

BRINGING MEDICINE TO THE MASSES: EXPLORING THE
RELATIONSHIP BETWEEN THE MEDICAL
DOCUMENTARY AND THE PUBLIC

by

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GLOSSARY

DIABETES

Diabetes, formally known as *diabetes mellitus*, or “flowing honey” in Greek, was first characterized by an excess of sugar found in the patient’s urine¹. This excess of sugar in the urine is a direct result of increased blood sugar levels. The increase in blood sugar is caused by the body either a) not producing enough insulin or b) resisting the effects of insulin present in the bloodstream.

Clinical diabetes has two different forms, Type I and Type II, that are physiologically different in origin but have related symptoms. Type I diabetics are usually diagnosed as children or in early adulthood, and their disease is caused by an autoimmune disorder that destroys the insulin-producing cells in the pancreas. Type I diabetics generally inject insulin in order to control the level of their blood sugar. If a Type I diabetic takes too much insulin or does not eat the correct amount of carbohydrates she will experience a hypoglycemic reaction. These hypoglycemic events range from slight dizziness and disorientation to a full coma and then death.

Type II diabetics are usually diagnosed as adults, although the number of children suffering from Type II is on the rise in the United States. Type II diabetes is caused by the patient’s body becoming resistant to the normal levels of insulin produced by the pancreas; this resistance is caused by old age, obesity, and genetic predisposition. Type II diabetics do not typically inject insulin unless they have an extreme case. Usually, Type II is treated by a) weight loss, b) following a diet with limited carbohydrates, c) medication that decreases the body’s resistance to insulin, and d) increased physical activity that naturally reduces the amount of sugar in the patient’s bloodstream and appears to increase the body’s ability to regulate blood sugar by increasing tissue sensitivity to insulin.

Failure to properly regulate one’s blood sugar levels, whether Type I or Type II, can cause blindness, loss of limb sensitivity, nerve damage, impotence, and decreased lifespan.

METANARRATIVE - the grand theory or authoritative answer for a question.

¹ *The Merck Manual of Medical Information, Second Edition.* Pocket, 2003.

ABSTRACT

The medical documentary seeks to bridge the gap between the traditional imbalance of knowledge between the patient and her medical practitioner. This paper will examine the issue of the imbalance of the doctor and patient throughout the history of medicine, explore how the medical documentary seeks to solve this imbalance, and the methods by which it does so. By comparing three related medical documentaries and examining the strengths and weaknesses of each one in its attempt to educate and engage the viewer, I will seek to create a broad model for future medical documentaries and relate how my thesis film fits this new model.

CHAPTER 1

INTRODUCTION

The world of medicine has changed dramatically over the course of recorded history, and these changes have had many effects on the masses. For all of the advances in medical technology that prolong the life of the patient there still exist problems with the doctor-patient relationship in terms of the exchange of information. The public has never been well-informed of the specifics of changes in scientific understanding (such as the creation of new drugs or the development of new medical techniques), and much of society's conception of medicine has been left to faith or is influenced by assault of new media (such as newspapers, television news, and pharmaceutical advertising).

Science films, on some basic level, exist to bring complex and difficult scientific concepts down to the level of the general public. Many documentary filmmakers have focused on the subject of medicine in an attempt to educate the general public on a variety of public health issues, medical innovations, and changes in the ways that we view and treat disease.

In this paper, I will argue that there is a fundamental disconnect between the medical establishment and the public, and that medical documentaries exist in order to bridge this gap. In this context, the most basic mission of a medical film is to take a concept that is difficult for a lay person to understand and present that concept in a meaningful way to its target audience. There are both successful and less successful ways to achieve this end. I will examine a selection of related medical educational films

in order to isolate the features that help a medical documentary to best engage and educate the public.

Medicine and Society

The development of modern medicine is inextricably linked to the needs of human society. Some of the earliest primitive healers (such as tribal shamans and Egyptian holy men entwining medical care with magic), Western science beginning with the Greeks, and the foundations of modern medicine being built during the Enlightenment all grew out of the individual's perceived need for the understanding of and remedy for that which ailed him (Kennedy, 17).

In order to determine how documentaries can help the lay person understand medicine, we must first examine the traditional way people understand medicine in terms of the doctor-patient relationship. In modern times, the relationship between the physician and the patient is constantly changing. Patricia Branca, in her 1977 article "Toward a Social History of Medicine (143)," classifies the chain of medical communication into three categories: great thinkers (e.g. Pasteur or Curie), who come up with high-minded, revolutionary ideas; physicians who apply the theories of those great thinkers to their everyday ministries to the sick; and the patients who receive a diluted, practical application of those theories. From Branca's position, we can draw a parallel to the shamans channeling the power of their deity in order to cure the commoner in this flow of power. For example, Pasteur's advances in vaccination science at the turn of the century constituted a new medical theory that was disseminated by medical practitioners

as a new paradigm, resulting in a society-wide belief that everyone should receive vaccinations to “ward” themselves from disease – this healing as “practical religious piety (5).” Science filters down through the different elements in Branca’s chain of medical communication and arrives at the doorstep of the average individual.

However, medical knowledge flows in both directions - these great thinkers make their discoveries and craft their theories by drawing on the experiences of the public. Michel Foucault writes of the growth of this modern medicine and how it developed at the bedside of the patient– it was impossible to further medical progress without the patient, and in this the patient provided the source material for study within the emerging science(54).

