cameramen. Mostly composed of two kinds of sequences, the film shows the people at work, dressed as office workers, and the equipment they use. As a film to instruct potential future contributors to the NHU, 'Unarmed Hunters' introduces viewers to the successive stages of programme-making and emphasises the manufactured nature of wildlife television programmes. The camera lingers over flatbed film editing suites (Steenbecks), stacks of reels, telecine machines, mixing consoles, and quarter inch tape decks, hands pushing buttons and turning knobs. The visual abundance of machinery, often looking complex, likens the production of wildlife television programmes to an elaborate industrial process, which only technical experts, wearing suits and ties, can adequately perform. By contrast, in this film Eric Ashby is seen from afar in the countryside, progressing in the undergrowth and carrying his 16mm camera in a wooden box. Dressed for field work in tweeds and wellies, he appears alien to the machine-saturated atmosphere of 'Unarmed Hunters', his demeanour further distancing him from NHU workers, clad in suits and looking more like civil servants than gentlemen farmers.

A possible interpretation of this sequence, set within a film which ascribes a pivotal role to post-production in the ecology of wildlife televi-

20 Crocker, N., 'Natural History Unit Library', Personal letter to A.T. Callum, 7 August 1964. BBCWAC R125/829/1.

sion-making, is to see it as attributing to wildlife cameramen a position at the periphery of the professional culture of wildlife television broadcasting that was being developed at the NHU in the early 1960s. This sequence, just like the whole film, invites viewers to participate, by providing the NHU with footage of wildlife, albeit limiting their role to that of external contributors. Within the context of the evolution of natural history filmmaking, such representations of amateur natural history cameramen signal the rise in power of the producer as the central figure of wildlife television to whose authority aspiring naturalist cameramen should submit themselves.²¹

The purpose of looking at these examples is to show that television representations of knowledge production enterprises – natural history here, but the phrase also encompasses medicine – that potentially involve viewers, can be analysed as providing these latter with role models, norming their participatory behaviour in these endeavours. As these sequences involving Eric Ashby suggest, such norming occurs both at the level of actual bodily, physical performances, but also with regards to positioning these participations within the ecology of these endeavours. Constructed as a role-model for aspiring amateur naturalist cameramen, Ashby defines the role as one that involves both an intimate connection with nature, the ability to blend into it (Ashby always appears more at ease with animals than with his fellow humans), and a submission to the authority of television producers. The sequences of wildlife television programmes examined here work to establish the hierarchical organisation of wildlife TV production in which viewers would have to insert themselves if they were to participate as contributors of footage, submitting themselves to the authority of producers. As we will now consider, *Horizon* episodes about biomedicine can similarly be analysed as establishing norms of behaviour for viewers to participate in health-care as patients.

Comparison with Medical Horizons

Let us therefore wind forward to some examples of *patients* in documentary TV. In this case, let us go to *Horizon*, the flagship British science documentary series. For the purposes of this paper, we focus on four programmes selected from a dozen *Horizon* episodes broadcast between 1964 and the mid-1980s with a focus on medicine. These episodes belong in successive regimes of science television as exemplified in the series. When looking at the history

21 Gouyon 2019.

of *Horizon*, the late Sixties are identified as the period when the series adopted a salient critical edge. The producers of the series at the time conceived of themselves as watchdogs. To them it was beyond discussion that, given the potentially deleterious effects of science on humanity's existence, their duty was to exert some kind of critical scrutiny over the development of science, technology and medicine.²² Instead in the 1980s the work of *Horizon* producers was more informed by the journalistic values of investigation, with the intention of providing audiences with a balanced coverage of these developments and establishing themselves as necessary intermediaries between an increasingly sophisticated scientific sphere and lay audiences.²³ The episodes chosen for this study map this evolution from the 1970s critical scrutiny to that of the 1980s era, one in which informational objectivity was claimed for journalistic coverage.

This time span revolves around the restructuring of the NHS between 1968 and 1972, which was undertaken to improve managerial and administrative efficiency, connoting a decisive shift within technomedicine to the centrality of the hospital as the preferred location for treatment (as opposed to the home or the GP's surgery), and increasingly for scientific research too. This reorganisation of the health care system was symptomatic of a broader ongoing political debate over how much the NHS should take on non-curative roles.²⁴ The programmes selected for consideration here therefore either address this transition as their main topic or represent the practice of medicine after the transition had taken place. Just as with the example taken from wildlife television, which did not set out to discuss the way wildlife cameramen should behave in the field but showed it nonetheless, none of these *Horizon* episodes directly set out to address the doctor-patient relationship. Yet they all feature a number of visual representations of this relationship, albeit in relation to narratives about doctors' training or the practice of medicine in hospitals. Like the examples featuring Eric Ashby discussed above, these *Horizon* episodes can all be interpreted as prescribing viewers a role to participate in medicine as patients.

22 Peter Goodchild (editor of *Horizon*, 1969–1976) interviewed in 1975, noted: “During the latter part of the 1960s, fairly obvious debates arose about transplants for example, about chemical or biological warfare and so on, and these began to make journalists in general, the public in general, question where science was actually taking us. Then there was the whole environmental revolution, we were in the midst of that, and I think this has meant that everybody now has begun asking where science, which is you know, one of the main forces behind progress, behind the shape that society is going to take in the future, is taking us”. (*In Vision*, BBC: 1975).

23 Hornig 1990; Boon and Gouyon 2014.

24 E.g. see Gill 1974; Klein 1972; Klein 1973.

As these four programmes all focus on ‘modern medicine’ – in the sense outlined in the NHS reorganisation – it is hospital patients we mainly see. The displacement of healthcare from the GP’s surgery to the urban hospital may have led the population in Britain to question the effect this change would have on the quality of the care they received. Particularly at stake here was the paternalistic doctor-patient relationship depicted for example in ‘On Call to a Nation’, discussed earlier. In the early 1970s, research-based medicine practised in the hospital was perceived as a rationalisation of healthcare, but one also with the potential to lead to the dehumanisation of the doctor-patient relationship.²⁵ For producers, at stake when communicating about this transformation of medical practice was thus the necessity to convince potential patients that despite the transformation of this relationship, the quality of treatment was not diminished. But as the present analysis will show, these television documentaries depicting hospital-based healthcare also performed specific hierarchies and provided viewers with role-models suggesting to them how to behave under the benevolent authority of clinicians.

Another debate in this period of the late 1960s – early 1970s was about whether patients ought to be treated and empowered as consumers of healthcare services. Some commentators, such as the sociologist Margaret Stacey (1974), contended that ‘medicine was a service industry that did things to and not for people; that the patient was both work object and social actor’ (Mold, 2015, p.8). From this standpoint it was inappropriate to introduce a consumerist dimension in healthcare. The idea here was that the imbalance of expertise between patient and doctor was inherent to healthcare provision, and made it impossible to characterise patients as consumers; the inherent imbalance necessarily placed patients at a disadvantage when it came to knowing about their condition and appropriate treatment. This asymmetry ‘of the doctor–patient knowledge–power relationship therefore made it difficult for patient-consumers to act as autonomous individuals’ (Mold, 2015, p.8). From this vantage-point, the *Horizon* episodes discussed here can be interpreted as weighing into this debate, emphasising the necessary passivity of patients’ submission to doctors’ cognitive authority if healthcare was to work at all.

The 1971 *Horizon* episode ‘What Kind of Doctor’ considers doctors’ training at St Thomas’s Hospital in London in this context, asking whether they receive the appropriate training to become GPs. The programme sets out to explore whether medical students, despite increasingly being trained

25 Dopson 1971.

to become clinicians, still retain the holistic approach to treatment which is said to be the hallmark of the GP in local communities. The programme's answer is to suggest that the solution to this dilemma rests with students, whose individual attitude will determine whether they will be able to strike the right balance between science and humanity. The main interviewees in the programme are teachers in the medical school or practising GPs, framing the debate as one internal to the profession. Patients, the most likely to be affected by the issue, are not given a word in the matter. Nor are they encouraged to participate in the debate. They are cast here as passive recipients of whatever health service the turn to scientific medicine yields.

To open the programme, the pre-title sequence offers an unambiguous depiction of patients' central yet passive role in 'modern medicine'. Following establishing shots of St Thomas hospital, presented in the commentary as 'one of the great teaching hospitals of London and the World' which was then being rebuilt 'to meet the higher standards of modern medicine' now that 'the treatment of diseases is transformed by science', the camera takes viewers inside one of the hospital's lecture theatres. There, a patient is shown being wheeled in and then undergoing an examination in front of the assembled students, to demonstrate his symptoms. During this performance of 'the medical gaze' (Foucault, 1963) in action, the patient, lying on a reclining chair, performs being ill, submitting himself to the clinician's inquiry. Although they share a space, the lecture theatre, at no point do students and patient directly interact, as if they were standing in two separated spheres. The clinician moves back and forth between these two discrete spheres. His discourse seamlessly changes from a direct address to the patient, asking him to perform certain tasks such as following the tip of a pen with his eyes, to describing the man's condition to the students using the third person singular, as if the patient were absent. When he does describe the patient's physical symptoms, the clinician manipulates him as an object, for example turning his head from left to right and back repeatedly to demonstrate that the affliction does not impede this movement. This programme presented as being about the doctor-patient relationship, introduces patients as little more than bystanders to a debate about their position in the healthcare system.

The following year, another *Horizon* episode seemed to give a more active voice to patients. The 1972, 'Are You Doing this for Me Doctor, Or Am I Doing it for You?' which, on the face of it, scrutinises who stands to benefit from scientifically informed healthcare, looked at a series of experiments conducted in different hospitals in the USA and the UK. It contrasts the case of the UK with that of the USA, pointing especially to an experiment

whereby children had been ‘voluntarily’ injected with hepatitis in order to study the use of immunotherapy to treat them. The problem here was that the children were mentally disabled, and that neither they, nor their parents, had been made aware that they were subjected to such experiment. The programme followed a debate in November 1971, where allegations had been made that such experiments were taking place in an NHS hospital. The Ministry of Health had responded that even if such experiments were taking place in the US, they could not take place in the UK.²⁶ The programme, based on a difficult case, interrogates the consequences of asking patients to surrender their agency, expressing fears about technomedicine. Contrasting the US and British cases, the programme reassured viewers that consent had been received for all experiments conducted on British patients. The 1971 and the 1972 programmes, which both presented themselves as questioning the authority of medicine, ultimately worked to reinforce it.

In the next two programmes, from a few years later, viewers are provided with examples of patients that suggest an almost complete surrender of their agency to the authority of medicine. The two programmes both relate to immunology and offer a portrayal of the use of antibodies as medical tools. The 1974 ‘A Matter of Self Defence’ considers immunology broadly and moves from vaccination to bone marrow transplant and finally research on immunotherapy, notably in relation to cancer treatment. A sequence depicts a child, who has received a successful bone marrow transplant, during a follow-up consultation at the hospital. This sequence which is meant, within the programme, to illustrate the potency of immunotherapy, can be interpreted just like the sequence featuring Eric Ashby in the wild discussed earlier. It is staged so that the child, who is the main object of the sequence, epitomises all patients in the context of research-based medicine, and so serves as a model of behaviour. In the sequence, the clinician manipulates the boy’s body and makes him lie-down, sit, stand-up, all the while talking to his mother, or to the camera. Parallels can be drawn with a sequence in the same programme which depicts lab-technicians manipulating rats. The patient’s agency is minimal, his body a prop in the treatment process.

This way of representing patients as passive recipients of treatment in the modern, science-based hospital only gets more pronounced in the 1985 ‘A Prize Discovery’.²⁷ Celebrating the achievement of Cesar Milstein, who in December 1984 had been rewarded with a shared Nobel Prize for his work on monoclonal antibodies, the purpose of ‘A Prize Discovery’ is to explain

26 Anon 1971.

27 Gouyon 2018.

Milstein's work and to emphasise the progress it allows in medicine. For example, the programme emphasises the advances in the treatment of cancer which monoclonal antibodies have made possible, such as more targeted radiotherapy.²⁸ In a sequence devoted to explaining how radioimmunotherapy works, a patient is shown being injected with monoclonal antibodies and then being placed underneath a scanner. The camera then cuts to a view of two doctors, seated in an adjacent room in front of a computer screen displaying a view of the patient's abdomen where tumours are highlighted. One of them comments on the image and goes on to explain the procedure the patient is undergoing.

These two programmes reiterate the lack of patient agency in the context of scientific medicine. They are seen as passive recipients of injections, lending themselves to being manipulated by clinicians, or submitted to the actions of machines. Comparing the 1974 *Horizon* programme with its 1985 counterpart reveals an enduring metaphor when it comes to the topic of immunology, that of warfare. In both programmes, the commentary is peppered with comparisons of antibodies and lymphocytes with defensive weapons. Antigens and infectious agents are likewise likened to invaders and offensive weapons. Unsurprisingly, the battlefield for the conflict thus outlined is the patient's body. The materiality of the body is transformed, turned into a computerised visualisation. But in this context, doctors' agency seems to be reduced too. It is limited to directing patients and administering the various treatments reviewed in these films. Ultimately, when it comes to curing disease, agency rests with non-human entities, monoclonal antibodies and other chemical compounds, or machines.

To paraphrase Michel Callon, the programmes analysed here create an actor-network that simultaneously gives rise to society and medicine.²⁹ The practice of scientific medicine as portrayed there is only possible because of the social relationship between patients, doctors, and biochemical compounds similarly defined in these programmes. Patients passively submit themselves to doctors' actions, who themselves are ultimately subservient to the agency of antibodies and other biochemical compounds. Patients' participation in research-based healthcare is through the willing provision of their body as raw material on which doctors can unleash the power of modern science.

28 E.g. Kohler/ Milstein 1975.

29 Callon 1987, 99–100. This Actor Network could be defined as being composed of patients, doctors, medical students, machines [e.g. scanners, computers], molecules [e.g. monoclonal antibodies], but also the bureaucrats enacting political decisions such as Richard Crossman's decision, as the secretary of state for social services in Harold Wilson's government, to restructure the NHS around hospitals.

Doing the Work of Medicine?

The examples of ‘On Call to a Nation’, natural history television and biomedical *Horizon* programmes demonstrate that it is possible to trace certain similarities between different genres of television made in the same broad synchronic bands of time. This parallels the finding that there were substantial similarities in the ways that television in the early 1960s represented members of the professions; whether those were scientists, literary authors or musical composers; all were treated with a deference that arose from the existing class relations of British society, conventions that were to be challenged by the 1960s social revolution.³⁰ The similarity between medical and other non-fiction television extends to the concerns of this essay that television can serve to propose kinds of action and imagined roles to viewers; that too was found in non-fiction television with themes other than medicine, as we saw with the example of Eric Ashby.

It is helpful here to consider the nature of participation in medicine by patients and by doctors as kinds of activity. On analogy with Christopher Small’s insightful verbing of the noun ‘music’ to create the new term ‘musicking’ to connote all musical activity, we propose thinking about participation in medicine, by all participants, as ‘medicining’. Where Small writes that ‘the fundamental nature and meaning of music lie not in ... musical works at all, but in action, in what people do’, we may portray participation in medicine in the same way, repurposing Small to assert: To ‘medicine’ is to take part, in any capacity, in health, ill-health or its treatment, whether by doctoring, by being a patient, by living a healthy life (or not), by developing new treatments or taking them, by consuming health media ... and much else besides.³¹ Or, to put it very simply, being a patient is participation in the practice of medicine. The way in which this may be distinctive, in relation to the case of science in general, is that the power relations between medicine and patient gives authority to the doctor by virtue of the vulnerability of the patient, a state of affairs that has long been the concern of medical historians and sociologists. Then, again, the iterative *performance* of medical authority and patient vulnerability can be seen as constituting the doctor and patient roles.³² But our examples show that patients’ deference to medicine and doc-

30 Boon 2017.

31 Derived from Small: “To music is to take part, in any capacity, in a musical performance, whether by performing, by listening, by rehearsing or practising, by providing material for performance (what is called composing), or by dancing”. Small 1988, 9.

32 Butler 1993; Boon 2020.

tors persisted well beyond the supposed universal changes in social attitudes associated with the 1960s.

As we argue, the effect of television programmes proposing modes of behaviour by ‘inscribing’ patient behaviour in medical documentaries is an effect separate from the deliberate intentions of the programme makers. Indeed, the BBC’s ethos of professional and medium-specific representational expertise was opposed to programmes deliberately becoming vectors for the views of other professional groups. Producers defined their practice as the exercise of specifically televisual skills, independent of the proponents of the subjects they represented, which Aubrey Singer expressed in a much-quoted 1966 lecture on science: ‘the televising of science is a process of television subject to the principles of programme structure, and the demands of dramatic form ... in taking programme decisions, priority must be given to the medium rather than scientific pedantry’.³³ In other words, making television programmes about science – or, in our case, medicine – was the business of television producers, not of scientists – or doctors. Producers saw themselves as masters of televisual technique, and that meant taking charge of the way the medium represented its subjects, without undue deference to how their subjects might have chosen to be represented. When television began seriously to make programmes about science and medicine, from the mid-1950s onwards, producers asserted this role. And it is true that organised and élite scientists found fault with science broadcasting, initiating a series of delegations to the BBC Director General in the late fifties and early sixties, in what was effectively a contestation of expertise between professional groups.³⁴ On the medical side, there was also occasionally considerable disquiet when television producers made programmes that trespassed on their professional ethics; the best-known case is that of ‘Your Life in Their Hands’, which the *BMJ* represented as a betrayal of the sanctity of the doctor-patient relationship.³⁵ But, if we watch these programmes now, it is clear that, whatever the journalistic independence of the producers, they continued to encode significant deference to doctors and to medical authority in their output, just as they did to scientists. And you might say that a range of prevailing doctors’ attitudes to patients were carried over to audiences via the televisual technique and grammar of the time.

33 Singer 1966. See Boon 2015.

34 Boon 2008, 186; Jones 2013.

35 Loughlin 2000.

Conclusion

This essay argues that television programmes advance propositions to laypeople about how to be a patient in relation to medical expertise; a ‘patient position’ is inscribed in these cultural products. It is striking to note that in all of our selected programmes covering three decades from 1958, patients are consistently presented as marginal to the medical stories being told. The ‘inscribed’ patient in every case is deferential to doctors or, worse, the anonymous object of medical practice, and so it follows that the role proposed to viewers must also have been to show deference and accept objecthood. This would not be what a reader of Alex Mold’s argument would expect. It is difficult to tell whether this finding is an artefact of the programmes we have selected. There must in the archive be programmes that address, for example, Michael Balint’s psychologised model of general practice, which recognised the psychodynamics of doctor-patient relations.³⁶ After the publication of his 1955 book, *The Doctor, His Patient, and the Illness*, Balint’s approach to the doctor-patient relationship, which explicitly made allowance for the effect of the doctor’s behaviour on that of the patient, became influential throughout the sixties and beyond. Equally, it would be natural to expect the journalistically minded producers of *Horizon* to be drawn to the implications of Ivan Illich’s critique of modern medicine, *Medical Nemesis* (1975). In either case, we might expect at least a richer rendering of the patient role and experience than in the programmes we have described here. As it is, a search of the BBC’s online database of programmes yields no immediate candidates.³⁷ But, to make such explorations is as much a matter of the historical sociology of medicine as it is a matter of the kind of close study of medical media that we have undertaken here. For the moment, we can only hope that we have succeeded in our aim of opening-up the question of patient roles in medical media for further study.

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36 Shaul Bar-Haim 2018.

37 URL: <https://genome.ch.bbc.co.uk/>. Of television programmes, the only Illich programme antedates *Medical Nemesis* by three years. There are no television entries under Michael Balint. The *Genome* data derive from a scan of the *Radio Times* and therefore cannot be expected to record all coverage, as the listings are often quite parsimonious.

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- ‘On Call to a Nation’, BBC, written and produced by Richard Cawston, broadcast 22 October 1958, broadcast 22 October 1958, B/W (sound) 72 minutes. URL: <https://www.bbc.co.uk/iplayer/episode/p013ylyp/on-call-to-a-nation?suggid=p013ylyp> [UK]
- ‘The Unknown Forest’, BBC (Natural History Unit), produced by Christopher Parsons, 1961, B/W (sound), 45 minutes
- ‘Unarmed Hunters’, BBC (Natural History Unit), produced by Christopher Parsons, 1963, B/W (sound), 30 minutes
- ‘What Kind of Doctor’, BBC *Horizon*, produced by Francis Gladstone and Brian Gibson, broadcast: 15 March 1971, colour



“Now even Television is Promoting Health?” On the Intertwined History of Television and Cardiovascular Disease Prevention in the German Democratic Republic, 1950s–1970s*

Stefan Offermann

Abstract

This paper argues that the historical trajectories of television and cardiovascular disease prevention in the German Democratic Republic are interlocking. These diseases were largely understood as caused by an unhealthy modern lifestyle. Healthcare experts were convinced that health education was an effective strategy to persuade the population to follow a healthy lifestyle. With its rise as a new mass medium, health educators increasingly relied on television as a means to put their message across. Yet the new medium itself was a target of health education measures as excessive TV consumption was considered a potential threat to cardiovascular health. This article deals with the history of health-related problematizations of TV consumption. In the 1950s and early 1960s, during an animated discourse on the strain of a modern lifestyle television was considered a potential source of overstimulation of the nervous system. As this article argues, this interpretation was undermined by a modified concept of TV consumption within the discourse of empirical audience research.

television, cardiovascular disease, health education film, problematization, governmentality, German Democratic Republic

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Introduction

In 1968 the famous East-German gerontologist Werner Ries published a guidebook on the prevention of cardiovascular disease titled *Take care of your heart!*¹ To achieve this, he argued, it was necessary to make good use of one's leisure time.² So his book also offered advice on one of the most popular leisure activities of that time: television consumption:

From a medical perspective [...] one has to warn against the common plague of watching television for hours and days. No reasonable individual would refute the value of this mass entertainment but an excess must be avoided. Many nervous dysfunctions are caused by television. Besides this, TV promotes physical inactivity and possibly increases body weight through "TV snacking and drinking". Alcohol consumption has also probably increased because of television. [...] However, it takes a certain willpower to not turn on the beloved tube or switch it off early enough.³

In the 1960s and 1970s, the German Democratic Republic (GDR) saw not only the rise of TV as the new leading medium but also an increase of cardiovascular disease. Medical experts and epidemiologists were convinced that the emergence of an unhealthy modern lifestyle was the main cause of the increase. Nervous strain and stress, lack of physical activity, high-fat diet, "overweight", and the "misuse" of alcohol, tobacco, and coffee (so-called *Genussgifte*)⁴ were considered the most serious "risk factors" making the emergence of arteriosclerosis or heart attack more likely.⁵ According to Ries and others, these risk factors were assembling around the practice of TV consumption turning this leisure activity itself into a potential threat to cardiovascular health.

