

## **Medical Mysteries that Defied the Experts: Physician Authority and Patient Responsibility in TV's *Mystery Diagnosis***

Vesta T. Silva

Mary Ann, a 20 year-old college student and babysitter, develops an oddly persistent cough. Initially thinking it is just a minor ailment, she becomes concerned as the cough persists and she begins to experience weight loss, night sweats, shortness of breath, and itchy skin. For three years her doctors tell her that nothing is wrong. Finally, Mary Ann finds a doctor who takes her concerns seriously and learns that she is actually dealing with Hodgkin's Lymphoma ("A Deadly Cough").

From the time Tiffany was a toddler, her parents suspected there was something wrong. She could not run, she often fell down, and she could not physically move or bend in the ways other children could. Tiffany's parents took her to dozens of medical specialists over a period of nine years only to be told again and again that they were just overanxious and that nothing was wrong. When Tiffany was 10 years old, they finally found a pediatric neurologist at the Mayo clinic who assured them that "something is indeed wrong" and provided them with Tiffany's devastating diagnosis, Pompe Disease, an incurable degenerative muscular disorder ("The Girl Who Fell Apart").

These are just two of the hundreds of stories of illness and frustration told over the 10 seasons of the reality TV program *Mystery Diagnosis*. The patients featured on the show routinely face not only their own health challenges, but a health care system that ignores, dismisses, and misdiagnoses them. Like many other Discovery channel programs, *Mystery Diagnosis* presents itself as both entertaining and informative—claiming to help viewers learn about rare diseases and medical science in an accessible and enjoyable format. The paratexts that surround the show reinforce its supposedly pedagogical function. For instance, its website offers quizzes on diagnostics and rare disease guides, quite literally positioning the show as teacher and the audience as students.

I argue that what the show is primarily presenting is not an education in rare diseases, but a very particular, and at times seemingly contradictory, vision of patient agency, responsibility, and medical expertise and authority. Through careful narration and

repetition of key phrases and story structures, each episode positions patients as worthy examples of “ordinary people” fighting against a largely unresponsive and incompetent medical establishment. Audiences are invited to sympathize with the patients and root for them as they search for (and eventually find) the truly expert doctor who can finally solve their mystery.

This portrayal of medicine both reinforces and circumscribes what is commonly understood as a neoliberal model of individual agency. Although the patients featured in the series in some ways match expectations for enterprising neoliberal subjects, their individual agency ends up being circumscribed by a deeply conservative vision of physician authority. Ultimately, *Mystery Diagnosis* presents a vision of medicine as a largely failed system that only works when it is driven by the tireless labor of worthy patients and the insights of a few exceptional expert practitioners.

## Television and Medicine

Lester Friedman argues that “the worlds of media and medicine exist in a unique symbiosis” providing viewers with an “alluring blend of scientific information and comforting advice” (1). Friedman sees such a “melding” of media and medicine as inevitable in our contemporary cultural context of rapid changes in medical technologies, swirling medical and ethical controversies, and uncertain economic times (2). Medicine provides media with a seemingly endless array of dramatic and compelling storylines from outbreaks of exotic and virulent microbes to the ethical dilemmas of genetic testing. And, in turn, medical institutions and individuals work to “manipulate the media spotlight for their own agendas” to pursue public approval, government funding, or simply to distract from the “less savory specters crouching in the shadows” (2).

While a wide range of scholars in various fields have addressed the intersections of medicine and media in fiction and non-fiction formats, little attention has been paid to the portrayal of medicine within the relatively new genre of reality TV. Medical reality TV includes a range of types of programs that differ in their foci and in their format. Some follow a specific doctor or group of doctors and their extraordinary cases such as *Dr. G: Medical Examiner* and *Sidney ER*. Others portray unusual cases in a specific setting such as *Untold Stories of the ER* and *Sex Sent Me to the ER*. Still others focus on bizarre situations within which people may find themselves—most often related to reproduction. These include series such as *I Didn't Know I was Pregnant*, and *I'm Pregnant and . . .*, which fills in the blank each week with a different categorization such as “in prison,” “a nudist,” or “an addict.” In addition to such episodic programs, the Discovery networks air dozens of health-themed reality TV specials that focus on persons with unusual conditions such as *The Girl with Half a Face* and *The Man Whose Arms Exploded*. Alongside these cable television offerings, news magazine programs such as *Dateline* and *Frontline* regularly feature health/medicine themed episodes.

