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Abstract
Using the example of ‘Machines for Living’ (8 April 1958) from the BBC’s ‘Your Life in Their Hands’ series, I explore doctors’ and patients’ performances on live medical television. The point is to examine how the grammar and technology of live television provided affordances and constraints to the representation of medicine, here the high-tech medicine of dialysis and heart-lung bypass at Leeds General Infirmary. I use several theoretical lenses to focus attention on the participants’ performances, including work by Erving Goffman, Richard Schechner, Espen Ytreberg, Judith Butler, and Paddy Scannell. Although the analysis is tightly focussed on a single programme, it is intended to be generally applicable to the analysis of medical, and indeed non-fiction television of all kinds.

Keywords: performance; live television; dialysis; heart-lung bypass; Erving Goffman; Richard Schechner; Espen Ytreberg; Judith Butler; Paddy Scannell

Your Life in Their Hands (YLITH), broadcast from February 1958, was the series that dramatically changed the representation of medicine on British television. The revolutionary character of the series derives from its character as a live outside broadcast, a format that placed a premium on the performances of the on-screen contributors to the programme, the focus of this essay. Its liveness and location required particular kinds of performance that were

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qualitatively different from those asked of participants in films. *Machinery for Living*, broadcast by the British Broadcasting Corporation (BBC) on 8 April 1958 from Leeds General Infirmary (LGI), the ninth programme in the first series, was concerned with the new medical technologies of renal dialysis and heart-lung bypass for cardiac surgery. The programme starts with an introduction from a London studio by ‘a physician in the Department of Medicine in a London hospital’. This is followed, within the programme’s 30-minute duration, by three main sections broadcast from Leeds, each led by a member of medical staff from the LGI: an introduction about the hospital, a sequence on the artificial kidney, and another on cardiac surgery using the Melrose heart-lung machine. The latter two main sections feature interviews with patients. The programme anchor closes the proceedings with general concluding comments.

By 1958, medicine was already a staple of non-fiction television, part of the roster of serious subjects the BBC considered worthy of coverage, which otherwise included, for example, politics, religion, the arts, science, and current affairs. In selecting the subjects to treat in its output, staff at the BBC also responded to the demands of interest groups. This was the decade in which, for various groups, including doctors, television began to seem to be the best medium to represent many subjects, on account of the audience that could be reached. Professions differed in their pursuit of representation in the medium. The pattern of medical participation in this particular programme was typical of the unevenness of responses of scientists and doctors to television; some embraced it and others rejected it. In the case of medical doctors, as represented by the British Medical Association, their brush with television over this particular series helped define a new approach that, ultimately, brought them closer to the medium, as Kelly Loughlin has shown. At the heart of that dispute were issues of professional confidentiality and the sacredness of the doctor-patient relationship, both tied up with an ethical objection to any activity that could be seen as advertising. In this series, these were treated by giving the doctors anonymity, though not the patients, as we shall see.

Those in charge of non-fiction television in the 1950s were in a crucible of expansion, serving the increase of viewers, seeking to develop new and compelling genres of broadcasting to convey these subjects, approaches that responded to the particular characteristics of the medium. In particular,
they focussed on the fact that virtually everything that was broadcast in that decade was live; so they made a fetish of the simultaneity of the medium. With *YLITH*, we see one of those interactions between available broadcasting technology, subject, and televisual form that is so distinctive of the development of the medium. From the mid 1950s, the BBC’s Outside Broadcast Department began to make its own programmes, rather than just providing a service to other departments. Producers were encouraged to develop new types of outside broadcast (OB) programmes, partially because the quantity of OB equipment in the regions had been increased so that the BBC could better cover sports matches; as these mainly took place at weekends, equipment was underused on weekdays. The department began to concentrate on ‘built OB’ programmes, as participants named them; OB that did not merely transmit existing events—such as the Coronation—into peoples’ homes, but that used real venues as television studios for programmes that reported activities authentic to the chosen site. The OB producers Aubrey Singer, with his science series *Eye on Research*, and Bill Duncalf, with *YLITH*, seized this opportunity, taking cameras into labs and hospitals, respectively. For *YLITH*, that meant a live broadcast from a different regional hospital for each week of the series.

Norman Swallow, a senior television producer, expressed the excitement of live television in his 1966 primer *Factual Television*:

> The viewer is watching something which is truly taking place at the very moment of transmission, and no one really knows what will happen. The tension which such a situation produces in the audience is something that was once regarded as one of television’s greatest assets, and to pre-record a programme (and thereby eliminate anything that departs from an arranged plan) is to throw this enormous advantage out of the window.

He went on more specifically to comment on cameras watching ‘surgeons at work, performing a real operation on a genuine patient’. His view was that ‘to transmit such a sequence live is infinitely more effective than to pre-record it, for there is always an added sense of occasion in being present

4 Recording was difficult until videotape recording became widespread, which did not occur before the end of the 1950s. ‘Telerecording’—filming from monitors—was problematic, and making programmes on film prior to broadcast was expensive.

5 In 1954, for the first time, the department was listed as a production rather than a facilities department. See BBC Staff Lists (available at BBC Written Archives Centre, Caversham).

