SCREENS IN WAITING ROOMS OF GYNAECOLOGY CLINICS: EXPLOITATION OF A TRUSTED PLACE

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ABSTRACT
This paper is focused on a specialized commercial television programme screened in waiting rooms of gynaecology clinics and specifically on the ways in which this programme is received by viewers/patients. The objectives of the study are achieved by analysis of interviews with viewers/patients. Reception of the programme is seen as an intersection of advertising discourse and medical discourse whilst the latter becomes a tool for legitimization of the programme.

KEY WORDS
out-of-home media – place-based media – medical discourse – gynaecology – bio-power – reflexive modernity

1. Introduction

This article examines how patients perceive specialized commercial and educative television programmes screened in the waiting rooms of gynaecology clinics. It is also concerned with the question of how the television screens as objects impact on patients' ways of experiencing the situation. To answer these questions, a qualitative research method was chosen, namely interviews with viewers/patients. To fully understand the context for this study, a couple of prior investigations need to be done. Firstly, concerning the character of the programme that can be preliminarily described as a mixture of commercials and health education, and secondly, concerning the character of the broader context of reception, which means that the place itself where the programmes are shown is regarded either as a source of powerful legitimization due to its role as an access point for an expert system (Giddens 1998), or as a locus of power/knowledge, medicine (Foucault 2005, 2010). The arrival of this type of media enabled the formation of two different kinds of areas. Firstly, it is a new place for advertisers to sell their products, and secondly, it is a new place for the viewers who can identify with the offered media product whilst a new audience group is formed.

The characterization of the programme mentioned above depends on the point of view of the producers: when offered to women, it becomes a tool of public health education, whereas for advertisers it turns into a perfect space for placing their commercials. It can be understood as the interdependence of two particular discourses: the first is a medical discourse; the second is an advertising discourse. The programme itself thus represents a very effective way of mutual reinforcement and utility: medical discourse produces numerous groups of viewers and legitimizes the programme itself, whilst the programme,

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when read in the light of the aims of advertisers as health education, can reinforce the high status of medical knowledge.

This topic addresses diversities of audience experience but also contributes to the study of the relationship between patients and medical professionals. In post-socialist countries, medical institutions are often seen as places strongly resistant to active patienthood and a participatory approach with patients (Hrešanová 2008). This article provides an insight into the dynamics of patients' empowerment as a dimension of post-totalitarian transformation.

2. Medical Discourse

As Foucault says, medicine has acquired a normative status in maintaining control over human existence (Foucault 2010: 55). By using the term *discourse* to describe this thematic area, I want to emphasize, in accordance with Foucauldian tradition, the emergence and distribution of particular knowledge and also of social practices, which are endowed with power (Foucault 2002: 78–79).[1] The chosen adjective *medical* thus demarcates this field[2] thematically. Medicine is understood as a synonymous term with medical science, the area of expert knowledge of the human body that somehow understands and forms the human body itself. The discipline of gynaecology and obstetrics thus represents part of this space.

The power of medical discourse is executed at the level of particular subjects and also at the level of populations as a whole, hence the normalizing character of medical discourse and also its function as an instrument of bio-power. Foucault (1999) calls this disciplinary and individualizing power towards an individual the *anatomo-politics of the human body*[3] which was later (in the middle of the 18th century) complemented with the *bio-politics of populations*. This kind of procedure aims to regulate and control the whole, the population itself (Foucault 1999: 162; Foucault 2005: 217–227). When talking about contemporary societies, Foucault calls them societies of normalization, where medicine is considered to be the one of the most important norm-setting areas. This is because it regulates both society and the individuals.

Medicine is a power/knowledge that can be applied to both the body and the population, both the organisms and biological processes, and it will therefore have both disciplinary and regulatory effects (Foucault 2005: 226).

The norm can be as successfully applied to a body that must be disciplined as to a population that must be regulated. Hence the absolute coverage of this power – from an individual to a population – that is typical for modern societies (Foucault 2005: 225–226).[4]

Nevertheless, this kind of knowledge does not escape a phenomenon that Giddens (1998) calls *reflexive appropriation*. Hence the reflexively appropriated knowledge forms a basis, on which individuals change their ways of living, feeling and understanding their

1 The term discourse thus refers to the symbolic character of this power.

2 The term field is not used in the Bourdieusian sense. It is meant to be understood as a general notion describing a discrete area of particular knowledge.