The relationship between the physician and her patient is unbalanced. The physician holds considerable medical knowledge compared to the patient, and in that knowledge holds the power over life and death. The physician controls access to this knowledge both at the level of the individual at the time of treatment and the general disbursement of medical knowledge in society. The accounts and diaries of physicians, instead of the beliefs, feelings and folklore of the common individual, dominate our understanding of the progression of medical science over the course of recorded history (Warbasse, v-xi). Additional factors, such as the economic disparity between the physician class and the general populace (Kennedy, 21-22) and the French system of medical education and the ivory tower of academia, aggravate this lack of connection between physician and patient, contributing to a general sense of the physician holding an elitist position within society.

The French system of medical education was the first to incorporate the “modern” metanarrative of scientific medicine. Lyotard (11) defines postmodernism as an incredulity towards metanarratives and modernism as an affinity for metanarratives. The moderns believed in metanarratives because they held that there could be an objective “true” answer for any question – modern medical thought indulges in these metanarratives because their metanarratives are borne of the scientific method (a positivist perspective). Nineteenth-century French medicine is positivist or “modern;” medical truth, in the academic sense, is a metanarrative that demands to be treated as an authority – the patient is expected to accept these theories out of hand. Throughout *The Birth of the Clinic*, Foucault is both critical of metanarratives and takes a postmodern view of medicine in that the grand theory cannot be trusted. Breaking down the doctor-patient relationship and giving medical knowledge to the public is postmodern in that each patient decides what works for herself personally, examining each grand theory in turn and either accepting or rejecting each on its merits.

In *The Medicine Show* (35-36), Peter Warbasse states that “the public must reach out and grab medicine in order to benefit most.” The individual stands to enjoy greater health and longer life when she has the ability to incorporate medical understanding into her own life. There is now a growing movement (in preventative medicine, for example) to educate the patient of her rights, options, and the landscape of current medical practice and research in order to break through the established order of physician/patient relationships. In our movement toward a more egalitarian society, we have opened new avenues through film, informative literature, and the internet that allow the public to seek

out medical information that will lead to the best possible medical care that is also in the public's best interest. The doctor will always have power and responsibility over the patient, but she no longer need be the keeper of mysteries. The patient can subject herself to the doctor's care without continuing ignorance about her condition and treatment.

Documentaries and Non-Fiction Film

The capture of light on film stock to reproduce motion has a history going back about 130 years. In 1892, in the early years of film, Georges Demeny used a version of Etienne Marey's famous photographic gun in an attempt to help the deaf. By recording short films of people speaking, Demeny hoped to use the images to train lip-reading skills for the hard of hearing (Barnouw, 4). This application of film as a scientific tool served as an important moment in the history of medical documentaries and nonfiction films.

Filmmakers from all backgrounds have played a part in the development of the medical film. The British government used health films as a component in their wartime propaganda (*Defeat Tuberculosis*, 1943; *Neuropsychiatry*, 1943) (Barsam, 187).

Feminist filmmakers incorporated health education into a larger agenda of liberation and empowerment (*Self Health*, 1974; *Our End of the Speculum*, 1977)(Barsam, 364). Today, documentary filmmakers use film to explain cutting-edge technology on the frontier of medical research (*Designer Babies*, 2001; *Regenerating Life*, 2001) or use medical topics as entertainment or spectacle for a general audience (*Mystery Diagnosis*, 2005; *Medical Incredible*, 2005). Throughout the development of this specialized sub-genre, the filmmaker has chosen a target audience and then focused educating this audience on a

specific medical topic. The lessons embedded within these films have traditionally been presented in the manner of an illustrated biology lecture – a presenter talks to the audience and the film cuts to images that reinforce the topic at hand. Known as evidentiary editing, this technique furthers the documentary’s main argument rather than working to further the narrative of the film in a dramatic way by clarifying the central story and moving the action toward a conclusion.

In the last few years, filmmakers have expanded the definition of the medical documentary by attempting different changes in style, tone, structure, and amount of content. They intend for these changes to increase both the viewer’s engagement with a given medical documentary, traditionally known to be less than scintillating viewing material. With so many changes being applied, it is worth giving a look to the effectiveness of the different methods that the filmmakers employ.

What makes a good medical documentary? The most basic mission of a science film is to take a scientific concept and explain it clearly to its target audience. For a medical documentary to be effective, it should establish an empathetic bond with the audience (engagement) and deliver factual content (education). This factual content can include both the scientific concepts underlying a medical situation as well as exploring the social and practical impact of a given disease. Documentaries deliver this educational message by providing factual content, and filmmakers engender engagement with the audience by implementing filmic techniques typically used in fiction films and advertising. Martin Medhurst, in “Propaganda Techniques in Documentary Film and Television: AIM vs. PBS (184-186),” outlines nine techniques of filmic propaganda used

to make effective propaganda films.² His list gives us a rubric by which we can categorize techniques used in a film in order to effectively engage the audience. The goal of Medhurst's propaganda techniques is to inform the audience and motivate the audience to action.

All medical documentaries use filmic artifice, but they don't have the same goal. Documentary filmmakers seek to engage the viewer for different purposes. The most common medical documentary seeks to engage a broad audience in an intellectual exercise, casually engaging the audience and explaining a medical issue for its edification. I believe that very few viewers identify with the patients featured in the documentary: there will be a pathos towards those poor unfortunates, and maybe a consideration of what it might be like to suffer that disease or malady, but it is unlikely that there will be strong identification between subject and audience.