6 For *Eye on Research*, see Boon, ‘Formal Conventions’.

when something dramatic is actually happening. To be allowed to watch something which took place yesterday or last week is a poor substitute’.8 This is the technological ‘script’, if you like—the constraint and affordance of available broadcasting technology.9

For the argument here, it is important to understand the particular ‘grammar’ of live television and how that relates to the programme’s subject. First, we should note that live television (TV) linked on-screen performers to viewers in a simultaneous form, with no opportunity for second takes to produce better results. Second, whereas in film-making sequences are constructed at the editing bench after the event from multiple shots, in live TV, the structure of the programmes is made by a director working at the time of transmission, instructing a vision mixer to cut between the signals coming from two or more cameras. TV cameras in the late 1950s were large and had to be wheeled around (‘tracked’) to change shots (and they did not generally have zoom lenses until somewhat later than 1958). Programme planning featured detailed choreography of where the programme’s participants, as well as the cameras not switched to the broadcast output, would need to move to be able to supply the programme’s next shot. Within this grammar, certain conventions were already well established by the late 1950s; for example, one camera might hold a medium close-up on an individual, whereas another might be a ‘two-shot’ including, perhaps, an interviewer and an interviewee. Cameras would often alternate, guided by headphone-instructions from the director, between ‘wide shots’, close-ups, and shots of visual material, including, in our programme’s case, several animated diagrams constructed by the specialist prop-maker Alfred Wurmser (Figure 1.1).10 These intricate devices, for which there seems to have been only one supplier, were cardboard models with moving parts, operated by their maker during the programme, often with a handheld pen pointing out salient details, to illustrate the words of the speaker.

Part of the language of live TV, especially before the widespread use of videotape (which became commonplace in the 1960s), was the incorporation of pre-prepared sequences shot and edited on film, and played in using a telecine machine at the appropriate moment. Producers saw these as part of

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8 Swallow, Factual Television, p. 148.
9 Akrich, ‘De-Scription’.
10 The diagrams are described as ‘Wurmsers’ in the surviving script, transcribed in Turney, ‘Disease’, pp. 246–251. See Neil, ‘Alfred Wurmser’. In a Panorama broadcast in 1956, there is a sequence showing Wurmser and one of his diagrams: http://youtu.be/2G36AaMDFdM?t=6m36s, accessed 5 February 2018.
the interpretive armoury of live television, not in any way as a failure of live technique; often, these would show outside scenes, or detailed explanatory sequences that had to be filmed and edited before the programme.

All these aspects were common to studio and outside broadcast programmes, but the latter had extra complications because they were staged at venues that might only have very constricted spaces for presentation, discussion, and camera movement. Unreliability of equipment, much of which, at that time, relied on valves rather than the more reliable transistors, could also be a factor; it was not unusual for a programme planned to use three cameras in different parts of the OB location to have to make do with two.

This analysis is concerned with the performances of human participants in the selected programme, on the argument that what doctors, patients, directors, cameramen, vision mixers, and the rest actually did in the making of the programme constitute its communicative enterprise. My aim is to follow the ‘performative turn’ to establish a kind and level of analysis that can be tested and extended.11 To be sure, usage of the term

11 See, for example, Licoppe, ‘Performative Turn’.
'perform' has been very broad and various indeed, extending as wide as Annemarie Mol’s suggestion within Actor Network Theory that we can think of ‘a reality that is done and enacted rather than observed’. In this essay, using a selection of the performance literature most relevant to my subject matter, I draw on work on performance from sociology, and theatre, literature, and gender studies that has long been influential, but which has, up to now, had little impact on our understanding of medical and science television. Erving Goffman’s sociology of the presentation of self in everyday life deployed a swathe of theatrical metaphors to describe the performed nature of everyday interactions. Richard Schechner, anthropologist and theoretician of theatre, focussed more on the nature of deliberate performances, including the relations between the performer and the part performed. The literature scholar Stephen Greenblatt historicized early-modern ‘self-fashioning’. Judith Butler, coming from an entirely different background in philosophy, has argued that gender is the product of iterative performances in a discursive sense. Each of these approaches is considered below as a means to interrogate and highlight what the doctors and patients are actually doing in this programme. I do not assume that ‘performance’ has the same meaning in each of these analyses; rather, my aim is to reveal their potency in interrogating what goes on in television.

The Performance of Machinery for Living

In commencing our analysis, the most basic point is to acknowledge the particularity and constructedness of the account of high-tech medicine Machinery for Living presents. Beyond noting and recovering the enacted and spatial performances of camera operators, vision mixers, and directors, there is much to be explored about the on-screen performances within this particular programme. Machinery for Living consists very substantially of a series of appearances on camera of speaking individuals, mainly men, of differing professional and class statuses. The televsional grammar of the time (whose basic features I have summarized above) required people to do things on-screen so that content could be conveyed; I am defining these actions as performances. A simple but telling example of this basic point is provided by the programme’s second sequence, the continuity shot that Ray Lakeland, the director in Leeds, had at the switchover from the

anchorman in the London studio to the Outside Broadcast action at the hospital (Figure 1.2):

A hospital porter walks down a hospital corridor pushing a wheeled stretcher past and away from the camera. A nurse emerges from a side turning and walks towards the camera, which ‘tracks back’ keeping her in vision and turning to the right to look in as she enters a room; in the room we see a professor sitting at a desk. The vision mixer switches to a second camera that holds him in medium close up.