3 This technology is extensively analysed in Foucault's monograph Discipline and Punish (Foucault 2000).

4 In *The Politics of Health in the Eighteenth Century*, Foucault (1980) emphasizes an influence of the family on socialization, where the family became the prime objective and also the agent of medical enculturation. He introduces this idea by using the example of child vaccination.

bodies. Alongside with changes in the experience of corporeality, there are also changes in the ways of expression, in the ways of speaking about it. Medicine thus represents an expert system (Giddens 1998: 32) that is deeply trusted by individuals and that makes them truly dependent on it, in the sense of calculating a degree of risk, to which they are exposed in the modern society.[5]

Physicians are understood in terms of *access points* (Giddens 1998: 79) of this expert system, and their role is taken as principal in acquiring trust in the health care system. This trust is unavoidable for many reasons. Human powers are limited in particular ways, and there is no chance to achieve an expert level of knowledge in all possible areas, even if there is the chance to get it at least in one of them. That is why an individual simply has to trust people who have achieved these expert levels (Giddens 1998: 129).

3. Character of Modern Gynaecology

Contemporary progress in medicine also involves a slightly darker side, not only an indisputable improvement in the quality of life and widespread well-being. The penetration of the health care area with the market mechanism creates an unceasing need to broaden the medical market. Apart from the innovations, there are also inherent risks and medicalization of physiological states that were earlier considered as natural and were not at the centre of the physician's attention (Padamsee 2011: 1343; Conrad 2005). In the case of women, the medicalization occurred in relation to their expulsion from the public sphere of life. The medicalization was important mainly because it enabled the woman's body to be turned not only into an object of knowledge, but an object that is "different" (Abbott and Wallace 1990: 105).

This difference thus created a distance between the exploring man-physician and the object of his exploration, a woman's body, and the development of modern gynaecology was enabled by these means. It is possible as well to understand modern gynaecology in terms of an open-ended sum of utterances that take a woman's body as their explored object, to which the characteristics mentioned above were inscribed. Moreover, these characteristics are continually reinforced and modified by these utterances themselves. Hence the place that is given to modern gynaecology to treat women's bodies and finally have them cured (Zetka 2008: 347).

The legacy of the Enlightenment, a notion of the "forever diseased" woman as described by Tinková (2004), can be understood as still valid because childbirth was not the only physical state deserving the physician's attention, which was transferred to another place. The same movement was applied to other natural occurrences in women's lives, i.e. menstruation, pregnancy, lactation and menopause (Renzetti and Curran 2003: 479; Padamsee 2011: 1347–1350). Moreover, gynaecologists and obstetricians are supposed to be endowed with an expert knowledge of women, which becomes the reason why they often become providers of primary care (Zetka 2008: 335, 342–343). This position allows them to define normal femininity and normal sexuality (Abbott and Wallace 1990: 105; Zetka 2008: 346; Renzetti and Curran 2003: 467). Renzetti and Curran (2003) also claim that there is no comparable medical specialty which would consider the reproductive health of men.

It is necessary to mention that such a specialty does exist in the form of andrology, a

5 The expert systems themselves can also construct some risks. In this case, the individual's dependence on an expert's opinion is much higher (Giddens 1998: 79, 113).

particular medical specialty, but it is also necessary to mention that andrology has never had and still does not have such an impact on men's lives as gynaecology has on the lives of women. When Schirren (2005) searched for the initial uses of this term, he found the oldest mention of andrology in 1887 (Schirren 2005: 143). Schirren noticed that the use of the term was also suggested by other physicians.[6] It means that andrology was not an established medical discipline until recently. This notion, according to Schirren, is evidence that it was primarily the woman who was taken into account when considering reproductive problems (Schirren 2005: 144).

The inception and development of andrology can be linked to the decrease in male fertility which was detected in the last few decades[7] and also to a particular shift in understanding sexual dysfunctions, which were no longer considered as strictly psychogenic phenomena belonging to the field of psychiatry. Thus Bancroft (2005) reminds us of the invention of Viagra as a physiological remedy for erectile dysfunctions (2005: 572–573).