Another common and troubling purpose often seen in medical documentaries is exploitation. This type of film addresses the freakish and spectacular cases of medical science, presenting its subjects in such a way that only a thin veneer of "science"

² "Techniques of Filmic Propaganda:

1. Decontextualization of sound and image through condensation and displacement
2. Recontextualization of sound and image through various narrative devices
3. A conscious attempt to appear natural, objective or fair
4. Use of pathetic figures to evoke strong emotional responses
5. Use of a privileged narrator, often employing the authoritative "voice-of-God" technique
6. Intentional reordering of filmic events for maximum rhetorical impact, without regard for the veracity of the representation or the structural integrity of the raw materials
7. Pursuit of a journalistic "line" or "angle" that often functions as the level of subconscious apprehension but that, upon subsequent viewings, is clearly present
8. Use of asynchronous associative logic that functions through metaphoric and/or metonymic techniques of sound and image
9. Use of visual ambiguity in conjunction with a scripted (planned) narrative logic that suggests an interpretation of the visual confusion on the screen without actually asserting such an interpretation is true. It is up to the viewer to draw the right conclusions from the clues provided."

separates these programs from a circus freak show. Instead of feeling empathy towards the patient, the camera guides the viewer to objectify the patient and dwell on the deformity or condition that makes her alien, instead of focusing on her humanizing features. The spectacle both attracts and repels the viewer, resulting in the “car crash” effect – the viewer can neither look comfortably at the sensational material nor take her eyes off it. The viewer is both shocked and comforted in the knowledge that this patient’s plight “could never happen to me.”

The third trend of medical documentary seeks to educate a viewer who is also the patient – usually, a person who has just been diagnosed with a condition and wishes to know more. In this type of film we see the most identification between the viewer and the film’s subject – because the viewer understands that in the most pertinent sense, she is like the subject herself, and that she faces the same problem as the subject and can learn the same lessons.

These three categories of medical documentary style exist on a continuum. The exploitative documentary is at one end – the film objectifies the patient and presents her as a monstrous being, and the viewer has little to no empathy for this “other” being. The general medical documentary is in the middle, creating some general empathy on the part of the audience but doesn’t push for the audience to identify directly with the patient in question. The patient-education film is at the opposite end of the continuum, as it demands that the viewer directly identify with the subject matter at hand and empathize with the patients the film depicts – the viewer has a vested interest, as the viewer is also a patient or caregiver in need of the film’s educational message. In this paper I have

chosen to restrict my examination of medical documentaries to these patient-education films in order to continue with my discussion of the traditional doctor/patient relationship.

CHAPTER 2

CASE STUDY: DIABETES RESEARCH/TREATMENT

Examination of Methodology
of Existing Diabetes Films

I elected to create a thesis film that deals with a) the emotional impact of diabetes and b) the gaps in communication between the diabetic patient and his physician. As my thesis film features diabetes as its scientific focus, I have selected three diabetes films to examine for their strengths and weaknesses. In an attempt to limit the scope of the comparison and provide a minimum standard, the American Diabetes Association has endorsed all of the selected films for their educational value. They are also similar in that they all run approximately 45 minutes and are all relatively new (1992 –2002).

What makes for a “good” medical documentary, and can we create a model for future films to emulate? For a film to be effective, it should contain a number of elements. First, the film should engage the viewer, so our model should include those filmic techniques or considerations that lead to audience engagement. Next, the filmmaker intends, on some level, for a medical documentary to be a teaching tool with a valid educational message.

Another crucial part of engaging the viewer is for the filmmaker to create a greater sense of the viewer’s identification with the film. The viewer sees a film’s protagonists and identifies or empathizes with them - “that person could be me.” Viewer identification in a film is implicit to the medium (on the most basic level, the camera eye

becomes the perspective of the viewer) and is also enhanced through a number of filmic techniques, including many of the techniques of filmic propaganda set out by Medhurst in footnote 2. However, viewer identification can be transformed into its opposite – alienation – when a seemingly objective film exhibits images, ideas or protagonists that run counter to the viewer’s own beliefs; the viewer may become irritated or angry and disengage. No longer a complicit partner in the filmic experience, the viewer may reject objective, factual information along with the offending material. To avoid alienating her audience, the filmmaker should consider racial, gender, political, cultural and religious differences in a sensitive way. In the health documentary, the film should also avoid a status quo divide in terms of the traditional doctor/patient relationship. If the filmmaker holds the doctor as a sacred, authoritarian figure, she risks treating science as faith and alienating and losing an audience that seeks an empowered, egalitarian medical paradigm.

I will examine the structure of each film and discuss how the structural choices made by the directing/producing team either support or impede the film’s educational mission. I will break down each film into its component parts: authority/narrator, cast composition, educational content, and emotional content. By pinpointing the aspects of each film that impede the stated mission of education and engagement, we can examine potential ways of improving the medical documentary.

Managing Diabetic Hypoglycemia, 2001

Managing Diabetic Hypoglycemia (MDH) is a forty-minute film sponsored by the American Diabetes Association (ADA). The film is narrated by pediatric physician H. Peter Chase, MD; the ADA selected Chase as the 2001 Outstanding Physician Clinician in Diabetes (2001 was also the year of *MDH*'s release). The introduction and segment transitions feature Kathy Jensen, RD, CDE.³ The creators of *MDH* intended for their film to be used as a teaching tool for patients recently diagnosed with diabetes and their families, friends, and coworkers. For the majority of the film, Dr. Chase addresses a collection of about thirty Type I and II diabetics and some of their family members in a classroom-style question and answer period. Periodically, the film displays a text-filled frame with a "memory point" that emphasizes a specific aspect of diabetes management. The filmmakers punctuate Chase's lectures with dramatizations of various diabetics playing out different hypoglycemic scenarios (e.g. a mother carefully testing her toddler's blood sugar level, a member of the high school girls' basketball team having a severe hypoglycemic incident in the middle of the night).

Narrator.

Chase's voice serves as narration over all technical slides and diabetic vignettes. He also explains the action during the classroom scenes from off-camera. Chase speaks onscreen often – he is an older white male, dressed as befits a doctor in a white lab coat, dress shirt, necktie, and name tag.

