The Confusion of Conditions

A Sociological Look at the Television Series *E.R.**

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E.R. is an American television series that portrays the daily activities of a medical team in the emergency room of a hospital located in Chicago. The pilot episode was broadcast on NBC in September 1994. The series was bought by France 2, which aired the first episodes in July 1996, and has presented a new season every fall. Michael Crichton created *E.R.* He wrote the pilot episode, which was produced by John Wells and directed by Rod Holcomb; he continues to supervise the writing of subsequent episodes which are directed by different people. A graduate of Harvard, the author of 22 best-selling books, he has a medical degree, but has never practiced medicine. It was during medical school that Crichton thought of the original screenplay for *E.R.*, which was produced twenty years later. He needed the authority that was granted to him by the success of his books and his film scripts (notably *Disclosure*, *Jurassic Park, Congo, Rising Sun*), as well as the support of Steven Spielberg, in order to be in a position to propose an original screenplay that in many respects went against much of what people expected in a television series, and concerning which he was not willing to make any concessions.

The Research

What is most striking when one questions viewers of the series is their sense of a true *powerful relationship* that is immediately established between the series and its audience and which develops throughout the seasons: violent rejection, strong enthusiasm, disgust, expectation, impatience, frustration, irritation, habit, weariness, (relief). In any event, the series appears endowed with a specific, very motivating energy. The aim of the present research is to attempt to understand how this relationship is established, first by analyzing the means the author uses to take control of his audience, and, second, how he succeeds in this, whom he controls, in what way, and for how long. This was carried out through a survey conducted among three categories of audience:

— audiovisual professionals and researchers who, from a technical point of view, attempted to describe what they found striking in the organization of the series, in how it was constructed, as well as in its form of writing;

— members of the medical profession: doctors, nurses, hospital personnel or emergency room professionals who commented on the series from the prospective of medical professionals;

— regular viewers of the series. The survey included individual and group interviews conducted immediately after certain episodes were aired, as well as an ethnographic follow-up of the show on Sunday evening in Paris and elsewhere among viewers who had agreed to meet with me.

In all, my research was carried out over four years; 150 people were interviewed[1].

Most studies on audience reception of television have attempted more precisely to qualify the nature of the relationship between the television viewer and the medium. As Daniel Dayan points out in the introduction to the issue of *Hermès* devoted to reception[2] studies have varied the nature and the breadth of the segments concerned through analysis (a specific program, a series of shows, a televisual genre, the collection of programs that the viewer amasses for himself or to which he is drawn, a channel, the medium as a whole, or finally, following a biographical approach, the traces of all the programs watched during a lifetime). They have then analyzed the range of viewers' attitudes, differentiating them using morphological criteria (age, gender, PCS, level of education, social status, etc.) following the perspective of a sociology of tastes, or using criteria of cultural association (nationality, origins), following a more anthropological perspective.

The limits of these approaches come both from the type of attitude in which they situate the audience and from that in which they place the work. First, because the audience appears to be subject to an evaluation of its abilities or of its performances that evokes a scholastic, rather inappropriate, relationship. Then, because there is a risk of a naturalization of the proposed interpretations: to establish a logical and one-to-one connection between a type of analysis and a cultural association is an attitude that crushes all other possible factors of interpretation and which, by practicing an eminently problematical shortcut, ultimately contributes to strengthening the stereotypes from which, sometimes, it emanates. Finally, because the program is, in fact, discretely devalued. (No one would dream of talking about the reception of the *Fleurs du mal* or of *Madame Bovary* without knowing the work, whereas such an attitude hardly seems to pose any problem for those who study the reception of televised fiction). Thus, by neglecting an internal knowledge of the work, one is deprived of the means to understand the concrete uses the viewers make of the schemas that it puts at their disposal and thus, as a result, to envision the role of fiction as that of bringing about significant change and of transforming one's perception of reality.

In contrast, I have attempted to change the perspective, that is, I have sought less to qualify modes of relationships with fiction than to multiply points of view on the work, while considering that the viewers in the diversity of their personal, social, and professional positions were likely to bring complementary and different perspectives to the series, which, without exhausting the meaning, could bring about an "activation of potentialities", to borrow Jauss's expression. These different perspectives are not focused on the viewer, but are oriented toward the work; they do not serve to explain the viewer, but attempt to analyze the work. From this point of view, the project resembles a study that deals with literary texts more than a study focusing on the media. This is not by chance:

studies of the media have always been more preoccupied with the audience, for it was in the audience that crucial issues linked to the appearance of mass culture seemed to be found. Literary studies, in contrast, have always been more concerned with the works themselves.

The research, whose preliminary results I will present here, proposes an internal analysis of the series *E.R.* which is supported by readings proposed by the different categories of viewers that I interviewed.

First Images: The Confusion of Conditions

Television series that involve doctors or medical personnel have existed since the beginning of the medium.[3] In France, health professionals constitute the second largest group of fictional heroes, following close behind professionals in law enforcement; in the U.S. hospital soap operas essentially comprise a separate genre in themselves. But *E.R.* breaks out of the usual framework of this type of series: first, by concentrating on a specific medical speciality (emergency medicine), then by taking place in a perfectly circumscribed locale (the hospital), finally, by occurring in specific conditions, since it plays on the close contact among the care-giving personnel.

In fact, the series enables us to take a journey: it brings us in with the patients and leads us alongside the doctors. It then pulls us away from the condition of the patients and brings us considerably closer to the experiences of the care-givers. That is, unlike most of the earlier medical series that, paradoxically, contributed to maintaining or even accentuating social differences, this series provides all the tools necessary to enable the merging of conditions.

The tone is set with the first images of the pilot. The series opens with a scene showing Dr. Greene asleep in the doctors' break room. A high angle shot. Suddenly a nurse bursts into the room, wakes him up; ("You have a patient".) He looks at his watch, asks that they page the intern on call. But he has to get up; the patient is none other than Dr. Ross, dead drunk, who shows up staggering at the E.R. desk. From the very beginning, the essential elements of the series are revealed: the difficulty of the doctors' work, the constraint that a lack of sleep means for them, the weakness of the heroes, the slight irony of hierarchical relationships, the sense of team, the irresistible attraction that the hospital has for those who work there, and their inability to extricate themselves from it, if only for an evening out drinking. And above all the fluidity of roles that immediately puts one of the members of the medical team in the position of patient and consequently contributes to the intermeshing of conditions. This scenario repeats itself later more dramatically with the suicide attempt by the nurse Carol Hathaway, the illness of Jeanie Boulet, or more comically, with the problems of Dr. Carter. In each case it is as if doctors and patients in fact share a common fate.

The Professionals'Point of View

This first part of the analysis focuses on the views of professionals and experts, as we seek to understand how technical and narrative choices affect how the work functions, and enhance that feeling of a *confusion of conditions*. We interviewed authors, screenwriters, producers, distributors, directors, editors, journalists on the one hand; literary critics, semiologists, specialists of the popular novel, historians, sociologists, anthropologists, psychoanalysts, on the other, to bring their points of view to the innovations of the series. The analysis that follows, therefore, with some reorganization presents the principal elements that came out of these conversations, which are then combined with commentaries by the authors of the series.

Obviously, what constitutes the originality of *E.R.* is not the subject itself, but the way in which it deals with it. The series differs in numerous ways from the normal structure of traditional French television series: we leave the universe of the recurrent hero, the focusing on a central character, the simple narrative thread organized around the rising importance of a central story, the clear hierarchy between the main plot and secondary plots. All of the classic principles of televised narration are thus clearly altered here.

> "I wanted to write something that was based in reality. Something that would have a fast pace and treat medicine in a realistic way. The screenplay was very unusual. It was very focused on the doctors, not the patients – the patients came and went. People yelled paragraphs of drug dosages at each other. It was *very* technical, almost a quasi-documentary. But what interested me was breaking standard dramatic structure. I understood that's what the screenplay did, but I always felt that it was compulsively watchable… In a certain way, I always felt it was in a special category, a strange thing that was its own with nothing else like it." (Michael Crichton)[4]

The Unity of Place

The series above all emphasizes a unity of place, which is rarely broken up by a few scenes shot outdoors. The great majority of the action takes place in the emergency room of a hospital in Chicago which is reconstructed on a closed set in the studios of Warner Bros. in Los Angeles, with the pilot having been shot in the abandoned hospital of Linda Vista. It is thus a limited space, separated from the outside world by a set of swinging doors. And everything is done to emphasize the contrast between an immense, hostile, dangerous exterior world, and the universe of the hospital, a closed microcosm, warm and confined. In doing this the series succeeds in an initial tour de force that leads to reversing the spontaneous perceptions of the viewers since it is the world of the hospital that becomes familiar, emitting an impression of security, whereas that of ordinary life is felt to be dangerous and hostile. This separation is emphasized by climactic details: rain, snow, sleet, extreme cold, seem to be the daily lot of the inhabitants of Chicago. At the same time, the border that marks these two spaces is both clear and fragile: they are the swinging doors which at any moment might open to allow the abrupt intrusion of the outside world. Abruptly, but legitimately. This is how the

connection between the two universes is constructed, a connection that establishes one of the novelties of the series: *E.R.* has constructed a design that places the hospital in the center of the city. "The emergency room is an intermediary zone between the city and the hospital. People are afraid of illness. But the emergency room is not yet illness. It is primarily the unexpected" (director). We have the impression that it is the only stable point in the midst of a series of concentric spaces that inevitably open up onto it. "*E.R.* has opened a new avenue in which the hospital speaks of society, whereas before, there were doctors amongst themselves or doctors and nurses" (producer). At the same time, the America represented is an America in crisis: we are very far from the triumphant images of the oil men of Dallas, with their beautiful wives, their big hair, their ranches, their makeup and their whisky. The main characters are physically bland, the extras many and faceless, the city agonizing. "We have an x-ray of society and of its urban poverty, which for once does not go through a police station" (producer). And part of the energy of the construct comes from the fact that the hospital, in its restricted situation, is up against something infinite or indefinite, that inexhaustible reservoir of distress which is the everyday world.[5]

The Unity of Time and Action

The series also has a certain form of temporal organization that rests on a linear unfolding, avoids anticipation, returns to the past, and plays with the contraction of time: for the demands of fiction, it condenses one day of activity into one episode, sometimes explicitly ("Pilot," "Day One," "Into That Good Night"…). In fact, the density of the exceptional events dealt with in each episode suggests an even wider temporal horizon. Furthermore, within this framework, the author does not renounce his prerogatives to reinforce dramatic characterization: the rapid staging or, by contrast, the sequential layouts that sometimes last several minutes are used to emphasize these differences in ambiance and to give the series its spasmodic rhythm which, for the viewers, is its principal characteristic. The rhythm is created by the alternation between rapid and slow scenes (tension/decompression), the slower phases serving to give even more relief to the phases of acceleration.