However, the expansion of andrology also means another expansion of the medical market. The question of the extent to which it could serve as a motivation for the foundation of this medical discipline remains unanswered. It can be taken for granted, though, that the idea of a healthy and docile population has an important effect and that it does not really opt for one sex more than for the other. Moreover, the willingness to pay for good health is characteristic of both men and women. The pharmaceutical industry makes use of this when situating its commercials directly in the space of medical offices (Conrad 2005: 5).

4. Television programmes in waiting rooms as an advertisement

A screen placed in a waiting room can be put into the category of out-of-home media, alternatively called place-based[8] media (McCarthy 2001; Romano 2006; Guthrie 2008; Story 2007). This kind of network media can be understood in the particular socio-political condition of the Czech Republic as a consequence of the development of the advertising market that is related firstly to technological progress and secondly to privatization and the subsequent infiltration of market mechanisms into everyday social life.

I should mention here that the place-based or the out-of-home media need not be necessarily commercial; they are also used for noncommercial and more sophisticated purposes, i.e. hospital radio often run by volunteers.

Out-of-home media, the concept embracing the programmes which are our concern here, can be characterized by the transfer of media from the private to the public sphere (Romano 2006: 14). Furthermore, Morley writes about the de-domestication of media, which he understands as a process of this transfer (Morley 2006: 33–36). This transfer thus results in a literal impossibility to define who is a member of a particular audience and who is not. Everyone turns into a member of an audience because of the saturation of the media landscape, even when that audience is dispersed and identifiable only with great difficulties (Abercrombie and Longhurst 1998; Romano 2006: 14–15). On account of

6 According to Schirren, Walker suggested this term in England in 1923, and Siebke in Germany in 1951 (Schirren 2005: 143).

7 However, Slepičková (2010) points out that infertility was also medicalized, hence in physician's consciousness it turned to a pathological state that has to be treated accordingly.

8 Another term can be found in thematic papers: *based-on-place* media (Romano 2006; Guthrie 2008). The terms are considered as synonyms.

the fragmented media consumption and diffuse character of the audience (Abercrombie and Longhurst 1998: 33), the particular need arose to capture viewers in different spaces and to hit audiences in motion (Romano 2006: 14–15; Guthrie 2008: 21). Hence the category of place-based media: the content of this media must be structured in accordance with the characteristics of their location. It is necessary to program them with respect to the period of time which can be spent by potential viewers at the place of installation. Place-based media allows for commoditization of individuals who are situated in the range of this media and for transforming them into the audience that can be sold on the advertising market (McCarthy 2001: 104).[9] Therefore patients in waiting rooms of gynaecology clinics perfectly represent this kind of audience.

5. Woman's View – structure of the programme

The following research analysed gynaecological patients who were exposed to the programme *Woman's View* while waiting for their treatment. *Woman's View* is produced and disseminated to the doctors' offices by the HI-LCD Media Company. The programme is comprised of particular spots and runs in a loop. The total length of the loop is about 20 minutes and the loop is broadcast during the physician's office hours. The programme is targeted at adult women and the providers themselves emphasize in their internet presentation the particular similarity of this programme to those for women in general.[10] The providers argue that the structure of the programme itself is supposed to reproduce the interests of the target audience, women aged 15+. The online archive of the programme, accessible from the provider's website, is divided into the following categories: *family, recipes, style, housing* and *health*. So these are the main interests of women defined by the programme itself.

The category called *family* comprises commercials of detergents, cleaners and spots which introduce some places worth seeing during a family trip. The idea of a contented family living in clean and healthy surroundings is emblematic of this category. A spot promoting disinfectants represents an example of how to make use of the potential of based-on-place media: it draws on gynaecology's status of expert knowledge to sell this product. It achieves this aim in a simple way: the disinfectant is recommended by a woman gynaecologist who is not a mere scientist; she is also a mother and she can share these experiences with the other women who are watching. The idea of *hygienic purity*, conditio sine qua non in the operating theatre, should also be necessary in case of home surroundings. The spot is designed to make great use of the legitimizing potential, which arises from the place of reception, i.e. a waiting room of a gynaecology clinic. The gynaecologist who is talking to her audience from the screen represents basically the same authority as the physician her audience is waiting for.