However, the new medium represented not only a health risk; from the early 1960s, health policy makers and health educators increasingly relied on TV as a supposedly effective instrument to motivate the population to adopt a healthy lifestyle and to manage one's own exposure to cardiovascular risk factors.⁶ This placed health educators in a paradox: While they welcomed television as a means of mass-communication the social practice of television consumption made them uneasy. Restricting broadcasting time would have tamed the risk of "excess" but in contrast to the early years of television in the 1950s this idea was no longer an option in the 1960s. Instead, health educators pursued a double strategy. On the one hand, they sought to increase viewership of their educational programs, despite occasional opposition from

1 Ries 1968. All quotations from German sources were translated by the author of this paper.

2 Ries 1968, 141.

3 Ries 1968, 145–146.

4 *Jedermann an jedem Ort...*, directed by Hanna Emuth (GDR 1970), 4:22–4:24.

5 Madarász-Lebenhagen 2013; Timmermann 2010.

6 Linek 2016, 68–74.

television stations.⁷ And they sought to induce the television service to give greater coverage to health topics by, for instance, producing their own health education programs.⁸ On the other hand, health educators addressed the viewers and integrated health-related safe-usage advice regarding the new medium into health education films and other materials on cardiovascular disease. Drawing on Michel Foucault's thinking on governmentality, political theorist Carol Bacchi argues that "[g]overning takes place through particular problematizations."⁹ This paper deals with the history of health-related problematizations of TV consumption and the techniques applied by GDR health education to govern viewers.¹⁰ As I argue, these techniques served to promote the "willpower" and ability to govern themselves through monitoring and regulating their viewing habits.

Addressing the ambivalent history of television as an instrument *and* object of health prevention, I seek to form a link between the history of knowledge production on cardiovascular risk factors,¹¹ the history of health education and cardiovascular prevention,¹² and the social and cultural history of television.¹³ In doing so, I contribute to the historical research on processes and practices of scientization and governing of the social since the 19th century. This research perspective explores the growing importance of scientific experts, the human and social sciences for the state's efforts to govern the population, for the economic sector, for the mass media or for the production of individual subjectivities.¹⁴ Analyzing the circulation of scientific knowledge about the problem of TV consumption and the practices of governing this problem, I rely mainly on research that applied Foucault's thinking on discursive and social practices to media history and explores television history as the

7 In particular, the question of fixed broadcasting slots represented a controversial subject. For instance, the German Hygiene Museum received a fixed slot for the series of health films called *Advertising on TV (Werbung auf Sender)* only after the health minister intervened (Schwarz 2011, 31).

8 For health education formats developed by East German TV, see Vollberg in this issue.

9 Bacchi 2012, 5. Michel Foucault used the concept of problematization to argue that a problem never objectively exists but is rather the result of productive procedures. The term captures the process of "how and why certain things (behavior, phenomena, processes) became a problem" (Foucault 1999).

10 Following Foucault's work on governmentality and the genealogy of the modern state I draw upon a broad concept of government that is not limited to state activities. Instead the term comprises all forms of 'conduct of conduct' undertaken by very different authorities and agencies including practices applied by an individual to govern or optimize oneself (Dean 2010, 17–21; Foucault 2005, 256).

11 Kury 2012; Rothstein 2003.

12 Madarász-Lebenhagen 2013, 2015; Linek 2016; Sammer 2015, 2019.

13 Ruchatz 2005; Meyen 2003.

14 For instance, see Raphael 1996; Brückweh/Schumann/Wetzell/Ziemann 2012; Reinecke/Mergel 2012.

history of media discourses.¹⁵ According to media scholar Irmela Schneider “media discourses [...] generate knowledge about media thereby negotiating their social and cultural function. They are discursive practices constituting descriptions and observations of media usage.”¹⁶ Picking up these discourses, health education sought to regulate the audience’s consumption. Regarding such feedback effects, Schneider argues that “media discourses decisively contribute to the construction and implementation of forms of usage [...]. At least since the 20th century media had risen in such importance that discourses on it became a significant element for forms of subjectivation.”¹⁷

With this theoretical framework, my first aim is to situate the health-related problematization of TV consumption within the broader context of the discussion on the social and political relevance of the medium. Put simply, this discourse revolved around the question of whether television should be considered primarily as a means to educate the people or (also) as a medium of entertainment and relaxation. Analyzing an – entertaining – health education film from 1964, which vividly illustrates the ambivalence of risks and opportunities connected to television, the article will consider the medicalization of TV dominant in the 1950s and up to 1964. In this period medical experts were convinced that television was a potential cause of nervous system overstimulation. Therefore, health education prompted TV viewers not only to switch on to watch the “right” programs, but also to switch off at the “right” time to avoid watching TV “for hours or days.”¹⁸ In the second part I will show that this medicalization of TV usage was based on a technocentric understanding of the new medium and a materialistic concept of the viewer as “irritable machine” (*reizbare Maschine*) – both ideas are rooted in a longer history of the scientization of the human body and its interaction with the environment.¹⁹ As I will argue in part three, this interpretation was challenged by empirical audience research. This discipline has become institutionalized since 1964 in the course of a broader trend of the implementation of social sciences that professionalized research on TV consumption. This increasingly hegemonial media discourse neglected health issues that related to the medium. Nevertheless, the new concept of TV consumption it produced contributed to undermining the dominant idea that the medium

15 For research applying the concept of media discourse to television history, see particularly Ruchatz 2005; Schneider/Spangenberg 2002; Schneider/Hahn/Bartz 2003; Schneider/Bartz/Otto 2004; as an instructive example of analyzing medical discourses on TV usage, see Bartz 2002; for the history of East German TV audience based on “historical data analyses”, see Meyen 2003.

16 Schneider 2007, 107.

17 Schneider 2007, 107.

18 Ries 1968, 145.

19 Sarasin 2001.

was capable of overstimulating viewers' senses. Finally, in my analysis of a health education film from 1970, I will illustrate precisely how the problematization of TV consumption had shifted. In addition to the new concept of TV consumption two aspects contributed to this shift: the intensified problematization of "malnutrition", "overeating" and lack of physical movement as side effects of TV viewing on the one hand, and the cultural habituation of TV viewing into a commonplace activity on the other.

This article draws in particular on health education films jointly produced by the state-owned DEFA-Studio for Popular Science Films (*DEFA-Studio für populärwissenschaftliche Filme*)²⁰ and the German Hygiene Museum in Dresden, which was the principal health education institution in the GDR.²¹ Recognizing the possibilities of TV, the Hygiene Museum built a professional infrastructure to facilitate the development and production of films in the early 1960s.²² From the 1960s until 1990, the Hygiene Museum commissioned the production of approximately 170 films. In producing the films, the Hygiene Museum was responsible for devising the thematic content and providing scientific expertise, whereas the production company was responsible for its artistic realization.²³ Such films were shown in cinemas and on television as part of early evening programming. They were also presented at organized screenings that included popular science talks and discussions with the audience. Such events were organized for instance by local health education institutions (*Bezirkskabinette für Gesundheitserziehung*) or the Hygiene Museum itself.²⁴ In total the corpus of my research consists of about 30 films that dealt with the problematization of cardiovascular risk factors related to diet, weight, and physical activity.²⁵ Seven addressed TV consumption as a poten-

20 In 1968, the studio became the DEFA Studio for Short Films (*DEFA-Studio für Kurzfilme*) and, in 1975, it was renamed the DEFA-Studio for Documentary Films (*DEFA-Studio für Dokumentarfilme*) (Knopfe 1996, 295).

21 Schneider 2011 provides a register of all films in the Hygiene Museum's archive. Basic information about the films is also available online: <https://www.dhmd.de/en/collections/>.

22 Hauptstaatsarchiv Dresden, 13658 Deutsches Hygiene-Museum Dresden, Nr. 62/22 (1962): Kunkel (stellv. Direktor) an Ministerium für Gesundheitswesen; Schwarz 2011, 27–28.

23 Philipp Osten reconstructed the cooperation between the two institutions in terms of producing the health education film series *You and Your Health (Du und Deine Gesundheit)* (Osten 2011, 54–68). The Hygiene Museum cooperated not only with the DEFA; for the short *Thousand Tele-Tips (Tausend Tele-Tips)* TV spots it worked with the state TV producer (Schneider 2011, 117–119). And for the production of the series *Advertising on TV (Werbung auf Sender)* the Hygiene Museum cooperated with a private production company (Schneider 2011, 123).

24 Schwarz 2011, 31–32. Regarding *Active Recreation* and *Everyone, Everywhere...*, so far, it was not possible to determine how they were distributed and where and when they were shown to audiences.

25 The films of this corpus were produced between 1964 and 1981. About 60 other films in the Hygiene Museum's archive addressed smoking, alcohol consumption, and stress as risk factors for cardiovascular disease or dealt with one of all of these factors without explicitly re-

tial health risk.²⁶ Here I provide a close reading of the puppet animation film *Active Recreation* (1964) and the live action film *Everyone, Everywhere...* (1970).²⁷ These films, produced six years apart, along with articles dealing with TV consumption published in the popular TV guide *Radio and Television in the GDR (Funk und Fernsehen in der DDR)*²⁸ and in the high-circulation health magazine *Your Health (Deine Gesundheit)*, as well as popular science publications on the emergence and prevention of cardiovascular disease and publications on empirical audience research aptly demonstrate contemporary representations of TV consumption and allow to trace a shift in the problematization of this practice as a health risk.

Leisure Time: Time for Active Recreation?

Television had become the most frequently undertaken and popular leisure activity by the late 1960s. According to a 1967 sociological study 68 percent of interviewees stated that television consumption was their preferred leisure activity, which was similar to figures for West Germany.²⁹ Due to daily routines usually being structured by work, most of the population watched television in the evening and the organization of after-work hours increasingly oriented towards the TV schedule.³⁰ Starting with the first surveys in 1964 until the end of the GDR, audience research revealed a continuous preference for entertainment programs.³¹ According to the findings, people usually considered television a means of amusement and relaxation. A worker pointedly explained this type of TV use: “When you’ve had a strenuous day at work, in the

lating them to the emergence of cardiovascular disease (Schneider 2011, 110–136). For methodological reflections on how to constitute a useful and manageable corpus of health education films, see Bonah/Cantor/Laukötter 2018, 4–6.

26 Except *Ist Sattsein richtig ernährt?* all of these films were commissioned by the Hygiene Museum and were produced in cooperation with the DEFA-Studio for Popular Science Films, respectively its successors. *Aktive Erholung*, directed by Kurt Weiler (GDR 1964); *Mußte das sein?*, directed by Wolfgang Heyer (GDR 1964); *Ist Sattsein richtig ernährt?*, directed by Ulrich Kluck (GDR 1967); *Jedermann an jedem Ort...*, directed by Hanna Emuth (GDR 1970); *Gewicht (Wegweiser Gesundheit Nr.2)*, directed by Wolfgang Heyer (GDR 1974); *Herz-Kreislauf-Prophylaxe (Wegweiser Gesundheit Nr.9)*, directed by Günter Biedermann (GDR 1975); *Mit dem Herzen dabei (Wegweiser Gesundheit Nr. 31)*, directed by Werner Kreiseler (GDR 1979).

27 *Aktive Erholung*, directed by Kurt Weiler (GDR 1964); *Jedermann an jedem Ort...*, directed by Hanna Emuth (GDR 1970).

28 Since 1969, the magazine was called *FF dabei*.

29 Wessel 1967; Meyen 2003, 40.

30 Meyen 2003, 62–65; Bösch/Classen 2015, 469.

31 Meyen 2003, 68f.

evening you want to relax.”³² Using TV broadcasts for pleasurable personal “mood management”³³ and physical relaxation might constitute a diverse and creative technique of the self. However, particularly in the 1950s and 1960s, the SED-leadership favored another idea of what television should be.

Striving for a fundamental transformation of society, which included the bodies and minds of citizens, the leadership of the Socialist Unity Party of Germany (*SED-Sozialistische Einheitspartei Deutschlands*) considered television – and other media – first and foremost an instrument for educating the population, a means to turn citizens into so-called socialist personalities.³⁴ According to the state leadership, the significance of television consumption was twofold. On one hand, watching television constituted a contact point where educational measures could reach their subjects. On the other hand, as a leisure activity TV consumption itself was an object of educational measures. According to the official Marxist-Leninist interpretation, in capitalist societies leisure was only an extension of people’s exploitation and alienation through work. Socialism, in contrast, gave its citizens the possibility to use their free time, which included TV consumption, for ideological and high cultural education as well as care for their health through “active recreation”.³⁵

Some TV producers working at the German Television Broadcaster (*Deutscher Fernsehfunk*), especially in the 1950s, also believed that this was the primary social and political purpose of the new medium. At the same time, the TV service was interested in exploring the aesthetic possibilities of the new medium and produced very different formats and programs. Furthermore, the television service was constantly competing with West German television. Due to geographical and technical circumstances, most East German citizens were able to watch West German programs. Therefore, the television service felt pressure to cater to the viewers’ preferences in order to prevent them from changing channels. This competitive situation also promoted the constant extension of broadcasting times including the creation of a second channel in 1967.³⁶ For this reason, the TV service purchased more and more TV series and movies from abroad; in the 1970s, 40 percent of all fictional series shown on GDR television came from the US or Western Europe.³⁷ Given these developments, even the SED leadership could not ignore the social and political importance of entertainment and

32 As cited in Meyen 2003, 73.

33 Maase 2009, 76.

34 Bauerkämper 2017, 18–20, 25–28; Brock 2009; Otto/Ruchartz 2005, 164.

35 Fullbrook 2011, 85.

36 Hickethier 1998, 104–107; Hickethier 2010, 119–128; Bösch/Classen 2015, 471–475.

37 Hickethier 1998, 329.

popular mass culture. In 1971 at the 8th Party congress Erich Honecker officially criticized “a certain boredom” of the East German television program demanding more high-quality entertainment programs without, of course, abandoning the aspiration to educate the population through television.³⁸ And two years later he eventually approved the everyday practice of watching West German television.³⁹

Health educators as well strived to take into account their recipients’ wish for entertainment. In 1962, assistant director of the Hygiene Museum Otto Kunkel wrote a letter to the Ministry of Health informing about the Hygiene Museum’s capacities for film production and trying to raise more money for film production. He explicitly used the audience’s wish as an argument: “Given the fact that the instruction of the population has gone through a major change, that is the people today prefer a manner of instruction that is combined with an entertaining quality, for instance TV program, film in contrast to exhibition etc., film gains extraordinary importance.”⁴⁰ As we will see, health education films succeeded in employing humor and empathy rather than the notorious raised forefinger. And puppet animation offered some suitable features to put this approach into practice.

Active Recreation (1964) belongs to a series of five puppet animation films using the devil as the main protagonist who seeks to “save” people from adopting a healthy lifestyle (*Teufel-Puppentrickserie*).⁴¹ Each film was directed by Kurt Weiler who was a renowned specialist in puppet animation (feature) films. This points to the artistic sophistication that time and again characterized the genre of health education film. The character of the devil was the series’ special gimmick and probably only the fact that a puppet was used allowed for the creation of such a main protagonist. He is a personification of the complex and sometimes intangible force that – according to the narrative – tempts people to make the wrong choices and to lead an unhealthy lifestyle. Consequently, adopting a healthy way of living means banishing this diabolic force. Instead of being confronted with an authority that directly advises viewers what to do, the film presents a cute little puppet that encourages them to identify and banish their own personal devil.

Unlike the six other health education films that deal with TV consumption, the narrative of *Active Recreation* revolves around contrasting two media-usage types as leisure activity. The film’s first part illustrates how misuse of the me-

38 Classen 2005, 209–216, 222–233; Ruchatz 2005.

39 Bösch/Classen 2015, 466–468.

40 Hauptstaatsarchiv Dresden, 13658 Deutsches Hygiene-Museum Dresden, Nr. 62/22 (1962): Kunkel (stellv. Direktor) an Ministerium für Gesundheitswesen.

41 Schneider 2011, 111.

dium ultimately causes the death of the consumer. The second part shows how correct usage leads to better health. In the beginning, the devil reports to his “fellow devils” that their “campaign for an inactive life and early death is a great success”. Standing in front of a wall chart showing rising graphs he continues: “Heart and circulatory problems are steadily increasing”. The scene switches to an office worker sitting at his desk, on which five telephones are ringing continuously; the devil comments: “If you do everything yourself, you won’t last long. If you’re always sitting, you already have one foot in the grave”. Then the office worker is seen driving home sitting in his car, he stops in front of the television that is already on.

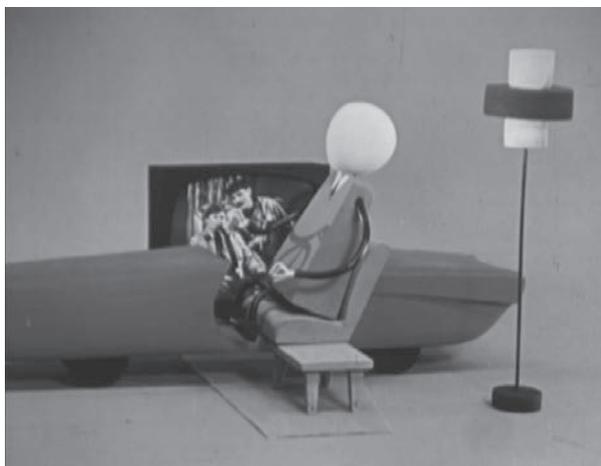


Figure 1: The “sedentary lifestyle” of office workers. *Active Recreation* [Aktive Erholung], directed by Kurt Weiler (GDR 1964), client: German Hygiene-Museum Dresden, producer: DEFA Studio for Popular Science Film (Potsdam).

This sequence illustrates another aesthetic feature of animation. The film reduces the visual complexity of the “real” world and focuses on specific objects (telephone, desk, tie) that are supposed to signify a certain profession (office work). Moreover, animation very easily abstracts from the physical laws and the built environment of “reality”. Turning the office chair into a car seat and then later into a TV armchair in one flowing movement, the film creates a simple and iconic image of the idea of the “sedentary lifestyle”.⁴²

Now at home after “a strenuous day at work” this office worker wants to “relax.” Using TV for relaxation resonates with the devil’s agenda. “Avoid

42 For a useful typology of the different forms of abstraction in animation film, see Feyersinger 2013.

moving your bodies, dear humans! And don't forget to strain your nerves". Effectively applying the aesthetic means of the medium, the film demonstrates the idea that television could cause sensory overstimulation. The camera moves behind the TV viewer who is looking at the screen.

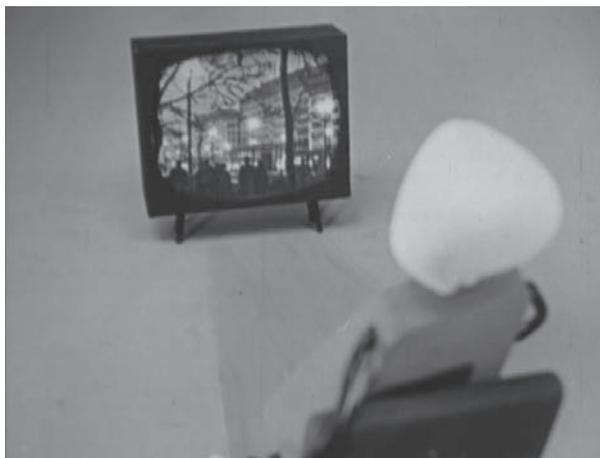


Figure 2: “Don't forget to strain your nerves!” *Active Recreation* [*Aktive Erholung*], directed by Kurt Weiler (GDR 1964), client: German Hygiene-Museum Dresden, producer: DEFA Studio for Popular Science Film (Potsdam).

The camera then presents a protagonist's point-of-view shot: the audience of the film takes the protagonist's perspective *in* the film. Together they are watching the protagonist's TV that shows a fast-changing sequence of images from different programs. We hear sinister music that gets louder, and the devil forcefully repeats “Your nerves, your nerves!” An abrupt rack focus shot then occurs and the image becomes fuzzy. However, this is still not enough excitation for the senses so the camera moves even closer to the TV so it takes up almost the entire screen. Moreover, the viewing axis is tilted.