While all of these formats could do with sustained scholarly attention, in this essay I choose to focus in particular on the sub-genre of medical mystery/diagnosis reality TV. This group includes programs such as *Medical Detectives*, *Diagnosis Dead or Alive*, *Monsters Inside Me*, and *Mystery Diagnosis*. These shows typically feature different patients and

doctors each week, yet maintain unity and continuity through narrative structuring rather than by building an audience relationship with any particular character or location. These programs are thus not about building up particular celebrity identities or creating long-lasting relationships between the viewers and the show's "characters." Thus, this format can more readily be understood as featuring the battles of all of us with a failing system. The patients and their cases are somewhat interchangeable. Indeed, it is in their very ordinariness that the show grounds its appeal—it could be anyone finding herself in such a situation. This is highlighted by the titles of many of the episodes which do not even name the patients. We are presented merely with "The Girl Who Fell to Pieces," "The Woman with Unusual DNA," and "The Boy Who Bit Himself."

Produced by True Entertainment for Discovery Health, *Mystery Diagnosis* has the most episodes (101) of any of the diagnosis focused medical reality TV programs to date, and this, along with its continued availability for viewers is why I have chosen to focus on it in this analysis. The series originally aired on the Discovery Health channel starting in 2005, and then aired its final new season in 2011 on the Oprah Winfrey Network when that channel took over Discovery Health. The episodes currently air in heavy rotation on the Discovery Fit & Health channel and many are "officially" available on YouTube. Clips of several episodes are also available on the show's website. Thus, although no new episodes are being produced, the show continues to be widely available to contemporary viewers.

I argue that it is crucial to consider medical reality TV programming such as *Mystery Diagnosis* more closely and carefully in the wider scholarly conversations about medicine and public culture, especially given reality TV's function as what Ouellette and Hay term a "cultural technology." They contend that reality TV operates as "an instrument for educating, improving, and shaping [viewing] subjects" in ways that are not duplicated by other fiction or non-fiction media formats (14). This analysis of *Mystery Diagnosis* contributes to our understanding of contemporary health communication and media studies of reality TV by considering the ways in which expertise, agency, and responsibility are constructed within a context of dramatic presentations of health and disease.

### **The Narrative Structure of *Mystery Diagnosis***

Every episode of *Mystery Diagnosis* follows a consistent pattern, and it is largely through that repeated pattern that the show develops its presentations of patient agency and physician authority. First, the stories of the patients (three per episode in the first season, and two in all the other seasons) are previewed. We see upcoming clips of the patients expressing their pain and frustration as they battle complex and often debilitating conditions. The show then cuts to its introductory sequence with the opening text playing across the screen as it is read by the voiceover narrator. "When illness strikes, we look to doctors to give us answers. But what if they can't? For these unlucky patients, diagnosis is a mystery."

Most of the persons profiled in the stories are white women, children, or infants, with some stories focused on adult white men and very few on persons of color (of any age/sex). Though the show provides information about the timing of each story (what year it was, how long it all took) and the cities/towns in which the people live, the stories are not

largely bound or driven by location or moment. Interviews with the patients and their friends/family along with voiceovers from the narrator serve as the primary means of advancing each story. Home videos and photos are intercut with stock footage of hospitals and medical images to add visual interest to the story, and key moments in the stories (visits to the Emergency Room (ER), patients collapsing, etc.) are reenacted, usually by actors.

In addition to the verbal construction of each story, audiences are given a number of visual and aural messages throughout the episodes. For example, each time a patient or family member comes to realize that the situation is far more serious than they had believed the camera focuses in on one side of their face, showing their eye closing matched by a low percussive sound. These eye closing scenes are common throughout the episodes and work to try to enhance the emotional drama of the stories.

Though there is some variety in the types of illnesses featured (genetic conditions, acute illnesses, rare syndromes), each story moves predictably through a set narrative progression. First, the audience is introduced to the patient and her/his family. Viewers are given some information about the patient (age, family relationships, etc.) and presented with a brief glimpse of her/his life prior to the start of the “mystery.” The story then moves to the presentation of initial symptoms followed by a misdiagnosis by an unnamed primary care physician, pediatrician (for child patients) or Emergency Room doctor. The mysterious symptom(s) continue to progress, and continue to be ignored and/or misdiagnosed by physicians. Generally, the patients begin a quest for answers, seeing “doctor after doctor,” sometimes for years. Over time new symptoms appear, usually described with words such as “shocking,” “terrifying,” or “puzzling.” Refusing to give up in the face of dismissal or continued misdiagnosis, the patient’s quest eventually finds a resolution, either through a critical worsening of the condition which brings in a new (better) expert or through the patient/family’s eventual location of the doctor who can finally provide an answer.