The glorification of a healthy and contented family, which should be the objective of every woman according to the programme, continues through the next categories of spots that are called *recipes* and *housing*. Spots subsumed under the umbrella label *style* give advice about how to put on one's make-up flawlessly "to be able to go outside". There

9 McCarthy argues that everyone turns into a member of the audience regardless of whether he or she is really watching. She ponders the question, of whether the presence of a particular viewer at the place of reception should be paid for: "We are not paid for donating our bodies to media corporations in this fashion, although they effectively rent out the time we spent waiting". (McCarthy 2001: 111)

10 *O projektu.* undated. http://www.hilcd.cz/o-projektu/ (3.12.2012).

is also a spot informing viewers about possible kinds of tights and their qualities that is a domain of the well-bred woman as well.

The most voluminous category of the archive is labelled health. Spots from this category predominate in the broadcast content because they have the closest relation to the context of reception, where the matter of health acquires a great degree of complementarity with the medical scenery. Food and drug commercials, spots promoting medical devices, private medical services and the insurance industry belong to this category. Public education spots dealing with the harmful effects of smoking, the curative possibilities in the treatment of menopause and the prophylaxis of cervical cancer can also be found in this category.

The HI-LCD Media Company, the provider of the *Woman's View* programme, declares on its website (in the "Information for Advertisers" section) that a waiting room is a trustworthy, calm and emotionally safe place. The company also emphasizes an element of trust that women are supposed to project onto their physicians. The trust is then, under the influence of site-specific surroundings, transferred to the programme itself. It is necessary, though, to admit that the programme contains a particular part of public health education. However, this education inevitably results in an increasing use of medical services that are mostly of a privatized character. Hence it is not possible to decide where to draw a demarcation line between the advertising and education, between reality and constructedness of broadcast risks.

6. Methods of research

The methodology of this research is based on analysis of data collected from interviews with patients exposed to the particular programme. The interviews were conducted and analysed with regard to the main question about respondents' perceptions of the programme *Woman's View* when watched in the medical waiting room. The interviews were based on a script prepared in advance and were understood as actively constructed narratives (Silverman 2005: 135). The sample of respondents was built to cover diverse age groups of women. Thus the final sample contains responses of women aged 20 to 54 years and consists of eleven interviews (one of them was conducted with two women at the same time).

The sample is supplemented with material from one focus group that consisted of five young women of the same age (23–24). Since their personal characteristics were not collected, they are not mentioned in the table of respondents. Moreover, the data from the focus group has an auxiliary character.

Some respondents were directly asked to participate; the others joined the research based on snowball sampling. The main criterion for including the respondent in the sample was the presence of a television set with *Woman's View* running on it in her gynaecologist's waiting room. Thus there are more than 10 different waiting rooms described by respondents in the data set, two of them situated in a hospital ward and the others situated in private gynaecological clinics. The varying sizes of the waiting rooms turned out to be an important factor in the analysis. The interviews took place in a neutral place, i.e. outside the waiting room, in a café or at a place chosen by the respondent; respondents were openly recorded by voice recorder with their previous agreement and they had been told to choose a nickname in order to ensure their anonymity.

The data was interpreted on two levels. Two modalities were detected in the patients' behaviour – they were analysed as patients and as viewers. The analysis was carried out in this way because it turned out during the sampling and questioning of respondents that these two levels were interdependent in a particular way.

Table 1: Overview of respondents in the sample

nickname	age	occupation
Barbora	54 years	physiotherapist
Beruška	20 years	saleswoman, sciences student
Hany	54 years	office worker
Irena	27 years	office worker
Iva	45 years	paediatric nurse
Kikina	24 years	student of pedagogy
Lenka	23 years	humanities student
Máca	24 years	law student
Martina	26 years	production manager
Monika	23 years	student of pedagogy
Sabina	21 years	humanities student
Šebestová	46 years	preschool teacher

7. Respondents Considered as Patients

When focusing on the way in which respondents consider and value gynaecological practice in their lives, it needs to be said that all of them consider gynaecology to be important and that attending the regular check-ups is understood as a norm.

Respondents, when asked to characterize their attitudes towards gynaecology as a medical specialty, were divided into two groups, approximately equal in size. The labels chosen for the groups are derived from the Foucauldian concept of discipline, one of the technologies of bio-politics, *the anatomo-politics of the human body* mentioned above. The patients are seen from the point of medical discourse and the effect of its power on them and their behaviour (they need not be aware of it). Two other characteristics – their relationship towards gynaecology and TV broadcasting in general – appeared to be important factors in respondents' perceptions.