But the most original aspect of the series comes from the way in which it deals with the temporality of emergency medicine. Everything occurs so that the viewers break from their personal experience since the common experience of an E.R. waiting room is one of extreme waiting. Long hours of patience are required. There is a sense of indifference, of neglected suffering, sometimes the fear of having been forgotten. In almost every interview the ordinary experience of the sick person is thus exactly the opposite of what constitutes the most noticeable characteristic of the series: rapidity and stress.

To achieve this change in experience the series tends to focus the emergency on only one of its dimensions (critical emergencies) and in so doing adopts the perspective of the lay person. In general, the situations in which one intervenes to save the life of someone are moments of euphoric

fellowship: a shared energy toward the other which corresponds to a sort of embellishment of the social tie. The moment of providing aid is accompanied by a feeling of excitation: people run in every direction, move around, are agitated, as if agitation were a way of manifesting one's power (or of escaping a lack of power) in the face of death. In other words, the ordinary public responds spontaneously to an emergency with speed, although that might not necessarily be the most appropriate reaction to a situation. And what by contrast defines professionalism, is the ability not to allow oneself to go at such speed: to react with calm indicates that the situation is "under control."

There is also, in principle, a maximum distance between the victim who is experiencing an unusual, catastrophic, extreme event, and the professional who is trained to provide standardized responses to it, with the help of the appropriate instruments that he has at his fingertips, since the unforeseeable had already been foreseen. A crisis on one side, routine on the other. In principle this asymmetry structurally – and lastingly – separates the condition of patients from that of the caregivers.

But the series manages to bring them together. How? By using staging and camera movements, but above all through the use of music. Granted, it happens that the series attributes the reactions of the ordinary public to the medical personnel (ambulances go at breakneck speed, gurneys take off very quickly, nurses and doctors hurry around to help patients, giving an impression if not of panic, then at least of great anxiety), but most often it is essentially thanks to the soundtrack, that is, by the crescendo of anxiety-provoking music that perspectives are superimposed and objectives (saving people) and methods (scientific competence) are fused together.

The Documentary Illusion

A unity of time, place, and action, *E. R.* relies on a structure that, in some ways, evokes that of the theatre. With its main stage, characters who enter and exit, swinging doors that open and close. But at the same time, the series is based on a strictly televisual structure, for it explicitly borrows from the documentary form, indeed, even from that of news reporting. This *modus operandi* was pushed particularly far with the filming of the first episode of the last season, which was shot live[6].

In fact, some of the visual effects are connected to the use of the Steadicam, a name for a camera that is carried in a certain way. It is made up of a spring-loaded rigging, a harness, and a little video monitor, and is very often used for news reporting. Using a system of sophisticated counterweights, the Steadicam eradicates involuntary movements by stabilizing the shot. Thus it has the maneuverability of a portable camera and the stability of a dollied tracking camera. The entire rigging weighs around seventy pounds and is balanced on the hips and shoulders of the cameraman who moves around with it, thus giving the scenes filmed their very characteristic fluidity, which makes the viewer feel he or she is actually part of the story. "With the Steadicam, you don't just have a subjective perspective, you actually enter into the scene. The area in which we film is not fixed as it is

with ordinary cameras, but can be renegotiated in function of the evolution of the situation" (director). 70% of the scenes in the series are filmed using this system.

But it is not only the filming method that creates the illusion of a documentary: the very staging contributes to it. One can, thanks to Janine Pourroy's book,[7] which provides many details on the material construction of the series, get a glimpse of the details behind the project. Indeed, the book provides an excellent presentation of the slightly kitsch association between the cardboard side of things, nicely detailed, and the meticulous, indeed conscientious efforts to obtain realistic effects. We learn that the sets constructed in the studio on three sound stages of around 9,705 square feet comprise the hard walls, the hallways, and the closed ceilings, which complicates the movements of the characters, but enables overhead lighting and restricts movements very effectively, which serves to convey the confined atmosphere of a hospital: a lack of space, a lack of air. Some thirty extras come and go in the frame, often with their backs turned, to produce the effects of density and agitation. Once or twice a year, the crew goes to Chicago to film the exterior scenes, preferably choosing very open spaces, which are used to air out episodes and avoid a sense of claustrophobia.

The authentic medical instruments (stethoscopes, radiology equipment, thermometers…) are provided free by the manufacturers. The pharmaceutical cabinets are filled with real bottles of medicines. The color of the uniforms respects the professional hierarchy. Real nurses on the set show the actors the medical techniques and language they will have to reproduce:

> "It was hard for the actors to say these things at first. It was a big mouthful. And early on, they needed to learn how to take over the situation like real doctors, which meant that if they were interested in the patient's abdomen, they didn't look at a patient's face – which goes against the actor's instinct. And sometimes the actors would look to the patient for approval, which is something a real doctor wouldn't do" (Michael Crichton).[8]

But, obviously, there are limits: to give shots, the prop masters use retractable syringes, and for operations, scalpels with a reservoir that place a thin strip of blood on the skin. They say they go shopping at the butcher shop and use discarded animal parts to represent human parts. They place the carcasses of sheep on jointed dummies, create body parts out of foam rubber and latex, cover rubber babies with yoghurt and strawberry jam. The make-up team uses creams and powders to give the actors scratches, redness, shadows under their eyes, and bruises.

The credibility of the production is reinforced by the installation of a demanding structure of documentation: certain screenwriters are both authors and doctors, such as Lance Gentile. Joe Sachs, also a doctor, is a technical production advisor. Neal Baer is a medical student. The association of E.R. doctors, the American College of Emergency Physicians, lent its support for the project. A systematic job of collecting data is carried out throughout the country thanks to a network of contacts maintained both in public hospitals and in private clinics. The authors read reports from the closest medical centers, and attend a program for nurses organized at Warner Bros. The stories they gather, sorted in function of their dramatic interest (serious situations, amusing ones, technical

details) are then inserted into the story line. As a result, the series is characterized by a concern with exactitude which is one of its main, unique qualities and it is expressed through the scrupulous use of an exact and precise medical terminology.

> "Traditionally, medical shows have had the attitude that the viewer has to understand what's going on medically at all times. So you hear characters saying a lot of ridiculous things like 'It's time to do the laparotomy! Joe, get that tube so we can see if there's blood in his stomach!' – when, clearly, everybody in the scene would know what a laparotomy was. Instead, we allowed the audience to feel as if they'd stepped into a real hospital" (John Wells)[9].

This choice is obviously very original. A screenwriter who had collaborated on a French medical series tells that *a contrario* each time he slipped a medical term into a dialogue, his script came back to him edited by the bosses of the channel with the note "incomprehensible, think of the viewers." One notes, however, that the viewers are not distressed by that language: "Give us sub-titles," a group of adolescents commented jokingly, at the beginning of a slightly complex dialogue. Curiously, they ended up not only getting used to it, but even wanted it: "All the science they hand us gives a sort of credibility. You're happy that someone has escaped a thrombosis, because that seemed to be really dangerous" (student, 19); "I don't need to know everything" (woman, 75); "I don't understand a thing, but it seems true" (fireman, 22); "I don't really try to decipher it" (woman, 24, ad agency).
Finally, not only is this abstruseness not really off-putting, it actually plays a role in the viewers' process of familiarization with the medical universe that is described in the series: "I have the impression that I'm really beginning to understand something, whereas the world of medicine is very, very closed and the rare times when I went to the hospital, I didn't understand anything and now, I'm beginning to understand. It's like when you learn a foreign language, when you learn with methods used now where they don't translate. It's the same thing: I have the impression that I understand much better: they clamp him, they give him 02 negative…" (woman, teacher). Immersion favors if not understanding at least the taming of that language which becomes less hostile because it is more familiar. This sometimes even results in assessments that might seem paradoxical: "In reality, it's worse. Because here, you don't understand anything, but you have the impression that they're speaking. Whereas in reality, it's a jargon, but there's nothing, there's no dialogue. Whereas here, you have the impression that there is a dialogue, that you can interrupt them and ask them 'what did you say?'" (woman, office worker).

Narrative Structure and the Televisual Genre

Another essential characteristic of the series is linked to the reduction in the number of heroes. The narrative structure is polycentric. There is not, as in the usual series, a main character, a recurrent hero on whom the attention of the audience is focused, but six characters (four men, two women) without the script indicating an order of preference among them. They are all on an equal footing and it is their interconnected stories that feed the plots. "One of the chief complaints about the script

was that you didn't know who you were supposed to care about" (John Wells).[10] They are surrounded by around twenty secondary characters and a large number of extras (some thirty new actors are hired for each episode).

In fact, this structure relies on the loyalty of the audience, for it assumes that the viewers will take the time to get used to the different characters, which is essential for the viewers to be interested in them. But at the same time, it opens up a certain number of narrative possibilities. First, because it leads to emphasizing the interactions that exist between the different people involved: the relationships they maintain are indeed at the center of the action and it is those relationships that will make them develop. Then, because it enables the plot to focus on the characters' weaknesses. The incompleteness of the characters is a source of developments, it multiplies the opportunities for disorder, for tension or conflicts, which opens up many more opportunities than does a single idealized hero. "What is great in this free-form soap writing, is that the screenwriters can blow-off a character and then resuscitate him later. Since you have five characters, one can be a jerk for three episodes. There are times when you're fed up, you don't have any compassion. And then things get better. The writers are aware of all that." (screenwriter). This polycentric structure also has the advantage of being able to evolve. The focal point can be moved depending on the periods, in function of the departure of certain actors (Susan Lewis) or of the desire to integrate second-level characters, bearers of new problematics, into the central sphere of action. Thus the fourth season is more focused on the E.R. nurses.

