“DOC-AGANDA”: MEDICAL TV SHOWS & MEDICAL EPISTEMIC AUTHORITY

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Abstract

This research paper consists of a critical examination of the medical TV show in relation to medical epistemic and cultural authority. In weaving together the histories of the genre and modern medicine, it reveals the interconnected nature of medical TV shows and medicine in the real world. In this project, literary disability studies are combined with media and cultural disability studies, television studies, and the medical humanities in order to expose the ideological ways illness, disability, health and healthcare are portrayed by the modern medical TV show. By paying particular attention to the representation of disability and illness in medical TV shows, this study exposes how the shows reinforce and uphold medical epistemic authority, and by extension the medical model and ableism. Using specific tropes of representation and close reading as a methodology to examine episodes of *ER* and *Grey's Anatomy,* this paper emphasizes the ways these shows devalue disabled embodiment and uphold mainstream liberal capitalistic values. These tropes include freakery and medical scientific progress; didacticism and the limits of the doctor centred formula; and disabled embodiment as untrustworthy/adversary to doctors.

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This doesn't count as my first book, Yayo, but this is still for you.

Contents

"Doc-aganda": Medical TV Shows & Medical Epistemic Authority

1. Introduction

Over the summer of 2022 I experienced a flare up of my chronic illness, which can be bad enough to render me bed bound for extended amounts of time. During this period, I spent a lot of the time binge watching television. Like many chronically ill people before me, I turned to the medical TV show, a well-known genre with a consistent formula and dozens of different shows to pick from. I settled in to watch *Grey's Anatomy* from the very beginning, setting myself up with over 18 seasons of attractive TV doctors behaving scandalously, all while caring for and curing hospital patients in the process. What I noticed, beyond the sometimes shocking and silly behaviour of the doctors themselves, was that the show featured disability and illness more than any other cultural product to which I'd ever paid attention. From my own isolated sick bed, caught up in my own personal experiences of disability and illness, I also noticed that the depiction of patients' experiences of their illnesses and healthcare were superficial and empty of any emotional content that did not relate directly back to the doctors. Watching the show, it was clear that it was constructed in such a way that I was only ever supposed to relate to the doctors who are the stars of the show. This was despite how much I would logically be much more able to relate to the patients, having frequently been one myself.

I also started to realise that this show, along with other medical shows, were presenting highly politicized messages about disability, illness, healthcare and the role of medical science in modern society. This realisation was concretised after I watched an episode of another show, *Last Week Tonight with John Oliver*, a late-night TV comedy

which produces in-depth analyses of social issues. In this episode about the TV show franchise *Law & Order*, Oliver explains the role police TV shows play in fabricating a popular image of policing which works propagandistically in favour of the institution, what is often colloquially referred to as "copaganda" ("Law & Order"). This episode originally aired in the context of increased media attention to the role of policing in our society and the harms inherent to its social functions of surveillance, social control, and the violent regulation of marginalised human lives. At the end of the episode, Oliver makes what to me seemed like a bold and erroneous comparison between cop shows and medical shows and their respective relationships to realism, accuracy, and the social harms associated with audience perceptions of these things:

> Think about it – you know *Grey's Anatomy* doesn't depict what happens inside an actual hospital. Those doctors are ridiculously hot, none of them are nearly tired enough, and it needs about 5000% more discussion of insurance. But if those medical professionals were routinely claiming that vaccines cause autism and herbal remedies cure cancer, we'd probably be having a conversation about it. ("Law & Order")

Oliver and his writers seem to feel that medical shows would only function propagandistically, in the way cop shows do, if they portrayed medical beliefs dangerously outside of the accepted realm of mainstream Western medicine. But it is precisely through a combination of realistic and accurate portrayals of medical procedures and the details of specific ailments (something which has been discussed at great lengths by medical professionals and has been seemingly ignored by Oliver) and the melodrama of medical practitioners and their encounters with patients, which make medical shows such a potent source of entertainment and of ideas about the medical system. Oliver positions alternative medical knowledge as the only potential harm that

could be produced by these shows, ignoring the pernicious ideological and epistemic claims to authority and power which emerge directly from mainstream medicine itself.