The shot does the work of reinforcing that this is an OB from a hospital, establishing the medical space of the programme, with visual cues such as the hospital architecture and staff uniforms as key signifiers. But we should note that the porter and nurse did not just happen to be in the line of sight of the cameras shortly after half past nine that evening, and it is no coincidence that the professor was sitting there; all were asked to perform these actions by the director to enable a televisual move between the anchorman’s introduction, and the professor’s setting of the scene in Leeds. In other words, real people in television are asked to play versions of themselves for the sake of, and within the constraints of, televisual narrative and technique. Medical staff are ‘playing doctor’, and their subjects are, equally, ‘playing the patient’. Furthermore, the pressures of live television force different kinds of performance than those in film, in part because of the lack of opportunity to re-take to perfect the contribution, and in part because of the director’s requirement to
deliver consecutive performances, often amounting to 30 minutes in total length.

Recognizing these appearances as performances is not simply post hoc theorization, as is clear from contemporary discussion. The British Medical Journal, in pouring scorn on YLITH, found fault with the necessity for performance:

Though the anonymity of the doctors is being preserved—for what that is worth in this publicity-seeking age—their colleagues may well think it is demeaning for doctors and nurses to appear as mummers on the television screen in order to provide entertainment for the great British public.13

The pejorative use of the term ‘mummer’ to describe the activities of the medical figures on-screen is potent: It is clear that contemporaries knew that appearing on television required non-actors to provide a performance fitting to the medium.14

Equally, the use of the term ‘performance’ is a commonplace of production correspondence between programme makers and participants; for example, James McCloy wrote to the neurologist William Grey Walter in May 1957 after the programme A Question of Science that ‘I would like to thank you for the sympathetic way you adapted yourself to the situation and for the authoritative performance you gave’.15

Paddy Scannell summarizes the ways in which camerawork conventions go beyond establishing a spatial sense of the venue (here, the LGI) to enable the viewer to locate the participants in relation to each other and to themselves:

TV camera angles and movements clearly generate implicatures [implied meanings]—about, for instance, the status of the relationship between speaker(s) in the studio and viewers in their homes. The camera monitors the faces of speakers and hearers in displayed television talk for corroborative evidence of participants’ personality, state of mind and alignment (or otherwise) with what’s going on. In this the camera behaves as we all do in what Erving Goffman calls ‘face engagements’ and acts, on our behalf, to produce effects of co-presence.16

13 ‘Disease Education by the B.B.C.;’ p. 388, emphasis added.
14 A point which Karpf, Doctoring the Media, p. 51 also mentions.
15 James McCloy to William Grey Walter, 1 May 1957, TVART1 William Grey Walter, BBC Written Archives Centre, Caversham, pp. 57–65, here p. 60.
By such techniques, television directors enable talk to do its work of conveying content. As Scannell argues, ‘[t]he talk that goes out on radio and television is recognizably [...] intended for and addressed to actual listeners and viewers’.17 Citing Barthes, he argues that ‘the grain of the voice gives rise to inferences about the speaker, and changes in voice are an important means of creating implicatures. Voice is the irreducible mark of the spoken, of its physical, embodied presence’.18 Unlike other televisual and filmic formats where off-screen commentary was favoured, in live TV such as *YLITH*, the requirement for talk to convey content also entailed the presence of people on-screen to do the talking—a visual as well as an aural presence. These televisual performances therefore necessarily feature ‘the age, appearance, sex and dress of participants; the manner and style of how they talk to each other’. All of these reinforce the constructed reality of the programme; they ‘give rise to warrantable inferences about the nature of the event there taking place, the character and status of the participants and the relationship of event and participants to viewers or listeners’.19

**Playing the Doctor**

To move from generalities to specifics, there are three kinds of human performance within *Machinery for Living*: by the ‘physician in the Department of Medicine in a London hospital’, Dr. Charles Fletcher,20 who was the ‘anchorman’ for the series; by the medical staff (all unnamed in the programme; see below), including Sir Ronald Tunbridge (Professor of Medicine at Leeds),21 Dr. Frank Parsons (the leading dialysis doctor based at the Infirmary), the lecturer in medicine, Dr. Brian McCracken, and the cardiothoracic surgeon Geoffrey Wooler;22 and by the four patients who appear in the programme, Mr. Gudor, ‘Delice’, Mrs. Mitchell, and Mrs. Lawless.

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17 Scannell, ‘Introduction’, p. 1. Similarly, Ytreberg, ‘Ideal Types’, p. 760: in media studies, researchers ‘have shown how the self-presentation and social interactions of persons in the broadcast media involves certain standardized behaviours appropriate to communicating with an absent party’.
20 Booth, ‘Obituary’.
22 All identified by Turney, ‘Disease’, pp. 192–232.
Let us begin with Fletcher’s performance. After the opening titles and signature music against a shot of a nurse filling a syringe, the vision mixer switches to a medium close-up of Fletcher seated at a desk, dressed in a white coat open to reveal a shirt and tie and waistcoat implying a three-piece suit. A bookcase is just visible to the left and a painting to the right, suggesting—according to an old iconography—the learned physician. Christopher Booth’s obituary suggests that ‘[t]all and distinguished in appearance, and with thespian qualities, Charles Fletcher was perhaps a natural choice for television’. As Fletcher speaks directly to the camera, probably from cue cards, about the importance of medical teamwork, then introduces the ‘two beautiful mechanical devices’ that are to be the topic of the programme, the camera technique underscores his authority by tracking into a close-up, only tracking out again to enable him to appear very briefly on a second camera in a two-shot with a monitor showing the outside broadcast feed from Leeds (Figure 1.3).