Once the final expert(s) enters the story, the narrative makes a significant shift, typically moving from a predominant tone of questing and frustration to one of relief and answers. The diagnosing physicians are the only doctors who are ever named in the program. The audience thus learns that, once the story mentions a doctor’s name, the mystery is about to be solved. What is remarkable about this solution segment is that, while at least one and more often a myriad of other doctors have run tests, done exams, listened to histories, and discovered nothing, the diagnosing physician often knows almost right away what the problem is. Tests are run, but it is made clear that they are only to confirm what the expert already knows.

In all cases, even when the diagnosed condition has no cure or treatments, the family and/or the patient directly remark on their relief at finally getting an answer. The narrator then notes that while the patient is glad to finally have the answer, “in the end [she/he] can’t help but wonder why it took so long to get a diagnosis.” We next see an interview clip with the diagnosing physician who explains that the particular condition is very rare and difficult to diagnose. Each story closes with a follow up on the patient/family post-diagnosis, letting the audience know how they are doing and what the future may hold for them now that they finally have the answers to their medical mystery.

## Expertise, Authority and Patient Agency

In our contemporary culture, it is impossible to imagine life apart from a reliance on expertise. We turn to “experts” to rebuild our roofs, to file our taxes, to evaluate the safety and reliability of our cars, and to diagnose us when we are sick. As Hartelius notes, these everyday contexts make expertise “at once pervasive and invisible” (1). Despite its pervasiveness, expertise today does not automatically carry with it the sense of indisputable authority we might expect. Indeed, the authority of traditionally credentialed experts on everything from environmental science to economics is increasingly subject to challenges and questions in public culture.

Such was not always the case with medicine. Indeed, in the early and mid-twentieth century, medicine experienced something of a golden age, marked by incredible growth in the success, funding, and power of the medical profession (Pescosolido, Tuch and Martin). After 1970, however, like many American institutions, medicine “suffered a stunning loss of [public] confidence” (Starr 379). Changes in the practices of insurance, the advent of managed care, an increasing corporatization of medicine, the rise of powerful patient advocacy groups, and the revelation of long term medical research abuses all contributed to a loss of public confidence in doctors and medical professionals. Though predictions of the “deprofessionalization” (Haug) of medicine have not been fully borne out, the proliferation of authority to a wider and wider range of non-credentialed experts (Rose) and the increasingly negative attitudes of Americans toward physicians (Pescosolido, Tuch, & Martin; Schlesinger) do highlight significant changes in the role and status of the physician in American culture.

The deployment of medical expertise and authority is clearly at the heart of *Mystery Diagnosis*. On the one hand, the series seems to confirm contemporary anxieties and distrust about the lack of reliability and capability of experts. Each episode opens with the narrator describing the stories as “medical mysteries that defied the experts.” As the patients go from “doctor to doctor,” or continue to return again and again to a misdiagnosing and dismissive primary care physician, the show’s narrative clearly positions these physicians as failures, more so because of the initial trust they receive from their patients. As viewers, we come into the show, knowing we are watching a program titled *Mystery Diagnosis*, that the initial simple diagnoses of flu, menstrual cramps, or migraines will be incorrect. In experiencing the conditions, however, the patients note that at this stage of the story they tend to accept their physician’s authority and trust that they know what they are talking about. As one young woman explains after her primary care physician gave her a diagnosis of mononucleosis, “We were definitely listening to the doctor and felt that that’s probably what it was” (“The Girl Who Fell Apart”). As these initial diagnoses prove to be incorrect, however, the patients become frustrated and less trustful—moving to match the already established skepticism of the viewers. After yet another misdiagnosis, this time of lymphoma, the same young woman observes that she has “lost confidence” even in her specialists and “wants someone new” to look at her case (“The Girl Who Fell Apart”).