All in all, this sequence is about acceleration, i.e. a sharp increase of audiovisual stimuli that the human senses have to perceive and the nervous system has to process. *Mise-en-scène*, cinematography, sound and montage seek to draw the audience's attention to specific aspects of audiovisual media. According to this depiction, using television involves a powerful and potentially harmful interconnection between its technical infrastructure and the visual and auditory senses. In this case, the viewer was unable to manage the power of the medium. In the next shot we see our poor and overstimulated office worker falling from his armchair and collapsing onto the floor before being taken away by ambulance.

“That’s it. The end!” The devil celebrates and makes a promise to the audience: “You could lie in this lovely ambulance too, if you live foolishly enough.”⁴³

Change of scene: we see three people standing and working on an assembly line. “I can also find victims here.” But it’s going to be different. After work, instead of driving home the exemplary worker takes his bike. Perplexed, the devil shouts “Hey! Who would want to subject themselves to such unreasonable exercise?” In the next scene we are once again in the protagonist’s living room and the camera is looking at the television. Confident of his success, the devil switches it on. “I can trap him with this.” But he is wrong. The screen shows a woman performing gymnastic exercises and the factory worker starts to imitate her movements in front of the television underscored by dynamic marching music. As we might expect, this type of program combined with such TV usage makes our little devil quite angry: “What? Even television is promoting health now?”

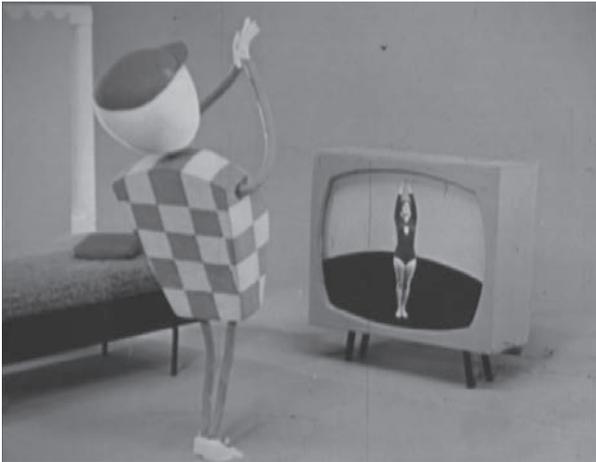


Figure 3: Exemplary use of the new medium. *Active Recreation* [*Aktive Erholung*], directed by Kurt Weiler (GDR 1964), client: German Hygiene-Museum Dresden, producer: DEFA Studio for Popular Science Film (Potsdam).

This punch line tells a lot about the perspective of this film on the complicated relationship between health educators and the German Television Broadcaster (*Deutscher Fernsehfunk*). Health educators frequently voiced

⁴³ Again, puppet animation seems to be particularly useful for depicting the hyperbolic and absurd situation of a collapsing body slipping to the ground due to TV consumption. Likewise, it is plausible to assume that presenting the risk of sensory overstimulation instead of other health risks must have been especially attractive for a puppet animation film specialist because it would allow for such a depiction.

the criticism that in view of its possibilities television was not sufficiently contributing to promoting the health of the audience. The film handles this serious matter in an ironic and humorous manner. The second scene is about to illustrate that TV can do better: The gymnastic program probably referred to *Notes for Medicine* (*Medizin nach Noten*) which was a periodic ten-minute exercise show first broadcast 1961.⁴⁴ Using the rhetorical means of inversion, though the devil's astonishment the film expresses its praise for television's decision to start broadcasting this show. Thus, this scene pointedly presents health educators' utopian idea of how the health risks of TV should be overcome – on one hand, by producing and broadcasting health-promoting programs that would attract an audience from the range on offer; on the other, encouraging the audience to develop and perform the ability to choose programs and leisure activities wisely based on individual health and well-being. But what exactly made television so powerful that one's life seemed at risk when consuming “too much”? And why were office workers more likely to be at risk of overstimulation?

Risking Sensory Overstimulation: The Television Viewer as an Irritable Machine

The idea of sensory overstimulation assumed that the human senses were only capable of receiving and processing a limited number of stimuli.⁴⁵ The idea that the human senses were at risk of being overwhelmed by the complexity of an unfamiliar medium thereby causing health and other issues is a recurring narrative in the history of modern media discourses that usually emerged during media upheaval.⁴⁶ The persuasive power of this narrative is related to the fact that at this early stage media discourses tend to revolve particularly around the technological infrastructure of the new medium.⁴⁷ Accordingly, also in the case of television history the idea that the new medium could emit too many stimuli was based on a technocentric understanding of TV. Such a perspective dominated health-related media discourses about television in the 1950s and early 1960s. If someone had missed *Active Recreation* one could learn more about this issue from the TV guide *Radio*

44 Initially, this format was a part of the program *Sports-Mix* (*Sport-Mix*) first broadcast in 1961. With the end of *Sports-Mix* (*Sport-Mix*) the format became a separate show in 1967. In 1968, for instance, it was broadcast at 9:50 and 15:45 (Steinmetz/Viehoff 2008, 239–240; Hickethier 1998, 304).

45 Schneider 2002, 261.

46 Kümmel/Scholz/Schumacher 2004, 8.

47 Scheider 2002, 250–251.

and *Television in the GDR* or in the popular health magazine *Your Health*. Referring to a typical narrative of early media discourse on television, one 1964 article published in the latter sought to identify the characteristic of television by comparing it with the previous leading electronic medium used at home: the radio. Sound emitted by this medium spreads outwards “spherically”, whereas according to “optical-physical laws” TV’s “lines of sight” (*Sehstrahl*) spread in a straight line forcing its viewers to orient their bodies, senses, and attention towards the screen.⁴⁸ Therefore, TV allegedly required an enormous level of concentration vividly described by a “specialist in neurology” who gave an interview to *Radio and Television in the GDR* entitled “Everything can be overdone.”⁴⁹ He was asked whether “[w]atching too much television [would] harm your nerves?” Resonating with *Active Recreation*, he argued that television

constitutes a passive but even though mental activity. The viewer is forced to follow the rapidly changing images, to merge visual and auditory sensation, and to mentally add color. Registering impressions and comparing them with former experiences, the viewer is collecting new sensations and perceptions, and thinks about the future. That is a heavy mental strain.⁵⁰

This might also describe the experience of watching a film in cinema since film and television have several common aesthetic aspects, namely cinematography, *mise-en-scène*, and montage. However, the cinematic experience was not the primary reference point for seeking to capture a specific structure of television. In comparison with the cinematic dispositive it would have been impossible to argue that the televisual dispositive was specifically characterized by its power to fix the viewer’s body and orient the senses towards a screen.⁵¹ Comparing TV with radio, on the other hand, the older electronic medium used at home allowed the claim to be made that television involved a risky increase of nervous strain.

Yet, the medical problematization of TV consumption was not only based on a media discourse that focused on the technological and physical interrelation between the device and the human body. It was also based on a specific understanding of the human body. Referring to a long tradition of interdisciplinary scientific discourses, the human body was conceptualized as an irritable and sensitive machine whose biological functions were regulated by the nervous system.⁵² This system was responsible for organizing and reg-

48 Eichwald 1964, 48.

49 N. 1964.

50 N. 1964; see also Nitschkoff 1972.

51 Drawing on Jean-Louis Baudry’s thinking on the cinematic apparatus, Hickethier 1995 seeks to distinguish a cinematic dispositive from the dispositive of television.

52 Sarasin 2001, 344–355; Kury 2012, 28–30; Stoff 2003.

ulating the interrelation between the human organism and its environment. Receiving and processing environmental stimuli, the nervous system was responsible for keeping the organism in a dynamic state of equilibrium (homeostasis). According to this understanding, when watching television visual and auditory signals stimulate the nerve cells of eyes and ears. In the next step, the excitation is transmitted to the central nervous system and finally to the brain where the nervous excitation can manifest as a conscious sensation.⁵³ Furthermore, these excitations are processed by the autonomic nervous system “which operates independently from our will” as television viewers could learn from another health education film.⁵⁴ This component of the central nervous system consists of two nerve cords, each of which transmits opposing “regulatory impulses” to the organs thereby “keeping their activity in balance.”⁵⁵ The sympathetic nerve activates a physiological response whereas the parasympathetic nerve has an inhibiting effect. Due to the self-regulating abilities of this system the human organism, in principle, was considered able to adapt to changing environmental conditions and stimuli. However, a one-sided exposure for a long period of time was believed to put the healthy state of equilibrium at risk, thereby engendering functional disorders of the organs, for instance, high blood pressure or poor circulation which in the case of the coronary arteries can become “a deadly danger.”⁵⁶

This medical concept was also relevant for the problematization of consumption practices that people often chose to combine with watching television. Drinking alcohol was considered to further weaken the “‘television resilience’ of the nervous system.”⁵⁷ Another expert warned against a “chain of poison” (*Giftkette*) when people smoke cigarettes, drink coffee or alcohol while watching television.⁵⁸ To prevent overstimulation of the senses while watching television, the TV viewer was prompted to govern the irritability of the body.⁵⁹ Health education motivated the individual to register and regulate quantity and quality of the environmental stimuli the body was exposed to. Two rationalities of self-government can be differentiated: moderation and balancing. The technique of moderation aimed at television “dietetics” that measures the time spent sat in front of the TV and the amount of food, alco-

53 Thränhardt 1958, 12–16.

54 *Mußte das sein?*, directed by Wolfgang Heyer (GDR 1964), 2:08–2:10.

55 Heyer 1964, 2:25–2:35.

56 Heyer 1964, 11:22–11:24.

57 Eichwald 1964, 49.

58 N. 1964.

59 Sarasin 2001, 20.

hol, coffee, and cigarettes consumed *en passant*.⁶⁰ The technique of balancing meant exposing the organism to opposing stimuli. “Fatigued nerve cells recreate even faster when their activity is further inhibited through the creation of excitation in neighboring areas of cerebral cortex. [...] That is called active recreation.”⁶¹ Therefore, also on the basis of knowledge about the nervous system office workers were especially prompted to do sports in addition to watching television after work to foster the recreation of nerve cells fatigued “after long intellectual work.”⁶²

The idea that office workers were particularly at risk of sensory overstimulation took center stage in a vivid discourse in the 1950s and 1960s that revolved around the term “manager’s disease.”⁶³ Historian Patrick Kury has shown that this discourse constituted an updated version of the “neurasthenia” discourse relevant between the 1880s and the First World War.⁶⁴ Then and now these discourses allowed the expression of concerns for overstimulation, overexertion and fatigue of the population – all considered negative (side) effects of modernization. Then and now acceleration, urban environment, working and living conditions, and technological infrastructure – including technological mass media – were at the centre of attention. Accordingly, *Active Recreation* shows that watching television was only one potential source of new and powerful stimuli. Another medium – the ringing telephone – became a symbol of an excessive increase of stress at the office.⁶⁵ Against the backdrop of these shared characteristics the specific dynamics of the “manager’s disease” discourse can come to the fore. Taking up terminological discussions in the West, East German medical experts rejected the term because of “the sociological uncertainty of this occupational title”⁶⁶ or the conviction that “our economic structure does not know them.”⁶⁷ In West Germany, the discourse focused on occupation groups that were considered society’s top performers and spearheads of post-war reconstruction and “economic miracle”. Therefore, suffering from “manager’s disease” was often associated with the acquisition of symbolic capital. East German medical experts criticized the idea that “manager’s disease [was] a privilege of the managers” because they rejected the effect of a social hier-

60 Schneider 2003, 74–75.

61 Thränhardt 1958, 53.

62 Thränhardt 1958, 53.

63 Kury 2012, 109–175. Kury only shortly touches the history of this discourse in the GDR.

64 Kury 2012, 167–168.

65 Kury 2012, 147.

66 Hollmann 1963, 433.

67 Gamnitzer 1957, 38. Thänhardt 1958, 49 used the term “functionary disease” (*Funktionärskrankheit*) instead of “manager’s disease”.

archy associated with that thinking.⁶⁸ Medical experts insisted that these diseases occurred in all occupation groups, that all genders were affected, and that more research was inevitable.⁶⁹ Nevertheless, statistical data available at that time pointed to the fact that male intellectual workers were statistically more significantly affected by cardiovascular disease.⁷⁰ So East German medical experts appropriated the concept's basic idea which allowed a causal connection to be drawn between lifestyle changes and new working conditions due to society's modernization (which affected first and foremost certain occupation groups) and the increase of certain diseases, in particular cardiovascular disease. As we will see in the last section, this gender and class bias remained relevant in the 1970s when worries about television's potential to overstimulate the viewer's senses already alleviated – not least because of the advent of empirical audience research.

Empirical Audience Research: Taming the Risk of Sensory Overstimulation

From the very beginning of regular television programming in 1956, different actors were interested in discovering more about this unknown entity called the audience for different reasons. SED officials were particularly interested in audience's reactions to programs that aimed at an ideological education of the people such as *Aktuelle Kamera* or *Der Schwarze Kanal*. TV producers, on the other hand, were mainly interested in audience's reactions, preferences and viewing patterns for reasons of effective and attractive programming.⁷¹ And health educators were eager to learn more about the recipients of their films and the effectiveness of their messages. The earliest efforts at collecting data about audiences occurred in public television rooms. Since 1956, so-called television correspondents visited these locations, observed the reception practices and interviewed selected viewers. Moreover, a Department for Impact Research (*Abteilung Wirkungsforschung*) was founded that was responsible for analyzing letters sent to the German Television Broadcaster (*Deutscher Fernsehfunk*). Eventually, in 1964 the Department for Audience Research (*Abteilung Zuschauerforschung*) was estab-

68 Gamnitzer 1957, 2; Kury 2012, 122.

69 Madarász-Lebenhagen/Kampf 2013, 161; Madarász-Lebenhagen 2015, 80–81; Kury 2012, 123.

70 Most health education films on cardiovascular disease are also characterized by a class and gender bias. Heyer 1964, for instance, included a male truck driver or a female industrial worker but the main protagonist of the film is a male office worker in a leading position.

71 Meyen 2003, 18–23; Otto/Ruchatz 2005, 185–187; Steinmetz/Viehoff 2008, 53–56.

lished. For the first time in the GDR, approaches and methods of quantitative social research were systematically applied to the study of TV consumption. Its first representative survey was conducted in May 1965; periodic “direct surveys” – interviews with approximately 1000 viewers – were conducted from 1968.⁷² According to its first director the psychologist Christa Oehme, the new department’s task was to overcome a knowledge deficiency about practices of TV consumption: “[T]here were no clear answers but only presumptions even in regards to the most simple and obvious questions about television practices.”⁷³ Therefore, researchers were interested in “all empirical facts that are related to the television viewer, their sociological characteristics, and their specific relationship to television.”⁷⁴

This process of professionalization and (social) scientization through the appropriation of empirical social sciences belonged to a broader trend in East German scientific and political history.⁷⁵ In the 1950s and up to the early 60s, the SED leadership regarded quantitative sociology conducting survey research as an element of bourgeois ideology and therefore as being incompatible with scientific Marxism-Leninism. However, in 1963 in the context of an international euphoria for scientific planning and Walter Ulbricht’s reform orientation the SED launched the so-called “New Economic System of Planning and Management” that integrated elements of market economy, calling for a systematic feedback between the consumers and the planning of production. So, the 6th Party Congress also announced the introduction of quantitative sociology and the establishment of new research institutions intending to produce scientific knowledge about the conditions and effects of political planning and intervention. The Institute for Demand Research (*Institut für Bedarfsforschung*) was founded in 1962. 1964 saw not only the founding of the Department for Audience Research but also of the Institute for Opinion Research (*Institut für Meinungsforschung*). In 1966, the Central Institute for Youth Research (*ZIJ – Zentralinstitut für Jugendforschung*) was founded that also engaged with studying media consumption. The implementation of these institutions represented a discontinuity in the political rationality of the GDR that is a new thinking of how the population can and should be governed gained in importance. Producing social

72 Meyen 2003, 18–23.

73 Oehme 1966, 812–813.

74 Oehme 1966, 812.

75 Otto/Ruchatz 2005, 188 rightly argue that “scientization” is not the appropriate term to denote this process since Marxism-Leninism that strongly shaped ideas about audiences and media impacts was already considered a scientific discipline. Therefore, they prefer the term *Empirisierung*. Sammer 2019 uses the term *Ver(sozial)wissenschaftlichung* to describe the increased importance of the social and behavioral sciences for health education throughout the 1950s and 1960s.

knowledge about the population meant increasingly taking into account the self-regulating forces of society and the individual as preconditions and starting points for political interventions.⁷⁶ In this context, empirical audience research strengthened the idea of an active and self-determined TV consumer. As we will see, this shift in media discourses had an impact on the health-related problematization of television.

The publications of Lothar Bisky, who worked at the *ZfJ* from 1966 and was one of the leading researchers in the field of media impact research in the GDR, are particularly useful for reconstructing theory and methodology of that discipline. In an article co-written with his colleague Lutz Burger they clarified what exactly constituted the scientific object of impact research: “Impact research primarily deals with the result and not the process of reception [...]. In other words: impact research studies determining effects of social communication on behavior, so we have to distinguish it from research that examines the process of reception.”⁷⁷ Bisky and Burger adopted and applied the terminology developed by renowned West German communication scientist Gerhard Maletzke. According to Maletzke, each communication process can be divided into three phases: pre-communicative, communicative and post-communicative.⁷⁸ In a narrow sense, Bisky and Burger reserved the term “impact” to denote the post-communicative phase that is the “result” of a transmitted message (the “communiqué”). But they argued that empirical impact research also has to deal with the pre-communicative phase to understand the “conditions” of successful communication. In contrast, the actual “process of reception” – the communicative phase – no longer systematically mattered. Visual and auditory senses were considered a neutral channel that merely guarantees the successful transmission and reception of a communiqué. The material techno-biological interconnection between the technology of the medium and the human body emerging in the moment of reception represented a matter of secondary interest. Accordingly, to identify “what is actually affecting the recipient” Bisky and Burger favored the method of content analysis.⁷⁹ Thus, the scientific attention moved away from the materiality of the medium and the recipient’s body and focused on the immaterial dimension of contents.

Considering the materiality of the reception process as not essential for understanding televisual communication, this approach tamed the power of television to stimulate the viewer’s senses and nervous system and confined

76 Reinecke 2010; Gansen 1997, 87–89.

77 Bisky/Burger 1970, 175.

78 Maletzke 1963.

79 Bisky/Burger 1970, 176.

it to a black box.⁸⁰ At the same time empirical audience research strengthened the viewer's agency to appropriate the contents of TV programs differently and to actively shape the results of communication processes. Instead of being understood as a relatively homogenous mass of irritable machines at risk of harm from too many televisual stimuli, viewers were now conceptualized first and foremost as subjects possessing their own opinions on different programs, viewing habits, and wishes regarding the broadcast schedule. Surveys constantly asking viewers about their "specific relationship to television", their attitudes, preferences and motivations presupposed and thereby contributed to producing a type of consumer able to choose from the TV schedule and reflect on personal attitudes, preferences and motivations underlying the choices.⁸¹ Empirical research was eager to unravel and organize the new contingency and diversity by correlating the data on TV consumption with "sociological characteristics" of the viewers.⁸²

Despite the growing importance of this discipline for understanding TV consumption, the idea of the apparatus' negative effect on the viewer's nervous system did not entirely disappear from scientific and public debate. For instance, the Central Institute for Cardiovascular Regulation Research (*Zentralinstitut für Herz-Kreislauf-Regulationsforschung*)⁸³ also examined the impact of television on blood pressure as reported by the popular science magazine *Your Health*.⁸⁴ Even Bisky and Burger mentioned research methods that studied the communicative phase, for instance by examining the "psycho-physical side effect" of film reception.⁸⁵ Although admitting that "these methods can reveal single aspects of immediate impact" they underlined "several objections" against this kind of research.⁸⁶ Consequently, they made no effort to build a conceptual and methodological bridge between approaches of psycho-physiological media research and empirical audience research. The new discipline created a more sophisticated but nevertheless one-sided understanding of TV consumption and media usage in general.

In order to understand why this new concept of TV consumption could have an impact on the German Hygiene Museum's production of health education films, one has to take into account that contemporary concepts and

80 For such a perspective on empirical audience research, see Otto 2004; Schneider/Otto 2007.

81 For an equivalent interpretation of surveys on dietary habits, see Möhring 2016, 317–318, 329–331.

82 Oehme 1966, 812.

83 Founded in 1972, this institute was GDR's major research facility that dealt with cardiovascular disease (see Timmermann 2005)

84 Nischkoff 1972; Eichhorn 1980.

85 Bisky/Burger 1970, 183; They mentioned that also the *Department for Audience Research* tested these methods.

86 Bisky/Burger 1970, 182–183.

methods in health education were also oriented towards the social sciences. Recently, historian Christian Sammer has shown that the traditional concept of health education as “*Hygienische Volksbelehrung*” fell into a crisis in the 1950s.⁸⁷ This approach conceived health education primarily as a knowledge transfer based on the assumption that rational insights into health risks would make people change their way of living. But health educators had to learn that there can be a huge discrepancy between people’s knowledge and behavior. From the 1950s onwards, East German health educators participated in an international discourse that oriented towards social and behavioral sciences that provided new concepts and methods promising to regain the ability to govern the population. According to these sociological, psychological and pedagogical approaches human behavior was not only shaped by rational choice but rather by a variety of factors such as individual attitudes, preferences, motivations or the social environment and (group) interactions. Therefore, the recipient of modern health education and the TV consumer of empirical audience research were characterized by the same social science aspects. Health educators were called upon to take these aspects into account when addressing audiences. Learning more about these dynamics was considered an essential precondition of successful educational measures.