The emerging grammar of non-fiction live television often entailed the use of anchormen, the role that Fletcher fulfils here. Paul Fox, editor of the current affairs programme *Panorama*, explained around this time that:

> [T]he personal contact between the programme and its audience is vital, and I am equally sure that the best way to establish the proper kind of contact is by means of a visible personality, someone who has down the years become something of a family friend, a regular visitor to the sitting room, a man whose words are respected and whose very presence has become (and I doubt I rate it too highly) a guarantee of integrity and common sense.\(^\text{25}\)

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23 ‘There were a number of pictorial conventions for representing a man who thought. Setting was one: a study-like environment, the possession of books and so on’; Jordanova, *Defining Features*, p. 41. See also Lawrence, ‘Medical Minds’.

24 Booth, ‘Obituary’.

25 Quoted in Swallow, *Factual Television*, p. 63, who gives no further citation.
Fletcher’s televisual familiarity was already established, as he had appeared (even if, again, anonymously) in the 1957 psychiatry series *The Hurt Mind*.\(^{26}\) Fox’s language of respect, integrity, and common sense, encoded in Fletcher’s introductory sequence, amounts to a core set of characteristics of expert performance, often linked to authority, as Espen Ytreberg, in a valuable 2002 analysis, argues:

> [For broadcasters,] an important means of communicating [...] public legitimacy is through persons of authority. Among other things, broadcasting is about converting institutional legitimacy into conventions of self-presentation, focused particularly round functions like hosting and anchoring.\(^{27}\)

For the producers of *YLITH*, it was important that the anchor be identified as coming from a relevant professional background, in this case medicine, unlike the cases of *Panorama* or *Monitor*, for example, where television people—respectively Richard Dimbleby and Huw Wheldon—fulfilled this function.\(^{28}\) Ytreberg refers to ‘the dictates of professional codes such as those of established journalism, which converts a need for trustworthiness and solidity into a measure of restraint and neutrality in self-presentation’. This, in turn, is converted into performance tropes: ‘speech, other sound production, mimicry and gesticulation are all subject to a certain rule-bound conventionalization in broadcast media’.\(^{29}\) Just as, in Ytreberg’s account, the professional codes of journalism are significant to the establishment of the ideal types of television performance, so it is clear that other kinds of period-specific professional code associated with the medical profession—and with patienthood—were essential to the kinds of medical performance found in our 1958 programme. The social conventions and expectations of the participants in this programme, as in others, framed the conditions of possibility for the representation of medical practice it contains. John Turney has summarized the constraints that medical participants placed on their involvement in the series:

> The programmes were carefully structured to allay professional concerns and, in particular, to avoid any adverse effect on the doctor-patient

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\(^{26}\) This programme is discussed in Long, *Destigmatising*, Chapter 6.

\(^{27}\) Ytreberg, ‘Ideal Types’, p. 759.

\(^{28}\) Similar assumptions about the importance of having a scientist-anchorman for *Horizon* preoccupied a closely related set of producers five years later; see Boon, ‘Televising of Science’.

\(^{29}\) Ytreberg, ‘Ideal Types’, p. 760.
relationship. Thus: doctors appearing in the programmes were not named; reference to diseases was kept to the minimum necessary for an understanding of the treatments shown; descriptions of symptoms that might give rise to anxiety were avoided; the availability of other treatments or that treatments were not necessarily suitable for all was acknowledged.  

These constraints set the terms of the doctors’ performances, leading to the same conversion of a ‘need for trustworthiness and solidity into a measure of restraint and neutrality in self-presentation’ in the on-screen performance.

With regard to doctors’ anonymity, the *Radio Times* billing simply stated, as we have seen, that ‘the series is introduced by a physician in the Department of Medicine in a London hospital’, without naming the anchorman Dr. Charles Fletcher, and the programme’s titles include only a generic acknowledgement of the medical staff, who are left unnamed. They list only key television production roles. Despite his being unnamed, with audiences therefore having no way of knowing, for example, that he was educated at the elite private school Eton, the received pronunciation of Fletcher’s voice would immediately have identified him as a member of the upper professional classes.

Tunbridge, introduced by Fletcher as ‘the professor of medicine in the university department of medicine’, sitting at the desk, speaks to the camera, glancing to his left (probably unsure of which camera to address). Behind him in the shot is a miscellany of clinical equipment. He outlines the history of the LGI before proceeding to a description of the human circulatory system, which is illustrated by one of Wurmser’s diagrams. He moves on to introduce the artificial kidney and the artificial heart and lung.

Tunbridge introduces Parsons as ‘the assistant director of the medical research unit in the urological department’. The camera pans right, and Parsons walks into the shot, towards the camera. Sitting down on a stool in front of the dialyser, he explains the ‘complex’ function of kidneys in simple terms. In a lecturing style, and probably reading from cue cards, he briefly delimits his concerns with acute kidney failure; he explains how, in these cases, waste materials can accumulate in the blood. ‘To illustrate this point,
I would like to introduce you to a patient, Mr. Gudor.’ During these words, he stands up, and walks to his right, curling up the microphone lead as he goes, offering his hand in a handshake, the camera following in a pan. They both sit down at the desk, by now vacated by Tunbridge, and begin a short interview. Only at this point is there a vision cut to a second camera showing a one-shot of the patient. The second half of Tunbridge’s exposition and all of Parsons’s explanation has been covered by a single shot, with movements, lasting two minutes and 25 seconds (Figure 1.4). Returning to the right, Parsons explains the function of the machine, once more making use of an animated diagram (shot, again, with a separate camera) and a sample of the cellophane tubing used as the machine’s dialysis membrane. He introduces a ‘doctor from the department of medicine’ (Brian McCracken), who concludes the exposition of the machine’s function, including interviews with Delice, ‘a little girl who was treated on this machine several months ago’ and Mrs. Mitchell, whose dialysis, filmed three weeks before, is shown in two edited film insets that he explicitly introduces. All the medical performances are confident, if varying in ease in their address to camera and in the required movements within the hospital room serving as a temporary studio.