This framing of medical shows in relation to cop shows helped me to structure an idea which has become the central point of this study: that medical TV shows function as propaganda for the medical system, highlighting and reinforcing medicine's epistemic and cultural authority. As a scholar working in the field of critical disability studies, I work from the understanding that disability, as well as the related concepts of health and illness, are socially mediated and constructed (Waldschmidt; Wendell). I also know that the institution of medicine has played a crucial role in the determination of these constructs, partly as a result of the utter dominance the medical industrial complex has over modern society (Withers). I also understand from literary and cultural studies that television, like other forms of cultural production, is a fraught cultural location, informed by competing interests that range from financial and corporate to creative and intellectual, and is also one of the most dominant forms of storytelling of our time (Butler 317–19). In other words, this topic emerged to me as a critical point for examining popular images of disability and illness, as well as a site in need of analysis and critique for the pernicious and subtle messages these shows convey about one of the most powerful institutions of the modern era. This project does not take as its point of critique the supposed accuracy of these shows, either to the realities of medical science or to patient experiences with the healthcare system in the real world. While it may be relevant in certain contexts if the public is taking information from these shows and assuming them to be medical facts, this study is more interested in how, truthfulness aside, constructs such as the recurring

narrative structures and tropes of representation portray medical authority in ways that uphold systems of oppression. This is done less so through accurate portrayals of the medical system and is, in fact, manufactured through the fictional representations which portray doctors, patients, and medicine in a certain light. This project acknowledges that social values and meanings are created, circulated, and reinforced through cultural texts, regardless of so-called truthfulness or accuracy to the real world.

1.1 Disability, Health & Medical Epistemic Authority

A defining feature of the medical TV show is its unquestioned embrace of the medical model of disability, one of the dominant forms of understanding disability in our culture. This medicalized understanding of non-normative embodiment posits disability as an individualized deficit and a naturalized bodily tragedy, orientated towards solutions based in cure and rehabilitation (Shakespeare). In contrast, this study functions from the theoretical basis that disability is socially constituted and mediated, a perspective which is generally lacking in the portrayal of disability in medical TV series, and which offers a critical vantage point from which to critique these shows. Disability studies, along with the different models which have emerged from the field to describe the social functions of disability, including the social, radical or cultural models, amongst others, have greatly contributed to the understanding of disability as a socially and culturally mediated identity category (Withers; Waldschmidt; Shakespeare). This study aligns with models of disability which include chronic illness, disease, and the categories of health and illness as operating along similarly complex notions of physical embodiment and its interaction with social constructionism (Wendell). In order to properly critique and analyse the ways

medical shows portray human interactions with the healthcare system, it is important to understand that health itself is not a neutral subject. Arguably the assumption made by John Oliver on his show that cop shows are obviously propaganda, but that medical shows are not, reveals an unstated assumption that topics relating to health are unpolitical, neutral and universal. Nonetheless, decades of scholarly research from multiple fields have discussed health and illness as social constructions, largely mediated by the increasingly powerful medical industrial complex (Wendell; Withers; Viney et al.; Zola). From this perspective, medical shows portray not a neutral concept of medicine and healthcare, but rather a very carefully mediated image through which decades of the shaping of public perceptions and values are reflected.

Following from the idea of health and illness as socially constructed, one of the central concepts of this study and a central target of its critique is the ultimate epistemic authority of modern Western medicine and the epistemic injustice which emerges as its consequence. In question here is not just the epistemic authority doctors hold over patients in healthcare encounters, but also the way that scientific medical knowledge has been made supreme in myriad sites in contemporary society, including educational, legal, and socio-cultural contexts. Again, Oliver's statement serves as an example of the pervasiveness of this authority, where the authority of policing is brought under examination, but the authority of medical knowledge can hardly be questioned without seeming absurd. In the early 1970s, sociologist Irving Kenneth Zola outlined in a now classic essay how the institution of medicine has become a powerful site of social control, edging out the more traditional institutions of religion and law. His essay notes how not

only have medicine and the medicalisation of everyday life become pernicious in all corners of human life and experience, but that medical science had become the principal means through which anything health related is understood, where health has come to mean everything related to the human experience of life itself. He also notes that the labelling of a subject under the umbrella of "health and illness" acts as a powerful "depoliticizer," marking an issue as individual and closing off options for other forms of intervention (213). Thus, Oliver is able to discuss policing in unequivocally political terms but is unable to discuss the institution of medicine as such.

This understanding of medicine as dominating the hermeneutical possibilities of life itself is further reflected in Lisa Cartwright's analysis of medicine's visual culture, which will be explored further in the next section. Cartwright argues that much of the early laboratory work within the field of medical research attempted to establish the modern concept of life, often through overtly visual means, which took on a wholly different meaning through Enlightenment reasoning and scientific experimentation.

> [T]he motion picture… was a crucial instrument in the emergence of a distinctly modernist mode of representation in Western scientific and public culture—a mode geared to the temporal and spatial decomposition and reconfiguration of bodies as dynamic fields of action in need of regulation and control. (xi)

The concept of life and its living processes which emerged through modern medical research is reflected in the ways medicine constructs its own authority through the establishment of boundaries between a good and bad life. Cartwright further notes that many early motion studies included people with movement related disabilities, such as epilepsy, where medical researchers attempted to regulate what is "normal" movement through the documentation of the uncontrolled movements of a seizure. Thus, medicine's

epistemic drive to control life is inextricably imbricated with disabled embodiment. In a similar vein, histories of death have demonstrated that death has never been a stable biological category, where the biological indications used to determine death are culturally mediated (Strange). The medicalisation of old age has further imbricated medicine in not just the determination of death, but also in extending life and in determining what constitutes good health in the final years of our lives (Ottaway). Much of the action and drama of medical TV shows arguably directly emerges from these distinctly modern concepts of life and death, where bodies are "dynamic fields of action in need of regulation and control," or in other words, requiring dynamic and action-packed intervention from TV's finest medical doctors.