Curiously, it is above all the peripheral characters (the patients) who help give the series its unusual structure. There are, in fact, quite a lot of them (512 in the first season, 45 in the first two episodes ["Pilot" and "Day One"], and feed a great number of secondary plots [up to eighteen per episode, versus three or four in classic televised or cinematographic screenplays]). In fact, one of the things that distinguishes this series from the usual medical series comes from the importance that it gives to the treatment of medical cases and above all from the number of cases that occur. From monitoring the pilot episode, it was found that 80% of the scenes deal with the relationships between doctors and patients, and the remaining 20% are divided among the personal and professional relationships of the medical team and their private lives.[11] This breakdown is interesting since its results are unexpected: the viewers who watch the series regularly all have the feeling that the personal lives of the doctors are featured much more than they actually are.

The priority that is granted to the medical side of the series, and the narrative choices associated with it, have determining consequences for the characterization of the series: first, it is what gives it its violent, indeed repulsive quality for the portion of viewers who can't tolerate the sight of blood (an accusation of voyeurism). "There are scenes that are really disgusting. The other medical series that deal more with the nurses and so forth, are really wimpy. Here, wimpiness is completely gone from the formula" (reporter and television critic). Then, because that priority is accompanied by a concern

with exactitude, that is what contributes to showcase the importance of the strictly technical dimension. (It is interesting to examine the scripts of the *E.R.* screenplays: they are surprisingly inexplicit, short and filled with impenetrable notations. Most exchanges are no longer than one line. They are never redundant with the shot and make no concessions to the lay person). Finally, this is what determines its heterogeneous dimension: just as the patients who irrupt into the emergency room are extremely diverse in terms of age, ethnic origin, and social class, and suffer from diverse pathologies (medical, surgical, social or psychiatric emergencies) of different levels of emergence (from vital urgency to a benign illness), the dramatic weight that is given to them is extremely variable.

In fact, every patient is the bearer of a micro-story which in some way is the ultimate and catastrophic version of daily, more or less ordinary, activities that have ultimately turned out badly (some evoke urban warfare whereas others are the result of cleaning the kitchen). They provide an opportunity to present a panorama of American society which is then systematically scrutinized. "You can rely on Americans to create a tableau so that as many people as possible can see themselves in it; you have to have different ages, different types of people, a palette of characters, of social backgrounds" (producer).

But what is interesting is that these secondary plots are dealt with in a way that breaks with most of the principles of the usual economy of script-writing: first, because the space that is granted to them is variable; some, potentially interesting, cases are dealt with quickly, with others they dwell on them for several minutes and sometimes longer, letting some stories continue from one episode to the next; then, because how they will be developed is completely uncertain: the same story might be scarcely mentioned or, on the contrary, be developed at length. The attention that is given to it is not determined according to the seriousness of the case: there are cases in which death is dealt with fleetingly, almost casually, whereas at other times the action stops for a long time on a tragic unfolding. Finally, their contribution to the central narrative line is completely unequal: some serve to clarify certain aspects of the central characters' psychology and to reveal their personalities (Carter's tenderness for old ladies, Benton's controlling authoritarianism). They potentially provide the opportunity to differentiate among the characters if, when confronted with an identical situation, they adopt different solutions. Others might even bring about profound transformations in their personalities, which will have consequences in the unfolding of their lives: this is the case of Mark Greene, following the death of the young pregnant woman in the episode "Love's Labor Lost." It is generally situations of professional failure that can have this impact, for as in all professions that have a decisive influence over the lives and deaths of others, failure and success are the objects of an asymmetrical judgment. But other stories stop short and are absolutely not developed, in spite of their strong dramatic potential. They lose patients whom they have been following for a long time, and then jump immediately into another case. The beginning is always allusive, the end sometimes

avoided. The method of treatment, irregular and asymmetrical, serves to make the situations doubly suspenseful, because we don't know what will happen to the patients. And because we don't know what the authors will tell us. They in fact retain the privilege of being either reticent or demonstrative.

In fact, it is as if the screenwriters are deliberately playing with overabundance, as if they felt sufficiently confident about the strength of the narrative thread to deviate from one of the most elementary principles of the economy of scripts which is that the effectiveness of the entire construction is measured by the necessity of each scene. The series plays on excess, by peppering the story with a profusion of plots, of characters, of unexploited situations, which it proposes, holds for a few episodes, then abandons, which gives the feeling of "a structure that is very open to coming and going, generous" (screenwriter). As if ideas were not precious, but plethoric, and as if one could harmlessly indulge in a true squandering of the resources of the story. This way of dealing with secondary plots determines the very unusual looped structure, which is characteristic of the series. But there are also three other consequences: first, it ultimately makes the secondary characters carry the strongest dramatic burden, since it is they who are confronted with matters of life and death. The primary suspense is thus not found among the heroes, which is relatively unusual. The narration thus has a disjointed aspect, following a post-modern aesthetic. "We wanted the pace to move in a way that would hold the audience's interest. The joke around here was that *E.R.* is the show for the era of remote controls because there is no need to channel surf: all you have to do is hang around for a minute or two and you're going to see another story." (John Wells).[12]

Next, it blends together classic differences in styles: one goes from tragic to comic moments. The series mixes elements borrowed from burlesque, drama, melodrama, comedy, indeed even horror films (when you see human body parts bursting out, forgotten cadavers lying around), following a rather unexpected alchemy. "There are always moments of absurdity. There are always moments such as when a troop of fifty boy scouts enter… There is always some crazy woman who is walking around somewhere… like an apparition… What I find terrific is the synthetic nature of that series. I don't think it's entirely new; it doesn't shake anything up. But it brings together an incredible number of elements. Both *Mash* and high comedy. Both social criticism and satire. That is what I find wonderful" (reporter).

Finally, it contributes to forming a certain type of hybrid genre. *E.R.* is both related to the serial (with stories that are continued) and to the series (with connected stories). One can't really say that each episode can be watched separately, because it takes a little time to get into the story, to identify the different characters, and to get interested in them. The survey clearly shows that *E.R.*, like most series, assumes that viewers have to get used to it; the people we interviewed who had watched only one episode had a very different view than those who had followed more. But at the same time, one can very easily miss episodes and "get back into it:" "It is a serial without really being one"

(screenwriter). This is what enables an evolution in the nature of the viewers' relationship with the series: the private lives of the doctors, their relationships among themselves, the stories of the patients, all contribute to forming a complex narrative fabric woven out of three narrative lines whose threads, of different lengths, intersect. This construction determines the components of the viewers' attachment and enables those components to evolve during the course of the different seasons. Entrance into the series occurs around the relationships between the doctors and the patients ("while channel surfing I happened upon it and I said, hey, that doesn't look too bad, and since there were only dead people, covered with blood and not too much illness, I became hooked"), but gradually it is the relationships among the team that take over. As if the true narrative intent was gradually unveiled and the medical dimension eventually appeared to be a pretext. This is moreover what led a group of adolescents to conclude: "it's like *Santa Barbara*, covered in blood."

Following this logic, the series doesn't adhere to an ordinary dramatic course of action, either. According to Umberto Eco, the ingredients that determine the success of popular works are the fact that they are endowed with clear and foreseeable ethical outcomes, and they have what he calls a "consoling" dimension. This is not to be confused with a "happy ending;" rather, it is linked to the fact that things occur the way they should occur. One aspect of the pleasure this type of fiction affords comes from the fact that it unfolds according to expectations and creates that "modest but irrefutable" pleasure in the satisfaction of anticipations. This element is missing in *E.R.*: the ending is always unforeseeable. "In *E.R.* the patients leave. They might leave dead or alive. But there is true suspense because there is the imponderable aspect of illness that is the strongest thing. Suddenly, for example, they have children die, which was never seen on television before. But that also creates suspense: in detective shows, people have fun guessing who is going to get killed. But here, that isn't possible; it escapes any literary genre. It is not coded, because it has no code. Because illness is the strongest of all" (producer).

If one assumes a purely technical approach alone, one indeed sees that the primary innovations of the series involve mixing genres and styles: the series falls back on the theatrical model and on the televisual aesthetic, borrows from comedy, melodrama, or tragedy, resembles a series or a serial, blends the conventions of fiction and the documentary. All of these formal innovations are employed to produce an impression of reality. How is that reality received by the different categories of audience?

The Views of Medical Personnel

To answer that question, I continued the inquiry by interviewing members of the medical profession. The first stage consisted of watching for ten straight days all the episodes of the first season with the chief of staff of a hospital located in the suburbs of Paris, then some twenty interviews were conducted with hospital doctors, doctors in private practice, medical students, interns, nurses, nurses

aides, emergency workers. I went to watch *E.R.* with interns in hospitals at night when they were on call. The study ended with a concerted task of coding patients from the first season of *E.R.*, with a specialist in the administrative management of care. I also used Jean Peneff's book[13] extensively, as it is invaluable for an analysis and interpretation of the series.

I must first comment on the approach I chose to adopt: I was not seeking to naively contrast the world of fiction with the real world and to approach doctors and nurses as holders of the ultimate truth about the universe described; rather, I was attempting to specify, by using them as favored informants, the elements that might have created this impression of reality and the reasons that had attracted them to the series.

The responses of the medical personnel I questioned were rather similar: they emphasized the *exaggeration* regarding everything that concerns the arrival of patients, and the *exactitude* concerning everything that dealt with how they are cared for.

Four points were made: the number of patients is completely exaggerated ("I've been on call entire nights without being disturbed"). The emphasis placed on dramatic or colorful situations leads the viewer to forget the much more banal dimension of everyday emergencies ("an emergency is not the building that collapses, it is the scalp wound"). The number of situations involving life-and-death cases is much higher than in normal circumstances, even in a city as clearly violent as Chicago, and the range of illnesses is rather fanciful ("Emergency medicine, increasingly, is not what we consider to be an emergency, but what patients consider to be an emergency. People come much more readily to the E.R. because it is always open, you don't need an appointment, you don't pay right away. And there are more and more doctors in the city who refuse to make house calls. We are obligated to see the patients. In fact, the atmosphere is very different from the series: people are forced to wait, and then there is much more routine work").

The doctors I questioned noted important differences linked to the specific nature of how emergency medicine is organized in France and in the U.S. (in France, the responsibility for responding to emergencies falls to the SAMU [Service d'aide médicale d'urgence – French ambulance and emergency service. – trans.] which is made up of teams of doctors who provide care to the wounded right on the scene of the accident. This system was put in place following a rise in the number of car accidents in the 1950s to avoid the dangers associated with transporting the wounded [14]. ("We pick up the wounded, we transport the dying, we hospitalize the dead," said Marcel Arnaud). The situation is different in the U.S., where the sick and wounded are immediately transported to the nearest hospital). Due to this type of organization, the responsibilities of the different professions are not the same; the paramedical personnel in the U.S. have the opportunity to provide medical care that in France can only be given by doctors (intubations, placing a central line, etc.). One can also mention the differences, noted as well by the viewers, in the systems of responsibility for care and in the importance of legal recourse.