To go a little deeper into the nature of these performances, we can refer to the ‘ideal types’ of television broadcaster that Ytreberg has identified in discourse on television. Although his purpose is to propose a four-fold classification of television broadcaster into paternalists, bureaucrats, charismatics, and avant-gardists, only the middle two terms are helpful to our discussion here. (The last type, marked by eschewing restraint and neutrality, only emerged much later in the 20th century.) But Ytreberg also quickly moves to dismiss the ‘paternalist’ type as ‘[p]art theoretical concept, part analytical tool and part derogatory term’, pointing out that ‘the image of the paternalist has frequently been invoked to characterize
a kind of patronizing elitism’. Instead, he proposes an alternative, ‘the bureaucrat’ type: ‘The traditional figure of the public service programme maker bore a string of resemblances to that of the ideal-typical bureaucrat. Most obviously these programme makers were employed in organizations that had close formal affiliations with the state and were structured according to the principles of state bureaucracies.’ The BBC was evidently one such organization. Ytreberg quotes Richard Sennett to describe the kind of performance involved in fitting this ideal type, exactly as we see and hear from the medical performers in Machinery for Life, arguing that ‘[s]elf-control […] appears as a strength, a strength of calmness and above-the-storm which makes telling others what to do seem natural. […] In reacting to this dominance those in need can come to perceive autonomous figures as authorities’. He suggests that: ‘A restraint of individuality and emotions communicates the power of formalized professional expertise.’

Of the ‘charismatic’ type, who come beyond paternalists and bureaucrats in Ytreberg’s taxonomy, he states:

The broadcasting ‘personality’ exudes a personal charm that functions to soothe and reassure the audience. It produces feelings of intimacy and rapport […]. The audience is invited to believe in what the charismatic says because the charismatic communicates his or her personal belief in it so intensely. […] Its formal qualities have been extensively elaborated; the use of informal modes of speech, the expressive manners, the extensive conversationalization approaching the patterns of everyday, unmediated interaction.

How do the medical doctors’ performances in YLITH relate to this? We witness in Fletcher’s and McCracken’s performances something in common with both the ‘bureaucrat’ and the ‘charismatic’ mode of television appearance, and, with Tunbridge and Parsons, perhaps a more unalloyed ‘bureaucrat’. Scannell’s basic point about dress is pertinent here: Unlike Fletcher, where medical authority is reinforced by his white coat, in the case of the doctors from the hospital, three-piece suits and ties are the order of

34 Ytreberg, ‘Ideal Types’, p. 761.
36 Sennett, Authority, p. 86, quoted in Ytreberg, ‘Ideal Types’, p. 763.
37 Ytreberg, ‘Ideal Types’, p. 763.
the day for their television appearance. We see them in scrubs or lab coats for the film inserts of the dialysis and use of the heart-lung machine. It is as though the medical doctor, garbed as ‘off duty’, is in a position to talk about his practice, whereas, in scrubs, he is limited to enacting medical practice.

In all three cases, we see an intensified version of the performance of self that was described by the sociologist Erving Goffman in his 1959 *Presentation of Self in Everyday Life* using a range of theatrical metaphors to convey the performed nature of interactions in everyday life. In that work, he was concerned with using the language of theatre to demonstrate ‘the constructed nature of identity, the self as a presentation or performance designed to be appropriate to the circumstances and settings in which it is produced in the presence of others’. Speaking of the ‘expression’ of a participant in an encounter and the ‘impression’ received, he also distinguished between an expression given voluntarily, and that ‘given off’ involuntarily. Both are visible in the televisial performances of all the participants in *Machinery for Living*. That is to say that the bearing and relative ease of the differing performances (the impressions ‘given off’) are as significant to the impression received by the viewer as those ‘given’ by the participants’ deliberate and controlled speech, and the choreographed and rehearsed movements within the programme’s improvised studio. Another of Goffman’s distinctions in *The Presentation of Self* is also at play here; as viewers, we experience the ‘front stage’ of the performance, but, at some level, we know also there to be a ‘backstage’ that is not presented to us. As Steven Shapin asserts in his application of Goffman’s *The Presentation of Self* to questions of trust in science, ‘[i]ndividuals present themselves to others as persons of a certain kind, likely to behave in certain ways, and, in so doing, request others actively to accept them as that kind of person. Trust in self-presentation is essential to interaction’.