Consequently, the German Hygiene Museum was greatly interested in the findings of empirical audience research including those of the Department for Audience Research. For instance, their findings on the correlation between usage patterns and socio-economic features promised to allow for a sophisticated target group orientation.⁸⁸ But unfortunately, after the short reform period in the 1960s the circulation of the results was usually heavily regulated and often suppressed by the SED in the 1970s and 1980s.⁸⁹ In 1971, Kurt Speier, then director of the Hygiene Museum’s Department for Health Education responsible for organizing and supervising the production of health education films, took the opportunity of a public conference to complain about this situation. He criticized that the Museum’s empirical knowledge supply was “currently not sufficiently secured.”⁹⁰ Arguing that

87 Sammer 2019.

88 Ludwig 1973, 160.

89 With the Prague Spring and its suppression, the SED leadership lost its openness to political reforms. Thus, the Party increasingly lost its willingness to refer to social knowledge about the population when governing it. Furthermore, constituting a crucial means for society’s self-observation this kind of knowledge had the potential of unintended and uncontrollable feedback effects. For instance, the SED did not want the population to know – on the basis of empirical research – about the degree of social inequality since it would contradict the ideology of a classless society (Reinecke 2010).

90 Speier 1971, 154.

the available “isolated information does not guarantee an adequate overview” he claimed that “very soon measures [will have to be] taken for a change for the better.” It is most likely that this did not happen since there is no indication in the archive of a comprehensive knowledge transfer or the implementation of a systematic feedback loop.⁹¹ But nevertheless, Speier’s statement demonstrates the Department’s high regard for the social sciences and the production of social knowledge about recipients. Analyzing *Everyone, everywhere...* a health education film produced in 1970 I wish to argue that despite the lack of systematic data the conceptual shift in understanding TV consumption resonated in the health education’s problematization and management of this practice.

Everyone, everywhere...: Governing a New Type of Television Viewer

In contrast to *Active Recreation*, this thirteen-minute live action film did not belong to a series of health education films. The title referred to the popular slogan Walter Ulbricht proclaimed in 1959 to promote popular sports (*Mas-sensport*): “Everyone, everywhere, should do sport once a week.”⁹² Accordingly, the film’s plot revolves around the main protagonist who – also functioning as voice-over narrator – wants to make a film on the positive effects of sports on health. So this is also a film that aims to encourage the population to perform active recreation. Throughout the film the main protagonist presents new ideas and starting points for how such a film could be made, thereby already delivering the information to the audience. Therefore, the entire narrative style is self-reflexive.

Before we move to the main protagonist’s living room, we first see him on a tram where a young woman smiles at him then offers him a seat.⁹³ When offered the seat he realizes he had misinterpreted her smile: Instead of sexual attraction she was offering to help an older man she thought would have trouble standing on public transport. Brought sharply back to reality he comments: “How could this happen to me?! At 40! Actually, it’s no surprise given my lifestyle.” Cut. We see a close-up of a TV that almost fills the entire screen. It shows images of Leipzig Central Stadium in which a major sporting event is taking place. “Avoiding every needless step,” the main protagonist’s interior monologue continues. “It’s not that I’m not interested in

91 The files of the German Hygiene Museum are located in *Sächsisches Hauptstaatsarchiv Dresden*.

92 Braun 2009, 414.

93 Emuth 1970, 7:05–8:25.

sport. Quite the opposite!” Now we hear the voice of the female commentator of the sporting event shown on the intradiegetic⁹⁴ TV: “Running, hiking, gymnastics, physical education, swimming, and track and field all in the guise of exercise, training and competition. All of which contribute to a healthy and cultured life. These activities are both available and necessary for everybody.” While her commentary can be heard the camera zooms out from the screen of the intradiegetic TV.⁹⁵ From this new point of view, we can see that the scene takes place in a living room and that the camera is located behind the intradiegetic television viewers who we recognize as our main protagonist and a woman his age – probably his wife. Very similar to the cinematography in the first part of *Active Recreation*, a contemporary audience watching *Everyone, everywhere...* in 1970 on their TV was now observing two people watching TV. Following the classical montage principle of shot/reverse-shot the camera now moves in front of the two TV viewers allowing the audience to see how they are interacting with the television and what they are doing while watching TV.



Figure 4 and 5: Watching people watching television. *Everyone, everywhere...* [Jedermann an jedem Ort...], directed by Hanna Emuth (GDR 1970), client: German Hygiene-Museum Dresden, producer: DEFA Studio for Short Film (Potsdam).

Establishing this perspective of second-order observation, which is observing how somebody is observing something else, this sequence intended to invite viewers to observe and monitor themselves as television viewers. Just like the

94 Diegesis denotes the fictional world which is created by a narration. Intradiegetic means that a figure, a statement or an act belong to this world, and that the fictional character is not reflected by this figure, statement or act. Here, the sports commentator is speaking from the protagonists' TV set addressing the protagonists, but at the same time, she can be heard by the viewer.

95 The depiction of television in Heyer 1974, 4:30–4:40 is characterized by the same cinematography. The film belonged to the series *Health Guide (Wegweiser Gesundheit)* broadcast in the evening before the popular Sandman (Schneider 2011, 120).

questions asked by empirical audience researchers prompted to reflect about viewing habits, underlying attitudes, motivations or preferences, the TV screen becomes a mirror reflecting the reception and consumption process of the actual audience. This reflexive loop is underlined by the main protagonist's voice-over that responds to the TV commentator's statement "Yes, I know this directive from the state council resolution on the purpose of physical culture and sports: 'Everyone, everywhere!' Apparently, some people also consider the chair in front of the television such a place." Referring to himself as the person sitting in the TV chair the man is emphasizing that he has joined us in observing him. The next comment reveals the temporal perspective of this self-observation. "Well, I know. I did too." Due to the usage of different tenses the main protagonist marks the person we are seeing at that moment as his former self and indicates that both are not identical. Evidently, in his case self-observation was just the inevitable starting point for a self-problematization that finally induced techniques of self-normalization.⁹⁶ Now in retrospect, after having become someone who leads a rational and healthy life, he is looking back into his living room seeing himself sitting in his chair watching sports on television. Drinking coffee. Smoking cigarettes. And eating chocolates. At the end of the scene in front of the television, we eventually witness the first step of his way to a bright future of a healthier life: His wife removes the box of chocolates from his radius of action. When he once again reaches for some chocolates with his eyes on the television, there is nothing there. A smile seems to signal his understanding – or his docility. Either way, this scene invites the audience to reflect on the importance of their social environments and the dynamics of (gendered) social interactions for shaping their health-related behavior.

This division of gender roles was common in health education films on cardiovascular disease.⁹⁷ In line with the gendered structure of the narrative the films' interpellation of the audience followed a binary gender order. On the one hand, *Everyone, everywhere...* addressed the risk group of male office workers prompting them to adopt a healthier lifestyle. On the other hand, it encouraged women to take responsibility as caring wives. In contrast to the male protagonist, the wife did not have to discover her responsi-

96 Self-normalization comprises a variety of techniques of the self. All are characterized by the individual's effort to adjust themselves to quantitative standard values in order to situate themselves within a normal range (Link 2013, 351–354, 389–418). Balancing and moderation are based on such a quantifying understanding of right behavior. They are meant to bring about a normalization of the TV consumer.

97 See for instance: Heyer 1974, 4:58–5:21; *Hygiene III – Fettsucht*, directed by Anonymous (GDR approx. 1965); on gender relations in GDR's health education, see: Linek/Pfüttsch 2016; Linek 2015.

bility through an elaborate technique of self-observation. This demonstrates to what extent these films implicitly presupposed (and reinforced) this form of asymmetrical gender order. Furthermore, taking into account contemporary insights from social sciences that (health-related) behavior was influenced by *all* forms of interactions with the social environment, health education films could be relevant for *every* citizen. When “public sanctions for health behavior of individual citizens [...], i.e. the permanent public valuation and assessment of behavior” are considered “one of the most important means to strengthen correct behavior and to alter inaccurate ones”⁹⁸ every citizen is asked to take part in the project of health education. Then these films have the task to teach every citizen whom they should grant recognition for demonstrating “correct behavior” and whom they should stigmatize for “inaccurate” behavior.

However, according to *Everyone, everywhere...* caring for the equilibrium of the body’s nervous system when watching television was no longer a normative aspect of correct and healthy behavior. Yet, the concept of nervous overstimulation had not disappeared from the film’s problematization of health risks due to modern lifestyle. Similar to the 1960s, an urban infrastructure characterized by different forms of acceleration and job-related stress were identified as roots of “sensory overload and increased strain.”⁹⁹ The danger of the TV was still seen, firstly, in its power to fix the viewer’s body to a chair for the duration of reception and, secondly, in the viewer’s habit of unhealthy consumption practices while watching TV. But the health risk was not about exposing the body to potentially harmful amounts of nervous stimuli. Instead, in the context of the intensified problematization of food consumption, body weight, and a reduction of physical activity the idea of a positive energy balance came to the fore.¹⁰⁰ With the ending of food rationing in 1958 nutritionists were already warning about the negative consequences of “malnutrition”, “overeating” and “obesity” on cardiovascular health. Yet, in light of a successive increase of food consumption especially in the course of Honecker’s program of “consumer socialism”, the late 1960s and early 70s represent the decisive phase of a persistent intensification of this discourse. Furthermore, the organization of work has gone through important transformations since the 1960s. Contemporary debates used the term “scientific-technological revolution” to denote these processes. Just like other developed industrial societies, the GDR experienced a structural transformation of production processes characterized by scientization,

98 Müller 1971, 191.

99 Emuth 1970, 4:40–4:43.

100 Weinreb 2017, 196–236; Kerr-Boyle 2013; Thoms 2011.

mechanization, and automatization. Moreover, these years saw an increase of office workers.

Against the backdrop of these transformations, active recreation in leisure time was not primarily presented as a means to compensate for one-sided nervous stimulation, but rather a technique to balance the reduced energy output due to the reduction of heavy physical labour on the one hand and an increase of food consumption on the other. Consequently, later in the film, the main protagonist is on his way to a healthier lifestyle and we can see him in a sports club or jogging through the streets with his wife and son.¹⁰¹ Moreover, balancing techniques were still to be combined with the rationality of moderation. Not only was moderate television consumption advised, but also that of food. Pralines occupy an important place in the history of the problematization of “TV snacking”.¹⁰² They appear again, for instance, not only in another health education film from 1974 but also in a manual on cardiovascular disease prevention published by the Hygiene Museum the same year.¹⁰³



Figure 6: TV snacking. *Weight (Health Guide Movement No. 2)* [*Gewicht (Wegweiser Gesundheit Nr. 2)*], directed by Wolfgang Heyer (GDR 1974), client: German Hygiene-Museum Dresden, producer: DEFA Studio for Short Film (Potsdam).

Since the booklet was used by health education institutions at the local level, it had a high circulation. The chapter “Recommendations for a Reasonable Diet” advised readers to “greatly reduce uncontrolled snacking while en-

101 Emuth 1970, 11:12–11:39; 12:42–12:53.

102 Ries 1968, 145.

103 Heyer 1974, 4:40–4:58.

gaged in other activities such as watching TV, preparing meals, reading, etc.”¹⁰⁴ A table in the chapter also listed the calorie content of various “nibbles” including pralines. The fact that this booklet mentioned television solely as a facilitator of unhealthy snacking, vividly illustrates that the health-related problematization of the medium had shifted. Furthermore, mentioning television in the same sentence with older everyday practices, such as reading and cooking indicates that TV consumption had become another common practice of everyday life by now. Presumably, processes of habituation and familiarization, on one hand, and the discursive de-dramatization of potential health risks, on the other, effectively influenced each other.

Conclusion

In this article, I sought to illustrate the potential of analyzing media discourses to shed new light on questions regarding the history of medicine and health. Dealing with the medicalization of TV consumption in its first two decades in the GDR, I delineated interconnections between debates on risk factors for cardiovascular disease and debates on television as a new social phenomenon. Despite the fact that the media discourse of empirical audience research was uninterested in the medical dimension of TV consumption, it nevertheless strongly resonated with the medical problematization of this leisure activity. Leaving behind a technocentric understanding of TV and emphasizing the consumer’s agency, contemporary concepts and methods from the social sciences including empirical audience research undermined the idea that the medium had the power to overstimulate the viewer’s nervous system. Furthermore, the analysis of health education films shows that this new scientific approach to the medium had ramifications for health prevention. Health education ceased to focus on technological aspects of the medium and secondary aspects associated with watching TV came to the fore. People could snack or sit in a comfortable chair for hours and days even without watching television, however, the medium was suspected to promote these unhealthy habits. The new perception of TV consumption indicates a discursive de-dramatization of the medium and a process of cultural habituation. Nevertheless, the situation of TV consumption remained an important starting point for the efforts of health educators promoting moderation and balancing as techniques of individual health prevention. Therefore, the history of health-related media discourses on television illustrates that even for

104 Barth/Schubert 1974, 5.1, 9.

the social order of state-socialist GDR the idea of a (self-)responsible subject was of systematic importance to manage the risks of enjoying the modern medium. Finally, the history of media discourses reveals that the history of modern subjectivity is also the history of an ir/rational (media) consumer.

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Television Programs

- Aktive Erholung*, directed by Kurt Weiler, client: German Hygiene-Museum Dresden, producer: DEFA Studio for Popular Science Film (Potsdam), 35mm, color film, sound, puppet film, 2:11 minutes, released on 26th June 1964 (DHMD 2007/645)
- Gewicht (Wegweiser Gesundheit Nr. 2)*, directed by Wolfgang Heyer, client: German Hygiene-Museum Dresden, producer: DEFA Studio for Short Film (Potsdam), 35mm, black and white, sound, live action, 5:43 minutes, 1974 (DHMD 2007/436)
- Herz-Kreislauf-Prophylaxe (Wegweiser Gesundheit Nr. 9)*, directed by Günter Biedermann, client: German Hygiene-Museum Dresden, producer: DEFA Studio for Short Film (Potsdam), 35mm, black and white, sound, live action/animation, 6:14 minutes, 1975 (DHMD 2007/578)
- Hygiene III – Fettsucht*, directed by Anonymous, client: German Hygiene-Museum Dresden, producer: German Television, 35mm, black and white, sound, animation, 1:03 minutes, approx. 1965 (DHMD 2007/882)
- Ist Sattsein richtig ernährt?*, directed by Ulrich Kluck, producer: DEFA Studio for Popular Science Film (Potsdam), 35mm, color film, sound, live action, 11:30 minutes, 1967 (DHMD 2007/536)
- Jedermann an jedem Ort...*, directed by Hanna Emuth, client: German Hygiene-Museum Dresden, producer: DEFA Studio for Short Film (Potsdam), 35mm, color film, sound, live action, 13:36 minutes, 1970 (DHMD 2007/866)
- Mit dem Herzen dabei (Wegweiser Gesundheit Nr. 31)*, directed by Werner Kreiseler, client: German Hygiene-Museum Dresden, producer: DEFA Studio for Docu-

mentary Films (Potsdam), 35mm, color film, sound, live action/animation, 6:03 minutes, 1979 (DHMD 2007/566)

Mußte das sein?, directed by Wolfgang Heyer, client: German Hygiene-Museum Dresden, producer: DEFA Studio for Popular Science Film (Potsdam), 35mm, black and white, sound, live action/animation, 14:17 minutes, released on 26th November 1965 (DHMD 2007/494)

Archival Material

Kunkel (stellv. Direktor) an Ministerium für Gesundheitswesen Abt. Wissenschaft Sektor Aus- und Fortbildung, Betr.: Koordinierung der Herstellung von Filmen auf dem Gebiet des Gesundheitswesens, o.D. (1962), in: Hauptstaatsarchiv Dresden, 13658 Deutsches Hygiene-Museum Dresden, Nr. 62/22 (1962)



Surgical Emotions: How TV and Newspaper Coverage Furthered the Cause of Heart Transplantation in France (1968–1973)*

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Abstract

This paper shows the influence of media coverage for the fate of heart transplantation in France. It argues that the media's support not only reinforced the graft's medical legitimacy, but also sustained the practice by mobilizing public support. Our study focuses on two peaks in media coverage. The first took place in 1968/69, as the first grafts in the world and in France were performed. The second occurred in 1973, when surgeries resumed in France following a four-year hiatus due to the mixed results of the early operations. French transplants were then largely covered on TV and in newspapers. We examine the reasons for these peaks in coverage and the underlying rationales of the alliance between French surgeons and journalists. Cross-analysis of TV and print productions sheds light on the media devices used to enlist the general public's moral support. It shows that state television proved an effective platform for doctors, allowing for a different kind of storytelling than in newspapers.

Television studies, science popularization, organ transplantation, France, heart transplant

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Introduction

In November 1965, the newspaper *Le Monde* (LM) announced that over 250 kidney transplants had been successfully performed since the first “French [...] victory report” in 1959 (LM 24-11-1965).¹ In 1961, the first kidney transplant between cousins had demonstrated the advancement in the understanding and mastery of tissue rejection, of rejection treatment and of donor-recipient compatibility. The institutionalization of the field of transplantation began with the creation of the journal *Transplantation* (1963) and of the scholarly society The Transplantation Society (1966). Medical specialists were hoping to be able to transplant other organs, including the heart. And at the time, several surgeons stated that they were ready to take this step.² Heart transplantation was discussed for the first time in France in a full-length film broadcasted in 1965 on the country’s first TV channel. The film gave a detailed step-by-step account of a homograft in a dog.³ The scientist interviewed in the film contended that human heart transplantation would only be feasible once rejection mechanisms could be kept in check and ethical barriers crossed. In June 1967, Paris hosted the first international congress of The Transplantation Society, where it was concluded that it was possible to extend transplantation to the heart, among other organs.⁴ In an interview with French reporter Pierre Bourget, the Boston surgeon John Merrill named three remaining challenges (1ère chaine, 20h, 27-06-1967): donor-recipient pairing, controlling the rejection mechanism, preserving the graft. Technical aspects were left unmentioned but did not seem to be an obstacle: extracorporeal blood circulation was already used for open-heart surgery, and surgeons had been experimenting with transplant on dogs for years, both in the United States and in France. In November 1967, the newspaper *Sud-Ouest* (SO) announced that the American surgeon Norman Shumway claimed to be ready to perform such a surgery as soon as the ideal donor was found (SO, 21-11-1967). He reported having performed nearly 200 heart transplants on dogs, with a success rate of over 60 percent. Indeed, the media covered the subject long before the first transplant was even performed; this medical first appeared to be eagerly awaited, at least in the French media that we analysed for the purposes of this paper.

1 The 1959 “victory report” refers to the first success of kidney transplant between dizygotic twins. LM article indicates that the patient led a normal life after the transplant. A television report was devoted to this transplant on 6 November 1959, Barrère 1959.

2 Nathoo 2009.

3 Barrère/Sciandra 1965.

4 Nathoo 2009.

On 2 December 1967, the first heart transplant performed by Pr. Christian Barnard at Cape Town's Groote-Shurr hospital was a watershed in two respects.⁵ First, on a medical level: three days after the Cape Town surgery, a transplant was performed on a baby in New York by Dr. Adrian Kantrowicz. Announcements of transplants kept coming; by late 1968, nearly a hundred heart transplants had been achieved worldwide. Second, the press extensively covered the first announcements, placing heart transplantation on the media agenda,⁶ whereas coverage of kidney transplants remained somewhat low-key. However, many of the attempts made in 1968 across the world ended in failure: a year after the first transplant, only 14 recipients out of 96 had lived more than three months. In many countries, the initial enthusiasm gave way to doubt and criticism. Following the death of the third patient in Britain, heart transplants were discontinued in Britain for nearly ten years.⁷ By the summer of 1969, only a few hospitals in the world continued to transplant hearts, including Barnard's in Cape Town and Shumway's in Palo Alto.

This research is based on a corpus of TV segments drawn from the national audiovisual archive institute (*Institut National de l'Audiovisuel*, INA), the repository of all French television audiovisual archives. We selected TV items that directly referred to or spoke of heart transplants.⁸ This corpus was complemented by an inventory of articles on heart transplantation in two newspapers: the daily newspaper of record *Le Monde* (LM) and the regional daily *Sud Ouest* (SO) over the 1966 to 1974 period. This data is drawn from the Europresse database.⁹ The early days of heart transplantation were marked by two peaks of media coverage (Figures 1 and 2). The first took place in 1968–1969, as the first transplants were performed in France and abroad.

5 On Barnard's first surgeries and the reactions they elicited in a variety of countries, see Cooper 2017; McRae 2006; Joubert 2018; Nathoo 2009; Danet/Medina-Doménech 2015. On the medical history of the early heart transplantations, see Cabrol et al 1986; Turina 2018; Colombo/Amirati 2011; Marion 1990; Guilmet 1997.

6 On media agenda see McCombs/Shaw 1972. The advent of the first cardiac grafts together with the first manned space journeys greatly contributed to durably install scientific and medical news in the media agenda with a strong focus on the actors of scientific achievement. On this point, see Bauer 1988.

7 Nathoo 2009.

8 We first used the key words "transplant" and "transplantation", then we isolated the segments that accounted for cardiac transplantation. Some actors – patients and surgeons – also received coverage that did not chiefly focus on transplantation. We have not integrated these items in this corpus.

9 <http://www.europresse.com/fr/>. We have identified the articles integrated in our corpus via the three key words: "graft", "transplantation" and "heart".