In many episodes, particularly those focused on girls or young women, the “expert” doctors not only fail to diagnose correctly, but eventually come to dismiss the patient’s complaints as psychosomatic. As audience members who presumably understand the basic

premise of the program, we know that there will be ultimately an underlying cause found that explains the patient's symptoms. This insight pushes us to see these stories as involving not just incompetence but actual abuse of authority, contributing perhaps to what Imber identifies as a culture in which the public perceptions of doctors include characteristics such as "uncaring, uncommunicative, self-interested, and ambitious" (300). The patients subject to these judgments often find their own family starting to doubt them, or may even begin to question themselves. In one heartbreaking episode, a family's primary care physician decides that since all the tests revealed no problems, their 11-year-old daughter must be lying about her extreme pain to get attention. The doctor counsels the parents to ignore the child's pain, make it clear they don't believe her, and force her go to school. Eventually the girl's condition worsens, and she loses her sight while at school. The child's mother has tears in her eyes as she tries to explain to the audience, "I was raised to believe that the doctor had the schooling, he had the training, the knowledge. You believed them, and you followed their instructions" ("The Girl Who Couldn't Wake Up"). While we may or may not sympathize with or excuse the parents' actions, the show clearly encourages us to feel horrified and outraged that the physician could abuse his authority and cause this girl so much unnecessary pain. Upon finding the physician who ultimately diagnosed her condition, the young girl drives the message home stating, "Finally someone important was going to believe me and help me" ("The Girl Who Couldn't Wake Up").

The dismissals of patient knowledge, particularly that of women and girls have a long history in medicine. What we see here is a continuation of the way in which that history opposes a rational, empirical model of knowledge (long associated with masculinity) to an experiential, bodily model of knowledge (traditionally linked to the feminine). This conflict between rationality and experiential knowledge is crucial to each narrative featured in the show. In the end, all the episodes come down to a patient or parent believing that their knowledge of their own body or their own child's body must count more than the opinion of the dismissive physicians and the negative results of the medical tests and thus deciding to continue to seek out further help.

This is where the distinction between expertise and authority becomes paramount. Authority, by definition, is a social relationship—that is, there must both be someone with authority and someone who submits to that authority for it to exist. Expertise, in contrast, could be defined empirically as superior knowledge and thus, could be understood as autonomous. A person could theoretically possess superior knowledge of a subject without any other person having to acknowledge or even know about her autonomous expertise (Hartelius). What is at stake in the portrayal of physicians in the series is not this isolated, autonomous vision of expertise as autonomous knowledge possession, but the exercise of authority—presumably based on superior knowledge—by these "expert" physicians. Since authority is a social relationship, to fully understand its portrayal we must consider not just the representation of the physician her/himself, but also the portrayal of the patient and her/his roles and responsibilities in that relationship.

Shifts in public culture have had as much, if not more, impact on the understanding of patient agency as on physician expertise. The second half of the 20<sup>th</sup> century saw the establishment and proliferation of patient advocacy groups, which often pushed for greater rights and respect for populations historically marginalized by medical practitioners.

Women, disabled persons, persons with mental health diagnoses, and subjects of medical research built on the successes of the civil rights movement to demand a “generalization of rights” both *to* competent health care and *within* the realm of health care (Starr 388). Specifically, such groups advocated for greater accountability and transparency within the physician/patient relationship. They argued that physicians should have to obtain a patient’s informed consent prior to performing any medical procedure, that patients should have access to their own medical records, should participate in treatment decisions, and should have the right to refuse treatment (Starr).

Even as such visions of patient rights in health care became widely accepted within public culture, neoliberal political change diverted attention away from one half of the twinned claims made by many patient advocacy groups, namely the right *to* health care. Indeed, as the twentieth century came to a close, medicine had moved from an institution with a strong social concern (seen in a focus on public or population level health interventions) to a highly atomized practice in which all the responsibility for health care fell on the individual patient. This shift mirrors the advent of a neoliberal politics of self-maximization, in which the individual is ultimately responsible for doing everything possible to ensure her/his own health (Rose). This notion of self-maximization matches precisely with what Ouellette and Hay note is reality TV’s conception of the viewer as “an individual whose most pressing obligation to society is to empower her or himself privately” (3). In the case of medicine specifically, Fuqua contends that “Through television and its many ways of addressing us as potential patients . . . we learn to think of ourselves as active agents in caring for ourselves. We learn to regard this care as, first and foremost, *our* responsibility—a responsibility to be performed by self-monitoring, self-regulating neoliberal citizens” (Fuqua 3).