³ Kathy Jensen is founder of Diabetes Wellness Network International, Inc. and president of Nutritional InPut, LLC (who produced the film in conjunction with Capture It Production Studios, Inc.).

Kathy Jensen plays the narrator in the remaining scenes. The film uses Jensen's voice only during segment transitions, always showing her physical self on screen. The filmmaker has shot all of Jensen's scenes in a room resembling the sitting room of a lavish home, filled with works of art, vases of flowers, and an oversized couch. Jensen speaks in general terms about diabetes, tying the segments together but avoiding any clinical or scientific references.

The filmmaker split the voices addressing the audience down very specific gender lines, and the decision to divide the narration in this way follows the way paved by other traditional nonfiction science films showing a patriarchal, all-knowing doctor narrator and a meek, marginalized female hostess. Chase fits the description of the stereotypical science film narrator – he is of advanced years, Caucasian, and has an advanced degree. His surroundings are always professional and austere, and he is imbued with a palpable sense of authority.

Chase's segments draw a sharp contrast with the use of Jensen as a joint narrator. Jensen is a well-dressed middle-aged woman in a domestic setting; she serves as a hostess guiding the viewer to the threshold of the male-dominated professional environment that Chase dominates. She has no contact with any patients, asks no questions, and takes care of the social niceties so that the serious scientists can concentrate on work.

The valorized male and marginalized female roles are not unusual stereotypes, but they no longer reflect the reality of medical practice. Robert Alley provides us with a snapshot of television's medical programs circa 1976; after detailing problematic male

dominance and female submission in a number of shows, he goes on to stress that this imbalance is a realistic reflection of that era's gender roles (238-240). This is no longer the case, as a number of current medical dramas (such as *ER* and *Bones*) allow for strong female protagonists and there is a growing movement in documentary to use female narrators in order to combat the effect of the white authoritarian male (*Living with Diabetes: Challenges in the African-American Community*, as an example).

Cast Composition.

The group of diabetics sitting in on Chase's discussion is fairly diverse in terms of age, gender, race, and whether they have Type-I or Type-II diabetes. During the question and answer segments, these different groups enjoy what seems to be balanced air time, allowing a four-year-old to give an answer or an elderly man to describe something in detail. No noticeable biases are present in Chase's selection of respondents for each question.

The film's gender balance breaks down completely during the diabetic vignettes. All the male diabetics in this film portray either doctors or serious sports enthusiasts. During the vignettes, male diabetics of all ages demonstrate responsible, conscientious methods of taking blood sugar levels, carrying the proper foods to help maintain good sugar levels, and looking to the future for further diabetes research.

Women do not fare as well in the world of *MDH*. All women within this film both possess stereotypical jobs or roles and are also shown repeatedly undergoing hypoglycemic reactions. This falls under the typical victimization and objectification of female roles in traditional film.

- One vignette shows a female hairstylist undergoing a hypoglycemic event while cutting an elderly woman's hair. She is disoriented, weak, and asks for forgiveness from her client while searching for a piece of hard candy.
- Another scene involves a woman who does not have diabetes. She is married to a male diabetic doctor, and together they have two diabetic sons that are interested in competitive mountain bicycle racing. She details how carefully she packs lunches for her three diabetic men.
- One young high school student reveals that she plays on her women's basketball team. In the following scene, she screams incoherently in her bed during a severe hypoglycemic reaction. Her mother rushes into her bedroom to hold her gently while her father rushes to find and then administer the glucagon shot that will save her life.
- A female schoolteacher admonishes a female kindergartener for not paying attention during a classroom lecture. The student is actually undergoing a hypoglycemic reaction of medium severity and needs medical or nursing attention.

The film lacks a single instance of a man undergoing a hypoglycemic reaction. Also, there are no females in positions of power throughout the film, whether that power comes from professional standing or the ability to manage diabetes responsibly. These gender stereotypes follow the theme set previously by the narrators.

Laura Mulvey addresses *MDH*'s typical portrayal of active males and passive females in her article on the implementation of gaze in traditional cinema (835-839). .

Through the use of the male gaze, the viewer retains control of the film and projects his own desires onto the narrative. The viewer then identifies with the male as the protagonist and follows his actions as his own. The camera gaze causes the viewer to objectify the female and, as such, removes her from any position of power or audience identification. Following this reasoning, it would be difficult for the viewer to accept the female characters in the film as being anything but passive, dependent objects – and possibly alienating anyone in the audience who believes that women do not belong in this role. Mulvey does make the point that women have accepted this role of being the object of male gaze, although this attitude is now rejected by both feminists and, gradually, “mainstream” women as well.

Educational Content.

MDH is a highly educational film in terms of its structure and content. The film is organized in such a way that an audience that has little prior knowledge of diabetes could walk away from the piece with a general understanding of the disease. The film is a fact-driven piece that emphasizes key points by reinforcing them with graphs, charts, detailed explanations, and definitions of clinical terms. *MDH*'s most apparent flaw would be how quickly it presents these ideas within the film – it is difficult for the audience to digest a massive quantity of facts delivered at a rapid-fire pace – but it remains a comprehensive primer on the disease for a film of this length.

The directors sacrificed character development and specificity of message by attempting to cover both Type I and Type II diabetes in the same film,. The educational component of the film is too general; mixing Type I information with Type II

automatically alienating a portion of the diabetic audience. For example, a Type II diabetic viewing this film would have little to no interest in the lengthy discussion of severe hypoglycemic events, as it would be rare for someone with Type II to undergo such an event. Another example would be weight loss - obesity is not a cause of Type I diabetes, and a Type I diabetic has no real need for educational material about losing weight.