Richard Schechner, theorist of performance, distinguished his study from Goffman’s as focussing specifically on ‘the doing of an activity by an individual or group largely for the pleasure of another individual or group’. Schechner describes the kinds of transformations that occur in such theatrical performances; most powerfully, he suggests that the performer is both ‘not himself’ (in the sense that he is playing a part) and

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39 Goffman, *Presentation of Self*.
‘not not himself’ (because it is only he who delivers the performance). This describes well the level at which the medical doctors are working in the programme: both authentically performing to deliver content that they are particularly qualified to provide, but within a highly artificial set of conventions that requires a particular style of performance. The medical doctors in the programme can be seen to be performing at these two levels: in the Goffmanian sense of playing the doctor as they might in any off-camera clinical interaction with a patient, and in a Schechnerian performance for the pleasure of, or at least to inform, the distant television viewer.

There is a resonance here with the work on early-modern self-fashioning initiated in 1980 by Stephen Greenblatt. In the sixteenth century, Greenblatt argues, self-fashioning came to be linked to ‘manners or demeanor, particularly that of the elite; it may suggest hypocrisy or deception, an adherence to mere outward ceremony; it suggests representation of one’s nature or intention in speech or actions’. As Peter Burke has argued, Greenblatt’s analysis went beyond Goffman’s assumption that there is a fixed self behind the façade and replaced it with a reconstructed, even invented, self. Richard Kirwan has also developed Greenblatt’s concern with singular figures such as Thomas More and William Shakespeare to incorporate self-fashioning into the analysis of less prominent individuals, in his case, early-modern university scholars:

[Int]individuality was seldom a feature of the more pedestrian self-fashioners [who] sought to advertise their social merits by conforming to the image of a social type or category. In their self-fashioning they followed or imitated the representational models preferred by their peer-group. More than anything they were eager to demonstrate the extent to which they belonged to an elite rather than to mark themselves out as charismatic individuals.

By analogy, this is helpful to our analysis in helping us to distinguish that part of the doctors’ performance in YLITH that specifically conveys membership of a profession, in this case, medicine, and those aspects or cases (perhaps, to an extent, Fletcher’s) that are about creating a more

44 Schechner, Between Theater, p. 6; Gouyon, ‘You Can’t Make’.
45 Greenblatt, Renaissance Self-Fashioning.
46 Greenblatt, Renaissance Self-Fashioning, p. 3.
47 Burke, ‘Representations’.
48 Kirwan, Scholarly Self-Fashioning, p. 9.
49 The notion of self-fashioning has also been deployed in the history of science, notably by Jan Golinski (‘Humphry Davy’) and, more recently, Heather Ellis (Masculinity).
singular individual performance not entirely constrained by membership of the wider group of medical doctors, bordering on the kinds of celebrity that television has particularly enabled.

It is also possible to see these performances in a further ‘performative’ sense that derives from the work of Judith Butler. This study of ‘performativity’ should not be confused with the sociology of Goffman or the anthropologically inflected theatre studies of Schechner, nor yet the new historicism of Greenblatt, as Butler has defined herself as working in a different tradition ‘wandering [...] between literary theory, philosophy, and social theory’.50 Writing in *Theatre Journal*, she comments that ‘[p]hilosophers rarely think about acting in the theatrical sense, but they do have a discourse of “acts” that maintains associative semantic meanings with theories of performance and acting’.51 This discourse, in her work, develops the philosophy of John L. Austin on ‘performative utterances’ into a formulation that performativity is ‘that reiterative power of discourse to produce the phenomena that it regulates and constrains’.52 Austin distinguishes between ‘illocutionary’ speech acts that bring about certain realities, as, for example, when judge-ments are pronounced by a judge, and ‘perlocutionary’ utterances from which effects follow only when certain other kinds of conditions are in place. In relation to the latter, she argues: ‘a politician may claim that “a new day has arrived” but that new day only has a chance of arriving if people take up the utterance and endeavor to make that happen. The utterance alone does not bring about the day, and yet it can set into motion a set of actions that can, under certain felicitous circumstances, bring the day around’.53

With respect to illocutionary utterances, those realities brought into being depend upon a speech act, but the speech act is a reiterated form of discourse, so we would be mistaken to overvalue the subject who speaks. The judge learns what to say, and must speak in codified ways, which means that the codification and ritualization of that discourse precedes and makes possible the subject who speaks.54

51 Butler, ‘Gender Constitution’, p. 519. The *Theatre Journal*, in the same issue, contained an editorial by Sue-Ellen Case (‘Comment’) clarifying its scope: ‘The readership and authorship of articles far exceeds previous disciplinary bounds to include those in anthropology interested in performance, those in art history who work on performance art, and those in the other language departments who work on international theatre.’
If this is true of the illocutionary utterances of the judge, then it must also be true of the formulaic language of differential diagnosis in doctor-patient relations. Furthermore, Butler’s point must also be true of the perlocutionary utterances of the participants in our programme. We may say that the performatively reiterating of a range of perlocutionary speech acts produces the authority of medicine.

Butler most famously developed her analysis, which can be seen to suggest a specific discursive mechanism for social constructionist accounts of reality, as a feminist account of the constitution of gender, especially in the case of women, elaborating Simone de Beauvoir’s statement that ‘one is not born, but, rather, becomes a woman’. Butler’s account applies equally to the constitution of masculinity: it is through repeated perlocutionary utterances that the masculine characteristics that Ytreberg and Sennett align with ‘bureaucrats’—namely restraint, neutrality, ‘self-control’, calmness, and being above-the-storm—are constituted. This can help us understand the account of medical relations encoded in *Machinery for Living*, especially that the authority of medicine in the programme is not only class-based, but also gendered. This perspective enables us to separate the part of the doctors’ performance that was specific to television and that which—where Butler is with Goffman—was an everyday part of the enactment of their professional role. But, whereas, with Goffman, the performances of everyday life are to be understood sociologically within the frame of theatrical performance metaphors, with Butler, we can see that television frames reiterative discursive enactments that are already the embodiment of professional activity, specifically around class, gender, and the tropes of speech and bearing that denote and reproduce medical authority.