In some ways, the patients of *Mystery Diagnosis* fit in well and reinforce this neoliberal vision of self-care. Many episodes feature scenes in which the patients express their valuation of individual agency and self-advocacy as advice to others facing serious illness. After her five-year quest for a diagnosis, one young woman looks at the camera and says, “you should be proactive in finding answers for your own health” (“The Girl Who Couldn’t Wake Up”). Another woman who says she felt “betrayed by all the other doctors” advises the viewers that “advocating for your care is the number one important thing you can do for your health” (“The Woman with a Knife in Her Head”). Encapsulating both the neoliberal logic of self-care and the experience/rationality contrast, another young woman who had her symptoms dismissed by doctors for years ends her story by saying, “If you think there is something wrong with you, no matter how crazy you think you are and other people think you are, you’re most likely right on track and keep pushing until you get the answers you need” (“Why is Emily Screaming?”).

In addition to urging perseverance and self-reliance, some of the narratives explicitly highlight the need to not blindly accept the authority of an initial diagnosing physician. One mother, whose daughter underwent surgery without being given all the information by her doctors, says bluntly, “The doctor lied to us” (“The Woman with Unusual DNA”). Her daughter, now grown, echoes with, “I felt betrayed by the doctors” (“The Woman with Unusual DNA”). An older, white male patient who lived with a misdiagnosis for eight years says to the viewers, “I would certainly urge everyone, regardless of the faith they have in

their physician, regardless of the qualifications of their physician, to seek a second or even a third opinion certainly. Especially if it is something unusual” (“The Purple Puzzle”).

Though seemingly fitting with contemporary challenges to medical authority, what these examples highlight is the ultimately conservative vision of physician authority present in the program. That is, while the show does challenge blind faith in medical authority and promote the idea of individual patient agency as the key driver of health and medical care, the narrative of the show ultimately ends up reinscribing physicians—even if only a few of them qualify—as the singular repositories of medical knowledge, expertise, and authority. None of these patients, and indeed, no one in the ten seasons of the program, ever urges viewers to move outside of the realm of traditional Western bio-medicine. In a very few cases, the patients may seek relief in alternative therapies or dietary supplements, but in every episode the ultimate authority for diagnosing and then treating the medical condition lies with a physician.

In his study of American attitudes towards physicians, Imber argues that “health may not be the exclusive domain of medicine, but medicine is still held accountable for diagnosing and treating disease” (306). While this may seem in contrast to the rise of patient autonomy, Fuqua notes that the contradiction between physician authority and patient agency is often inherent in the intersections of television and medicine. This type of reality TV in particular “promote[s] a vision of consumer-patient autonomy that is, nevertheless, reliant on others . . . for health” (3).

Imber argues that the complexity of modern understandings of disease and the technological processes of diagnosis have undermined the “charismatic authority” of our physicians, replacing it with “diagnostic and prognostic” technologies that generate uncertainty, rather than trust (306). In *Mystery Diagnosis*, however, the narratives initially position physicians as nameless, faceless, clueless, and even sometimes vicious, only to restore the personal and almost mystical authority of the physician in the end of each story. Such authority arises, not from the advent of a new test or new technology, but from the unique personal insight of the truly expert physician.

In many of the episodes the diagnosing physician is able to solve the mystery by simply seeing the patient or reading her/his file. For example, one diagnosing physician explains, “When I first met Allie, I immediately thought that she had a metabolic disorder” (“The Girl Who Fell to Pieces”). Another doctor notes that, upon meeting the girl in the episode, “I had a strong suspicion as to what her diagnosis was” (“The Girl Who Couldn’t Wake Up”). Upon finally finding the right expert after two years of misdiagnosis, one patient observes, “Within 30 seconds, Dr. Jaffer immediately knew what my problem was” (“The Man Covered in Boils”). Another girl who had gone to numerous specialists and had begun to “question [her] sanity” described her initial consultation with her diagnosing physician, who told her, “I think I know what you have” (“The Man Covered in Boils”). A particularly dramatic episode follows one family who had for four years been seeing numerous doctors at a specialized clinic to treat their son for Melnick Needles syndrome. When the family sees a new geneticist in the practice, the doctor takes one look at their son’s records and says that he does not fit the criteria for Melnick Needles at all. None of the other physicians seeing the child every few months ever even noticed what is presented as a glaring

disconnect between the boy's diagnosis and his symptom presentation ("The Boy Who Could Break").