Scientific Validity

But at the same time, everyone I spoke to was aware of the exactitude and the technical precision of everything in the series that relates to the strictly medical realm. It is interesting, by the way, to watch the series along with them: they have fun guessing the diagnoses, are surprised at certain techniques or certain prescriptions ("they shock much more often than we do"), comment on the therapeutic choices ("I wouldn't have done that"), worry a fraction of a second before the main characters about the outcomes of their (bad) decisions. They imperturbably kept their calm and poise before terrifying images, but grimaced with suffering when the nurse abruptly awakened an intern on call. A father, who is a doctor, questioned his daughter, a medical student, to test her knowledge and to assess the quality of the education she was receiving. She trembled when Carter opened the envelope containing the results of his internship. I was told that medical students use the series to review for their multiple-choice exams. The series has also been integrated into the everyday life of hospitals ("I think the chief of staff looks like Mark Greene"), even serving more direct uses ("Now all the interns are called Carter").

The Truth of Interactions

Medical personnel especially approved the quality of the almost ethnographic description of the division of work, hierarchical relationships, and the logic of the internal functioning of the hospital. They also emphasized the technical precision of the terminology. Precise in English, it is also rigorously exact in French. It is in fact a doctor, Dr. Papon, director of the E.R. at the American Hospital, who carefully translates the technical terms. He also seeks to respect that characteristic combining of scientific vocabulary and familiar speech (abbreviations, slang) which characterizes the ordinary way people speak in a hospital environment.

Working conditions are also described precisely. "In hospitals people are very eager to project a certain image of themselves that reflects competence, knowledge, years of study, the scientific aspect. That ensures them a certain prestige, but the flipside is that there are entire realms of their activities and difficulties they encounter that are not known. Ultimately, *E.R.* describes those aspects very well."

In particular, it reveals everything dealing with the physical and emotional fatigue that are related to changes in body rhythm and a lack of sleep: "The nights you're on call are exhausting; there's no way to describe how exhausting it is. Because after a night of call, you go right into a day of work. In fact, that's the reason no one wants to do it anymore. The hospital depends entirely on foreign interns. Luckily they pay the interns badly; that forces them to do night call."

As Jean Peneff reminds us, one of the unique characteristics of the hospital world is that different categories of professionals constantly work together. In other professional environments subordinates are not in constant contact with their superiors. Offices are far apart, activities are clearly

disconnected, social distance is combined with a spatial distance. The hospital is a dense locale of collectivity within which all activities are carried out under the watch of others, which gives superiors the opportunity to continually evaluate their subordinates, and vise versa. This has a certain number of important consequences, because the smooth functioning of the unit depends on getting everyone to work together in close contact; people with greatly different salaries, a different level of training, and who are often from different social backgrounds. "There is something very well done, which is the relationship between Carter and the nurses. Interns are young, whereas the nurses have been around awhile. Since they have a certain amount of experience, they contribute to making a diagnosis, but they can't complete it. Because they know that doctors and nurses are not from the same world. They can help the interns, or on the contrary, if they act a bit too over-confident, they can let them dig their own holes." One of the consequences of these close quarters is the alternation between moments when the hierarchical gap is closed and moments when it is abruptly reasserted. Once, when there was one of the attendings kneeling down fixing a sink, another attending who was asked commented: "When something doesn't work in the unit you have a tendency to repair it yourself, because you want things to work. You wouldn't see that in a regular company." Another time, you see Mark Greene bend down to pick something up off the floor ("You see, that type of gesture is very important to maintain a good atmosphere in a unit."). But at the same time, the smooth functioning of the whole also demands that the hierarchy be abruptly reinstated. It is done via an authority established on the invocation of scientific competency (the nurse Carol Hathaway will not succeed in becoming a doctor).

The series also manages to convey the density of the environment: unidentified individuals constantly go back and forth in front of the camera, giving the impression of agitation; one senses the difficulty of getting away even for the most personal activities and the impossibility of being alone. Every activity is subjected to the view of others. Doors are always open, cubicles separated by cloth curtains, conversations carried out in the hallways are continued into the bathrooms. Meals, always eaten in a hurry, the composition of which really surprises French viewers, are always eaten in a group.

A hospital is not just a place for medical care. Many of the conflicts portrayed in the series involve the relationships between the hospital administration and the organization of care. The character of Kerry Weaver represents better than any other the demands of the institution. Similarly, the issue of the hierarchy between units and specialties seems to be very important (as Everett C. Hughes explains, professions whose intellectual prestige is the highest are also those in which internal differentiations are the most unbending). The doctors I interviewed thus spoke for a long time about the hierarchy that exists between different units, as it is represented in the series, as it exists in the U.S. and as it is found in France, recalling that emergency medicine is far from being at the top of the professional hierarchy: because they attract a very heterogeneous clientele, they fulfill a role as

social worker, because they aren't very specialized, because they have no connection to research, they function with a young and mobile personnel who will not spend their entire career there.

This concern with exactitude also characterizes the description of the relationship with patients. As Peneff recalls, the patients who come to the E.R. have generally been stricken unexpectedly in the course of their daily activities and did not expect to end up there. They didn't have time to prepare themselves. The series portrays this aspect of surprise very well; it shows patients in party clothes or in mourning attire, disguised as Santa Claus or dressed as a majorette, along with many various objects embedded in a wide range of sites (a key in a stomach, cigarette lighter in a chest, an earring in a trachea, etc.). Patients who weren't warned, but who are very concerned with what is happening to them; they don't know the rules of how a hospital functions, and must then be informed, made to understand that the principle "first come, first served," doesn't apply in an E.R. ("What has changed most with the success of the series is that people are much more willing to wait. They know that when they have to wait, it is not out of negligence or ill will, but because there are more urgent cases"). One must also manage relationships with the families, inform those who are far away (while trying to avoid making a mistake, as Carter did when he told despairing parents that their very alive son had died), contain those who are nearby ("We are always shocked to see parents in the cubicles watching all that is going on"), ease the despair of those who love too much, the revenge of those who don't love enough, get involved in family squabbles, reconstruct genealogies, learn not to treat the wife like the mistress, manage the social differences between the familiar homeless man who must be undressed and cleaned and the young rich girl who has crashed her father's Cadillac, cultural differences (use immigrant children as interpreters when their parents can't communicate), decide to alert the authorities and call the social services. ("When are we supposed to alert them? It's not always simple"), notes a doctor during a scene when there is a schizophrenic mother who has brought her little boy for a consult thinking he is deaf because he can't hear either the voice of his grandmother (who has been dead for years) or that of Lady Di ("Is it always necessary to take a child away from a crazy mother?"). One must also know how to handle the announcing of bad news: here, too, the series offers a great number of different solutions and reactions, from the little girl whom they did not inform of the death of her mother because she was too weak to take the news, to the mystified old man who believed up to the end that they would be able to save his wife ("I had to tell a mother that her child had just died suddenly. She replied: 'I know what it is; I saw it on *E.R.*'").

The Truth of Feelings

> "There is something else, too, that is very well done, which are moments of emotion. Usually, we're rather impervious, and that is preferable. But there are always times when you absolutely don't know why, and you are overwhelmed by a patient. Maybe because he reminds you of someone or because you put yourself in his place."

Doctors also recognize themselves in this description of the hospital as an *extraordinary place of life*. A place that is hard to leave. "The moment you finish your shift, you pass along the charts to the team that is coming in, and suddenly the things you thought you cared most about now seem completely unimportant." But conversely there are also times when it is difficult for doctors to go home. One time when Doug Ross insisted that Mark go home to see his wife, a doctor commented: "Those times, truly bizarre, when you've finished your shift but you hang around. You can't leave. As if you are too tired to adapt to the outside world and to people who don't understand at all what you go through."

Scientific precision, the believability of interactions, the truth of feelings: the representatives of the medical world who agreed to be interviewed liked the series. The doctors in hospitals because they found elements of their daily lives in it; doctors in private practice because it enabled them to relive the period of their training and the reasons why they had chosen the profession; nurses for the quality of the representation and the depth of the connections. All were ultimately in agreement on the fact that the definition of the profession in *E.R.* essentially rests on its vocational dimension.

From the Perspective of Viewers

My conversations with medical and hospital personnel enabled me to sketch a model of interpretation for an analysis of the series. It became possible to make use of that model to enlarge the study to include a much broader group of viewers. It was thus conversations (with individuals or in groups) on the one hand, and an ethnographic follow-up of the show among diverse people in their homes, on the other hand, which comprised the elements of this new phase of the present research.

Here, again, adhering to the logic of the project, I did not seek to explain the differences in interpretation by differences in the ages, the gender or the social status of the respondents: I would have feared, by establishing a rigid connection between demographics and reaction, arriving at overly-mechanistic interpretations. If any elements of differentiation occurred to me, I purposely did not focus my efforts in that direction.[15] Rather, I attempted to identify the general and shared paths of entry into the fiction.

This approach was necessary because the interviews, although in a different form, largely involved the elements that we have already presented: they all listed the speed, the rhythm, the realistic, indeed hyper-realistic aspect of the presentation – realistic often meaning bloody – the unusual mixture of stories of doctors and those of patients, American society in crisis, the unforeseeability of outcomes, the fallibility of the heroes, the failures in private lives, the ethical aspect, etc. As if a consensus might be established rather easily on the elements that differentiate the series from usual programs, even if the commentaries are more or less prolific depending on the social and cultural background of the interviewee and the lexicon of the criticism more or less well mastered. These comments describe a space of interpretation that coincides, as Umberto Eco would say, with the rights of the text.[16]

But if these comments describe the formal characteristics of the series in a relatively coherent way, they do not take into account what one might call the dynamics of appropriation. What is it that makes the series inspire interest, connection, pleasure? At what moments and in function of what type of scenes or situations do the viewers feel attracted, absorbed, brought into the story? To answer this question, it is above all reactions gathered in front of the T.V. screen that are enlightening: while focusing on them I would like to propose an analysis of receptive dispositions by distinguishing three modalities: identification through association (the heroes are like us), identification through compassion (they are more unfortunate than we are), and identification through admiration (they are better than we are).

