Walter M. Robinson, "Watching Boston Med," *The Journal of Clinical Ethics* 24, no. 1 (Spring 2013): 67-9.

Watching *Boston Med*

Walter M. Robinson

ABSTRACT

The author reflects on the ABC news documentary series *Boston Med*—both what it achieved, and what it could have achieved.

When I watched *Boston Med*, I was startled by the world it portrays. As the other commenters have noted, television shows of this type are the result of editing down many hours of filming; they are, as Neal Baer writes, "highly crafted, and they seek the unexpected, the twist or turn, the emotional, in order to make a show that will appeal to an audience."[1] The other commenters have taken on the issues of consent, informed or otherwise, to filming, and I leave it to them to parse out the answers to these issues.[2] What interests me here are the decisions made by the filmmakers in constructing the series. Since the show is a constructed version of events, edited from what may be hundreds of hours of filming, we are free to judge the show's constructed version of "reality" in comparison to our own experience.

From my perspective as a clinician and ethicist who trained and practiced for many years in the hospitals depicted in *Boston Med*, I find much of the filmmakers' constructed reality a cynically false rendering. In *Boston Med*, clinicians are most often depicted as callous, competitive, self-absorbed, or arrogant, and patients depicted as cartoonish saints or sinners. Out of the many hours of filming, the makers of *Boston Med* have constructed what they must believe to be a set of truths about American medicine; they are truths I did not recognize. For the most part, the filmmakers draw caricatures of clinicians, and create compassionless, mocking cartoons of people with serious illness. The filmmakers cannot respond that they are simply showing what happened; as Baer notes, they will have made scores of choices of what to show and what to leave out, and they bear responsibility for the results.

The show constructs two kinds of patients: good ones and bad ones. Good ones are eternally grateful to the staff, unfailingly polite, willing to wait forever. In particular, good patients must placate and please the doctor to get attentive care. In the show's most extreme example, good patients do not sue, even when a physician makes a serious error. Good patients applaud when the doctor walks in the room, comment on his or her attractiveness or charm, and exclaim their "faith" in the doctor; in the world of *Boston Med*, good patients see the doc-

Walter M. Robinson, MD, MPH, is a Visiting Fellow at the Hastings Center, Garrison, New York, *wmacr@mac.com*.

tor as a religious figure. In contrast, bad patients make specific requests and pursue them because they have educated themselves on their own condition. Bad patients have mental illness or addictions that disrupt the flow of medical care. Bad patients complain about extensive waiting or duplicate testing. Bad patients do not behave. They kiss their sandwiches. The show suggests that because they are bad patients, the public should feel free to mock them.

The white-hat black-hat simplicity of that depiction is foolish enough, but more disturbing is the suggestion that this contrast arises from the clinicians, rather than from the filmmakers' search for cheap theatrics. No scene is included in which an observer rejects this false moral dichotomy, save for one discharge nurse who knows the mother of a chronically ill child is stressed beyond her limits and demonstrates a caring and compassionate response; that response is far more common than any of the callous attitudes the show depicts, but it is less dramatic, I suppose, than the ones the filmmakers chose. Another brief moment shows a skilled emergency room nurse speaking with a patient in a firm but lighthearted way, skillfully diverting his concerns and reassuring him at the same time, containing his behavior so that the work of the emergency room can get done. In my experience, this happens scores of times every day, on every ER shift. It is a hallmark of excellent nursing, but it is evanescent in the world constructed by *Boston Med*.

Boston Med seeks out clinicians making fun of or being irritated by patients, and presents such scenes without context. The depiction of an encounter between a woman, her mother, and a young surgical resident is typical. No mention is given of the diagnosis, the reason for presenting to the emergency room, or the disposition. The women are styled as drug-seeking, irrational pains-in-the-neck for the young doctor. He says their suffering is not part of his job. But what else did he say? Was he concerned that he felt indifferent to their suffering? Was this a moment of frustration or a pattern? Were the filmmakers serious about telling the story of this encounter, or did they just want the viewer to feel the cheap thrill of superiority? Wouldn't anyone serious about getting the full story explore it more?

All of this could have been otherwise. *Boston Med* saves for last an episode on face transplantation that demonstrates what the rest of the series might have been. The sorrow and hardship of deciding to donate organs, especially facial tissue, is shown with sufficient time to get a clear picture of the family's struggle. The episode explores the entirely human reluctance of the family to make the donation, and then shows the family respecting the donor's wishes, to honor issues that were important to him. The suffering of the recipient and his family after his disfiguring accident is shown in a way that preserves their dignity and avoids the sideshow motif the filmmakers previously used to depict a patient with mental illness. This episode also illustrates the highly professional work of the transplant team. Their discussions with the donor's family and the recipient demonstrate compassion and candor. These clinicians function as a team without the juvenile competitive attitudes highlighted in the rest of the episodes. The subtlety and complexity of these scenes demonstrate that the television format, with its commercial pressures, does not in fact demand sensationalism. A well-told story will captivate without melodrama.

This last episode demonstrates what all of *Boston Med* could have been, and makes clear the effects of choices the filmmakers made in the first seven episodes. The series as a whole could have illustrated the hard work and complex choices made under uncertainty by physicians and nurses working in premier Boston hospitals. It could have shown those doctors and nurses handling the stress of their work without sensationalism. It could have presented patients as we know them to be, fully rounded people struggling with illness, complex and burdensome care, and the bureaucracies of healthcare and insurance, as well as negotiating their relationships with the changing set of clinicians, for better and worse. Sick people and their families could have been honestly portrayed as having good and bad days, as do we all. Physicians and nurses, young and old, could have been presented as struggling, not always

successfully but at least earnestly, with the difficult work of caring for the sick. Yes, we physicians and nurses are flawed in just the sorts of ways all humans are, and some of us are arrogant and haughty and let our stress interfere with our compassion. But the stylized, hyped-up world of *Boston Med* is not a true one; it is a simulacrum of the truth designed to tease, not inform.

By choosing the tell the story of these hospitals in a more mature way, the makers of *Boston Med* could have sparked a renewed public involvement in medical training or organ donation or chronic illness or the cost of care or the burden of illness. There are dozens of well-made documentaries that strive to do just that, likely with less of a budget and less access to these institutions than *Boston Med*. Instead, the filmmakers wasted the opportunity to present a thoughtful look inside the world of the modern hospital. They chose to portray people as types, as stock characters, using a style that depends on the melodramatic moment rather than the well-considered narrative of character and deed. They spent hours in the hospitals, but failed to see the real human drama going on in these institutions. *Boston Med* describes the lives of patients and clinicians in the way reality television describes life: sensationally, poised to reveal and savor the hasty reaction, more concerned with the melodramatic transgression than the slow and hard labor of living with illness or working in a modern research hospital.

NOTES

1. N. Baer, "First, Do No Harm," in this issue of *JCE*.

2. T.M. Krakower, M. Montello, C. Mitchell, and R.D. Truog, "The Ethics of Reality Medical Television," in this issue of *JCE.*