In each of these cases, as in the other episodes, the diagnosing physicians do run tests, but the narrator often categorizes them as "confirming" what the doctors already knew or suspected. Thus, *Mystery Diagnosis* frames the process of diagnosis as a personal process usually working at the level of the whole patient. This marks a return to the idea of the charismatic and brilliant physician as hero, rather than an acceptance of a model of medicine based primarily on empirical data and specialized testing. The series thus reinscribes the doctor as a worthy authority who exercises what Hartelius describes as the "artistic aspect of expertise," the performative enactment of the expert's "position, knowledge, and experience in a public manner" (9, 10). The physician here is "performing" his/her authority through the recognition and naming of the correct diagnosis.

Even episodes which require longer or more extensive consultations with the diagnosing experts reinforce or explicitly reference this model of medical authority. For example, in one case that eventually led to a diagnosis of adult-onset Still's disease, a rheumatologist muses on the diagnostic process:

And so, it really takes us back to the beginning of medicine, which is [where] the story that a person tells and their signs and symptoms are the hallmarks of the diagnosis that we have to rely on. Sir William Osler . . . was one of the great physicians. He once said, 'it is more important to know the patient who has the disease than the disease the patient has.' ("Frenetic Genetics")

Here the physician explicitly references a return to the physician-centered, rather than test-centered, model of medical practice. The nature of the doctor as expert authority depends on her/his ability to embody this directive to "know" the patient and thus "know" her disease.

The performative vision of medical expertise is reinforced in multiple ways in each episode. Unlike the patients and their families whose interviews are exclusively shot in a studio with a solid colored background, shots of the physician are often placed in a hospital or medical office setting, thus showing him/her enacting their medical role. Additionally, after each diagnosis, the series includes a moment when the narrator notes that, while the patient and her family are relieved to "finally" have an answer, they "can't help but wonder why it took so long" to get that diagnosis. This statement is always followed by an interview clip with the diagnosing physician who remarks on the rarity of the condition in question (and, at times, other factors that may have complicated the diagnosis). The physician's acknowledgement of the condition's rarity does not actually excuse or explain the earlier physicians' failures so much as it reinforces the performative expertise of the diagnosing physician. The failures of all the other doctors create the grounds on which the diagnosing physician can display legitimate authority. The ability to recognize and to name rare conditions is thus the performative *sine qua non* of medical authority.

Kenneth Burke emphasizes that the act of naming is always a "creative" act, an act which by the speaking of the word creates "something" from the nothing that preceded it.

Prior to the speaking of the name by the diagnosing physician, the patient is merely a person with a collection of symptoms. The naming makes the patient legible within the health care world and mobilizes an array of institutional and cultural forces from proper treatments to support groups. In each episode, once the condition is named, this new legibility is represented for the audience via a graphic of a diagnostic text book with the entry for the named condition highlighted—we can literally “read” about their condition. The naming also allows for the expression of relief by the patient and/or the family—even in cases where the diagnosis is for a condition without effective treatments or cures. While such relief might initially be puzzling, especially given the serious nature of many of the diagnosed conditions, I argue that it is actually this achievement of legibility—the establishment of the patient as a recognizable subject—that explains such an emotion. It is not relief simply based on knowing the condition’s name, but relief in finally occupying a known, secure, place in a now once again coherent medical system. As the mother of the child misdiagnosed with Melnick Needles explains after receiving their new “correct” diagnosis of Hajdu-Cheney Syndrome, “It was very satisfying to know that we actually have a diagnosis that there is no doubt about” (“The Boy Who Could Break”).

### **The Limits of Patient Agency**

The conservative reinscription of physician authority also has implications for the possibilities of patient agency and self-care depicted in the series. Initially, the patients seem to be the ideal neoliberal subjects of medicine. The vast majority of them are white and heterosexual and seem to be living middle-class lifestyles. This is perhaps not surprising given both the range of persons represented on television generally and the populations most affected by shifts in contemporary visions of patient rights and responsibilities. Halpern argues that “segments of the patient population may differ markedly in the degree to which they embrace autonomy and rights” with those who are white, well-educated, and middle-class making up the vast majority of those “most interested in participating in medical decision making” (845). Thus, the patients of *Mystery Diagnosis* fit with and reinforce existing visions of the persons likely to be involved in neoliberal projects of health care consumption.