Identification through Association: Multiple Structures Interactions

In exploring the first modality I would like to propose an interactionist-inspired analysis of the mechanisms of identification. Indeed, it seems to me that the characters in the series lend themselves particularly well to such a proposal. The key concept to use in this analysis is thus the concept of identity as Anslem Strauss developed it in *Mirrors and Masks* in 1959. His concept of identity rests on the idea that people play roles and that the roles they assume are determined by their belonging to a referential collectivity. Since each individual belongs simultaneously to a certain number of collectivities, he possesses in some ways a layered identity and can, in function of the situation in which he finds himself and of the way in which he evaluates it, use a certain register of reactions which is determined by the type of association he is establishing.

As Strauss reminds us, psychiatrists and sociologists are interested in interaction, but "the psychiatrist is considerably more interested in the 'interpersonal relations'… sociologists generally put more social structure in the interaction: their attention is given to persons as members of social groups and organizations. Persons become role-players rather than individuals. Two persons in interaction are never merely persons, but group representatives… When sociological analysis becomes relatively complex, then the sequential enactment of a person's many memberships may be studied." He adds that interactions are both structured and incompletely structured, that the official attributes linked explicitly to status are completed marginally by official attributes the absence of which can cause complications and malaises and above all that a mode of interaction can change from one moment to another or from one phase to another. There are thus, he reminds us, "… important differences between ordinary everyday interaction and the vastly simpler sociological model where persons of given status act more or less in a single status at a given time."[17]

There is something portrayed very well in the series concerning these displacements from one statutory reference to another, and the hesitations or confusions that result from them. The doctors are often confronted with patients who force them to leave their professional status, placing them on a footing where the patient might more easily control some of the interaction. Sometimes the

patients confront the doctors' sexual identity (Carter learns this at his own expense), sometimes their racial identity (Benton violently refusing any acknowledgement of black patients who might attempt to create a certain complicity with him on that basis), sometimes also their religious identity ("you're Jewish? " a patient asks Mark Greene, who doesn't answer). One of the dimensions of medical training indeed consists of perfecting the techniques of distant response which, to avoid sliding from one dimension to another, often rests on an ostensible unawareness of those invitations to complicity. The intern Carter takes some time to learn them: he acts like a man with a woman, as a young man from a good family with a confused old jazz singer who is stricken with Alzheimer's whom he takes on a stroll an entire afternoon, etc. At the same time, for all the doctors, there are moments when these differentiations are destroyed and blend together: these are moments of emotion which are always moments when death breaks ties of love (as if those deaths alone justified sadness). Beyond any statutory reference, then, belonging to a common and shared humanity becomes most important.

Apart from these unusual situations, the skill of a character comes from his ability to correctly control his modes of interaction. Here we have one of the keys to the progressive weakening of the character of Mark Green. He is clearly one of those who is most defined by his sense of medical responsibility. It is thus that part of his identity upon which he leans with most consistency, but his slight statutory rigidity is also the source of many of his difficulties. Because he is a doctor when he should be a husband; a doctor when he should be a parent. Always a doctor when he should be a lover. His story of missed love with Susan Lewis is largely explained by disconnects linked to the fact that he behaves just a little too long as a "doctor-colleague-friend" with a person who was already a "doctor-colleague-lover." Obviously, when he changes his hair style, lets his beard grow and wears blue contact lenses in an attempt at seduction, he is attempting another realm of adherence. But it does not last long: obviously, in the collectivities in which Mark belongs, that of doctor is more solid than the others. This is, moreover, what leads to the collapse of his personality, when medical errors attack him at the very core of his essential self-definition. This is not the case with Doug Ross. And it is certainly this slightly different alchemy that explains his huge approval rating among adolescents. As for Benton, to understand his personality as the result of the extremely tight control he exerts over his identity as a black by his identity as a surgeon appears more interesting than a purely psychological interpretation (Benton is ambitious) or one even based on a simple social typology (surgeons don't have many human qualities).

The advantage of this model is that it gives a dynamic to the characters and enables one to analyze most of the dramatic developments. Not only does it take into account a part of their dilemmas, but it grants the viewers access to them, viewers who share with each of the characters some of the collectivities upon which they fall back (they can thus be a white man, father, living in the suburbs, married to a feminist, head of a department, etc.), or something else again. They thus recognize

rather easily the type of resources mobilized and the universe of reference involved. They also understand the price of the negotiating that must be carried out. The model proposed by Strauss thus provides a tool for the analysis of the behaviors of the characters in the series. It is even more relevant than the classic criteria of psychological analysis and, furthermore, enables one to account for the processes that bring about the attachment of viewers: this is because in the palette of those layered identities a certain number are common to some and others common to others and because they can be shared. Finally and above all, it consequently restores the medical identity into an identiary conglomerate that relativizes the significance of that dimension and thus favors the construction of a sense of proximity with the characters. The reactions gathered during my observations confirm these different points.

It is obviously not the smallest of paradoxes, when one knows the use that the interactionists have made of the notion of dramatic art for the description of social life, to reinvest these categories in the analysis of fiction. It is like a return to the sender. But this approach provides a tool for description so original and so efficacious that one is tempted to pursue the exercise. We can then go to the next stage and continue the work of deconstructing multiple identities, this time by placing ourselves at the very heart of medical activity. We will now look at the work of Everett Hughes for support.

A Profession Like Any Other

"In the end, it's a profession like any other," commented a Portuguese mason while laughing at a scene when we saw one of the characters allow himself to be congratulated by a superior for some good work he did not do. "What strikes me," said an office worker, "is not really the fact that it's in a hospital, but the fact that it's a series about office life."

These comments recurred often during the viewings, in different forms, always going back to the same idea which is that, in the end, every profession has something in common with all the others. And this idea is very well understood by the series.

"We need to rid ourselves of any concepts which keep us from seeing that the essential problems of men at work are the same, whether they do their work in the laboratories of some famous institution or in the messiest vat room of a pickle factory,"[18] writes Hughes. This passage in context served as a preliminary methodology to provide a solid base for a comparative study of professions. But this remark is of interest to us insofar as it introduces the possibility of dealing with professional life, which is susceptible to generalization and therefore, in our view, capable of resonating with the experience of viewers.

The text that follows, using disparate elements, resumes the analytical inventory that it proposed and which provides an organizational tool for the reactions of viewers during the airing of an episode. It is regrettable, however, not to have the means to propose a visual montage that would illustrate these different aspects with the scenes from the series.

• *The Position of Beginners*

Many sympathetic reactions were evoked by the attitudes of the young intern Carter, especially in the first episodes: obviously the experience of the novice who is trying to understand the functioning of the unit, who is overwhelmed by the surge of new and different information and must hide his anxiety, mask his fatigue, act as if he were retaining every thing and understood everything, resonates among the viewers. Everyone has, at least once in his life, been in a situation as a beginner and tense with the desire not to reveal his insufficiencies; to have to mask the laborious nature of training and seem capable of mobilizing all available resources with an ease and a natural air that are, in reality, only accessible through experience. The rapid visit Benton gives of the unit, the abbreviations he uses, the numbers with which he fills his presentation that make it obviously impossible to memorize, the mix of technical, human, relational, and topographical information, the speed of his delivery, are in this regard a model of the genre: "This is the admissions desk. If you have to admit someone or ask for a chart, do it here. That's Timmy. Don't shake his hand; he's afraid of getting sick. The lab is over there. We do haematos, blood counts, centrifugations. The chemicals are marked D on the labels. If you want something quickly, mark it STAT. The chem lab is 7022, the hemo lab is 6944. Remember all that." The monologue continues for a long time until it ends with "OK, that's all. Any questions?"

• *Hierarchical Relationships*

One can also watch how the nurses and the personnel at the reception desk function to remember, still while following Hughes, that in all professions people who are in a subordinate position think that part of their function consists of preventing their hierarchical superiors from making mistakes. This sense of preventing very serious mistakes from being made is sufficiently gratifying to take on a lot of importance in the definition they have of their activity and give significance to their work.

• *Preferred Tasks*

The scripts indicate precisely an entire hierarchy of tasks based on criteria some of which are rather clear, and others less obvious. Thus we see the nurses pass along down the line the task of cleaning up a homeless man, and among the interns, that of performing rectal exams. Obviously unsanitary procedures descend the length of the hierarchical chain and are assigned to those who cannot refuse them. (As Peneff shows, in the hospital, the professional hierarchy is arranged by distance from filth, dirt and human waste matter). The fact that such tasks are thus delegated is quite characteristic of the functioning of the hospital universe, but the way in which they are is no less so: an order given in a rapid and ostensibly detached tone, a bit more detached than if it were an ordinary order, so as to be obeyed, while attempting to avoid being indebted.

By contrast, certain complex surgical procedures appear infinitely desirable and represent high stakes for the people who are able to perform them.

There are also preferences for patients. This is, it would seem, a common element in all service professions. (Hughes suggests that even priests show preferences for some of their sinners). One again notes the fact that the habitual treatment of certain pathologies leads to a certain hardening of the heart, a fact, moreover, that the doctors interviewed also noted. There exist, however, in similar situations, patients who are likely to inspire sympathy.

In all professions, as well, one sometimes comes up against people who prevent one from doing one's work properly, absurd or badly adapted rules, budgetary constraints that hinder efficaciousness or thwart the goals that one has set for oneself. One also has the tendency to protect oneself from the consequences of a professional mistake by avoiding certain risky activities; the notion of risk – of critical risk – is obviously at the heart of the series. In all professions, there are moments when hierarchical relationships are discarded and moments when they are, by contrast, abruptly reasserted. There are people who try to appear in a good light, superiors who reap the benefits of collective actions, or who blame subordinates for mistakes they, themselves, have made; who assign risky tasks to subordinates so they do not have to risk making a mistake. There are also rituals of inclusion (such as send-offs or anniversary celebrations), practices of humiliation, quarrels of assignment, moments of negligence; differences in atmosphere between the beginning of the day and the end of a shift, the beginning of the week and the day before the weekend; moments when the social calendar imposes itself on the work day (Halloween), moments when private life forcibly breaks into the workplace, (Mark Greene and his wife), or in a very official way (nurse Hathaway's missed wedding). These, then, are joyful images where one sees the characters trade their white coats for wedding clothes. Ultimately, in all professions one must manage the often positive but sometimes complicated effects of the mixed nature of work.