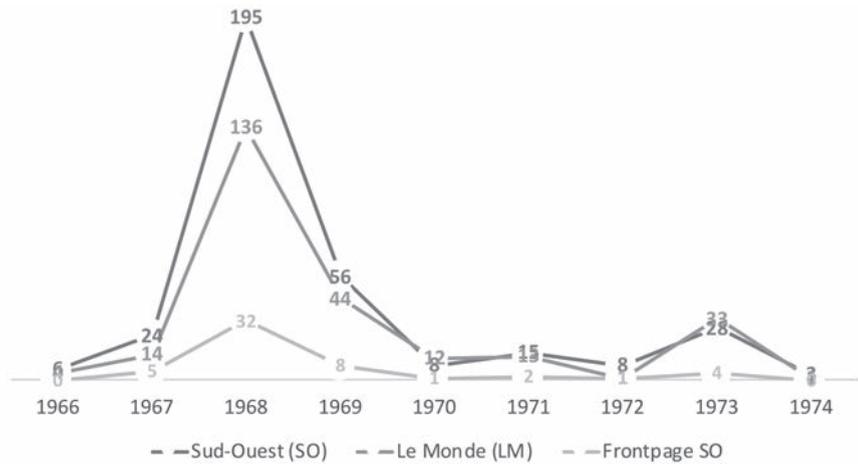


Figure 1: Number of articles on heart transplant per year (1966–1974) in the regional daily paper *Sud-Ouest* and the national *Le Monde*. Half of the collected articles were detailed articles on medical firsts that were often announced on the front page. The other half consisted of short accounts, referring to transplants achieved outside France or to the health status of grafted persons.

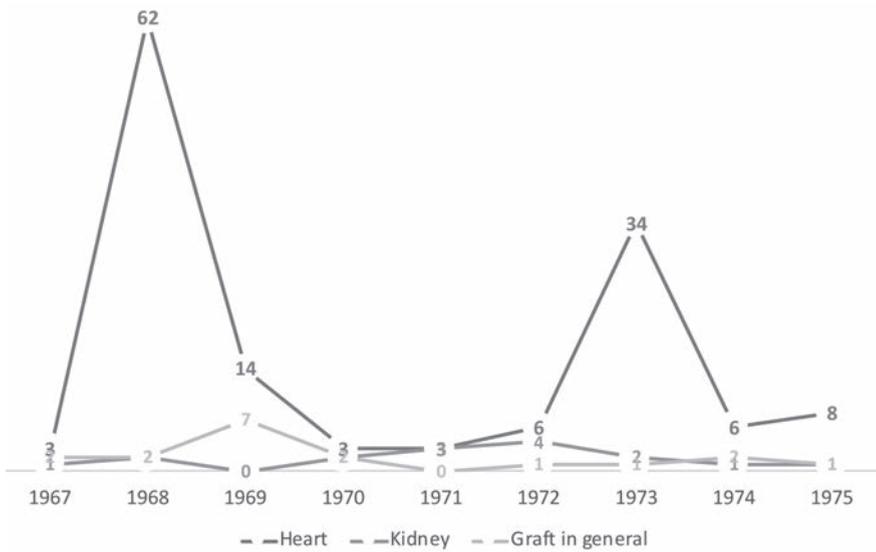


Figure 2: Number of TV segments related to heart, kidney and others organ transplants and transplantation in general per year (1967–1975) in INA descriptive records. Only a few sequences related to graft were broadcasted prior to 1967. Heart and kidneys transplants are the most prevalent, while other organ transplants were scarcely covered in TV sequences during this period.

Ten transplants were performed in France in 1968; only four patients survived for more than three months (three lived over a year). That year, 195 articles on the subject were published in the regional newspaper SO, 136 in LM, and 62 television clips on the subject have been catalogued by the national audiovisual archive institute. Then, in 1973, after a four-year hiatus owing to the mixed outcomes of the French transplantations, operations resumed. Six surgeries were performed during the year; three of the patients survived over a month. These transplants were the subject of 33 articles in LM and 28 in SO, as well as 34 TV segments. Each case was largely covered on TV and in newspapers before August, when coverage peaked before fading again.

The media coverage of heart transplants in France is a somewhat paradoxical story in itself.¹⁰ Indeed, this coverage remained intensive and positive even in 1968, when the survival rate was low. While the newspapers – especially at the national level – covered both criticism and praise of heart transplantation, TV tirelessly heralded and supported France’s leadership. In this article, we set out to examine how this media coverage may have contributed to developments in the medical field. Indeed, it served as means to popularize a type of surgery whose scientific and social legitimacy did not initially go uncontested. In January 1968, Shumway had already noted in a TV segment on the subject that the increase in the number of voluntary donors had been “one of the beneficial effects of the total coverage of this event by press and TV”.¹¹ French television played its part in this by producing a great narrative designed to have audiences accept and embrace heart transplantation on a moral level.¹²

Having characterized the distinguishing features of French TV and newspapers in the years between 1968 and 1973, we will now narrow in on the coverage of the first heart transplants of 1968 in both types of media. Emphasis will be placed on the way in which surgeons, patients and reporters addressed audiences. We will then pursue the same approach for the year 1973. Differences in coverage in both types of media between the two periods will be demonstrated. The media histories of four patients that are particularly emblematic of these periods will be studied in greater detail, giving insights into the ways in which surgeons used TV as a platform for express-

10 Studies on the links between heart transplants and the media are quite rare. Nathoo 2009 has focused mainly on British media, which delivered very different narratives from French media. Danet and Medina-Domenech 2015 have studied narratives presented in the Spanish press. Joubert 2018, for her part, has explored the way South-African medias accounted for the Cape Town’s transplants. Although these contributions are particularly valuable for contrasting media treatment in different countries, no intercontextual comparison has been undertaken yet.

11 Schiller/Désiré 1968.

12 Chavot/Masseran 2012.

ing their engagement and their feelings about transplantation. Lastly, the connections between surgeons and journalists will also be investigated.

Storytelling and Heart Transplantation in Newspaper and on TV

The newspapers and TV told the story of heart transplantation in different ways: their respective technologies and organizational forms framed their ways of reporting and developing narrative on the subject. In the 1960s and 1970s, reading the newspaper was a daily habit for a large portion of the French population.¹³ The data for our analysis comes from a regional daily paper and a national one, both cited above, with different editorial approaches.¹⁴ SO, which boasted the ‘highest circulation in the Southwest’ of France,¹⁵ covers Bordeaux and the surrounding region. This means it reports primarily on local news: for instance, the tenth French transplant recipient of 1968, Bernard Marion, who underwent surgery in Bordeaux, received particularly extensive coverage in SO. The paper was a staunch advocate of heart transplantation, and covered the story of each recipient. Transplantation was personalized in the process and brought into the readers’ everyday lives; articles were often illustrated with photographs.

With a long and storied career under its belt, LM was, in the 1960s and 1970s, considered to be the “newspaper of record in France”.¹⁶ Its editorial policy emphasized cross-checking information, reporting on international news and providing in-depth coverage. LM pursued a critical line, especially during Charles de Gaulle’s presidency. During the period under study, it strived to report on scientific developments as objectively as possible. There was little room for images in LM. Doctors, however – at least at the time of the first transplants in Cape Town – found it a welcoming platform.

In the 1960s and 1970s, television became increasingly widespread in France, although it was still a relatively new object in people’s homes,

13 On newspaper readership in the 1960s and 1970s, see Mouillaud/Têtu 1989; Eveno 2010.

14 On the history of the press and TV, see Jeanneney 1996. For a sociological approach to the press, see Esquenazi 2002a.

15 In 1968, SO’s circulation was ca. 110,000 copies. The paper was going through an expansion phase, and would reach a circulation of 400,000 in the 1980s. Source: <https://fr.wikipedia.org/wiki/Sud-Ouest> (Date consulted: March 2019). On the regional press in general, see Ballarini 2008; Martin 2002.

16 In 1968, LM’s circulation was 355,000 copies. The paper was also expanding, as it would circulate nearly 500,000 daily copies by the 1970s. Source: https://fr.wikipedia.org/wiki/Le_Monde (Date consulted: March 2019).

wrapped in the aura of modernity.¹⁷ The French television broadcasting company (*Radio télévision française* - RTF) offered two channels in 1968; the third channel was created in 1972. In these early years, this was state television, heralded by the government as the leading source of information for the French people – President de Gaulle would use it to address his audience directly.¹⁸ Later, President Georges Pompidou affirmed both the power of television and the duties of TV journalists: “whether one wants it or not [...] television journalists are not exactly journalists like the others. They have additional responsibilities. Whether one wants it or not, television is considered to be the voice of France, by the French and by foreigners alike”.¹⁹ Television was intent on broadcasting the greatness of France; heart transplantation, performed by French surgeons, was part of that greatness. As Pompidou noted, TV journalists had something of a special status: as they basked in the glow of the small screen, not only did they have to inform the audience, but they were also bound to refrain from overstepping certain boundaries, as the medium was considered extremely powerful.

It was thus through this small, but powerful screen that audiences often learned about heart transplantation.²⁰ Audiovisual technology allows for a very different kind of storytelling than newspapers. The subjects are brought to life by sound and images; the audience is plunged *in situ*, and may be sometimes more moved, convinced or scandalized than by words or photographs alone. The recourse to live broadcasts also allowed TV viewers to experience events almost as insiders, and provided visible evidence of the reality of achievements in the field of heart transplantation. In short, viewers are called to become virtual witnesses of surgical exploits: immersed with sound and image, enjoying the live broadcasts, they are “in the place”.²¹ Bringing these many viewers virtually into the operating or the patient’s room increases the value of the evidence. The viewers see and uptake the

17 On the history of television, particularly in the 1960s and 1970s, see Bourdon 2014; Veyrat-Masson/Sauvage 2012.

18 In doing so, he bypassed parliament, thereby taking on a far greater role. See Esquenazi 2002b.

19 Press conference of 22 September 1972, cited in Jeanneney 1996, 284.

20 Nelkin 1987.

21 The concept of “virtual witness” was first developed by Shapin and Shaffer in their analysis of the air pump in 17th century Britain. This witnessing passed through a written diffusion of knowledge. This notion was then mobilized by Kirby who explained that cinema renewed this form in the 20th century: the immersion of the public in fiction films allows them to validate scientific knowledge for themselves. The concept has also been judiciously used in the analysis of educational films during the 20th century. It appears that the television reinforced this process in the 1960s and 1970s with the use of live broadcasts, a technical innovation that had been widely glorified by the TV presenters. See Schapin/Shaffer 2005; Kirby 2011; Bonah et al. 2018.

reality of the success of the operation and are moved by the state and the words of the patients as if they were truly there. Likewise, as is the case for any other subject, the transformation of technologies and practices in TV influenced the form and content of transplant stories. In the 1950s and 1960s, long-format shows would allow viewers to experience medicine through filmed surgeries. Scientific explanations were provided by interviewed doctors. In the 1970s, talk shows became popular; in that form, the audience could identify with the layperson asking questions to the experts.²²

Indeed, while medical advances, legislative developments, political orientations, and, obviously, the survival of patients shaped the history of transplantation in France, the media also played a key role in the development of heart transplantation during that period. Securing the moral support of a variety of audiences would effectively sustain the practice of heart transplantation in the long term. The mainstream audience's embrace – especially families – would boost organ donations; the approval of these surgeries by medical professionals would confer them legitimacy; lastly, the development of the practice hinged on public funding. All of these objectives are mentioned, alternatively by surgeons and journalists, in the corpus of television programmes that we have assembled. Herein, the media constituted a hub, where these different types of support of heart transplantation came together. We will now attempt to understand how TV in the 1960s-1970s forged storytelling around transplantation that differed markedly from the narratives and analyses presented in newspapers.²³

1968–69: The Coverage of the First Heart Transplantations in France

The Coverage of the Cape Town Transplants

The first heart transplant performed by Dr. Barnard on 3 December 1967 marked the beginning of media coverage on these surgeries. On 5 December, its technical and moral implications were discussed in LM. SO devoted a full page to the event. The paper profiled the donor, Denise Darval, a 24-year-old woman who had died in a car accident,²⁴ and the recipient, 56-year-old Louis Washkansky, as well as the members of the medical team. A resident surgeon involved in the operation provided insights into the retrieval, the graft, and the precautionary measures that had been taken. Newspapers went on to give

22 Soulages 2007.

23 On the respective specificities of TV and the print press, see Lochard/Boyer 1998.

24 On coverage about the donor, see Danet/Medina-Doménech 2015.

regular updates on the health of the “man with the grafted heart”. Upon his death, 18 days after the transplant, the media specified that his lungs had failed; not his heart. The medical and media hype remained intact: for the Cape Town surgeons, the principle of heart transplant had been wholly validated (SO 22-12-1967).

Washkansky's death was an opportunity for TV to assert the scientific, therapeutic and moral legitimacy of heart transplantation. In the *Panorama* programme entitled “Washkansky did not die for nothing” (*Washkansky n'est pas mort pour rien*), broadcasted on December 22,²⁵ several French surgeons highlighted the value of this surgery. Pr. Jean Lenègre pointed out that nearly “a third of French people die from heart disease”. Considering the defects that still plagued the artificial heart, transplantation appeared to be the best solution for patients with a fatal prognosis.

The coverage of the second transplant, performed in Cape Town on 2 January 1968, was absolutely identical. The name of the recipient was known before the surgery – 56-year-old Dr. Philip Blaiberg (SO 02-01-1968). On 3 January, a SO headline read: “Mrs Haupt faints as she gives away her husband's heart”. The article described the stages of the surgery in detail; the principle of tissue compatibility was explained in a box inset to the article. TV aired a dozen segments and interviews on the transplant. The surgeon was presented as a heroic character. In another episode of *Panorama*, broadcasted ten days after the surgery and entitled “The heart: Cape Town - these doctors at the end of the world” (*Le cœur: Le Cap ces médecins du bout du monde*),²⁶ donor, recipient and surgeon were woven into a single narrative. The segment begins with the interview of the donor's wife, surrounded by her family. She explains her decision to give her husband's heart to help another person. For his part, Barnard appears both as a talented and a deeply human surgeon. Science and humanity merge to form a coherent narrative whose meanings are not negotiable: heart transplantation is depicted not only as a landmark medical advance, but also as a culturally acceptable medical practice.²⁷

25 Bourget 1967.

26 Larriaga 1968.

27 The television staging shows a positive narrative, far from the myth of Frankenstein or certain negative cinema fictions of the time accounted for by O'Neill 2006. It is a matter of showing that it is possible to give one's own organs. On this point see Chavot/Masseran 2018.



Illustration 1: Newspaper and TV reports on the second Cape Town transplant. Both insist on the part played by the family of the donor. Left, headline of SO stating “Mrs Haupt faints as she gives away her husband’s heart” (SO 03-01-1968). Right, the TV report starts with the interview of the donor’s wife. Then, Barnard describes the discussion he had with Mrs Haupt.

Nearly a hundred heart transplants were performed in 1968 alone. Medical first upon medical first – with the first transplant on a black person, the first in Europe, the first on a woman, etc. Yet, in early 1968, French TV was mainly interested in following Blaiberg’s every move. The patient was interviewed on his hospital bed a few days after the graft. A March 1968 episode of *Panorama*²⁸ showed him walking and being driven around the city with a voiceover, treatment usually reserved for heads of state. Blaiberg’s longevity after the transplant – 19 months and 15 days – made him a poster boy of transplantation.²⁹

Barnard appeared as heart transplantation’s main advocate. Six days after the first surgery in Cape Town, he already claimed to be looking for a second heart. Regarding the retrieval, he argued that a “doctor should not have to artificially keep a man whose brain has suffered irreparable damage alive” (SO 29-01-1968). He supported French surgeons who were considering performing similar operations themselves, and hosted them in Cape Town in mid-January. During a visit to Paris, he announced: “the first European transplant will be performed in France” (1^{ère} chaine, 13h, 03-02-1968).

28 Bernadac 1968.

29 When Barnard was asked, during a visit in Lyon, whether performing multiple heart transplantations might be premature, he quipped back: “Ask Dr. Blaiberg what he thinks about that” (LM 27-01-1969).

In their reports on these world firsts, newspapers and TV emphasized the same elements: the pain and generosity of the donor's loved ones, and the recovery of the recipient. Surgeons found in the media an essential platform to defend the legitimacy of heart transplantation. These features formed the core of an initial story that would be reproduced for virtually each case. However, unlike newspapers, TV gave life and faces to transplantation. Visualization generated emotion, and brought the audience closer to the operations that took place halfway across the world. Television's own status as a symbol of modernity and an object of desire reinforced the impact of this storytelling.³⁰

The ten French Grafts of 1968

French surgeons prudently waited until April 1968 to perform their first heart transplant. An organ sharing network (LM 23-02-1968) had been set up in public hospitals, and a circular now authorized surgeons to pronounce brain death prior to retrievals (circular dated 25 April 1968, reported upon in SO 27-04-68). Unlike Barnard, the French surgeons operated discreetly, during the night of 27–28 April 1968. On the next morning, a communiqué was read on TV; a press conference was aired in the afternoon.

Television offered a wealth of detail on the circumstances of the retrieval, the graft and the treatment. The journalist Pierre Bourget conducted exclusive interviews with the main protagonists: Prs. Maurice Mercadier, Gérard Guiraudon and Christian Cabrol (1^{ère} chaine, 20h, 29-04-1968). The surgeons did not disclose the donor's identity, but the media soon did. On 30 April, SO presented the donor's parents, whose son had been "impressed by the successful graft in Cape Town" (Illustration 2). A photograph of the young man was featured in the middle of the page. The trajectory of the patient, Clovis Roblain, who "kept his disease a secret in his village" was described in detail. The human angle in the newspaper's coverage contrasted with the highly technical register of the press conference. A second press conference was held the next day to announce the patient's death, the cause of which was attributed not to the graft but to exhaustion.

30 Chavot/Masseran 2019.



Illustration 2: Comparison of SO and TV reports on the first French heart transplant in SO and TV. SO scenarises the donor’s parents and the patient while TV offer technical information through the voices of surgeons. Left, third page of SO dated 30 April 1968. Upper-Right, interview of Prs. Maurice Mercadier, Gérard Guiraudon and Christian Cabrol by Pierre Bourget (1^{ère} chaine, 20h, 29-04-1968). Lower right, press conference announcing patient’s death (1^{ère} chaine, 13h, 30-04-1968).

These two press conferences held at the Pitié Hospital in Paris were exceptional. Indeed, in May, the French medical association asked for the “public to be informed only by an official communiqué, in compliance with the rules of medical confidentiality”, to prevent “the publicity surrounding some therapies” from becoming “detrimental to the advancement of science” (SO 07-05-1968). Subsequently, surgeons had a smaller part in the coverage of the nine other transplants performed in 1968.

Despite these efforts for discretion, the media continued to publish details on the identities of recipients and donors. When the second French transplant was performed on 8 May in Montpellier, the news was only kept secret for 24 hours. A TV crew arrived the next day and interviewed the paramedic who had transported the donor to the hospital. The evening news broadcast featured an interview of the donor’s wife and a colleague of the grafted patient (Illustration 3). As far as technical aspects went, the media were only given a communiqué and a tour of the operating room. The surgeons’ reluctance to communicate left journalists with a bitter taste. On 10 May, a SO headline ran: “Montpellier surgical team opts for stringent discretion policy”. The patient survived two days.



Illustration 3: Humanizing heart transplant. TV crew interviewing a paramedic, the donor's wife, and a colleague of the grafted patient (1^{ère} chaîne, 20h, 09-05-1968).

The same scenario unfolded for the third transplant, performed on 12 May by Pr. Charles Dubost at Paris's Broussais Hospital on Father Boulogne. TV reporters managed to interview one of the recipient's cousins and his sister and showed the place where he had spent his childhood. Wariness about the procedure was expressed: "I can't see the point of putting a new heart in a tired body", the Father's cousin told the interviewer (1^{ère} chaîne, 13h, 16-05-1968). Other relatives praised the patients for their courage and congratulated the donors. These interviews allowed the viewers to project themselves more easily and may have fostered a positive image of transplantation in some of them.

The televisual approach was at the time incompatible with that of the French Medical Council (*Conseil de l'ordre des médecins*). TV journalists attempted to naturalize the connection created by the graft between individuals that initially had nothing in common, and to tell a full story that emphasized the personality of the donors and recipients.³¹ This led them to breach medical confidentiality and to seek out information outside of the medical field.

The New Ambassadors of Heart Transplantation

When the first surgeries took place, the surgeons appeared to opt for a very formal type of relationship with the media: they were in touch with journalists only during press conferences, and left recipients, family members and donors loved ones to take on the role of transplantation advocates. The third French transplant, performed on Father Boulogne, heralded a new approach to communication on transplantation. Unlike the first two patients, whose bodies were weakened by disease, Boulogne embodied the ideal patient. He was fairly young (56), overall healthy despite his heart condition, and most

³¹ SO also published narratives that involved the same protagonists that appealed to emotion, unlike LM.

importantly, a volunteer for the graft.³² To Dubost, “both in clinical and moral terms, he met the rigorous criteria for which the indication for heart transplant should always be based” (LM 15-05-1968). Boulogne was the first French patient to survive the graft for over two weeks. On the strength of this positive outcome, Dubost claimed that technically he could perform one graft per month at the Broussais Hospital (SO 16-06-1968).