7.1. Docile Patients

The *docility* of a patient can be understood as a result of flawless and undisturbed power working at the level of an individual who becomes disciplined. The process is provided by the institution of family that works as a primary agent of medicalization, as well as education, media and the institution of gynaecology itself.

This kind of patienthood seems to be, in accordance with in-group respondents, the best and the most favourable for women to attain. But this is not something natural, on

the contrary, it is something that has to be achieved over a long time. The path to this, probably the most optimal patienthood, begins within the family and virtually never ends. In the view of this group the phrase, *"I don't mind [going there]"* (Martina), became the emblematic one. Gynaecology was termed a *"common part of life"* (Hany) and respondents emphasized that an examination and its typical course does not bring them any difficulties and that they do not feel any restraints during this procedure. However, this group did not emphasise the importance of gynaecology in comparison to other routine medicine: gynaecology was often compared to dentistry.

7.2. Intractable Patients

The respondents in the second group were called *intractable* patients. From their point of view, gynaecology acquires a status of great importance in their lives and in the women's lives in general. It could be said that this group takes it too seriously.

To uncover the reason for the constitution of docile patienthood seems to be less complicated. It could be said that socialization and enculturation of respondents run successfully and that they do not see particular aspects of the gynaecological practice as problematic. The next possible explanation for docile patienthood could be an absence of serious health problems because these problems could lead the respondent to emphasise the importance of gynaecology. On the other hand, intractable patienthood does not automatically correspond to a higher sickness rate, even though this was declared by one respondent (Monika). This patienthood is better understood as a failure of the power mechanisms which could lead to successful socialization and enculturation that make women think that gynaecology is a "common part of life". This can be caused by numerous factors. A negative experience in access points to the expert system, namely the physicians themselves or other experts, leads to a sense of a disturbance of intimacy, which is an obligatory part of a gynaecological examination.

Other recordings also revealed a certain tendency to refuse the experts, e.g. Irena mentioned some educational messages that were intended to persuade her during her teens that made her feel uncomfortable: the contents of magazines for girls, including gynaecological issues, were intended to educate and encourage girls towards putting their shyness, embarrassment (and clothes) off, to be without the constraints that could have been obstructing. The deliberate rejection of these messages by women can be understood as their aim to become different from the majority and also as a conscious effort to keep their distance from medical discourse and from its normalizing power.

The next kind of response in this group overemphasizes the experts and their power and importance. Thus gynaecology is seen as something very unique, as the key to a woman who is regarded as a specifically functioning person. This interpretation of women's bodies though the means of omnipotent hormones, pregnancy and childbearing, reflects the very idea that gave rise to gynaecology itself. This idea enabled people to understand women as a completely different being, whose health is very frail because it is affected by childbearing. Thus the emphasis on female hormones can be understood in terms of shifting this initial idea in accordance with contemporary knowledge. To conclude this section, the emotiveness that accompanies the check-ups and other ways of meeting the access points can be understood as a result of an imperfect socialization which did not liberate patients from the restlessness and uneasiness they feel. It could be said that the

power working through medical discourse failed in a particular way.

8. The Waiting Room as a Specific Context of Reception

The screen in a waiting room belongs to the category of place-based media. That means the programme profits from the place where the screen is placed. In this case, the programme profits from the characteristics of the waiting room, which can be grasped as a gendered place whose characteristics are strengthened by the programme itself.

The programme represents an element, which brings a particular intensification of printed text meanings that were in the waiting rooms before the arrival of the screens. Moreover, there is a great correspondence in the content of the printed and broadcast material, although the degree of attention, which is enforced by these dissimilar kinds of media, is highly different. Whilst the leaflets could have been ignored, it seems practically impossible in the case of the screens.