Identification through Compassion: Managing Connections

We may now broach another dimension, one that enables viewers to have a second modality of identification on the order of compassion: the issue of managing connections, notably all those relating to private life which in the series appear particularly problematic: "They all have a completely rotten private life" (man, maintenance agent). "Those people are heroes at work, but in life they get along so badly…"

"What is clear is that even if the series lasts for 500 episodes, Susan Lewis will never make a life with Mark Greene, or with anyone. She is always alone, and we keep waiting… That woman has everything, she wants children, she is pretty, she is intelligent and all, so normally in a series she would find Mr. Right, and Mark Greene is the same. But here, no way" (woman, secretary).

The series portrays heroes around thirty years-old who are trying to build their lives. That is, they are caught up in a very aggressive approach, one that is no doubt characteristic of the current times, through the will for mastery that the approach manifests over the unfolding of their destinies. But

this mastery is dissymmetrical: active in their professional lives (as opposed to the patients), the characters are rather passive in their personal lives. "They don't succeed; they go through things" (woman, office worker). Personal lives are not just sacrificed, they are above all broken down. Connections are made but never work out. As much as the professional path seems to present a certain form of cumulativeness, so does the personal life seem impossible to organize. Very often everyone's difficulties are connected to adjustments in calendars: the characters are not in sync. What might have worked at one time comes too soon or too late. And those who know so well how to coordinate their movements in the act of saving a life are incapable of doing the same concerning more mundane questions, such as building a home together.

One also has the feeling that the fact that the professional path is so well charted makes it easier to manage than the domestic path: stages do not depend on the characters, they are clearly defined (taking tests, salaries, the logical sequence of stages in function of evaluations), their passage strongly ritualized (celebrations, changing of lab coats, changing floors), their consequences understood. Whereas in contrast the personal life unfolds following a less distinct, chaotic and uncertain course, with situations that are always reversible.

Each character presents a different way of dealing with such failures. With Mark Greene problems connected to the compatibility of the professional lives of a couple are broached (is it possible for both members of a couple to be successful? How to decide where to live? How to prioritize?), then that of reconstruction, of separation with children, of the difficulty of reconstruction. With Susan Lewis the question of being a professional woman in a certain age bracket is raised; with Doug Ross it is the dead ends of sexual liberalism; with Carol Hathaway, the recurrent trials of badly-handled break-ups; with Jeanie Boulet the problems connected with being contaminated with the HIV virus, but also the issue of maintaining intimacy with a former partner, beyond divorce; with Benton, the difficult emergence of the paternal feeling, etc. One could cite numerous examples, while noting that certain problems are very original (the relationship between Susan and her sister, her attachment for the child she takes in, the avuncular connection) and that in the end, it is always relational situations that cause the characters to develop.

Beyond this inventory, we must note that the dominant feeling is the radical impossibility of a lasting amorous success, integrated into the very heart of the actors' anticipations. Love continues to be of interest, but doesn't cause one to dream, nor one's heart to pound. The treatment of the characters' affective life is accompanied by a certain fatalism, as if the life of a couple were destined for failure so inevitably that it is no longer even sad. But at the same time it is when death separates old couples who love each other that one can truly measure loss: "The most moving moments were last week, with a couple of old people and the grandmother died" (woman, office worker). Old couples in love are at the highest level of the emotional hierarchy on *E.R.* One dreams more of them than of the current love affairs. As if they represented a bygone past.

If one senses a clear renunciation of the optimal management of horizontal connections, vertical connections, on the other hand, incite high anxiety, whether it is the possibility of taking care of one's parents (the death of Benton's mother) or of one's offspring (Benton's child). This is especially true with Susan Lewis and her niece. This is where the tension between the professional and the personal lives is felt most intensely. And viewers participate in this all the more intensely since they know that the characters have *very good reasons* to reject familial obligations. Reasons to which they are strongly attached. It is neither egotism, or careerism or offhandedness that leads Mark Green to those constant late arrivals that ultimately destroy his marriage. As for the situation of Susan, who is confronted with the unbending nature of the daycare center's closing hours and with the well-orchestrated feelings of guilt that always accompany them, her plight found many echoes among young mothers facing the constant problems that are rarely evoked out of fear of the bad use that might be made of them, of the difficulty of balancing one's professional life and one's family life. In a certain way, the series clearly indicates how impossible it is.

Viewers react strongly to these dilemmas that resonate with the personal situations that they have experienced or recognize. But at the same time this situation of repeated failures is determinative for their appreciation of the team. Those failures do in fact evoke a feeling of pity, of compassion. ("That poor Mark. That poor Susan. That poor girl, there she is with AIDS now"). Now, if admiration is a feeling that causes a distance, compassion is a feeling that brings people together. Failure in one's personal life, with its sacrificial dimension, is thus a decisive element in the dynamics of the rapprochement of conditions. It is that which even enables the organization of the passage from one condition to another. That young woman from Normandy who, after being a nurse's aide is today a childcare worker, shows well through the intensity of her reaction the position in which she finds herself compared to the heroine, constructed both of connivance and of moral superiority: "I liked Susan a lot, her energy, her sweetness, she was sweet with the patients, she knew what to do. At the beginning she had a wonderful side to her. And then, yesterday, she ruined everything: she wanted to keep that baby. There was an egotistical element. I understood that she wanted to protect the child, but in the end, if her sister wanted to take the child back, it was her right. She had completely hidden the fact that she wasn't its mother and that the feelings of a mother could never be the same; her attitude bothered me more than anything else. I wanted to turn my T.V. off" (woman, licensed childcare worker).

Ultimately, if one does a relational assessment of the series, one notes that the only relationship that truly functions is the link of camaraderie: "In this world of no concessions, whose difficulties are shown, it is possible to establish wonderful connections. We all have human feelings: paternal, filial love. But the one that makes you go beyond yourself, the strongest of all human feelings, is camaraderie. These are people who ended up in the same unit and who learned to discover each other. They all have their qualities, their faults, their problems, but they also share basic values and

have been led to act together. It is an incredibly romantic notion," stresses Irène Théry in the interview she devoted to the series during the first part of the research. Indeed, camaraderie is different from friendship, from love, from intergenerational solidarity. It is accompanied by a type of behavior and a range of specific emotions cemented by collective efforts, shared risks, common objectives. It is an extremely strong connection that rests not on dual relationships but on collective relationships, in which third parties always intervene, contributing to inserting dyads into a longer relational chain. A connection made from proximity, from daily contact, constrained by the certainty of an obligatory common future (at least in the short term). While playing with intimacy, given and taken, the object of controlled incursions during moments of confidences, erased the moment life continues its course. Camaraderie is a relationship based not on words, as are relationships that fail (in the series), but on action. Shared action. Strongly regulated by the institutional dimension. For, truthfully, it is not a connection of choice. All the chosen connections in *E.R.* are fragile: even friendship, in the end, is not very resistant. In contrast, this particular connection, a mixture of warmth and of complicity, appears solid. It describes a large part of the pleasure of work, in a version that is obviously very idealized since there is neither meanness, nor pettiness, nor routine – none of those elements that make professional life laborious or painful. A large part of the pleasure viewers experience seems to find its source in the fine description of this connection which is very rarely depicted in fictions: this very specific form of professional "brotherhood."

Identification through Admiration

The third type of receptive response inspired by the series is associated with an identification through admiration. The series in fact constructs a tableau that puts characters into place who are fallible, fragile, and irreproachable. One can quickly take an inventory of their shared qualities: courage (in the face of physical demands, moral fatigue, nervous fatigue); selflessness: beginning with the pilot episode we see Mark Greene refuse very advantageous conditions that were offered to him by a private practice job; as for Benton, even more explicitly, he gives the total of his salary ("We have a shift of 36 hours and rest for 18 hours, which makes 90 hours per week, 52 weeks a year; for this work we are paid a salary of $23,739 before taxes, and in addition we have to make the coffee"); a sense of human dignity (which is conveyed in particular by the fact that they always interact with the patients using their names); an absolute respect for life; a refusal of any form of instrumentalizing the human being. And above all, they have an ethics of individual responsibility, that ethics of individual responsibility being hardened by the collective organization. For if the characters may be cynical in their personal lives, they are never so in the carrying out of their duties. They have an unfailing professional ethics. If they are mediocre, as we have seen, in the management of their personal lives, they are irreproachable in how they conduct their professional lives. Which doesn't mean they are infallible: they might commit errors, be mistaken, be surpassed, etc. Unlike the usual figure of the

positive hero who, because he is morally pure, succeeds in his undertakings, the heroes of *E.R.* are fallible. But their intentions are never guilty. ("The series introduces a difference between: being a good person and making a mistake," explains a person who was interviewed). We are therefore in a model that distinguishes actions from intentions (and it is on the latter that one is judged) and which separates professional ethics from those of one's private life (the one being intransigent and the other much more easily susceptible to compromise), following a very clear hierarchy that places the heroes at the service of patients. An interviewee explains this point of view very well: "When someone watches this series he might say: 'Hey, I'm like so-and-so, in the end we're similar, that's cool…' And suddenly all the heroes they see, but who are not really heroes because they resemble them, become heroic the moment they must be doctors. That "reassures" people, it "reassures" their anxiety about death, an anxiety we all have: it's at the moment when it's serious that the doctor becomes irreproachable. That is, the coward becomes courageous, the one who has AIDS forgets her condition, those who are in love forget they're in love… all of a sudden, the doctor becomes a super hero, a superman who forgets everything else. And who is able to perform and to save a life and if the life isn't saved, it's really because it wasn't supposed to be, because they tried everything. So I think that for people it is interesting to know that these superheroes are people like them, but at the moment when they are in danger, then they become supermen. And I think that's why everyone really likes this series, it's because they have weaknesses, they are capable of being hungry, thirsty, cold, being wrong, and all. Except when our lives are in their hands, and then they are irreproachable." (woman, analytical psychologist).

Since the ethics of individual responsibility that goes through the series with much insistence is associated with the experience of human failings, it is the group that is responsible for assuring fixed objectives. It is the group that will overcome, catch, compensate for, indeed also sanction individual errors. The group is not just an accompanying collective, it is the support and the guarantor of the respect for shared values and of the efficacious way they are implemented. The entire structure thus rests on this collective – not individual – heroizing.