Father Boulogne greatly admired science and the work of his surgeons, and proved an eager interviewee, to the point that he gradually became the face of heart transplantation. In an interview with the magazine *La vie catholique illustrée*, from his sterile hospital room, Boulogne presented himself as the person who allowed “[...] doctors to bring a first experiment to completion, conducted as prudently as possible”.³³ He entrusted his body and soul to science in order to share his experience with the Church and society at large, and to allow each individual to develop an informed stance on transplantation. In September 1968, he was interviewed on the programme *Point Contrepoint* (2^{ème} chaine, 26-09-1968). Disputing prejudice against organ donation, he offered his personal, mechanistic vision of respect for the body: “If you open a grave after a month, you have this kind of putrid juice in which worms and maggots crawl [...]. For a loved one’s organ to be of service to a new being is far more respectful”. Asked about the donor, he added: “When you have a second-hand engine in your car, you’re not thinking about the previous owner”. The story ends with a long scene showing him walking up six flights of stairs, thereby demonstrating that his heart is working perfectly (Illustration 4).



Illustration 4: The Heart transplant ambassador Father Boulogne. The interview with Father Boulogne ends with a long scene showing him walking up six flights of stairs (2^{ème} chaine, 26-09-1968).

32 All heart transplant patients were condemned without this last chance operation. Nonetheless they had to give their consent before the operation. Unlike other patients, Father Boulogne volunteered for such operation and asked Dubost before Barnard achieved his first heart transplant (LM, 15-05-1968).

33 This interview was partly reproduced in SO’s 11 July 1968 issue.

In November 1968, Boulogne became active in an organ donation campaign that often relied heavily on guilt as a mechanism. He claimed that “refusal to donate constitutes a crime by omission”. Dubost, who found himself unable to perform more transplants due to lack of donors, supported him (SO 25-10-1968).

Seven grafts were performed in France between 10 November and 22 December 1968; but only two of them received media coverage. The first to be covered was performed on Emmanuel Vitria, the ninth French recipient, who underwent surgery in Marseille on 28 November. Like Boulogne, Vitria was a volunteer. In the days that followed the operation, he largely co-operated with the media and agreed to be filmed and interviewed in his sterile room, through a closed-circuit television system (1^{ère} chaine, 05-12-1968). His considerable longevity – nearly 19 years – and enthusiasm would make him a fixture in the media in the 1970s and 1980s.

The second graft that received coverage was performed on Bernard Marion in December, in Bordeaux. The regional paper SO devoted a full page to the event, weaving a narrative that connected the donor, the patient and the surgeon. SO regularly followed the new local star, covering his family’s visit to the hospital, twelve days after the surgery (03-01-1969); his discharge from the sterile room (23-01-1969); and his death (05-08-1969). This patient received heavy local press coverage, but was rarely mentioned by television and national press journalists, which reflects the highly centralized nature of national media in France.

When these first transplants were performed, newspapers used essentially argumentative resources to convince readers of the value of the operations. The regional press additionally relied on emotion in its coverage of local patients, who its readers could relate to, as in the case of SO. As audiovisual media, TV was able to demonstrate the effectiveness of heart transplantation by personalizing it, as it did with the storytelling around Father Boulogne. Technological contrivances, such as interviews from sterile rooms, brought the audience even closer to the patient.

Heart Transplantation in France Is Questioned

Although not a single transplant was performed in France in 1969, the media continued to follow up on the subject. Newspapers reported on international news and developments pertaining to the French graft recipients. TV covered transplantation-related issues in a number of programmes. Two shows – “Cardiac surgery at the time of transplant” (*La chirurgie cardiaque à l’heure*

de la greffe) and “Restoring life” (*Redonner la vie*) – broadcasted in February and September 1969³⁴ began with footage from an operation (Illustration 5). The surgeons involved – Pr. Jean-Paul Binet and Dubost – were featured as on-set guests. Viewers were presented with audiovisual evidence of the operation’s technical feasibility. These included graphic images, showing an open rib cage and expert hands replacing a sick heart with a healthy one, complete with technical voiceover commentary. Surgeons were thus given free rein to expand on a mechanistic, scientific approach to issues pertaining to the functioning of the heart, disease, death and donation. Demonstrated by experts and illustrated by a film, this interpretation left little room for the expression of alternative views.



Illustration 5: The show “Restoring life” began with an 8min sequence of heart transplant filmed in a didactical way. Each stage from the organ removal to the graft of the replacement heart was punctuated by white board drawings. It is said that the two heart atria of the patient have been preserved to follow Shumway’s protocol.

During the same period, other programmes were dedicated to the cultural aspects of transplantation. The show “Fragment of a heart narrative” (*Fragments d’un récit du cœur*), broadcasted in December 1968,³⁵ outlined the symbols attached to the heart in various cultures, with input from scholars in the humanities and representatives of several religions. Yet, the programme ended with a surgeon’s opinion: to Pr. Lenègre, “in many ways, the heart enjoys respect, consideration, even though from a physiological standpoint it doesn’t deserve it; it is merely a pump. It is only an organ that is tasked with a fairly modest service, not a glorious one; it has to ensure blood circulation”. Thus, the discussion was resolved with a one-sided scientific interpretation, arguing the need for organ donation without regard to any other (cultural, emotional, etc.) considerations. Street interviews included in the same programme additionally showed that laypeople were ignorant, or in some cases spread false information about organ retrieval, thereby lending even more credibility to the scientific case for donation.

34 Barrère 1969; Boursaus/Robrini 1969.

35 Chouchan 1968.

At a time when heart transplants were suspended, it is interesting to see how recipients discussed organ donation on TV. A profile of Father Boulogne was broadcasted on the anniversary of his graft.³⁶ He was again filmed walking up flights of stairs, and his views had not changed significantly. The viewer was however led to understand, by the end of the segment, that the graft had not left his body and soul fully intact. Upon being asked, “if you had to do it all over again, would you?”, the patient voiced mixed feelings:

Father Boulogne: “Maybe. If I had known how high the price to pay was, I don’t know, as a human, what I’d have done. With the grace of God, maybe. But, I can’t answer, because, you know, it would be preposterous on my part, to say yes, straight away. I agreed and so it is, I endure it with all my heart. Would I do it all over again? That is something else”.

At the time, Boulogne was the only patient who allowed himself to express his struggles with his experience of the graft, while also defending it. However, this critical testimony on his experience would often be left out of the transplant stories shown on television.

Emmanuel Vitria was less reflexive about transplantation than Father Boulogne, and visibly less affected by adverse effects; he adopted a simple, sincere attitude when he discussed it. He frequently appeared in documentaries or on TV shows from late 1969 onward, after Boulogne’s death. He did not campaign for organ donation, but spoke out as a living witness.

Heart transplantation surgery was still covered by TV even though it was no longer being performed. This coverage had educational purposes; cultural – religious, symbolic³⁷ – aspects were discussed and the few surviving grafted patients were invited to express themselves. Television continued to support heart transplantation and worked at boosting its scientific and moral legitimacy. Conversely, newspapers no longer dealt with the legitimacy of transplantation; LM, for its part, even became critical on occasion. This difference in coverage may be seen as supporting evidence for our hypothesis that television was the modern ally of heart transplantation in France, owing to its interest and technological specificities.

36 Bourget 1969.

37 Thus, several TV sequences tend to bring the public closer to transplantation and to the patients, such as street interviews highlighting the meanings organ transplantation may have for ordinary people (1^{ère} chaine, 19-09-1969), or a Vitria interview in the football stadium of the *Olympique de Marseille* (3^{ème} chaine, 26-01-1973). Through the process of identification, these images may force in some way an inscription of transplantation in the public’s daily life. In addition, the filming of citizens “like others” and the insistence on moral values gave rise to a “two-headed” discourse in which cultural aspects reinforce the authority of scientific arguments. See Chavot/Felt/Masseran 2000.

1973: French Heart Transplants, From the Limelight to the Shadows

The interruption in heart transplant surgeries, in France and many other countries, ended in 1973. Newspapers was a valuable forum for surgeons who advocated for waiting to resume grafts, including Dubost, who had been affected by the death of his two patients, Joseph Forès and Father Boulogne. In September 1970, at the World Congress of Cardiology in London, where supporters and critics of transplantation squared off, he argued that “[...] heart transplantation should not be pursued further [...] as long as we have nothing better to offer to patients. The tissue typing for both patients who were operated on was very good. Yet, the immunosuppressive treatment they had to go through was very hard on them” (LM 14-09-1970). *Le Monde* contrasted this stance with the work of US surgeon Shumway, who “indeed has his mind set on proceeding with further operations, and currently remains one of the only surgeons to perform this operation, at the pace of ten surgeries a year”. Hence, the press staged a clash between two authorities: while Dubost was the author of the first successful French heart transplant, Shumway enjoyed unquestionable authority as a pioneer and international specialist of heart transplantation. Nonetheless, the newspaper – and the printed press in general – stayed neutral in the “quarrel over transplantation” (SO 18-12-73), although Dubost’s position was more often reported upon than Shumway’s. This editorial preference can be explained by the proximity between the French media and French surgeon.

Newspapers also mentioned the operations and deaths of American transplants, often in news in brief sections. In the early 1970s, TV coverage of heart transplantation was for its part relatively muted. Still, Vitria made regular appearances both in papers and on television, particularly on the anniversaries of his operation. The “vice-dean of heart transplant recipients”³⁸ was depicted both as a miracle survivor and a man who happily performed everyday tasks (Illustration 6). His longevity helped sustain media interest in heart transplantation, and his recurring appearances showed that journalists did not reject the practice, as was the case in countries such as the UK.³⁹

38 This phrase was often used to refer to him in the media.

39 Nathoo 2009.



Illustration 6: “The art of being a grandfather with a twenty four year old heart” (SO 3-12-1972).

The Renaissance of Heart Transplantation in France

In this climate of defeat, the announcement that Pr. Daniel Guilmet had performed a transplant on Georges Caillez at the Foch Hospital in Suresnes on 24 January 1973 came as a bolt from the blue: the first channel interviewed the surgeon as he left the hospital in his car (1^{ère} chaine, nuit, 24-01-73). The other channels and papers quickly picked up the news. The Caillez surgery heralded a shift in the media coverage and in the relationships between surgeons and the media. First, television was the first to cover the operation; newspapers followed in its footsteps. Secondly, it gave a platform to a staunch advocate and actor of transplantation, at a time when the papers had rather been relaying surgeons’ calls to provisionally halt surgeries. That Guilmet adopted TV as a forum was no accident: he was attempting to convince the broadest audience possible, an effort for which television was better suited than any other media.

By 25 January, Guilmet already explained that the operation and post-graft treatments had improved and that he should be performing “one operation each month, as Shumway does”. He added that this required “working on the public so that the graft gains acceptance among the families”, and on doctors “who take no interest in the graft” (2^{ème} chaine, 20h, 25-01-73) or “oppose” it (1^{ère} chaine, 20h, 25-01-73). In his appearances, Guilmet thus clearly aimed at securing the moral support of the public and of his colleagues. Regarding the public, organ donation had to be supported, as too often relatives vetoed it. Doctors were called upon to support heart transplantation first, to put an end to the quarrel that muddled its image, and secondly, so that brain-dead donors could be identified in all hospital units to make more grafts available.

Television was particularly well suited to conveying this message. Through image and sound, it showcased alternatively the surgeon, wearing his white coat, a figure of expertise and authority, and Cailleuz's wife – at the hospital or in her home – who expressed both her hopes and her gratitude. Asked by a journalist about her experience of her husband's graft, she replied: "this was the only solution for me to keep him" (1^{ère} chaine, 20h, 25-01-73). Scientific authority and emotion were intertwined on the small screen, in a bid to be as effective as possible in eliciting moral support from a broad audience. Lastly, on the brand new third regional channel, Vitria voiced his enthusiasm about the operation and his support to the graft recipient (3^{ème} chaine, *Actualité méditerranée*, 26-01-73).

On 4 February 1973, TV used an improved version of a device that had been inaugurated with Vitria; Cailleuz was filmed live in his sterile room (Illustration 7). This televised presentation of evidence was different from the one that had been proposed for Father Boulogne's surgery. In 1973, the body was exhibited at a time when it had barely recovered, thereby indicating that while this had admittedly been heavy surgery, recovery was swift and the treatment did not have particularly negative effects. The possibility of watching the patient strengthened the evidence: there he was, facing the viewer, in "excellent health", as the journalist put it. This was an advantageous set-up for TV journalists, a feat no other media would have been capable of. This was also of value for the transplanting surgeon, making the result of his operation visible, almost tangible. The respective agendas of the journalists and the doctors were both furthered (1^{ère} chaine, 13h, 04-02-1973).



Illustration 7: Live filming of Mr. Cailleuz in his sterile room during an exchange with his wife (a glass window separates them), followed by the interview of Mrs. Cailleuz (1^{ère} chaine, 13h, 04-02-1973).

Cailleuz's death on 18 March did not put a stop to heart transplants. Having told the story of his graft, TV now took it upon itself to educate viewers about why it had failed. The first channel showed a fun animated video that explained the mechanism of rejection, depicting the immune system as a regiment of Roman soldiers, defending the body by adopting the tortoise formation. Infectious el-

ements were little devils, which ended up defeating the soldiers (Illustration 8). The cartoon was shown on several occasions when transplants were performed in 1973. These were opportunities to educate the audience and play down the potentially dramatic consequences of the procedure.



Illustration 8: A science popularization clip explaining the mechanism of rejection (1^{ère} chaine, 20h, 18-03-1973).

On the following day, a press conference was held, during which Guilmet appeared determined to continue to perform transplants, on the grounds that the surgery offered a 30 percent chance of survival to otherwise hopelessly ill patients, citing Shumway’s work. Also, he contended, performing multiple surgeries would ultimately improve the procedure, which he called “the last hope for heart patients who feel like they are lost” (1^{ère} chaine, 20h, 19-03-73). The professor came off both as an expert and as a human being, which could help in justifying his practice in the eyes of the audience.

In SO, Guilmet’s message appeared to have served its purpose: the journalist seemed to be sold on his TV appearance. Indeed, in a piece entitled “Heart transplants: the pros and the cons” (SO 20-03-1973), the writer took a clear stance in favor of transplantation. The article provided an important forum for Guilmet’s opinion: proceeding with further surgeries appeared to be necessary, and it was noted that “even Professor Dubost is in favor of re-suming transplants”.

Three other surgeries followed. On 3 April, Pr. Pierre Marion attempted another heart transplant at the Lyon hospital; the patient died a few days later. In a televised press conference, Marion declared that the second phase of heart transplantation was now underway (after that of 1968), benefiting from the experience acquired with kidney transplants (1^{ère} chaine, Nuit, 30-04-73). On 12 May 1973, Guilmet grafted a 26-year-old man. Television was not on the front line as far as coverage went; newspapers followed the story most assiduously. One of the focal points was a medical first: the heart was transported from one hospital to another,⁴⁰ which required a technique for

40 Up to that point, organ retrieval and graft were performed in the same hospital.

cooling and preservation that was extensively described. The patient survived over a year. The following operation, performed in June again by Guilmet at the Foch Hospital, was also reported upon in a rather sober way; the journalists being satisfied with information coming from Guilmet's press releases. The patient survived for a few months.

Coverage on the first grafts of 1973 emphasized new developments. On a medical level, first, there was a focus on the transportation of the organ, a process that was conducive to dramatizing emergency, which would be an important feature of subsequent graft narratives.⁴¹ In televisual terms, then, a number of technical innovations were implemented, such as live filming, computer graphics, or interviews with the surgeon on his way out of the operating room. In effect, television covered its own breakthroughs as much as the transplantations: all of these sequences were presented as exclusive and exceptional both in medical and in audiovisual terms. Lastly and crucially, as far as Guilmet's operations were concerned, the surgeon controlled the media coverage, used the media. He left behind from the formal setting of the press conference and went out to talk to reporters. He did not only defend heart transplantation in general, but also and most importantly his own practice of transplantation in particular.

Televised Emotion: Little Céline's Graft

By August 1973, France had two new graft recipients who were lived beyond a month after surgery, in addition to Vitria.⁴² Under the circumstances, the media were therefore rather hopeful as they latched onto the case of Guilmet's fourth graft recipient of 1973: Céline Mawoué, a 13-year-old girl with cardiomyopathy, whom they soon took to calling "Little Céline" (*la petite Céline*). Guilmet sought out and fueled this media coverage, by inviting a reporter from the daily newspaper *France-Soir* to attend the operation. This time, the surgeon picked newspapers to bring his message across. There was no question of filming the operation, as was done in 1968; this was about telling a story, where the medical message came first. *France-Soir* ran headlines such as "Heart transplant on a 13-year-old girl – Professor Guilmet's fifth operation"; "How Céline received a 24-year-old man's heart".⁴³ A photograph

41 Chavot/Masseran 2012.

42 Guilmet often mentioned the milestones patients had to overcome to increase their chances of surviving the graft: the first ten days, the beginning of the second month, the first two years (after which the risk of rejection no longer exists). The first two months are therefore highly symbolic. See for instance SO 13-05-73.

43 *France-Soir* 11-08-1973 (document not included in our corpus).

of a man wearing a white coat carrying a cooler up the hospital stairs took up a quarter of the front page.

However, it was TV that announced the event on 10 August: Guilmet expressed the “great hope” of being able to perform grafts on other ill children. He explained the ins and outs of the operation and boasted the approval of “the vast majority of French cardiologists”. Lastly, he announced that as soon as the material conditions to do so were met, he was going to be able to perform one operation each month, noting that there was already a waiting list of about fifteen patients. Television did not just serve as a forum for the surgeon. It offered a complete story, painting a portrait of Little Céline, interviewing her friends and her doctor. It also trotted out another previous graft recipient, Alain Riffaudot, whose functional body it exhibited on this occasion. Riffaudot reported having seen Céline on her way back from the surgery and expressed his enthusiasm about transplantation, which would save “a child”. Emphasis was also placed on the fact that Guilmet was the first to resume transplants in Europe (1^{ère} chaine, 20h, 10-08-73).



Illustration 9: Little Céline described by her Girl Scout leader and Alain Riffaudeau, grafted three months earlier (1^{ère} chaine, 20h, 10-08-73).

The newspapers did not quite take to this glorification. That the surgeon only invited *France-Soir* made other journalists angry; they felt they had been discriminated against. Thus, “in a press release published on Friday 10 August, the national union of journalists’ trade unions [...] protested in the strongest terms against the fact that news liable to be of interest to French and international public opinion as a whole was given exclusively to a single press organization” (LM 13-08-1973). LM gave a platform to critics of transplantation, such as Pr. Alain Carpentier, who argued that other techniques – like the bypass operation, which was in the process of being developed – would make costly heart transplants irrelevant. In response, Guilmet used the small screen to seek out the public’s moral support to transplantation, which he stressed was not a “luxury surgery” (LM 15-08-1973), but a “useful” technique, with the added benefit of relieving social security and one that would allow members of the workforce to remain active. The surgeon also appealed

to emotion when he claimed that each viewer knew among his relatives and loved ones a cardiac patient for whom “something had to be done” (2^{ème} chaine, 20h, 11-08-73).

Having become a media personality, Little Céline died on 7 September 1973. A few days before, she was shown drinking, eating, smiling, getting up and walking in an “exceptional”, “deeply moving” TV segment (Illustration 10). Despite her death, television did not question heart transplantation; quite the opposite, in fact, since Guilmet was still and announced that he would continue to perform operations. However, the special relationship that had developed between the surgeon and the media appeared to be frayed.



Illustration 10: Filming of Little Céline in her sterile room (1^{ère} chaine, 13h, 03-09-73).

Indeed, in late September, Guilmet performed a new graft, which was covered very minimally on television and in the newspaper. This virtual silence in the media came from the surgeon’s own silence; he had announced on TV and in the press that he did not “need personal publicity” (LM 02-10-73). His change of attitude was a response to criticisms. The Minister of Health, Michel Poniatowski had in fact spoken out against the publicity surrounding Little Céline’s graft (1^{ère} chaine, 13h, 10-09-73). The French medical council had also issued a statement on the subject, reproduced in LM: “Some surgical procedures [...] were the subject of repeated, inopportune publicity events in newspapers, on radio and on television. The bureau of the French national council wants to make it clear that it condemns such practices [which] place their author in the spotlight” (LM 01-10-73).

The media also lost its appetite for “graft stories”. New cases were still reported upon, but the enthusiasm that had surrounded Little Céline’s operation was no longer *de rigueur*. First, newspapers now covered transplantation in far more critical terms. Even SO, which had always voiced its support to heart transplantation, was less passionate, and made room for Dubost, who argued that “as of now, there is no indication for heart transplants” (SO 22-10-73). Secondly, surgeons now adopted a much more low-key, cautious communication strategy, as had been the case in 1968. The heart transplant

performed by Cabrol in December 1973 at the Broussais Hospital was only made public two days after the surgery. Neither the patient's name nor the circumstances of the operations were mentioned. No press conference was held, even when the patient died shortly thereafter.

Arguably, the craze around Little Céline's graft marked both the peak and the end of an era of alliance between the media and organ transplantation. The storytelling around this operation had every ingredient of a fine televisual narrative, both medical and emotional, centered around a brave surgeon and an ill child.⁴⁴ The media agenda was also ripe for such a story, as this was the fifth French graft of 1973. Additionally, Guilmet had been quite deft at developing relationships with some journalists. There is no doubt that he hoped this coverage would help him secure the public's moral support, which he absolutely needed in order to raise enough funds through donation to open the transplantation center where he planned to operate on one patient each month (LM 13-08-1973; SO 3-10-73).