However, if we look a bit more closely, the patients featured in the series are not actually engaged in the quintessential neoliberal project of self-actualization. Theirs is not a maximization of potential and minimization of risk as discussed by scholars such as Rabinow, Novas, or Rose. They are not “biological citizens” or “somatic individuals” working with newly available knowledge of the self to take responsibility for minimizing their health risks (by getting the right tests, consuming the proper supplements, etc.). Rather, these patients are purely reactionary. Their conditions and their symptoms happen *to* them, without any individual actions taken to contribute to or to minimize their risk. The continual marking of symptoms as “surprising” and “shocking” underscores that these are not patients actively influencing their own health. In these stories, determination and advocacy are not used to improve themselves, but only to respond to their seemingly impossible situations.

Thus, the role of the patient in *Mystery Diagnosis* is radically circumscribed—far more so than in other depictions of medicine or in other forms of reality TV. While the program invites its viewers to guess the conditions and to see themselves as more

perceptive than many medical professionals, the patients themselves are only superior to others in their determination and refusal to give up in the face of frustration.

Additionally, unlike other reality TV programs focused on makeovers, weight loss, or lifestyle advice, *Mystery Diagnosis* does not generate any specific recommendations that are likely to apply to the majority of viewers. The final appeals of some patients to the viewers urging them to advocate for their own care and to trust themselves are more general ideological positions without any specific guidance on how to accomplish these goals (nothing to buy and no specific script to follow to find the right physician). Thus, *Mystery Diagnosis* cannot be seen to fully participate as a cultural technology for “self-actualization” in the same way other programs may do so. It is not, as Ouellette and Hay propose, providing us with “a resource for acquiring and applying practical knowledges and skills” (14). While it does present patients as responsible for their own health, that responsibility is not equated self-reliance—as they remain dependent, even for their legibility as subjects within the medical realm, on the charismatic physician expert.

This contradiction can also be seen in the presentation (or lack thereof) of the economics of health care in the series. Neoliberal models of health position patients as consumers, seeking out the best value for their health care dollars, yet the economics of health care are nearly completely absent within the series. The patients in *Mystery Diagnosis* consume a truly impressive array of medical resources, from numerous prescription medications, to repeated CT and MRI scans, to countless laboratory tests, but the patients themselves are not seen as responsible for choosing to do so and the show includes no mention of how the patients pay for any of it. Fuqua notes that health care consumerism is not readily reduced to understandings of “shopping,” or other “leisure-based” models of consumption, but that it shares with such models an underlying idea that “there is a desired outcome or reason for us to purchase the product” (10). That is to say, when we see ourselves as health care consumers, our primary motivation is self-care or improvement. The patients’ lack of agency in this pattern of consumption, the absence of any sense that the resources used are paid for, and the ways in which these resources are seen to completely fail the patient diagnostically, all contribute to a sense that the patients are not engaged in the neoliberal practices of savvy health care consumerism.

## Conclusions

The impacts of reality TV, like any other form of popular media, cannot be understood in a simple cause/effect relationship. Audiences of programs like *Mystery Diagnosis* are certainly aware that the stories presented have been selected by producers as fitting the model of the series (long quest, unusual symptoms, ultimately successful diagnosis, etc.). However, the presentation of patient agency and authority presented in the series does contribute to viewers’ cultural understandings of health and medicine in our contemporary world.

*Mystery Diagnosis* presents a complex and contradictory vision of medical authority and patient agency. On the one hand, physicians, particularly general practitioners, pediatricians, and ER doctors are subject to harsh judgments of clinical incompetence and/or personal indifference. At the same time, medicine is reified as the sole bearer of diagnostic

authority, with a romantic vision of the “good” doctors as those who can see past the tests to the health of the whole person. Similarly, the view of patients is conflicted, in some ways consistent with the self-reliant, enterprising neoliberal subject while simultaneously restricting patients to a reactionary role in their health. Unable to make choices to make their lives and health better, these patients can only exercise their agency in their continuation of their quests to find the right physician.