So the idea of femininity, which is mediated to the waiting patients, strongly intensifies the characteristic of the waiting room as a gendered place. This effect of the programme is apparent from the responses of Martina who watches it in a different context from the others. The waiting room she is used to waiting in is shared with a general practitioner's office. She describes her situation like this:

> *So, actually I don't mind it [the programme] but when there is a man sitting, who is going to that physician, it's so embarrassing, isn't that so.*

Martina as a viewer does not feel comfortable in the shared waiting room because, as she stresses, issues are often intimate. However, Martina was not able to point out what exactly causes the discomfort she feels while watching the programme accompanied by men:

> *... so, it's like, it's intimate, so when there is the man, so ... I think that if we were sitting somewhere ... somewhere at some sexologist and there was a speech about cocks and there was no one but guys and me, a woman, so they must feel awkward, too. [...] Maybe it's not comfortable for that man either.*

Martina's immediate comparison with sexology shows that she understands the programme by contrasting gynaecology with a field that is embarrassing for men, not women. Martina summarizes the whole programme this way:

> *It's about cleaning, healthy food and care for your vagina.*

Let's say that for Martina the programme is finally reduced to that of, "care for your vagina", while the vocabulary she uses gives evidence of her attitudes towards the programme. Martina considers the programme embarrassing because of the kind of femininity that is transmitted by the programme and which does not correspond with the idea of femininity that Martina appreciates and with which she can identify. Furthermore, she is afraid that she could be linked to this broadcast kind of femininity. It is because she is aware of the existence and functionality of a typification scheme which she regards as unflattering and insulting when applied to her.

9. Respondents Considered as Viewers

The gathered data brought four categories and four possible ways of viewing into being. It is necessary to emphasize, as far as the viewer's attention is concerned, that none of the respondents can be classified as a non-viewer. The reason is clear: from time to time, all of the patients, even if they are willingly trying to ignore the programme, somehow pay attention to the screens. Moreover, they remember some particular spots. Hany says:

> *... although I'm reading, my eyes from time to time seek that screen, but if I'm involved in that reading, I just switch myself off and I don't care about it.*

The screen in the waiting room is taken into consideration in all cases, as well as the content it brings. It turns out to be extremely difficult to avoid it, partly because of its size and volume, and partly because the programme is somehow appealing. There are respondents who like and appreciate it alongside with those who cannot stand it at all. Some of them feel defenceless, some of them feel free to choose. These ways of reception were divided into the following categories: involved, indifferent, resistant and reformist audiencehood.

These categories were formed on the basis of some further criteria. The most important is the kind of patienthood mentioned above – an umbrella term for the attitudes towards gynaecology. The aversion or affinity towards particular media is also of importance.

9.1. Involved viewing

Involved viewing can be characterized by a certain degree of becoming involved in the programme, alternatively by a certain appreciation of viewing it in comparison with other activities, as Máca says:

> *You've got a feeling that you're doing something, that you're not sitting there without a purpose.*

This audiencehood was detected in two possible forms. The first one is involved on the basis of the respondent's patienthood. Karolína describes her viewing activity like this:

> *I get stressed by it when I watch. 'Cause there are always things that can happen to you, isn't that so? So I get stressed and then I search for the leaflet to find some way to prevent them and whether the things they are saying are really true and if I can't find some of the symptoms they are speaking about on my body.*

In this case the viewers get involved in the programme and on this basis, they engage in another activity, the search for more information. A lack of distance makes them watch the programme with negative emotions. The modality of their audiencehood is closely related to their overall approach to gynaecology and also to their experiences from the access points of this expert system. Karolína is an intractable patient who does not put her trust in the physician. Apart from the absence of communication, she argued that in the office, she is used to going to a different physician every time. Thus Karolína does not in fact trust them. Their impersonal approach does not assure her that the physicians are capable of helping her cope with the risks that are emphasized by the programme.

However, there can be also different situations in the sense of the viewer's emotions towards the programme. Intractable patienthood can also be related to another way of reception. The extent of involvement in the programme is the same, and the viewers are also highly attentive. However, the reason for their attention is different. From their point of view, the programme represents an element that is welcome and that they actively use. In contrast to the former group, who are distressed by the programme, this group comprises viewers whom the programme helps to rid of stress. Sabina describes its calming role like this:

> *Maybe it's better, I think, because when someone is nervous, waiting there and doing nothing, it must be much worse for him. I think that maybe the TV can calm you down a bit and also entertain. [...] Although, there is such a programme that deals with gynaecology and so on, but it's just TV, and sound takes your thoughts away.*

For Sabina, the check-up means a stressful event because of her shyness that she is not able to lose together with her clothes. In any case, Sabina trusts her physician, thus, she does not read the programme as a sequence of risks that can strike her, moreover she is not so focused on the content itself. This can be inferred from the low number of spots she was able to remember when asked. In her statement, we can find a tendency to approach the screen in the waiting room in the same way as a domestic television: *"It's just television."* Sabina shares this characteristic with the other respondents that belong to the same audience group. Their viewer activity is based on the habit of watching television at home. In this case, the affinity towards the particular type of media plays an important role in their reception. These viewers are involved based on what part TV plays in their everyday life. Kikina comments on her viewing activity like this:

> *...when you're sitting there it's much better [to watch] than staring at nothing. It's true, and it's been like this since he [physician] has got the TV that I stare at that telly. I watch those commercials.¨*

The familiar word "telly" has quite a high frequency in Kikina's responses, moreover it reveals the way in which Kikina primarily perceives the programme. She also points out its informational aspect: *"...one is curious about the latest news."*

Negative attitudes towards television as a kind of media also have an influence on viewers' ways of watching the programme. They can be traced in the responses of Irena (an indifferent viewer) and Beruška (a reformist).

9.2. Indifferent viewing

Indifferent viewing is characterized by the distance that viewers from this group try to keep during their evaluation of the programme. For example, the distance of Ms. Šebestová is based on her awareness of gynaecological knowledge. But she also admitted that not every woman can acquire such a degree of knowledge as she has. She realizes the presence of advertising in the contents of the programme, but she does not need to ponder about it. It is because she is convinced that her physician knows *"what he plays to his patients."* Ms. Šebestová thinks that the physician simply cannot play or recommend anything potentially harmful. She supposes that he somehow supervises the broadcast contents

and thus he is responsible for them. This notion does not correspond with reality because the programme is produced by different people.

The idea of the harmlessness or the ineffectiveness of advertising turned out to be a widespread and strongly held belief among respondents. They simply do not believe it could affect their decision making processes and they think the same about the other people. They see themselves as bright and unimpressionable people who know how to resist. But one could instead argue that they do not realize the power of advertising. Underestimation of the commercials in the majority of the sample can partly be ascribed to their trust in experts which they acquired in the course of (successful) socialization. As long as many respondents think that their doctors keep some control over the programme, they transfer the trust they have in their doctors to the programme itself. As a consequence, some of them underestimate the potential impact the commercials may have on them.

The negative attitude towards particular media can also have an impact on the way of reception. Irena was, as she says, surprised by the screen in the waiting room. Her audienceship modality represents the opposite of the former, which is based on positive attitudes toward television in general. Irena suggests:

> *I don't have a television or I just don't watch it and there is no particular reason, that I would mind something on it, but I've learned to live without it and I just spend my time differently.*

Irena admits that she watches the programme and she emphasizes that the programme can eventually be a source of information. She also realizes the advertising but she does not need to ponder about it:

> *Because it can't be so absolutely harmful, the things they are offering there, but then it can't be so absolutely helpful, those things from the commercials. It must be the kind of things which won't harm you nor help you, but sometimes they can be pretty expensive.*

Irena then confesses that for her, waiting is not something to prepare for. At this point she agrees with most of the respondents who subjectively consider their waiting period short, even if they said they had been waiting for 5–10 minutes or even half an hour. Irena puts it as follows:

> *I don't prepare for it anyway, you know, so it must be a total accident that I have something [to read] with me, and the main thing is, that it won't cross my mind to take it out for such a short time.*

There, an interpretation is offered, in that a short waiting period implies the reception of programme in a certain way, because viewers do not need to prepare for *"such a short while."* It should be mentioned here that the programme is structured accordingly. That means the sequence of particular spots takes approximately 20 minutes and then repeats, because women are not expected to wait in the room for a longer period. Hence the absence of a need for any time killers to be brought. But the category of resistant viewing proves that this suggestion cannot be taken for granted in every case.

9.3. Resistant viewing

This category is typified by the respondents' active denial of any attention invested in watching the programme. These kinds of viewers do not feel attentive, on the contrary, they emphasize that they can choose an alternative way of spending their time in the waiting room. Thus, their attitudes towards the programme are based on a certain kind of refusal and skepticism. It should be mentioned here that the viewers from this group were characterized by high self-esteem and a somewhat dismissive attitude towards the problem in general. It could be argued that the resistant viewers presented to us more self-enhancing narratives than the others, although the others undoubtedly did exactly the same. Thus the resistant viewers are characterized by trying to avoid the viewing activity or at least pretending to do so.