Emotional Content.

The tone of *MDH* is didactic and clinical; the characters even tell personal anecdotes without any apparent emotion on the part of the diabetic in question. The reduction of patients to medical cases is another symptom of the doctor/patient divide, and further emphasizes that scientific study should be our predominant mode of understanding disease. There is no character development – when Chase asks the audience a question, each audience member receives only a first name and replies with a deadpan answer. This sterile treatment of the characters within the film divorces the audience from the action, as there are no characters with which to empathize.

MDH Conclusion.

Overall, *MDH* conforms to the didactic, expository structure followed by the majority of medical documentaries. An educated presenter, usually a white male physician, imparts wisdom to the audience in the style of a controlled classroom lecture with excellent visuals. The flaws of *MDH* are the result of a lack of emotional and empathetic connection with the audience. The scope of the film is broad, and a

significant amount of academic ground must be crossed in order to provide the take-home messages endorsed by the ADA.

One major problem in *MDH* is the gender imbalance in the narration and composition of the overall cast. In Janice Law Trecker's article "Sex, Science and Education," she argues that the very development of modern medicine forced women out of the field.

Nowhere is this shift in what constituted forbidden knowledge more clearly illustrated than in medicine. In the medieval world woman was the physician, and long after, the housewife's simples and potions and her nursing skill largely determined the health and safety of her family. At the dawn of the industrial era, women still dominated one medical specialty, obstetrics and gynecology, and the midwife was a respected figure in every American community. Once medicine became a science, however, attitudes changed, and even the midwife was driven from the field by professionally educated male practitioners. Suddenly medical matters were improper for women to know, and a decent, prudish ignorance plus a deferential confidence in the male physician became the correct female attitude (88-89).

The gender divide in *MDH* echoes the idea that women are barred from the science of medicine – in the film, the doctors are all male, the women receive instruction from the doctors, and there is no discourse about the information the doctors dispense. This divide would make it difficult for women to be receptive to the core message of the film – there are no positive female protagonists with which to identify, and the film (however unintentionally) suggests that women are removed from the realm of proactive diabetes care and management. With nothing but the educational material to tie the viewer to the film, it is difficult to retain the empathetic engagement of the audience.

Diabetes for Guys: A Guy Flick, 2000

Diabetes for Guys (*D4G*, as suggested by the dust jacket) is a 45-minute film that is the product of a collaboration between the ADA and Stephen Furst. Furst is a Type II diabetic, known for having appeared in *National Lampoon's Animal House* as Kent 'Flounder' Dorfman. Furst was first diagnosed when he was seventeen years old but spent years overeating and ignoring his skyrocketing blood sugar levels. The filmmakers intend for this film to be a humorous, semi-autobiographical look at Furst's struggle to overcome his bad eating habits, acknowledge his medical condition, and work to bring his diabetes under control.

D4G takes a radically different approach from other ADA-sanctioned films. Instead of conforming to the traditional didactic, instructional form that *MDH* uses, *D4G* enters the land of parody and exuberant spoofs of *au courant* Hollywood blockbusters (*Mission Impossible*, *Austin Powers*, *Forrest Gump*, *Jaws*, *Psycho*, etc.). Actor Stuart Pankin plays the role of a younger, less disciplined, and heavily overweight Stephen Furst. (For the sake of clarity, I will henceforth refer to the character of Furst by the name of the actor, Stuart Pankin.)⁴

⁴ At the beginning of the film, Pankin prepares for a big Friday night – renting movies at Blockbuster, buying an enormous pizza to take home, and assembling an impressive collection of junk food and remote controls in a pile next to his recliner. As he watches each tape he rented, each movie plot seems to become warped and the story begins to discuss the dangers of being an out-of-control Type II diabetic. The filmmakers intercut the series of movie parodies with scenes of Pankin becoming increasingly aware of the danger of allowing his diabetes to run unchecked, culminating in his revelation that he must take charge of controlling his disease.

Narrator.

Furst narrates the introduction and the conclusion; the rest of the film plays out like a fiction piece with Pankin as the main character. Furst lends his segments a kind of breezy casualness about Type II diabetes; his authority is minimal, mostly from having been undermined in an introductory scene where he is hit in the face with a banana cream pie.

Pankin's character is that of the "bad" Type II diabetic, and he plays the role for comic effect rather than believability. Throughout the film, he is simple and boorish; his reclamation of self at the end of the film borders on the farcical. This style of narration is a departure from the traditional approach that *MDH* takes; however, the filmmakers have buried the educational message in a heap of one-liners and physical comedy gags. Aside from Furst's introduction and conclusion, it would be possible for the viewer to watch *D4G* and be completely oblivious of the fact that it is a diabetes film.

Cast Composition.

Intending for the film to be semi-autobiographical, the filmmakers were limited in casting of the main character and needed to select someone that resembles Furst (white, male, overweight). The cast is made up of only Caucasian males; this limitation may simply be an effect of the movie parodies chosen for the script. The male-centric balance is to be expected in a film with a specifically male target audience. However, despite its lack of variety in cast, at least no attempt is made to judge anyone besides its hapless protagonist.

Educational Content.

D4G is nearly devoid of any explanation, discussion, or detail about diabetes. The film has an overwhelming message of weight management, but barely mentions actual diabetic complications (sexual dysfunction, loss of eyesight, decreased sensitivity in extremities). For example, the film covers sexual dysfunction in an *Austin Powers* parody in which Pankin, playing the titular role, suffers from erectile dysfunction and cannot consummate his relationship with a 1960's-style go-go dancer. At the end of the film, the cast runs through a laundry list of symptoms of Type II diabetes at a breakneck pace, seemingly to allow more time for the bloopers reel.