We may also use this interpretation to speculate on the sources of the particular kinds of performance that doctors deliver on television as being in the doctor-patient consultation, in the lecture hall of a teaching hospital,

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55 David Armstrong (‘Doctor-Patient Relationship’) has illuminated the potency of differing general practice tropes in his investigation of the patient’s view.
56 Quoted in Butler, ‘Gender Constitution’, p. 519, emphasis in original.
57 Butler’s account follows Simone de Beauvoir’s citation of Merleau-Ponty’s ‘claims that the body is an “historical idea” rather than a “natural species”’ as support to her assertion ‘that “woman”, and by extension, any gender is an historical situation rather than a natural fact’; Butler, ‘Gender Constitution’, p. 520.
58 Here, we see an echo of Steven Shapin’s assertion that ‘a personal identity has to be continually made, and is continually revised and remade, throughout an individual career in contingent social and cultural settings’; Shapin, *Social History of Truth*, p. 127.
in the conference hall of the academic medical specialist, in the gender relations of the home. It would certainly be worth pursuing this point further, but, within the scope of this essay, there is no room.

Playing the Patient

It is significant that the patients—Mr. Gudor, the child Delice, Mrs. Mitchell, and Mrs. Lawless (Figure 1.5)—by contrast with the medical staff, were named in the programme. It is not clear whether these were their real or substituted names. We may suspect that the doctors’ anonymity reinforces their authority, whilst the naming of the patients underlines their lower status as the objects of that authority. The inclusion of real patients on television was highly unusual for the period; their presence on live television was certainly rare, if not exactly unprecedented.59

Patients were present in the programme in two ways: as mute bodies—one undergoing dialysis, the other in a demonstration film of the heart-lung machine ‘as it would be used in an operation’.60 Both had been shot, contrary to Swallow’s description, three weeks in advance so as to be able to feature patients as post-treatment witnesses to their treatment, which is the second way in which the viewer encounters them. The BBC Archive file for this programme is mainly silent on the recruitment of the patients to appear in either way. But there were certainly contingencies relating to the portrayal that affected their representation. Not only did the final programme differ substantially in detail from the script taken to the operating theatre,61 but events on the ground forced changes in the programme: two of the patients whose operations were filmed in March 1958 for this programme died within

59 Anne Karpf mentions that the 1957 psychiatry series The Hurt Mind featured recovered patients; Karpf, Doctoring the Media, p. 50. It’s not clear to me whether this was filmed or live.
60 Tunbridge in a link sequence between the film and the programme’s final interview.
the week, and it was decided that it would be improper to use the footage.\textsuperscript{62} The literal script had to be altered.

In all four of the patient sequences, we witness their performances in the same range of ways that are visible in the doctors’ performances. Let us take the example of the conversation between Dr. Parsons and Mr. Gudor. Parsons's first question—‘How long have you been in this country?’—marks Gudor as an immigrant. Next, he is asked when he first came to the hospital (at which point there is a cut to a medium close-up on him), and whether he remembers much about it. Then with a cut to a two-shot, Parsons explains why it’s unsurprising that Gudor cannot remember; a motorcycle accident had caused skull and pelvis fractures, a concussion, cessation of normal kidney function, and partial paralysis in his right leg. This description of Gudor's medical condition is delivered via a 30-second static two-shot, whilst Gudor listens and looks around, avoiding the camera. In response to a question from Parsons, Gudor replies that he lives in Halifax. Back in two-shot, in a 40-second sequence, Parsons explains Gudor’s transfer after six days to the LGI. ‘By this time, his waste materials in his blood had accumulated to extremely dangerous levels, and we were able to remove these from his blood by means of the artificial kidney.’ Gudor is asked how he feels now, whether he can get about, about his paralyzed leg, whether he has been discharged from the hospital in Halifax, and whether he is receiving any further treatment. He is held in a medium close-up whilst he answers the questions briefly. The interview closes with Parsons getting up, saying: ‘It’s very kind of you to come along tonight and to see you looking so well.’ Throughout, though Gudor is the most assertive of the patients featured, it is Parsons who describes his condition and the treatments; Gudor is constrained by the format, reproducing the medical social reality of 1958, to listen whilst he is described, and to give brief, deferential answers to questions about the more prosaic aspects of the aftermath of his accident.