Conclusion

In this paper, we have chosen to focus on the 1968–1973 period, which witnessed two peaks in heart transplants and in their media coverage. At least three factors appear to have had an impact on media coverage of transplants. First, we have observed that not all surgeons had the same approach to the media. For instance, Guilmet's 1973 activism stands in sharp contrast with the cautious, reserved attitude adopted by French surgeons in 1968. When surgeons cooperated with the media, or actively sought them out, access to information and increased opportunities boosted coverage.

Secondly, the graft recipient's involvement in the coverage was essential. Blaiberg, Boulogne, Vitria and Marion appeared to cooperate with the media because they had made a choice to promote science after undergoing a transplant. By welcoming the presence of cameras and journalists, they showed in their own words, and by having their body filmed, that they were volunteers for the operation, that it had been successful, and their testimonies alleviated the doubts and criticisms voiced elsewhere in public arenas. Lastly, the media's choice to focus on a given patient hinged on whether their cases lent themselves to effective storytelling, as was the case in the coverage of Vitria, Marion, Caillez, and especially Little Céline.

44 Chavot/Masseran 2012; Cardon/Heurtin 2016.

Our analysis shows that special relationships between surgeons and journalists developed during these two periods. In 1968, although the French medical board demanded that surgeons limit their communication, they made TV appearances, and showed themselves eager to be interviewed and to contribute to documentaries for state television. At the time, they were involved in the very production process of these segments and programmes; their views prevailed over those of the journalists and their own approach to heart transplantation was conveyed. This involvement allowed them to assert the scientific, therapeutic and moral legitimacy of transplantation.

By 1973, the relationships between surgeons and journalists were radically different. Guilmet, for instance, used the media to counter the scepticism voiced by other doctors and to attempt to ensure the sustainability of transplantation. He teamed up with the media to promote it, showing a clever grasp of media relations. The media, especially television, were forums for him to express his views, and conduits for transplantation stories that appealed to emotion to various degrees. He enlisted journalists in his efforts to gain moral support from the public and the medical community, to sustain and extend the practice. In the latter case, TV was no longer concerned with educating the public, as it had been in 1968; the focus shifted to appealing to emotion through storytelling. Surgeries were no longer filmed, but patients were shown gradually recovering their health and social lives thanks to their new heart. At the same time, newspapers, hindered by far slower production mechanisms than TV, which increasingly relied on live broadcasts, became both a follower and a critic of these new trends. 1973 was ultimately a pivotal year, between the era of the pioneers and the development of a persuasive, strategic communication to promote organ donation.

The media's attitude during that period – especially television – also reflects their role in the reaffirmation of “French greatness” promoted by presidents de Gaulle and Pompidou in the country's post-war boom period known as *trente glorieuses*.⁴⁵ Television was enlisted in that project, and landmark achievements of medicine were an important part of it. By 1968, the media already partly attributed Barnard's success to France: the French work on tissue compatibility between donor and patient and effective anti-rejection treatments were cited.

All signs thus suggest that the unconditional support of the media helped French surgeons, unlike their counterparts in other countries, to prepare, strengthen and justify their commitment to heart transplantation in 1968 and 1973. Television was then the best media to showcase scientific advances and

45 Vassallo 2005.

emotionally powerful stories, capitalizing on both registers to affirm the greatness of French surgery. The alliance between journalists and surgeons is likely to have indirectly boosted and directly publicized the French leadership in the field of heart transplantation at the European level, and even globally, at the time.

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Filmography

- La chirurgie cardiaque à l'heure de la greffe*, directed by Igor Barrère, produced by ORTF (Igor Barrère, Etienne Lalou) 1st channel, 78 minutes, broadcast on 4 February 1969
- Redonner la vie*, directed by Pierre Boursaus, Claude Robrini, produced by ORTF (Pierre Charpy, Edmond Henry), 1st channel, 60 minutes, broadcast on 24 September 1969
- Fragment d'un récit de cœur*, directed by Laurent Chouchan, produced by ORTF (Claude Santelli) 2nd channel, 42 minutes, broadcast on 21 December 1968
- Chirurgie cardiaque et chirurgie expérimentale*, directed by Igor Barrère, Roger Sciandra, produced by ORTF (Igor Barrère, Etienne Lalou) 1st channel, 64 minutes, broadcast on 16 December 1965

Episodes of television programmes (news broadcasts not included)

- “Le père Bourlogne”, Point contrepoint, directed by François Moreuil, produced by ORTF, 2^{ème} chaine, 10 minutes, broadcast on 26 September 1968
- “Le père Boulogne: un an après”, *Panorama*, directed by Pierre Bourget, produced by ORTF, *1ère chaine*, 12 minutes, broadcast on 8 May 1969
- “Quelques pas avec Blaiberg”, *Panorama*, directed by Christian Bernadac, produced by ORTF, *1ère chaine*, 14 minutes, broadcast on 22 March 1968
- “Le coeur: Le Cap ces médecins du bout du monde”, *Panorama*, directed by Guilbert Larriaga, produced by ORTF, *1ère chaine*, 14 minutes, broadcast on 12 January 1968
- “Washkansky n’est pas mort pour rien”, *Panorama*, directed by Pierre Bourget, produced by ORTF, *1ère chaine*, 14 minutes, broadcast on 22 December 1967
- “Greffe du rein: histoire de deux frères”, *Cinq colonnes à la une*, directed by Igor Barrère, *1ère chaine*, 10 minutes, broadcast on 6 November 1959



Book Reviews

Ahlheim, Hannah: **Der Traum vom Schlaf im 20. Jahrhundert.** Wissen, Optimierungsphantasien und Widerständigkeit. Göttingen, Wallstein, 2018. 695 S. Ill. € 39.–. ISBN 978-3-8353-3247-8 (e-book: 9783835342460)

Wer sich mit der Geschichte des Schlafs befasst, steht vor einigen Herausforderungen. Schlaf gilt in den Naturwissenschaften als eine anthropologische Konstante. Dass sich der Schlaf ebenso wie andere Verrichtungen der klassischen Diätetik wie Atmen und Essen durch Kultur, Umwelt und Ökonomie verändert, muss bisweilen erst erklärt werden. Ihn zu beschreiben erfordert idealerweise die Bereitschaft, längere Zeiträume auf der Basis sozialhistorischer Quellen zu untersuchen. Es bedarf eines durch die *Annales* geschulten Blicks; anderen Herangehensweisen entzieht sich der Schlaf. Auch Schlafende selbst können wenig berichten. Fast wie der Tod ist der Schlaf, wie Friedrich A. Kittler meint, der Introspektion nicht zugänglich. Der kanadische Historiker Kenton Kroker hat seine 2007 erschienene Studie zur Geschichte der Schlafforschung folgerichtig *The Sleep of Others* genannt. Einfacher, das hat sein Buch gezeigt, als eine Sozialgeschichte des Schlafs ist die Geschichte der Konzepte zu schreiben, die zu seiner naturwissenschaftlichen Beschreibung erdacht wurden.

Auch der Titel des hier besprochenen Bands ist geschickt gewählt. Die Göttinger Historikerin Hannah Ahlheim befasst sich in ihrer umfangreichen Habilitationsschrift mit Konzepten von Medizinern, Wissenschaftlern, Militärs und Ökonomen, die sich auf die Erfassung und Kontrolle des Schlafs richteten. Daneben legt sie private Selbstzeugnisse, sozialhistorische Quellen und an entscheidenden Stellen auch künstlerische Positionen. Diese scheinen mit den Optimierungsutopien der Wissenschaftler überraschend häufig unvereinbar.

Ahlheim beginnt «oben», bei der Wissenschaft. Der erste Teil ihrer Arbeit widmet sich der Herausbildung von Konzepten und Einordnungen des Schlafs zu Beginn des 20. Jahrhunderts und beschreibt die Anpassung, Abwandlung und Neuentwicklung physiologischer und psychologischer Methoden. Für das erste Jahrzehnt des 20. Jahrhunderts sind Nervositätsdiskurs und Psychoanalyse die prägenden Themen. Dann folgt ein Sprung zu den klassischen Quellen der Sozialgeschichte, Berichte der Enquete-Kommissionen von Krankenkassen und Wohnreformern, Reportagen aus Schlafstätten und Asylen und Beschreibungen des Schlafgängerwesens, das den rasanten Wachstum der Großstädte in der Zeit der verzögerten deutschen Industrialisierung begleitete.

Dem Muster, Wissenschafts- und Sozialgeschichte miteinander zu verschränken, folgt der gesamte Band. Militärischen Effizienzstudien werden private Feldpostbriefe aus dem Archiv des Museums für Post und Kommunikation gegenübergestellt.

Das zweite Kapitel greift für die 1920er bis 1940er Jahre zunächst die Themen Rhythmus und Chronologie und die Bemühungen, den Schlaf anatomisch zu lokalisieren, auf. Später rückt der Fokus auf seine biochemische Determinierung. Im Detail werden die Experimentalanordnungen des EEG-Erfinders Hans Berger und des Schlaf-Polygrafen Nathaniel Kleitman analysiert, über die ausführliche Studien vorliegen, die von der Verfasserin gewürdigt werden. Doch auch viele eher unbekannt wissenschaftliche Nebenwege bei der hirnelektrischen Vermessung des Schlafs kommen zur Sprache. Mit ähnlicher Akribie widmet sich Ahlheim Schlaf- und Weckmitteln. Als Beispiel sei hier die Diskussion über das Methamphetamin Pervitin genannt, das in jüngster Zeit durch populäre Veröffentlichungen über den Einsatz bei der Wehrmacht bekannt wurde. Ahlheim rezipiert sowohl die ersten Studien zum Thema von Karl-Heinz Roth als auch die den aktuellen Forschungsstand repräsentierenden Arbeiten von Peter Steinkamp, was sie nicht hindert für ihren eigenen Zugang neue Originalquellen zu Rate zu ziehen. Neben der zuverlässigen Rezeption der Sekundärliteratur und der konzisen Auswahl der Archive für die eigenen Fragestellung liefert Ahlheim gesellschaftspolitische und kulturhistorische Einordnungen der historischen Diskurse auf einer großen Bandbreite von Reflexionsebenen.

Das reicht so weit, dass Ahlheim mit Verweis auf Ulrich Herbert die These prüft, ob sich in den 1950er Jahren auch in der Geschichte des Schlafs eine Westintegration angedeutet habe. Anzumerken ist, dass auch Ahlheims Buchs mit seinem Zuschnitt auf Deutschland und die USA dieser Orientierung folgt. Die meisten Zuspitzungen aber liefern lebendigen Diskussionsstoff und sind alles andere als platt. Das Buch ist eine Gesamtdarstellung im besten Sinne, auf der Höhe des aktuellen Forschungsstands, klar und spannend geschrieben, so packend, dass auch interessierte Laien etwas davon haben. Mit ihrer kritischen Analyse biologischer Vermessungsstrategien wird Ahlheim dem Gegenstand auf wissenschaftshistorischer Ebene allemal gerecht. An den Schlaf selbst führen ihre kulturhistorischen Quellen unmittelbarer heran. Beispielsweise, wenn sie Sophie Calles Projekt aus dem Jahr 1979 beschreibt, für das die Künstlerin den Schlaf von 29 Personen fotografisch dokumentierte. Doof ist, dass der Verlag am Register gespart hat. Wer die facettenreiche Studie nach Lektüre als Kompendium nutzen möchte, muss das von diesem Werk bestehende E-Book konsultieren.

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Cavanaugh, T. A.: Hippocrates' Oath and Asclepius's Snake. **The Birth of the Medical Profession**. Oxford, Oxford University Press, 2018. 192 p. £ 21.99. ISBN 9780190673673 (e-book: 9780190673680)

Das Buch des in San Francisco tätigen Medizinethikers T. A. Cavanaugh versteht sich als «a work in medical ethics that relies on contributions from numerous disciplines, including history, classics, and philosophy» (S. 4). Das Buch ist in vier Kapitel eingeteilt: nach der Schlange des Asklepios geht es um den Text des Hippokratischen Eids, um das Problem iatrogener Schäden und um die Fragen professioneller Autonomie. Im Anhang findet sich der Text des Hippokratischen Eids mit einer von Cavanaugh selbst erstellten Übersetzung und ein schmales Literaturverzeichnis. Hin-

sichtlich seines historischen Gehalts, der hier im Fokus stehen soll, ist das Buch mit Vorsicht zu genießen, die Darstellung ist in Grundzügen anachronistisch und im Detail oft fehlerhaft. Aber der Reihe nach. Ausgehend von den Versuchen, die Schlange als Attribut des Heilgottes zu erklären, darunter auch die längst obsoleete, es handle sich um eine Anspielung auf den Medina-Wurm, gelangt Cavanaugh zu einer eigenen Erklärung. Danach verkörpere die Schlange das «homöopathische Prinzip», da sie zugleich verletze und heile. Dieses Prinzip sieht Cavanaugh auch in der mythischen Szene der Heilung des Telephos durch Achill dargestellt. Passenderweise zeigt das Titelbild das bekannte Marmorrelief aus Herculaneum. Cavanaugh versteht es, gefällig formulierend und frei assoziierend eine suggestive Erzählung zu weben, die viel über sein Interesse an klassischen Bildungsgütern verrät. Das zweite längere Kapitel handelt vom Text des Hippokratischen Eids. Cavanaugh ist durchaus vertraut mit den antiken Quellen, aber die moderne Forschung zum Eid kennt er nicht. Daher hält er die Autorschaft des (historischen) Hippokrates für «plausible» (36). Die Existenz der deontologischen Schriften des *Corpus Hippocraticum* ist ihm keiner Erwähnung wert. Stattdessen fokussiert er die antike Medizinethik im Eid und erläutert unter dieser Prämisse abschnittsweise dessen Inhalt. Hier mischen sich solide Befunde mit luftigen Behauptungen, wie im Einzelnen zu zeigen wäre. Ein Beispiel möge genügen: das «Schneideverbot» des Eids erkennt Cavanaugh zutreffend als kategorisch, d. h. derjenige, der den Eid schwört, wird nicht chirurgisch tätig. Die Schwierigkeiten, die diese Passage aufwirft, werden seit Jahrzehnten kritisch diskutiert, aber Cavanaugh hat eine ganz einfache Lösung, wie sie im beginnenden 21. Jahrhundert zeitgemäß scheinen mag. Da das kategorische Schneideverbot nicht zur Realität der hippokratischen Medizin passe, schließt Cavanaugh mit verblüffender Logik, diese Passage gehöre daher nicht in den Eid («this text does not sit well», 65). In einer Folgerung, die seine tiefste Überzeugung ausdrückt und dennoch nur 86 Zeichen benötigt, stellt er fest: «Indeed, truly, really (if I may so speak of it), it seems not to belong to the Oath» (66). Cavanaugh passt demnach den Text des Hippokratischen Eides dem Bild an, das er selbst für angemessen hält, eine Arbeitsweise, die wenig mit Geschichtswissenschaft zu tun hat. War das Buch bis zu diesem Punkt zumindest seinem Anspruch nach an Quellen orientiert, streift Cavanaugh in den beiden folgenden Kapiteln die Fesseln kleinlicher historischer Methodik ab. Er postuliert einen zeitlosen «Apollonian/Asclepian account of medicine», der sowohl untereinander als auch gegenüber dem «Hippocratic account» wesentliche Unterschiede aufweisen soll. Dieses Konzept verfolgt er frei assoziierend in der Frühen Neuzeit und macht diesbezüglich kurz Halt beim französischen Arzt Joseph-Ignace Guillotin, dem Erfinder der nach ihm benannten Hinrichtungsmaschine. Wir befinden uns im Problemfeld der ärztlichen Mitwirkung bei staatlich angeordneter Gewalt gegen Körper, aber die verschiedenen Erzählfäden finden kaum mehr zusammen. Erleichtert nimmt man auf der letzten Seite zur Kenntnis, dass an den meisten amerikanischen Medizinschulen bei der Abschlusszeremonie ein Eid, oft geformt nach dem Modell des Hippokratischen Eids, geleistet wird. In summa hat Cavanaugh ein Buch vorgelegt, das Probleme der gegenwärtigen Medizinethik mit historischen Veratzstücken ausstaffiert. Materiell ist anzumerken, dass das kleinformatige Büchlein zwar ansprechend ausgestattet, aber so klein gedruckt ist, dass der Text mit Mühe und die Endnoten praktisch nicht lesbar sind. Insgesamt handelt es sich um einen gut

gemeinten Versuch, der möglicherweise in populärethischen Kontexten als anregend betrachtet werden wird, aber in seiner historischen Substanz nicht überzeugt.

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Retzlaff, Stefanie: **Observieren und Aufschreiben. Zur Poetologie medizinischer Fallgeschichten (1700–1765)**. Paderborn, Wilhelm Fink Verlag, 2018. 231 S. Ill. € 59.–. ISBN 978-3-7705-6146-9 (e-book: 9783846761465)

Die «Fallgeschichte» hat als Reflexionsfigur in den Kulturwissenschaften Konjunktur.¹ Ursprünglich wurde der Begriff als Kategorie in den praktischen Sozialwissenschaften wie Psychologie, Pädagogik, Medizin, Jura oder Psychiatrie entworfen,² um an paradigmatischen Krankheits- oder sozialen und rechtlichen Problemfällen den Graben zwischen Theorie und Praxis für den Lernenden mit einer Brücke zu versehen. Das Paradigmatische, also Allgemeine eines «Falles», der nicht mit jeder beliebigen einzelnen Erscheinung der Krankheit oder des Rechtsproblems identisch ist, zielt mithin auf eine soziale Praxis im therapeutischen oder rechtsprechenden Bereich. Ein solcher «Fall» ist im Kern auf die Praxis ausgerichtet, seine sprachliche Formation auf eben diesen praktischen Zweck gerichtet.

Dass auch Literatur am empirisch Einzelnen je unterschiedliches Allgemeines realisiert, ist spätestens mit Hegels *Ästhetik* unbestritten; neuere Literarhermeneutiken weisen auf diesen Sachverhalt auch deshalb ausdrücklich hin,³ weil die Aufgabe der Interpretin/des Interpreten eben darin besteht, das jeweilige Allgemeine der Dichtung im Prozess des Verstehens auf den Begriff zu bringen. Allerdings ist nur in den seltensten Fällen jenes Allgemeine der Dichtung auf eine pädagogische, soziale oder politische Praxis ausgerichtet; sei es in der auf die Ausbildung moralischer Gesinnung ausgerichteten Literatur der Aufklärung, sei es in der politischen Literatur des Vormärz. Doch selbst solche Dichtung ist auf jene subjektiv abgezielte Praxis objektiv nicht zu reduzieren, weil auch sie wie alle Literatur auf Reflexion, nicht auf Handeln abzielt. Kurz: Literatur realisiert keine Fallgeschichte und Fallgeschichten sind nicht Literatur.

Die so genannte Ausweitung des Textbegriffs im Rahmen des «*cultural turn*» hat allerdings solcherart Differenzierungen eingegeben. Der entscheidende Grund für die kulturwissenschaftliche Legitimation jener Ausweitung des Gegenstandsbereiches und gleichzeitigen Einebnung seiner inneren Differenzen liegt in einer erkenntnistheoretischen Prämisse, die trotz sachlicher Kritik an ihr zum Dogma geronnen ist und aufgrund ihrer Unhaltbarkeit auch zum unhinterfragten Glaubensinhalt gerinnen musste, um als Prämisse wirksam zu bleiben: die These nämlich, dass «jede

1 Vgl. hierzu u. a. Pethes, Nicolas, *Literarische Fallgeschichten. Zur Poetik einer epistemischen Schreibweise* (Konstanz 2016); Wübben, Yvonne, *Büchners Lenz. Geschichte eines Falls* (Konstanz 2016).

2 Vgl. hierzu u. a. Stuhr, Ulrich/Deneke, Friedrich-Wilhelm (Hrsg.), *Die Fallgeschichte, Beiträge zu ihrer Bedeutung als Forschungsinstrument* (Heidelberg 1993); Kimmeler, Gerd (Hrsg.), *Zur Theorie der psychoanalytischen Fallgeschichte. Konstruktionen (in) der Psychoanalyse* (Tübingen 1998).

3 Vgl. hierzu Kablitz, Andreas, *Die Kunst des Möglichen. Theorie der Literatur* (Freiburg 2013).

epistemologische Klärung [...] mit einer ästhetischen Entscheidung verknüpft» sei.⁴ In der methodologisierten Variante der hier zu besprechenden Arbeit von Stefanie Retzlaff lautet dieses Dogma: «Das Buch [d. i. die vorliegende Studie] fragt ebenso nach den ästhetischen und darstellungsmethodischen Strategien wie nach den epistemologischen Implikationen einer fallbasierten medizinischen Wissenstechnik» (S. 12f.).

Für die Umsetzung dieses Dogmas reicht dann zumeist schon, dass man «narrative Strategien» an medizinischen Fallbeispielen nachweist (wobei selbst der Begriff der «Strategie» ungeklärt bleibt), um jene Prämisse der systematischen Verbindung, ja Identität von Erkenntnis überhaupt und Erkenntnis des Schönen bestätigt zu sehen.

Und so wird dann munter drauflos rekonstruiert, wobei sich die Autorin keineswegs an den gesetzten Zeitrahmen von 1700 bis 1760 hält, sondern von Vesalius (45f.) bis Adolfe Quételet (61f.) eine Fülle an Texten heranzitiert, um die wissenschaftliche Funktion der stets poetisch formatierten Fallgeschichten zwischen der Beobachtung und ihrer schriftlichen Fixierung zu belegen. So versteht sich die Studie auch selber: als Fortschreibung der Fallgeschichtsforschung der neuen Kulturwissenschaften. Dabei gehört es schon zu den Fehlern der «Granden» dieser Forschung, niemals geklärt zu haben, was denn ein «Fall» ist, der in literarischen Geschichten in diesem Status und damit als «Wissensform» (74) reflektiert würde, bevor man Qualifikationsarbeiten wie die vorliegende auf den Weg bringt.