Emotional Content.

In order to reach the desired target audience (middle-aged, overweight males in a state of denial about having diabetes), *D4G* attempts to make all of its arguments on a visceral, emotional level. By playing off the guilt and anxiety that plague the main character, the film tries to engage the viewer without using the didactic approach that is likely to scare him away. The filmmakers have structured the story in such a way that Pankin is a hero in spite of his own self-destructive actions, and the viewer is emotionally invested in seeing Pankin succeed in reining in his Type II diabetes.

D4G Conclusion.

D4G is irreverent and comic, laughing in the face of documentary tradition. Also, it focuses on a specific target audience – men struggling with obesity – and limits its scope to the treatment of Type II diabetes. Unfortunately, the educational message is

undermined by the film's emphasis on comedy and an extremely focused audience. Considering that *D4G* is an ADA-sponsored film, it is surprising that the educational message was bypassed in such a way. In the attempt to make diabetes "fun" and accessible, the filmmakers inadvertently marginalized the content of the film.

The filmmakers' primary goal for *D4G* is to educate by entertaining. For the film's budgetary and content limitations, it does a reasonable job keeping the interest of the audience. Unfortunately, the use of comedy complicates the delivery of the film's message. Comedy and sarcasm run the risk of trivializing the emotional gravity of the subject matter. Also, setting up jokes takes time, taking away from film time that could be used on further explaining factual content. We should not bar comedy as an effective mode of relaying scientific information in documentary film, but *D4G* is a case in which the medium (as defined by Marshall McLuhan (15)) has overwhelmed the message. In this case, sketch comedy prevents the factual content of diabetes care management from reaching the audience in a meaningful way.

D4G, in its use of comedy and sarcasm, raises the important question of how the filmmaker can effectively combine education with entertainment. If the film relies too heavily on entertainment, it runs the risk of either obscuring facts or excising factual content completely. On the other hand, *D4G* is targeted at overweight men – is it really necessary for it to concentrate focus on a strong educational message? The film may get its main messages of weight control and overcoming denial across to its audience in a general way, but this leaves the viewer with a single take-home message without any supporting information. If this were simply a film about obesity, the filmmaker would be

able to succeed by imparting this generalized message. With a topic such as diabetes, however, the supporting details are the focus of the educational message – this is a complex disease that the public doesn't understand, and a failure to flesh out the educational message in the mind of the viewer is a fundamental failure to encapsulate the core values of the medical topic at hand.

MDH is at the other extreme of the entertainment/education balance, providing an enormous amount of factual content but failing to meaningfully engage the viewer. Although the filmmaker presents the details of diabetes in a comprehensive way, there is no reason for the viewer to engage with the subject matter. The gender balance of the film alienates female viewers, and the dry, humorless approach makes it difficult for any audience member to retain the information that the film delivers.

Obviously, we need to create a balance between entertainment and education in medical documentaries. This balance is elusive, as it may be specific to the sensitivity of the topic with which the film deals. For example, it would be inappropriate to be too irreverent or comical when dealing with chronic diseases with high fatality rates, and equally inappropriate to use a dour, heavy-handed approach to a film on a trivial ailment (bunions, for example). I would make this topic-based consideration of balance part of my model for future medical documentaries, for it is worth some thought on the part of the filmmaker when creating the tone of her film.

Living with Diabetes: Challenges in the
African-American Community, 1993

The Michigan Diabetes and Research Center produced *Living with Diabetes: Challenges in the African-American Community (LWD)*. *LWD* is a series of twelve two-to five-minute episodes that dovetail with a discussion guide that is included in the packaged materials with the DVD.

Narrator.

The leader of the discussion group, Kate, serves as the narrator that ties the vignettes together. Kate is a middle-aged, African-American woman who works in a diabetes clinic as a laboratory technician, and she facilitates each of the support group's meetings.

The writers of the vignettes crafted Kate's role in such a way that she is assertive without being too forceful, empathetic to the variety of problems that the group discusses, and sympathetic in general.

Cast Composition.

LWD takes place at a Baptist Church, home to a fictional diabetes discussion group of African-American diabetics and their families. Led by a discussion facilitator, the group casually discusses different aspects of diabetes as a disease. As the film establishes the topical issue for each episode, the segment cuts to a vignette of the characters in question acting out the disagreement, misunderstanding, or confrontation in question. Topics covered include denial of having diabetes, difficulty of discussing diabetes with a long-term family physician, marital conflicts, and anxieties about rising

healthcare costs. Each episode has an accompanying chapter in the discussion guide that allows the audience to discuss a given topic with a greater degree of detail.

As this film concentrates on social problems caused by misunderstanding diabetes, it would be expected that considerable attention would be given to the balance of the casting. The entire cast of *LWD* is African-American, as would befit the target audience of African-American diabetics and their families. The filmmakers have evenly divided the cast by gender - the discussion groups have both men and women and the vignettes give each sex ample air time. The filmmakers planned the treatment of each gender in a more thoughtful way than in *MHD*. Women and men appear equally as stubborn, irresponsible, or uninformed; pro-active, educated and emotionally available characters are of both sexes. For example, “I Do Not Have Diabetes” shows a middle-aged woman refusing to accept her diagnosis, and “You Can Do Something” features an older man refusing to tell his wife about his doctor’s recommendations at his latest appointment.

Educational Content.

The film organizes the episodes by subject; for example, episode two deals with discrimination because of diabetes and feelings of denial, while episode six deals with choosing a provider and using the health care system effectively. Within each of these social situations the film exposes the viewer to a series of facts about diabetes that come straight from the mouth of a diabetic with no intermediary. The “take home message” for each episode is memorable and easily grasped without being oversimplified for the audience.