Similar patterns of deference are seen with Delice, Mrs. Mitchell (the one patient featured both in the insert film and in the live programme), and Mrs. Lawless. Each has their condition described, whilst sharing the shot with the doctor doing the explaining. Each is asked what they recall and how they now feel. All are deferential to the doctors, the women’s diction and manner is, in each case, shy. Mrs. Lawless had undergone open-heart surgery the previous July; her interviewer is her surgeon, Geoffrey Wooler. Here again, in two-shot, Wooler gives an account of her condition and treatment as the object of his surgical practice: ‘In July 1957 I operated on her using the Melrose heart-lung machine and I was able to improve the function of her mitral valve.’ He asks

\textsuperscript{62} File T14/1,833, BBC Written Archive, Caversham.
her (cut to medium close-up): ‘Now Mrs. Lawless, how ill were you before this operation?’ She hesitates, nervously; he prompts: ‘Were you very ill?’ She answers that she was bedbound. She is asked ‘do you feel any better now?’, to which she replies briefly and deferentially, ‘yes, thank you very much.’ We may note that the quality of these patient performers was evident to some viewers at the time, as is clear from the audience report for the programme: ‘There were occasional complaints to the effect that the introduction of patients merely “wasted time”. “They contribute nothing to the programme. They all look bewildered. They slow down the pace, upset the balance and embarrass both doctors and audience”, a photographer alleged.’

It is possible to apply the analytical tools proposed for the doctors’ performances to understand the patients’ performances, too. Within the setting of the improvised studio, all of the patients are presented static and seated, whilst both Parsons and McCracken move from standing to seated. The child is partially shown in a special lower-angle shot, reinforcing the doctor’s greater height. Following Scannell, we may note the differential in the formality of clothing: Gudor’s patterned pullover and open-necked shirt, Delice’s specially purchased dress, Mrs. Mitchell’s dressing gown, Mrs. Lawless’s shirt and cardigan. Here, it is the contrast with the more formal dress of the medical men that begins the work of marking the patients as being of lower status than their interlocutors. We may recall here Richard Sennett’s comment, quoted by Ytreberg, that ‘[i]n reacting to this dominance those in need can come to perceive autonomous figures as authorities’. We may safely speculate, following Goffman, that the impression the patients ‘give off’ conveys more to the viewer than the impression they deliberately give. In a Butlerian sense, their deference is perlocutionary, constituting objecthood to medical authority on the basis of a separately existing class differential. This class dimension combines with the power relations of gender to reinforce the observable female deference to male authority, which we may take as a product of Butlerian performativity. Following Schechner, the patients are the ones delivering their performances, but the circumstances of the performance make them ‘not themselves’ at the same time as it is they who deliver the performance. Of our interpretive frames, only the Greenblattian self-fashioning is absent, eclipsed by the patients’ status as the objects of medical treatment.

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63 File 9/7/33, Audience Research 1958, BBC Written Archive. Audience research worked via panels of viewers, who ‘scored’ the programmes, giving an ‘audience appreciation’ score (in this case a high 89) and qualitative data of the kind quoted here. See Silvey, Who’s Listening.

64 Sennett, Authority, p. 86, quoted in Ytreberg, ‘Ideal Types’, p. 763.
These components of patient performance are, to an extent, products of the ways in which television was developing in the late 1950s. John Corner has written of the 1956 ITV series *Look in on London*:

The element of class confrontation (often signalled by dress as well as by speech) tends to be made more obvious by the style of interview representation, which uses continuous question and answer sequences and extensive ‘two-shot’ framing to elicit and present the information rather than the variety of more oblique, post-shoot devices which might now be used in the development of occupational or personal themes.\(^{65}\)

**Conclusions**

My intention in this essay has been to demonstrate the potency of understanding what people do in television programmes as varieties of performance, understandable using the many kinds of analytical tool that have developed under the broad heading of the ‘performative turn’ in the humanities and social sciences. For the purposes of the account here, the particular medical subject matter of high-tech therapeutics is not especially significant, but for the possibility that the extremity of the medical conditions necessitating their use might have served to exaggerate the class and gender relations on show. In that sense, it would be valuable to compare other medical programming from the time to check that what we see here isn’t an artefact of the particular subject matter. More valuable would be to draw comparisons across time, not least because 1958 falls early in post-war society’s turn to the psychological, which includes, of course, Goffman’s analysis of performance and the introduction, with Michael Balint, of psychoanalytical self-consciousness into general practice.\(^{66}\) In that sense, we can expect sample programmes from later decades to have called forth differing kinds of performance, just as doctor-patient relations in general have, up to a point, been affected by the social revolutions of the 1960s and, especially, their sequels in the patient activism of the Human Immunodeficiency Viruses (HIV) era and the diluted celebrity culture of the age of social media.

It would be contrary to the spirit of this essay to assume that *YLITH* could provide a transparent window onto the doctor-patient relations of the late

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\(^{65}\) Corner, ‘Interview’, p. 45.

1950s. All the same, it is worth noting that, of the three models articulated by Szasz and Hollender in 1956—activity-passivity, guidance-cooperation, and mutual participation—all the interactions seen in *Machinery for Living* belong in the first category, which is analogous to the parent-infant relationship [...] this model is not an interaction, as the person being acted upon is unable to actively contribute. The patient is regarded as helpless requiring the expert knowledge of the doctor, and treatment is commenced ‘irrespective of the patient’s contribution and regardless of the outcome’.67

Kirsten Ostherr’s *Medical Visions*, in considering the ‘production of the patient’—as its subtitle promises—considers in a single gaze imaging technologies and visual media, including television.68 My concern here has been less with medicine than with television or, at least, with how television achieves its effects; how the ‘grammar’ of the medium, at a specific point in its development, required doctors and patients to do particular kinds of things in front of the camera by way of communication about the new capacities of high-tech medicine. The question of how performances by doctors and patients (including fictional representations) ‘produced patients’ is complex and elusive. Programmes such as *YLITH* must have contributed to this, but to explore how, precisely, must be the work of another essay.

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