Dabei stellt sich allein die Frage, wie denn die Autorin zu den Quellen ihrer Arbeit und deren Anordnung gelangte. Vieler dieser Quellentexte werden nämlich nach Forschungsliteratur zitiert, so Leibniz nach Krämer (55) oder Boyle nach Daston (57). Auch werden lateinische Quellentexte wie Boerhaaves *Institutiones medicinae* nach englischen Übersetzungen zitiert. Überhaupt scheint es für die Autorin wichtiger zu sein, die Autoritäten ihres kulturwissenschaftlichen Forschungsparadigmas zu zitieren (von Foucault und Daston über Vogl und Pethes bis zu Koşenina); es sind deren Thesen, nicht etwa ihre an den Gegenständen selbst entwickelten, die in dieser Studie verifiziert werden. Kritiker – z. B. an der Prämisse Maxima einer Identität von Erkenntnistheorie und Ästhetik und damit an einer so genannten Wissenspoetologie⁵ – kommen dabei gar nicht erst zu Wort.

Gleichwohl gelingen der Autorin gemäß ihrer sympathischen Apologie der Erfahrung einzelne Beobachtungen, die als gelungen und erkenntnisfördernd bezeichnet werden können, so die leitmotivartige Betrachtung von Johann Georg Zimmermanns *Erfahrung in der Arzeneykunst* von 1763/64, der man eine eingehende Analyse und Interpretation gewünscht hätte; so einzelne Urteile über Johann Gottlob Krügers *Experimental-Seelenlehre* von 1756 (111ff.). Aber insgesamt bleibt ihr «Aufschreiben» diesen Beobachtungen äußerlich, von fremden Kategorien bestimmt, die von den Kirchenvätern und -müttern der Kulturwissenschaft inauguriert wurden.

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4 So schon Vogl, Joseph, *Kalkül und Leidenschaft. Poetik des ökonomischen Menschen* (München 2002), S. 13.

5 Vgl. hierzu u. a. Eric Achermanns Sammelrezension: «Bernd Blaschke, *Der homo oeconomicus und sein Kredit* bei Musil, Joyce, Svevo, Unamuno und Céline. 2004 – Eske Bockelmann, *Im Takt des Geldes. Zur Genese modernen Denkens*. 2004 – Joseph Vogl, *Kalkül und Leidenschaft. Poetik des ökonomischen Menschen*. 2002» In: *Arbitrium* 24/1 (2006), S. 116–129 oder auch Köppe, Tilmann, «Vom Wissen in Literatur» In: *Zeitschrift für Germanistik* (2007), S. 398–410.

Weißer, Christoph: **Chirurgenlexikon. 2000 Persönlichkeiten aus der Geschichte der Chirurgie.** Berlin; Heidelberg, Springer, 2019. IX+501 S. € 93.45. ISBN 978-3-662-59237-3 (e-book: 978-3-662-59238-0)

Benötigt man in der Ära von Wikipedia und digitalen Nachschlagverzeichnissen noch ein gedrucktes Lexikon? Ist deren Zeit nicht bereits abgelaufen? Ist es nicht leichter und verführerischer auf allgemein verfügbare und kostenlose Informationen zu vertrauen? Auf jeden Fall. Nur kennt man dann nicht den Urheber der Beiträge und so werden Fehler nicht erkannt, aber häufig kopiert und übernommen. Im Falle der Biografien von Ärzten zeigt sich der Wert eines Lexikons in besonderem Maße. Denn die biografischen Notizen im World Wide Web werden meist nicht von Medizinerinnen, sondern von geistes- oder kulturwissenschaftlich sozialisierten Autoren verfasst. Dies hat zur Folge, dass im Gegensatz zu älteren Nachschlagwerken nun nicht mehr die naturwissenschaftlichen Forscherleistungen oder ärztlichen Erfolge einer historischen Persönlichkeit im Mittelpunkt stehen, sondern vielmehr Details ihrer politischen und gesellschaftlichen Biografie. Dies trifft insbesondere auf Akteure zu, die in Mitteleuropa in der ersten Hälfte des 20. Jahrhunderts tätig waren.

Der Würzburger Medizinhistoriker und Chirurg Christoph Weißer benennt im Vorwort seines Lexikons noch weitere Aspekte, die es verunmöglichen, die Tradition früherer biografischer Verzeichnisse fortzuschreiben: die bis in die Mitte des 20. Jahrhunderts dominierenden und sich stets wieder ergänzenden chirurgischen «Schulen» sind längst zerfallen, scheinbar eindeutige Traditionslinien haben sich aufgelöst und die Spezialisierungstendenz macht es endgültig unmöglich, genaue Trennungen zwischen Disziplinen und Persönlichkeiten vorzunehmen.

Daher erscheint es sinnvoll, ein Lexikon von Einzelpersönlichkeiten zu verfassen, in deren Biografien sowohl die ärztliche Schaffenskraft als auch politische Verwicklungen und gesellschaftliches Engagement Erwähnung finden und darüber hinaus noch durch nicht inflationär gebrauchte Querverweise sinnvolle Verbindungen zwischen den einzelnen Persönlichkeiten hergestellt werden. Dies ist Weißer gelungen, wie beispielsweise die Kurzbiografie von Georg Magnus (1883–1942) zeigt (S. 206). Wenige Zeilen genügen, um aufzuzeigen, welche Teile seiner Karriere Ergebnis von Forscherleistung waren und in welchem Umfang die Affinität zum NS-Regime hilfreich war. In der Literatur zu seiner Person werden sowohl zeitgenössische Nachrufe als auch medizinhistorische Aufarbeitung genannt. Im Gegensatz zu früheren Lexika aus der ersten Hälfte des 20. Jahrhunderts und in auffallendem Unterschied zu den stets um ähnliche Inhalte bemühten Kurzbiografien in digitalen Verzeichnissen (Wikipedia) nennt Weißer epochenspezifische Vorgehensweisen, z. B. im Falle des Chirurgen Mätthäus Gottfried Purmann (1649–1711), der durch Erfahrungen im Kriege, eigene Erkrankungen und außerakademische Tätigkeiten zu neuen Erkenntnissen im Falle von Blutstillung und Operationen gelangte (257f.). Diejenigen Ärzte aus anderen Disziplinen, die herausragende Beiträge zur Weiterentwicklung der Chirurgie geleistet haben, werden großzügig integriert, z. B. der Orthopäde Karl-Heinz Idelberger (1909–2003) oder auch der Allround-Medizinphilosoph Paracelsus (1493–1541).

Die Kurzbiografien umfassen die Seiten 1 bis 358. Darauf folgt ein höchst interessantes Verzeichnis der Lehrstuhlinhaber chirurgischer Fächer an Universitäten im deutschsprachigen Raum, eine Liste der Direktoren berufsgenossenschaftlicher Unfallkliniken und der Präsidenten chirurgischer Fachgesellschaften im deutschsprach-

chigen Mitteleuropa. Im hinteren Teil des Buches finden sich ein genaues Personen- und Sachregister. So werden u. a. zeitgenössische und aktuelle Krankheitsnamen aufgeschlüsselt und erklärt. Bei all dem Lob sollen die Schwachpunkte des Buches nicht unerwähnt bleiben. So wird dem Leser aus den wenigen Zeilen im Vorwort nicht klar, nach welchen Kriterien Personen aufgenommen wurden, die in einer Zeit vor der Definition des Begriffs «Chirurg» im modernen Sinne tätig gewesen waren. Für das 19./20. Jahrhundert umreißt die Liste der genannten Fachgesellschaften den Rahmen des Buches: Chirurgie, Orthopädie, orthopädische Chirurgie, Unfallchirurgie, Viszeral-, Thorax-, Herz- und Gefäßchirurgie sowie Traumatologie. Die Konzentration Weißers auf universitär tätige Fachvertreter lässt diejenigen außen vor, die beispielsweise in niedergelassener Praxis oder in Provinzkrankenhäusern tätig waren und dennoch bedeutende Forscherleistungen erbrachten. So fehlt z. B. der in Essen tätige Chirurg Fritz Reischauer (1896–1963), der in den 1950er Jahren auf den Kongressen der *Deutschen Gesellschaft für Chirurgie* diejenigen Kollegen das Fürchten lehrte, die aus der Schweiz die Chiropraktik importiert hatten.

Gleichwohl handelt es sich bei dem vorliegenden Buch nicht nur um eine höchst verdienstvolle Studie, sondern auch um einen Ansporn an das Fach Medizingeschichte, die Deutungshoheit über die Vergangenheit nicht einfach anonymen Akteuren mit unbekanntem Qualifikationen zu überlassen.

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1968. Le sport fait sa révolution à Mexico. Sous la direction de Grégory Quin et Anaïs Bohuon. Paris, Editions Glyphe, 2018. 182 p. € 18.-. ISBN 978-2-35815-252-5

L'année 2018 a vu la publication de très nombreux textes à l'occasion du cinquantenaire des événements de l'année 1968. S'inscrivant dans ce mouvement, Grégory Quin et Anaïs Bohuon en ont profité pour sortir le troisième volume de leur trilogie consacrée aux liens entre médecine et sport. Partant du constat que jusqu'ici les Jeux olympiques (JO) d'été de Mexico (1968) ont surtout été traités sous l'angle de l'histoire politique, il s'agit ici de mettre «en lumière un autre aspect de ces Jeux, consécutif de l'organisation contestée de cette compétition dans cette ville située à plus de 2200 mètres d'altitude, de la quête de l'optimisation de la performance et de l'institutionnalisation des contrôles antidopages et de féminité» (pp. 15–16).

Le livre s'ouvre par un texte de Alex Jimenez Elias qui fait office de prologue. En effet, l'auteur revient sur les enjeux de l'organisation des JO à Mexico et en particulier sur la manière dont les organisateurs ont essayé de répondre aux critiques liées à l'altitude. Mais, il s'agit également pour eux de faire face à un défi politique de taille, les JO étant pour la première fois organisés «dans un pays encore en voie de développement» (26). C'est pourquoi, l'organisation des JO concerne au premier chef le gouvernement mexicain qui va largement s'investir dans la mise en place de l'événement et en particulier militer pour la faisabilité médicale des JO.

Puis, les contributions de Barbara Hug et de Stefan Scholl évoquent la préparation des athlètes en vue des JO de Mexico, respectivement en Allemagne et en Suisse. Les deux auteur-e-s abordent la manière dont les médecins se sont emparés des questions

liées à la santé et à la performance. Ils s'accordent sur le fait que les JO de Mexique «ont permis le déclenchement de nombreux projets de recherches autour de la médecine du sport à une échelle jamais vue auparavant» (48) et provoqué «des réflexions au sein des Comités Nationaux Olympiques (CNO) [menant] à l'émergence de programmes de préparation jamais imaginés jusqu'ici» (149). Les deux textes sont très éclairants car ils détaillent précisément les différentes mesures prises depuis 1963 en Allemagne et en Suisse dans la préparation des athlètes ainsi que la teneur des débats qui existent entre les médecins impliqués dans ce processus.

Les deux derniers articles traitent plutôt des conséquences des JO de Mexico sur les structures du sport. Ainsi, Grégory Quin explique combien ces Jeux jouent un rôle important dans la mise en place du Comité national pour le sport d'élite en Suisse au début des années 1970. En effet, à la suite des premières discussions suite aux échecs des JO d'hiver d'Innsbruck de 1964 – durant lesquels les athlètes suisses ne remportent aucune médaille –, la préparation nécessaire pour les JO de Mexico permet indéniablement d'amplifier les débats sur le sujet. Marcel Reinold évoque quant à lui le cas de la lutte antidopage en montrant comment les actions depuis Mexico 1968 se sont focalisées essentiellement durant près de quarante ans sur l'aspect médical. Or, cette posture a eu comme effet de négliger d'autres types de preuves: les témoignages, les preuves visuelles ou encore les perquisitions. Selon Reinold, cette manière de procéder a permis à de nombreux athlètes de passer entre les mailles du filet et aux autorités sportives de fanfaronner au sujet des résultats positifs de la lutte antidopage.

Les contributions de l'ouvrage soulignent bien l'importance croissante de la médicalisation dans le sport de haut niveau et révèlent que c'est un «système médical» qui a été mis en place dans la deuxième partie des années 1960. De plus, les auteurs rappellent tous un point important de cette médicalisation du sport: l'influence du contexte international, et en particulier de la Guerre froide, sur la dynamique des recherches. Enfin, le livre apporte également des éléments instructifs sur la circulation des savoirs. Certes, les JO sont une compétition (sportive et politique) entre les nations, mais ces événements sont aussi l'objet de discussions et d'échanges entre de nombreux acteurs. Ainsi, les trois éditions des prés-olympiades organisées en 1965, 1966 et 1967 à Mexico afin d'aider les délégations à prendre leur repère permettent la tenue de nombreuses conférences ou autres colloques entre les médecins présents. De même, des médecins allemands et français procèdent régulièrement, entre 1966 et 1968, à des échanges sur la question de l'acclimatation des athlètes à l'altitude. Le prétexte du cinquantenaire de l'année 1968 n'a donc pas été futile, cet ouvrage permettant indéniablement d'alimenter les discussions sur la médicalisation du sport, un sujet assurément d'actualité!

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Marketplace, Power, Prestige. **The Healthcare Professions' Struggle for Recognition (19th–20th Century)**. Edited by Pierre Pfütsch. Stuttgart, Franz Steiner Verlag, 2019. 256 p. Ill. (Medizin, Gesellschaft und Geschichte – Beihefte, Band 70). € 49.–. ISBN 978-3-515-12294-8 (e-book:978-3-515-12299-3)

In dem von Pierre Pfütsch herausgegebenen Sammelband *Marketplace, Power, Prestige* stehen die Entwicklungen verschiedener Gesundheitsberufe während des 19. und

20. Jahrhunderts im Mittelpunkt. Als Antrieb für diese Wandlungsprozesse werden insbesondere Konflikte begriffen: «Conflicts reveal different perspectives, promote change, and serve to generate decisions.» (9) Die insgesamt neun Beiträge behandeln die übergeordnete Fragestellung, wie und warum Konflikte zwischen Gesundheitsberufen aufkamen, wer involviert war und welche Ziele die Beteiligten verfolgten. Vor diesem Hintergrund gliedert sich der Band in drei Hauptteile:

Der erste Teil «Interprofessional Conflicts» wird von Karen Nolte eröffnet. Sie zeichnet nach, wie die Zuständigkeit für Anästhesie in Westdeutschland vom Ende des 19. bis Mitte des 20. Jahrhunderts von weiblichen «nurse anaesthetists» zu männlichen Anästhesisten überging. Hierbei spielten insbesondere geschlechtsspezifische Zuschreibungen der Tätigkeit in Auseinandersetzung mit der Chirurgie eine Rolle. Daran anschließend widmet sich Eileen Thrower der Etablierung von «nurse-midwives» in Georgia/USA in den 1970er und 1980er Jahren, die letztlich als Pflegekräfte mit Zusatzqualifikation hierarchisch unter der Medizin, aber über der Pflege positioniert waren. Pierre Pfütsch behandelt den Rettungsdienst in der BRD seit den 1960er Jahren, dessen Entwicklung zum einen durch Konflikte zwischen professionellen und freiwilligen Rettungssanitätern charakterisiert war, zum anderen durch solche zwischen Rettungssanitätern und Ärzten hinsichtlich des jeweiligen Verantwortungsbereichs.

Den Auftakt zum zweiten Teil «Conflicts Within a Profession» bildet Christoph Schwamms Beitrag zu Männlichkeit in der westdeutschen Pflege seit den 1960er Jahren, wobei er insbesondere die Diskussion um die Einführung des Zivildienstes als Grund für deren Abqualifizierung sieht. Um die Alternative zum Wehrdienst möglichst unattraktiv zu machen, wurde die 'Unmännlichkeit' der Pflegetätigkeit herausgestellt. Geertje Boschma untersucht die kommunikativen Strategien hinsichtlich der Wirksamkeit der Elektrokrampftherapie in der niederländischen Psychiatrie seit den 1960er Jahren. Damals neu und weit verbreitet, war die Methode in der 1970er Jahren mit dem Einzug psychotherapeutischer Verfahren auch international sehr umstritten, bis sie in den 1990er Jahren neue Prominenz im Kontext der biologischen Psychiatrie erhielt. Sylvelyn Hähner-Rombach (†) nimmt eine geschlechtsspezifische Analyse der Diskussionen um die dauerhafte Anwesenheit von Müttern auf Kinderstationen in Deutschland seit der Nachkriegszeit vor. Dabei kam es nicht nur zu Auseinandersetzungen zwischen den Kinderkrankenpflegerinnen und den Müttern hinsichtlich der Zuständigkeit für die kranken Kinder in pädiatrischen Kliniken, sondern auch zu Konflikten innerhalb der heterogenen Kinderkrankenpflege.

Der dritte Teil «Conflicts due to Changes in Social Conditions» beginnt mit dem Beitrag von Jane Brooks über britische «nursing sisters», die während des Zweiten Weltkriegs gemeinsam mit Ärzten in Kriegsgebieten arbeiteten. Unter den dortigen Gegebenheiten weichten die Hierarchien der Professionen und der Geschlechter auf. Die Autorin stellt die Vergemeinschaftung des Gesundheitspersonals den strengen Hierarchien in zivilen Krankenhäusern entgegen. Eyal Katvan zeigt anhand von Zahnärzten im Mandatsgebiet Palästina in der ersten Hälfte des 20. Jahrhunderts die Stratifikation der Profession im Kontext der Einwanderung von jüdischen Zahnärzten aus Deutschland. Während deren formale Qualifikation nicht anerkannt wurde und sie lediglich als Assistenten unter den alteingesessenen Zahnärzten arbeiten durften, professionalisierten diese sich wiederum in Abgrenzung zu den niedriger qualifizierten Immigranten. Aaron Pfaff rundet den Band inhaltlich ab, indem

er in seinem Beitrag die konfliktreiche Entstehung eines Gesundheitsberufs für eine spezifische Patientengruppe nachzeichnet. Aufgrund konkurrierender Zuständigkeiten bei Schulungs- und Trainingsangeboten für Diabetespatienten kam der Beruf des Diabetesassistenten seit den 1950er Jahren in Deutschland auf, um zwischen Arzt und Patient zu vermitteln.

Angeichts der Debatten um die Deprofessionalisierung der Medizin und die Professionalisierung der Pflege wäre eine durchgehende theoretische Auseinandersetzung mit *professionalization* im Kontext von Markt, Macht und Prestige sicherlich auch fruchtbar gewesen. Nichtsdestotrotz ist die Erklärung professioneller Veränderungsprozesse anhand von Konflikten ein überzeugender Ansatz und funktioniert hier als übergeordnetes Konzept für alle Beiträge sehr gut. Der gut komponierte und überaus lesenswerte Sammelband bietet zum einen eine Fülle von thematisierten Gesundheitsberufen und zum anderen eine internationale Perspektive durch die Darstellung von Entwicklungen in unterschiedlichen Ländern.

Lisa Pepler, Berlin (DE)



Books Received

Fischer-Radizi, Doris: **Vertrieben aus Hamburg.** Die Ärztin Rahel Liebeschütz-Plaut. Göttingen, Wallstein Verlag, 2019. 367 S. Ill. (Wissenschaftler in Hamburg, Band 2). € 29.90. ISBN 978-3-8353-3383-3

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Susanne Michl / Thomas Beddies / Christian Bonah (Hg.)

Zwangsversetzt – Vom Elsass an die Berliner Charité

Die Aufzeichnungen des Chirurgen Adolphe Jung, 1940–1945

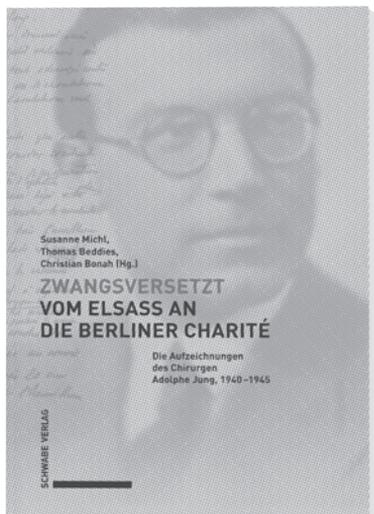
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Den Elsässer Arzt Adolphe Jung schlägt es nach der Niederlage Frankreichs 1940 an die Berliner Charité, wo er an der Klinik Ferdinand Sauerbruchs bis zum Kriegsende tätig ist. Aus unmittelbarem Erleben berichtet Jung vom schweren und gefährlichen Arbeitsalltag während des Bombenkriegs und der finalen «Schlacht um Berlin» im Frühjahr 1945.

In Berlin lernt der präzise Beobachter ebenso NS-Prominente kennen wie Angehörige der Opposition. Obwohl er selbst gefährdet ist, unterstützt er den Widerstand. Er operiert bis zur Erschöpfung und nimmt Anteil am Schicksal von Kollegen, Patienten und den wenigen Berliner Vertrauten. Die Aufzeichnungen Adolphe Jungs bieten einen faszinierenden Einblick in die Lebenswelt eines elsässischen Chirurgen während des Zweiten Weltkriegs.

Herausgeber

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