Emotional Content.

LWD is, by far, the most emotionally engaging film of those I reviewed. The writers scripted each vignette in such a way that characters, regardless of whether they were portrayed as the protagonists or antagonists for the scene, are generally multifaceted and sympathetic. Over the course of twelve episodes, the film engages the viewer emotionally - even those scenes that do not apply personally (i.e., information for Type II diabetes presented to a Type I viewer) convey a sense of the social and interpersonal issues at hand. This social relevance helps to keep elements of this nature from being dismissed out of hand by the viewer.

LWD Conclusion.

Overall, *LDH* does an excellent job of balancing the issues at hand for both Type I and Type II diabetics. The casting was extremely balanced, and the writing was strong enough to support the themes at hand without losing the desired level of sincerity. The filmmakers have imbued each episode with a strong dramatic element, and this element significantly broadens the audience for the film even to those who are not part of the African American community – anyone who knows someone with diabetes would take something away from this film.

LWD is a more effective medical documentary than *D4G* or *MDH* in that it is able to elicit and maintain the emotional engagement of the audience while effectively delivering factual information. Diabetes is not trivialized, nor is it treated in a cold, clinically-based fashion – the filmmaker has found a proper balance between entertainment and education for the medical topic at hand. The filmmaker achieves this

balance by developing characters more fully, avoiding an authoritarian narrator, and being sensitive to how the film portrays gender roles. *LWD* avoids the errors made by the other two films and, in doing so, appears to more closely fit our model for medical documentaries.

CHAPTER 3

THIRD MEMBER OF MY MARRIAGE: LIVING WITH
A DIABETIC (THESIS FILM)

For my thesis film, I created a fifteen-minute self-reflexive documentary outlining my experiences with individuals in my everyday life who have diabetes (both Type I and Type II). This piece is intended as a personal exploration of the everyday practical and emotional complications of diabetes on both diabetics and those who support them.

I chose to make a self-reflexive documentary using myself as the narrator. By inserting my own personal reactions to the script I was able to emphasize the impact of diabetes on all involved parties while also explaining the emotional states of each interview subject. A more traditional third-person narrator would have resulted in less of an empathetic bond between film and audience, as the audience would be one level further removed from the emotional content of the film (e.g., the journey that the main character takes in learning about diabetes and being a supportive diabetes caregiver).

In *TMOMM*, the filmmakers limit the composition of the cast in the same way as in *D4G* - the autobiographical nature of the story demands certain racial and gender considerations. For example, I limit my cast in that I must include the interviews of family members in order to tell my story.

Diabetes, as a documentary subject, is unique because of the dual nature of the disease. While the symptoms of Type I and Type II are similar (hypoglycemic episodes when overcorrected, dangerous long-term consequences), the causes of each form are physiologically disparate. None of the films that I have selected for analysis specify

whether the film is intended for Type I or Type II diabetes, a factor I would consider significant for target audience selecting a piece for viewing. Films such as *D4G* and *MDH* fail to target an audience (Type I or Type II) effectively, and their general approach results in a lack of engagement with the audience – a Type I diabetic would have little interest in the Type II sections of each piece and vice versa. *LWD* and *TMOMM* effectively avoid this audience disconnect by focusing in on the issues that affect both clinical types (personal emotional reactions, relationship issues, and difficulties encountered on a daily basis). These emotionally-based issues are universally understood, and they can be used in a film that deals with both types of diabetes in order to broaden the appeal of the film by increasing the film's relevant audience.

My educational message for *TMOMM* has two different facets. First, I wanted to give a broad overview of the practical side of diabetes; this includes injections, blood sugar monitoring, and hypoglycemic episodes. Second, I was interested in showing the ways that diabetes impacts the interpersonal relationships of both the diabetics in question and myself (the narrator) as a diabetes caregiver. In my interview with each subject I attempt to arrive at a summary of those practical aspects by having each subject detail her emotional responses to each challenge in terms of the management of her diabetes. By marrying the two, it prevents the subject matter from being presented in a cold, clinical manner and keeps the facts within the context of the individual while also preventing wasted emotional energy from stealing the show entirely away from its goal of providing some educational content. Through the course of *TMOMM*, the viewer learns about the difference between Type I and Type II diabetes, the necessity of blood

glucose monitoring (for both types of diabetes), insulin injections, diabetic complications (such as Lorraine's loss of part of her foot), and the effects of diabetes on interpersonal relationships. Also, I present these lessons in a context that avoids sensationalizing the disease and I consistently present diabetes as a manageable disease that still allows for normal activity (as shown in the racquetball sequence) and normal relationships (as suggested by the wedding footage).

Although this film is of limited use in instructing a diabetic how to better manage her disease, it does give the diabetic insight into how other diabetics cope. *TMOMM* is particularly valuable as a tool for diabetics to educate their loved ones or caregivers in that it provides a foundation of general diabetes education but does not overwhelm the viewer with unnecessary technical detail. The film also familiarizes the viewer with different emotional or social obstacles that the diabetic may face. The diabetic patient is empowered in that she is not necessarily dependent on the physician educate her caregivers, and the patient is able to perform such outreach at her own pace as befits her situation – this film could be used as a communication tool to aid the patient in bringing up difficult issues with her loved ones.

My thesis film illustrates a real, autobiographical instance in my own life that I wish to relate to others. I want to represent reality as objectively as possible. However, while creating a narrative out of my life experience I resort to a number of filmic techniques. For example, I employ the technique of changing temporality – examples include creating a montage of the most significant parts of a longer action (such as in the

blood-testing segment) and cutting together unrelated shots that together signify the Midwestern winter – in order to achieve maximum rhetorical effect.