Merging the Different Perspectives

It is now time to gather together these different perspectives that have been analyzed in an attempt to understand the mechanism of the series and to respond to the initial questions, while systematizing the gathered information. The initial idea was to show that the series *E.R.*, in a rather original way compared to earlier medical series, expresses the rapprochement of conditions among doctors and viewers, in order to ask, in a later phase of the research, whether there exists a reverse effect, in everyday life, of this modification of representations.

In this article, I am dealing only with the first part of this question, focusing the discussion on an internal analysis of the series and reserving the second dimension, about which I would like nevertheless to briefly mention a few hypotheses, for a later study.

The series *E.R.* brings us into the world of medicine. First, it establishes a world that it describes in the most realistic way possible. But at the same time, it does not take the external, distanced, objective look at it that generally accompanies a realistic stance. On the contrary, it invites the viewer to penetrate into this world by multiplying calls for complicity and by constructing positions of identification that he can assume. And at the same time it defines this world that it portrays as real as a perfectible world, a world of challenge, a world inhabited by intransigent ethical demands. In other words, the story constructs a world, makes us enter into that world, and that world is an ideal world. Realism, a call for identification, and idealization are the three pillars on which the mechanics of the series rest.

Throughout the weeks and the seasons the series undertakes to familiarize us with the world of a hospital. But it does so in a unique way since the narrative and dramatic choices favor a concern with exactitude and the impression of reality. Which, as we have seen, is highly demanding in everything that concerns the technical part of the series (terminology, movements, treatment techniques, procedures, diagnoses), and reflects the desire not to stoop to the level of the audience, but to bring the audience to its level. This process is not without consequences: by unveiling the reality of everyday life in a hospital environment, the series causes us to modify our views of the doctors who practice there. By using narration techniques very close to ethnography, the series ends up with an analogous consequence: familiarization with a foreign universe. One can, in this regard, look at the problematics of Meyrowitz, when he speaks of the effects of television on the stratification of ages, and analyzes as one of the main consequences of television on childhood the fact that children, having henceforth access to information that are no longer filtered, know things they didn't know before, but also and above all know that they weren't supposed to be shown it: "A group's shared but special information was once accessible primarily to those in a shared but special location. Socialization into a new group, therefore, has traditionally been linked with new access to the group's territory and to the knowledge and information available in it."[19] Just as television gives children access to the secrets of adults, the series gives us access to the secrets of doctors. And similarly, access behind the scenes of the medical world consequently leads to the dilution of a portion of the prestige of doctors, that which was based on seclusion, inaccessible knowledge, the mastery of the secret. This doesn't mean that scientific competence becomes completely insignificant; it remains very important, but it is relativized. One indeed understands that doctors are not masters over life and death, that they are in a situation in which they can miss things: the extent and the limits of their knowledge are more clearly identified. This process is accompanied, then, by a displacement of the conditions of heroizing: we go from a heroizing based on social distances, scientific competence and the prestige

that were associated with it, to a heroizing based on a respect for ethical values. Which means that this program causes us to move from one position in which the issues are social, creators of distance, to a position in which the issues, much more familiar, or common, are moral issues.

From this we can identify more precisely that which determines the true uniqueness of the series which is found in the way in which it combines realism with that particular form of heroizing.

In fact, the series borrows a certain number of classic components from the realist plan of which it fully assumes the consequences (desire for verisimilitude, care given to the description of the motivations of the characters, a didactic intent, a concern with precision, a taste for detail, a desire to fully exhaust the real, etc). But it uses them according to modalities that diverge from our literary and aesthetic habits: indeed, realism as a literary current has generally been put to the use of a critical perspective. Human criticism (realism relates then to the unveiling of the shameful dimensions of a person). Social criticism (realism then relates to the denunciation of injustice and exploitation, in a tradition developed, for example, by Emile Zola and the naturalists).[20] It is rare, however, for realism to be used with a view to edification (The only current that seems to have attempted that association being socialist realism).

Now, precisely in *E.R.*, realism is not connected to a position of human or social criticism. It is *used as an instrument for rendering a heroic position credible*. Realism is connected to heroizing, which for us constitutes a completely unusual connection.

In other words, the detailed, exact, precise, authenticated techniques of description that define the uniqueness of the series are associated neither with an objective of pure and simple description, nor to a critical position: realism is not an end, it is a means. A means that serves to render a fictional project based on the exaltation of a certain number of positive values *credible*. An instrument used for the goal of making us understand *what the world would be like if it were inhabited by people of good will*.

Of course, there is no ethical pact that requires fiction to present an exact portrayal of reality. However, there is a tradition, solidly established in France at least, that associates realism to a certain form of criticism. It is the transgression of this association, then, that is the source of most of the criticism heard about the series, whose argument I would like quickly to sum up. This criticism in fact suggests that in this combination of extreme realism and collective heroism there is a dimension that is dishonest. Because one would serve as a point of support for the other. The delusion would come from the fact that the series seems to obey an imperative of description, in a neutral and objectivist perspective whereas in reality it selects what it shows, ignores tensions, injustice, inequalities, and consequently serves ideological interests.[21] Criticism is differentiated, then, by the levels at which it is located and which involves different scales. For some, in the broadest context, the issue is the consolidation of the *American way of life*. Granted, the America presented is an America in crisis, but its repair remains possible: devotion, the sense of the collectivity, being promised as ultimate solutions to fight against the deterioration of the social fabric. For others, the objective is the

consolidation of the medical profession itself, which comes out strengthened from this operation. Finally, for others, on an even more restricted scale, the purely self-referential goal is the justification of the series itself. But in all these cases the denounced mechanism assumes a reciprocal consolidation of the two terms of the construct (realism and idealization).

But what the present analysis suggests is rather different. The viewers who were questioned were not subject to the illusion of this enchanted world. The survey shows that there was no *confusion* between the imagined world and the experienced world, rather the establishment of a process of *comparison*. The series offers viewers a certain number of analytical and cognitive resources that enable them to better understand that which distinguishes the universe presented from ordinary experience and to refine reflection, precisely because the fictional universe is an ideal world and because it offers a firm, coherent, and constructed base upon which the comparison can be made. And because of this, by providing the tools to analyze the gap between the real world and the ideal world, the fiction leads to the displacement of the terms of judgment, from a judgment of scientific competence, which patients cannot evaluate, to a judgment of human competence, which they have every right to claim.

The following excerpts from the interviews enable us to localize the modalities and issues of this form of reflexivity:

"When you watch, you're forced to admire it. But isn't it a false admiration because things don't happen like that" (man, fireman).

"Doctors are not less competent, they aren't as close to the patients. It's that the sick person is a ticket, a number" (man, office worker).

"That's exactly right, we're cattle to them, that much is clear" (man, construction worker).

"(in *E.R.*) they ask the patient his opinion before giving him a test. Here, if you go to the emergency room no one asks your opinion. They take you in, and boom, you don't know what's going to happen to you" (woman, office worker).

"Mark Greene is a real doctor. A real doctor…" (woman, maintenance agent…).

When the fictional experience resonates in one's life experience, it allows one to reflect on a gap in realities, to hone the sense of difference and to better understand what is at stake. It offers the opportunity to reevaluate past experience: "My father spent two years in the hospital. What I experienced was a factory, there is no human contact. And then, I think they are people who have seen so many things that in any case, they don't realize that for you it's nevertheless the first time you're suffering, whereas them, they see suffering all day long. In fact, I find that in *E.R.*, they are very human" (woman, office worker). And there is a transformation of the expectations that pre-form judgment about the future: "When I went to the emergency room, I recognized everything. I was just surprised not to find all those people I like. A bit later I expected to run into Hathaway" (woman, teacher).

Thus the fiction provides, although differentially, the cognitive, affective, and moral frameworks that are mobilized in the analysis of ordinary experience.

The process of familiarization whose principal stages we have described enable the dissipation of some of the effects of panic associated with a lack of knowledge about the world of the hospital and with the shock of finding oneself there, as well as some of the effects of intimidation associated with the difficulty of understanding: the medical universe is tamed, is more common, less frightening, indeed even more routine. One recognizes the instruments, the objects, the vocabulary, the procedures, the principles of organization, the rules of functioning. In that order, something has occurred, something irreversible, along the lines of an apprenticeship. But at the same time, the connection that has been established with the characters in the fictional framework modifies the conditions in which the return to the real is effected, for it is a connection of great intimacy (very characteristic, moreover, of the televisual experience of which it no doubt constitutes the most unique characteristic.[22]). One is struck by the familiarity that develops between the viewers and the characters in the series, which is seen in the minor criticisms, little affectionate remarks ("Hey, that's the first time she's bothered by his hair"), regardless of the background of the person who says them, thus indicating a certain abolition of social distances. The feeling that emerges at the end of this study is that this familiarity has different weight for different categories of audience and that there is, at the moment when one is confronted with real-life experience, in this intimacy accomplished in fiction but socially impossible, something like the experience of a promise not kept, especially for those who have experienced a relationship with the medical world that ultimately and fundamentally remains an experience of domination.

Notes

*. First publication in "La confusion des conditions. Une enquête sur la série télévisée *Urgences*", Réseaux, 95, 1995, pp. 235-283.