## Works Cited

- “A Deadly Cough.” *Mystery Diagnosis*. Discovery Health. Produced by True Entertainment. 8 June 2008. Television.
- “The Boy Who Bit Himself.” *Mystery Diagnosis*. Discovery Health. Produced by True Entertainment. 23 March 2009.
- “The Boy Who Could Break.” *Mystery Diagnosis*. Discovery Health. Produced by True Entertainment. 30 March 2009.
- Burke, Kenneth. *The Philosophy of Literary Form*. Oakland: University of California Press. 1974. Print.
- “Frenetic Genetics” *Mystery Diagnosis*. Discovery Health. Produced by True Entertainment. 27 August 2007. Television.
- Friedman, Lester D. “Introduction: Through the Looking Glass: Medical Culture and the Media.” *Cultural Sutures: Medicine and Media*. Ed. Lester D. Friedman. Durham: Duke UP. 2004. 1-11. Print.
- Fuqua, Joy V. *Prescription TV: Therapeutic Discourse in the Hospital and at Home*. Durham: Duke UP. 2012. Print.
- “The Girl Who Couldn’t Wake Up.” *Mystery Diagnosis*. Discovery Health. Produced by True Entertainment. 15 December 2008.
- “The Girl Who Fell Apart.” *Mystery Diagnosis*. Discovery Health. Produced by True Entertainment. 20 April 2009.
- “The Girl Who Fell to Pieces.” *Mystery Diagnosis*. Discovery Health. Produced by True Entertainment. 27 April 2009.
- Halpern, Sydney A. “Medical Authority and the Culture of Rights.” *Journal of Health Politics, Policy and Law*. 29.4-5 (2004). 835-52. *Project Muse*. Web. 17 June 2014.
- Hartelius, Johanna E. *The Rhetoric of Expertise*. Lanham: Lexington Books. 2011. Print.

- Haug, Marie. "Deprofessionalization: An Alternative Hypothesis for the Future." *Sociological Review Monograph*. 20. (1973). 195-211. Print.
- Imber, Jonathon B. "Doctor No Longer Knows Best: Changing American Attitudes Toward Medicine and Health." *America at Century's End*. Ed. Alan Wolfe. Berkeley: University of California Press. 1992. *UC Press E-Books Collection*. Web. 17 June 2014.
- "The Man Covered in Boils." *Mystery Diagnosis*. Discovery Health. Produced by True Entertainment. 23 August 2010.
- Novas, Carlos. "The Political Economy of Hope: Patients' Organizations, Science and Biovalue." *Biosocieties* 1. (2006). 289-305. Print.
- Novas, Carlos, and Nikolas Rose. "Genetic Risk and the Birth of the Somatic Individual." *Economy and Society* 29 (4). (2002). 485-513. Print.
- Ouellette, Laurie, and James Hay. *Better Living Through Reality TV*. Malden: Blackwell Publishing. 2008. Print.
- Pescosolido, Bernice, Steven Tuch, and Jack Martin. "The Profession of Medicine and the Public: Examining Americans' Changing Confidence in Physician Authority from the Beginning of the 'Health Care Crisis' to the Era of Health Care Reform." *Journal of Health and Social Behavior*. 42. (2001). 1-16. *JStor*. Web. 17 June 2014.
- "The Purple Puzzle." *Mystery Diagnosis*. Discovery Health. Produced by True Entertainment. 10 December 2007.
- Rabinow, Paul. "Artificiality and Enlightenment: From Sociobiology to Biosociality." *Essays on the Anthropology of Reason*. Princeton: Princeton UP. 1996. Print.
- Rose, Nikolas. *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton: Princeton UP. 2007. Print.
- Rose, Nikolas, and Carlos Novas "Biological Citizenship," *Global Anthropology*. Eds. Aihwa Ong and Stephen Collier. Oxford: Blackwell, 2003. Web. 2 June 2009.
- Schlesinger, Mark. "A Loss of Faith: The Sources of Reduced Political Legitimacy for the American Medical Profession." *Milbank Quarterly*. 80. (2002). 185-235. *Wiley Online Library*. Web. 22 June 2014.
- Starr, Paul. *The Social Transformation of American Medicine*. New York: Basic Books, Inc. 1982. Print.
- "The Woman with the Knife in Her Head." *Mystery Diagnosis*. Discovery Health. Produced by True Entertainment. 14 April 2008.

“The Woman with Unusual DNA.” *Mystery Diagnosis*. Discovery Health. Produced by True Entertainment. 20 September 2008.

“Why is Emily Screaming?” *Mystery Diagnosis*. Discovery Health. Produced by True Entertainment. April 11, 2005.

### **Suggested Citation**

Silva, Vesta T. “Medical Mysteries that Defied the Experts: Physician Authority and Patient Responsibility in TV’s *Mystery Diagnosis*.” *Trespassing Journal: an online journal of trespassing art, science, and philosophy* 4 (Fall 2014). Web. ISSN: 2147-2734

**Vesta T. Silva** is an Associate Professor and the Department Chair of Communication Arts at Allegheny College. Her work focuses on representations of health and medicine in popular culture in the contemporary United States.