Hany is reconciled with the presence of the screen in waiting room, as she puts it:

> *I take it as a common part of this world, that those commercials run everywhere and so on, so they also arose in here, but anyway I doubt that someone would take it as some instruction for what kind of medicine to buy and so on.*

But she minds the volume of the programme because she is used to spending her time in the waiting room reading a book she takes with her regularly. Monika describes the situation as follows:

> *Yes, I'm also in there, I would also be forced [to watch], but I take my own book with me. But this then depends also on that woman [a physician], how she'll arrange it. [...] It's like, it's pressure from the physician, because she has nothing else in there, there is just the television, but you, from your point of view, you've got a choice.*

It is necessary to mention that the spatial disposition, the size of the room, plays its part in the exercise of free choice. It is hard to imagine a situation when a woman sits in a small room successfully trying to avoid the programme whilst the screen occupies almost half of the opposite wall. Resistant viewers pointed out that the waiting room they sit in is spacious, as did indifferent viewers. On the contrary, respondents from other groups emphasized the small size of the room, and the contrast between a small room and a big screen.

9.4. Reformist Viewing

This category represents the last identified way of watching the programme and can be characterized by the respondent's belief that the content itself is not valuable for them. If the resistant viewers consider the programme as something inappropriate for them, they are able to imagine someone who could find it useful. On the contrary, reformists are not able to imagine that the programme could ever be useful. Moreover, a certain unwillingness to abandon their point of view and try to watch the programme differently, trying to be literally in somebody else's shoes, is typical for viewers in this category. Viewers within this category realize the potential of media and imagine its better use. Beruška says:

> *Producing such a programme is a piece of cake. I could do it myself.*

Viewers from this group point out the advertising aspect which bothers them. While Be-

ruška has a certain understanding of the commercials, Lenka does not. She stresses the pervasive character of the programme; she literally speaks about it as *"propaganda"*. Her absolute resistance to commercials is exceptional within the sample. This more informed outlook can be explained by her background (she studies psychology). Other respondents were more likely to show reconciliation with the advertising character of the programme. They either believe it is powerless and harmless, or they have an understanding for the advertising in the waiting room because the physician needs money like everybody else. Lenka appreciates the programme as follows:

> *It didn't give any news to me [...] So I don't think it's so important that it's here.*

She also suggests some changes to the programme but she is aware that it is not entirely possible.

In the reformists' accounts of their approach to the programme, emphasis on a certain involuntariness can be found. That is why they want a change, because they feel they have to watch the programme. They share similar characteristics with the involved viewers in respect to this emotional approach. But involved viewers do not want to change the programme for they see it as an educational one, whilst reformists see it as commercials, in which they have no interest.

10. Conclusion

The main objective of this article is to explore and identify the different ways of reception of the programme *Woman's View*. The programme was considered as the intersection of medical and advertising discourse where the former turns into a tool of legitimization of the programme. The analysis was rooted in a Foucauldian framework, namely in the concept of bio-power and power/knowledge in general. The theoretical framework was also supplemented by Anthony Giddens' theory of reflexive appropriation of knowledge. This helped to clarify the different positions which are held by physicians and patients within the medical discourse.

The data from interviews with viewers/patients revealed that some of them do not take themselves to be very attentive to the programme and that they are able to negotiate with the producers and providers, if they want to. The discovered modalities of reception are influenced by many factors. In my analysis, I pointed out three of them: firstly, the attitudes towards gynaecology as a particular medical discipline, which are dependent on the socialization and enculturation of women, on their experiences with the access point of the expert system, and also on the degree of reflexively appropriated knowledge. Secondly, the attitudes towards television media in general, or alternatively the tolerance or intolerance of certain types of media, also play a part in formulating the viewer's standpoint. Finally, the spatial disposition of the waiting room that can either set women free from the obtrusiveness of the programme or make them more likely to be captive. The following modes of reception were discovered: involved, indifferent, resistant and reformist viewing. The involved audienceship can be characterized by a certain degree of getting involved in the programme whereas the indifferent one is typified by the distance that viewers try to keep during their evaluation of the programme. The resistant viewers actively deny the concept of a captive audience and the reformists find the programme completely useless

while suggesting how it can be better used.

The results of this research should be verified with a larger sample; alternatively they could be complemented with results from other methods of research. Participant observation in a waiting room or interviews with producers of the programme and physicians can be considered.

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