1. The research was conducted in Paris and elsewhere, in extremely different locales; the questions were asked in real time, that is, while the show was airing, or immediately afterwards, because I realized that it was very difficult to interest viewers in the series outside the times when it was on TV; people questioned at random showed a very great detachment from the story and its characters ("It's not just that we're not interested anymore, we're angry at them… We feel abandoned, or we say that we've been had a bit, but that we won't be taken in again." An attitude that gradually faded when the new season began: "It was a little difficult to get back into it in September; the first episode was difficult. With the first episode you sit in front of the TV and you watch and you don't really want to. Then afterwards, I don't know, the mechanism… you find yourself glued like a moron to the TV…) I attempted to analyze the evolution of viewers' relationship with the series, that is, the way in which it gradually takes its place in the televisual landscape of the viewer and contributes to changing his horizon of expectation. The research was thus conducted over four years, following the rhythm of each of the seasons. Most studies dealing with audience reception are concentrated over a very short period, at the risk of allowing a specific dimension of television – the continuity of the connection between the viewer and the fictional characters that is established throughout a long story – to escape. This continuity, associated with the nature of the serial, is a fundamental given of the televisual experience, as Dominique Pasquier has shown very well in her work on *Hélène et les garçons* (Pasquier, 1999). It is continuity that enables the viewer gradually to become accustomed to the characters, and from that point of view renders the experience of following a television series closer to that derived from reading a novel than to that of watching a movie,

which is shorter and more contained. Just a word to say that this has been a difficult project for several reasons linked notably to the plan I had imposed on myself: to go to the homes of unknown people on Sunday evening is a much more intrusive experience than I had imagined. The choice of the series itself was problematic: the violence of the scenes and the moral problems that the series evokes created an ambiguity that was difficult to escape: the accusation of voyeurism, the concern with being caught deriving pleasure from the spectacle of the suffering of others, constituted a sufficiently serious obstacle that created a feeling of unease that was impossible to shake in the course of the viewings. Two other types of problems arose: difficulties in deepening the conversations when one remained focused on the contents (which leads one to think that the mastery of the lexicon of criticism is in no way spontaneous; it assumes an instruction that takes place at a precise moment in life, at school, at the end of the secondary school, and it is truly available only in those conditions); the difficulties in channeling digressions when we went off the subject. The most interesting moments in these interviews occurred when the story triggered the telling of personal experiences. Very quickly people went off on their lives, their experiences in the hospital, with illnesses, doctors. These permanent comings and goings between the story and personal experiences were difficult to manage in a survey because one has the impression of being off the subject and of being involved with a type of inexhaustible commentary. Unless one decides to focus one's subject specifically on the way in which the fictional experience resonates in the subjects' life experiences.

2. Dayan, 1993.

3. When one looks at the database of the INA [Institut national de l'audiovisuel – French national television archive. – trans], various titles emerge, such as *Janique Aimée* (1963), *Le Chirurgien de Saint Chad* (1976), *Erika Werner* (1978), *Docteur Teyran, Marine Verdier* (1981), *Médecins de nuit* (1986), etc.

4. Pourroy, p. 2. (We were unable to interview Michael Crichton. All quotations from the professionals who participated in developing the series are thus taken from the book by Janine Pourroy, as well as from the press conference given at NBC, Universal City, California, July 25, 1994. See also Spignesi, 1996.)

5. For Iouri Lotman, one of the most important categories to apply to the organization of a spatial structure is the "open/closed" contrast: "The articulation of a text in function of a limit of this type is one of its essential characteristics. It doesn't matter if it concerns a division between friends and enemies, the living and the dead, the poor and the rich, or according to even other criteria. What is important is found elsewhere: the border that divides the space must have value as an absolute and the internal structures of the two divisions must be different. Therefore: the correspondence between types of spaces and types of heroes, the original definition of the concept of event (the transfer of a character from one semantic field to another semantic field) and the binary division between a text with subjects and texts without subjects" (Lotman, 1977), cited in Jauss, 1994.

6. A few notes excerpted from a group interview with newspaper television critics regarding the live episode: "It's great, great. All of a sudden, they talk about what it is to be an actor… what it is to act. The falling into an abyss… You see everything the television crew is supposed to film."

Since you know it's live, you know they are flipping out so they don't forget their lines. They are supposed to be their characters in an assumed reality recreated by fiction.

"Live fiction has never existed."

"You've already seen a film. While knowing that the actors are acting.

You know what is happening behind the image. Whereas in general, the image is the proof that it happened… and yet… the staging…

"And yet, it's not filmed theatre. Because in general theater is a single stage. And here, they're moving around."

"It's crazy."

"It's deep."

"It's totally deep."

"And wouldn't I do it!"

"There is something demystifying which in fact reinforces the mystification. But a different one."

"This makes the viewer participate in the product. He is at the center of the action. He is told that he is being told everything, shown everything. He gets a kick from looking behind the scenes."

"Exactly."

"They're playing with all that. Fiction is playing with itself."

"It's a sort of crash test. As if the creators of this series wanted to test all the limits of the series. The technical limits. Live. With eleven cameras. With rehearsals, etc. while taking the risk of failing…"

"You have the impression that they don't know the camera is there."

It shows the actors' limits, too. They arrive exactly at the right angles. They don't bump into each other. It's an amazing ballet. There is an unbelievable scene with Mark Greene who is attempting to operate on a guy and there's a girl, a nut case, in the room with drumsticks who is beating on the operating room window, because there's no music. A little. But you hear the girl who is beating her drumsticks; Greene who is trying to resuscitate the guy and at that moment, there's the reporter who discovers there are no more batteries in his camera. He is having a heart attack. And the image is fading. The guy doesn't have any more batteries…

7. Pourroy, *op. cit.*

8. Pourroy, *op. cit.* p. 14.

9. Pourroy, *op. cit.*, p.18.

10. Pourroy, *op. cit.*, p. 4.

11. I wish to thank Pierre Grimblat for sharing the results of his study of the pilot episode, which he carried out as a member of the Hamster corporation.

12. Pourroy, *op. cit.*, pp. 19-20.

13. Peneff, 1992. Jean Peneff's work on doctors has been essential throughout this study, and it will be cited on many occasions. Peneff has also written an article on the series (Peneff, 1998).

14. Lareng, 1995

15. A few remarks, however, concerning this path that I chose not to follow: it seemed that more *people with a higher level of education* noted the scientific validity of the whole series than did less culturally-advanced subjects, who were more reserved on this point ("it seems true now, we'll have to wait and see…"). As if the former group had tools to monitor the strength of the information delivered, which the latter were lacking. They felt content, then, to identify the medical vocabulary as coming out of an attempt at effect, but without claiming the right to verify it.

Men appeared more sensitive than *women* did to scenes of suffering or to surgical procedures. They spoke loudly, looked away, changed the subject. As if, in matters of television taste, they preferred violence that was upright to violence lying down. *Older people* clearly felt more concerned by the situations of patients at the end of their lives, which, while viewing certain scenes, created a sense of irrepressible malaise. A lack of shame. A lack of tact. It is a program that is not easily watched in the company of others. No doubt because a work of fiction is only bearable when it maintains an aesthetic or reflexive distance with reality. The stark reproduction of reality, accomplished through biographical means, has something wild, something simply hopeless about it. *Adolescents*, on the other hand, enjoyed it and did not feel at all implicated in those same scenes: they were primarily aware of the artifices that characterize the scenes and of their more or less great narrative efficaciousness, analyzing the moments when things fell back into the typically American series ("when you no longer say: those Americans sure are talented, but: those Americans are idiots"). Loyalty to the series is varied: *boys*, who are not very interested, mainly comment on the reasons why they prefer *XFiles*; the *girls*, nonchalantly and cheerfully, sometimes in front of their boyfriends – discussing the possibility of becoming the restorative partner of the charming pediatrician, the character in the cast upon whom the entire fan club is focused (out of the 460 letters received by France 2 during the third season, 231 were addressed to George Clooney, and the others to the rest of the cast. Among those we interviewed three sisters called their dogs "Dougy" in honor of Doug Ross).

16. At most, the biggest differences were found among people who had only watched one or two episodes and those who were avid viewers. The former group had only scattered remarks about the series, which informed us above all about what they thought of American fiction in general, and plunged us into great perplexity. Until, by luck, we discovered a text by Umberto Eco putting limits on possible assessments: "To write that a text is potentially infinite does not mean that every act of interpretation can have a happy ending. There are interpretations that are patently unacceptable… The limits of interpretation coincide with the rights of the text (which doesn't mean that they coincide with the author's rights)." Eco, 1989.

17. Strauss, 1997, pp. 72, 76. Other passages are significant, as well: "As if the interactional picture were not complicated enough, ordinarily two actors may be operating from differently understood status bases. One man may assume that he is a doctor talking to another doctor, while the other is acting like a Negro toward a white. It more often happens, of course, that the interaction is only temporarily 'out of joint.' Some of the nicer byplays of irony, humor, embarrassment, fright, and the like are traceable to this kind of temporal disjunction…From the point of view of identity, we all belong to several collectivities, and each individual thus has a great number of possible status relationships at his disposal. During an interaction he may mobilize one or the other, or even pass from one to the other." p. 76.

18. Hughes, 1970, p. 147.

19. Meyrowitz, 1985, p. 60; see also "La fin du secret des adultes," *Réseaux* , 74.

20. Here is what Ian Watt writes about the origins of realism: "'Réalisme' was apparently first used as an aesthetic description in 1835 to denote the 'vérité humaine' of Rembrandt as opposed to the 'idéalité poétique' of neo-classical painting; it was later consecrated as a specifically literary term by the foundation in 1856 of *Réalisme*, a journal edited by Duranty.

Unfortunately much of the usefulness of the word was soon lost in the bitter controversies over the 'low' subjects and allegedly immoral tendencies of Flaubert and his successors. As a result, 'realism' came to be used primarily as the antonym of 'idealism,' and this sense, which is actually a reflection of the position taken by the enemies of the French Realists, has in fact coloured much critical and historical writing about the novel. The prehistory of the form has commonly been envisaged as a matter of tracing the continuity between all earlier fiction which portrayed low life: the story of the Ephesian matron is 'realistic' because it shows that sexual appetite is stronger than wifely sorrow; and the fabliau or the picaresque tale are 'realistic' because economic or carnal motives are given pride of place in their presentation of human behaviour. By the same implicit premise, the English eighteenth-century novelists, together with Furetière, Scarron and Lesage in France, are regarded as the eventual climax of this tradition: the 'realism' of the novels of Defoe, Richardson and Fielding is closely associated with the fact that Moll Flanders is a thief, Pamela a hypocrite, and Tom Jones a fornicator.

This use of 'realism,' however, has the grave defect of obscuring what is probably the most original feature of the novel form. If the novel were realistic merely because it saw life from the seamy side, it would only be an inverted romance; but in fact it surely attempts to portray all the varieties of human experience…" Watt, 1957, pp. 10-11.

21. This position is particularly well defended by Jean Peneff in the article he devotes to the series: basing it on a study he carried out between 1990 and 1992 at Cook County Hospital in Chicago, he compares the image created by the series with that which he observed himself. He offers an eloquent report on his ethnographic observations which show a universe quite different from that presented by the series: long hours lost in the waiting room by disillusioned and passive individuals, discouragement, slowness, cutting back, priority given to recommended patients, targeting of preferred populations. He criticizes, then, a production intending to satisfy an audience whose *expectations remain the consolidation of the democratic myth of an egalitarian practice of medicine* and *which would offer a sort of local anesthesia to political consciousness.*

22. Chalvon-Demersay, Pasquier, 1991.

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