In the Midwestern winter montage, I combined short shots of different outdoor scenes (such as a frozen lake with an ice fishing shanty, icicles hanging off of the roof of a dilapidated ranch house, the American flag moving gently against a snowy backdrop) and use them as a lead-in to the interview with my grandmother. The narration over these shots discusses my childhood growing up in Wisconsin and the trips that my family took to visit my grandparents' home. This is not archival footage; it was shot at the same time as my interviews and depicts my grandmother's home in the present. I use these images to transport the viewer from the present to a place in the past in an attempt to provide some context for my grandmother's discussion of her diabetes diagnosis (an event that happened years ago).

My film centers around a Type I diabetic, and I felt that it was important to the educational message of the film that I include a scene in which Dan injects insulin into his body. This is another area where I departed from the straight "truth" of my film, as I made a series of conscious decisions about what to include and what to avoid in order to bring my point as clearly as possible without alienating my viewers. I could have chosen to use footage of Dan injecting into his thigh or of Dan bleeding after the injection – Type I diabetics commonly experience both of these scenarios, and I could have included either of them in my film in order to heighten the viewer's perception of diabetes as a dangerous disease that intrudes on the patient's life. Instead, I chose to show Dan injecting into his abdomen while his hands just barely concealed the moment the needle

entered his flesh. I made this decision in order to show Dan's daily diabetes care as a routine instead of as a sensational, gore-filled event that would shock and possibly alienate my intended audience.

In addition, I use music to influence mood, attempting to invoke the melancholy, absurdity, and eventual acceptance of living with an incurable disease. By making these shifts in time and emphasizing certain facets of the characters' personal disclosures I attempt to sway the audience to my desired goal, which is to impart a sense of the emotional impact of a chronic disease and to create a positive mood regarding both the future of diabetes research and the everyday challenges that diabetics face.

I believe I have created a film that conforms to my desired medical documentary model. By having my narrator speak in first person, I removed the authoritarian figure from the narration and opened an avenue by which the viewer can receive an unmediated viewpoint from someone on the same end of the doctor-patient relationship. I use humor, but not at the expense of factual content or in a manner that would alienate viewers by being over the top or offensive. Also, I have chosen a female narrator in an attempt to pull away from the model of the "voice of God" narrator found in traditional science documentaries.

Ultimately, I am interested in creating a film that takes back power for the patient. In the case of *TMOMM*, this ends up being more of an emotional empowerment than a data/knowledge empowerment for the viewer. Rather than learning a laundry list of technical medical information about diabetes, the viewer learns about the daily experience of a diabetic and the caregiver (such as injections, blood glucose monitoring,

hypoglycemic episodes) and also learns about how different people view diabetes as a disease in a philosophical, rather than clinical, mode. Although this may not be a typical goal of a *science* documentary (where technical content reigns supreme), I feel that this is a valid and important goal for a *medical* documentary.

I attempt to empower the viewer by drawing them in and then, once the viewer is engaged with the material, attempt to educate the viewer on her own terms within the scope of her own emotional landscape. My film has no doctors in authoritative white lab coats – the patients own this film, telling their stories without mediation by a medical professional, and the viewer relates to those patients directly. The traditional doctor-patient power imbalance can be undermined by providing the patient with the relevant tools for better understanding her physical condition. Her physician no longer holds the only keys to her longevity, and she can take some measure of control over her own health and well-being.

CHAPTER 4

CONCLUSION

In this paper, I break down three medical documentaries in order to uncover some of the problems unique to this sub-genre. Each film helps to reveal different aspects the filmmaker must consider when crafting a film that attempts to both educate and engage the viewer. *MDH* attempts to fully educate the viewer about diabetes and offers excellent factual content, but it fails to offer any emotional content that would help audience engagement. The audience ends up being alienated further by the film's authoritarian white male narrator and marginalized female characters, making it difficult for the viewer to accept the educational message. *D4G* valiantly tries to depart from the traditional didactic documentary format, but its humor overshadows the educational message and leaves the audience without any significant new information about the topic at hand. A film fails if it gives plenty of content without engaging the viewer (as with *MDH*) or if it entertains or inspires but does not give clear information (as with *D4G*). *LWD* found an excellent balance between engagement and entertainment while dealing with gender and racial issues in a sensitive and modern way.

The successes and flaws of these three films help us to hit upon the following design goals present in my model for medical documentaries. First, the fundamental goal of a medical documentary is to educate by relaying factual information to the public. Without some educational message, the film has little to no value for an audience member interested in the film's subject matter. Next, the film should engage the

audience in such a way that allows the audience to be receptive to the educational message of the film. If the audience does not engage emotionally with film it will be more difficult for each viewer to retain the film's delivered information. A subsection of this engagement would be how the film handles the gender balance and racial stereotypes; these issues must be sensitively managed in order to prevent the film from alienating audience members who would otherwise engage with the content of the film. Finally, the film must strike a balance between education and engagement, and this balance appears to be topic-specific as a sliding scale that is partially dependent on the topic at hand (i.e. the severity of the film's subject disease).

TMOMM corrects for the problems of *MDH*, *D4G*, and *LWD* by following the model that I have outlined above. The emotional content has been structured in such a way to maximize the audience's engagement with the film, and the educational content of the film is present but not overstated. *TMOMM* gives the audience an increased understanding of the daily routine of diabetes and the specific physiological pitfalls that could possibly arise. It shows the procedures by which diabetics control their disease and describes the process of diagnosis through the eyes of three different patients. There are no white lab coats present, and the patients in the film relate their personal accounts to the patients in the audience, thus shifting the balance of power out of the hands of the physician and giving the audience the tools with which to make informed decisions and be proactive about their own medical treatment.

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