One component of the knowledge system through which medicine exerts its epistemic authority is what is known as the clinical or medical gaze. Originally defined as a term by Michel Foucault, it has been used extensively in disability studies and the medical humanities in scholarship which describes the effects of medical epistemic power on individuals and society at large. Essentially, it describes a bio-medical way of looking at human beings and the human body employed by doctors, but also increasingly in other social and cultural areas of society (Ostherr). Through the medical gaze, "medicine claims to 'see' diseases that lie deep within the body, bringing them into being as objects of consciousness and intervention. This distinctive way of seeing permits the doctor to know and label our diseases and, on those grounds, to orchestrate interventions in our bodies" (Greenhalgh 4). The term refers to how medicine effectively constructs the human body through discourses and practices, extending the critique of medicalisation

where social issues are transformed into diseases. Under the clinical gaze, the human body is constructed as an object of medical inquiry and investigation through the disciplining powers of medical knowledge (Lupton 99–100). The medical gaze is thus a manifestation of medicine's epistemic authority, where the body constructed through it is the ultimate truth, with the power to invalidate our own perceptions of our own bodies with authoritative regimes of observation and testing (Wendell 122–24). The medical gaze is inextricably tied up with visuality, having been constructed over the centuries of medical research which have privileged visual techniques as the ultimate mediation of the doctor-patient encounter (Ostherr). This emphasis on visuality becomes more important later in this study when considering the similar aesthetics of both television and medicine.

1.2 Television & Ideology

What should also be noted here is the constructed nature of storytelling through the medium of television, especially in the context of medical shows which often follow a heavily formulaic structure. As with all literary-cultural production, there is a reciprocal relationship between how television reflects societal and cultural environments and how it in turn contributes to shaping them. This has been remarked upon at length through literary disability studies, which notes how stereotypes become static tropes of representation, which in turn reinforce the shallowness of real-world stereotypes (Garland-Thomson, "Extraordinary Bodies" 10–12). In contrast with traditional perceptions of film and the cinema, television has historically placed an emphasis on the portrayal of events which occur in the real world (Bignell 21). This representation of realism can be seen in the screenings of live events, as well as in television's tradition of

fictional dramatic shows which heavily emphasise a firm basis in reality. This was the case with shows such as *ER* and many medical dramas which preceded it, as will be seen in the section to follow on the history of the medical TV show. Nonetheless, television portrays "only selected images and sounds, chosen by someone else, and present[s] them according to the conventions of storytelling and reporting which are established by television institutions and by legal regulations" (Bignell 23). Thus, television is a form of representation, even when it purports to represent real or realistic events and as such is inherently ideological (214). In constructing the kind of realism that many television shows claim, they rely on a common code of representation and judgement, based around a concept of "normality" (216), which echoes Garland-Thomson's elaboration of the concept of the "normate" discussed later in this study. From this perspective, it is clear how television can perform the social function of reinforcing concepts of normalcy or the unmarked centre, which is done partly through representations of stereotypes of the social Other, which emerge as tropes, which in turn reinforce those cultural stereotypes in our daily lives (Garland-Thomson, "Extraordinary Bodies" 11).

In discussing forms of cultural production such as network television, it is important to consider genre and formula in terms of how these are shaped by ideology and how they in turn restrict options for representation. In *Playing Doctor,* Joseph Turow convincingly argues that the formula for the medical TV show has hardly changed over its eight decades of existence. This means that, alongside restrictions of what kind of stories can be told about healthcare and its provision, "entrenched patterns of the formula along with the risks that television creators see in tinkering with them have sustained

outmoded understandings of the health care system as the basis for key aspects of doctor shows' institutional realities" (381–82). This formula eventually defines the genre, providing "security and appeal" to viewers, as well as "constrain[ing] by repetition" what kind of stories can be told (Bignell 60). The following section on the history of medical TV shows and modern medicine will show just how intimately the institution of medicine has been involved in the shaping of this consistent genre and formula. This exposes the potential consequences of a portrayal of the medical system controlled by those who already hold the cultural and epistemic power over it in the first place.

As far as noting social constructions, it would be useful at this point to note some of the boundaries and limitations of this study. By focusing on two American primetime TV shows, I am purposefully limiting my analysis to the cultural production emerging from a US hegemonic system. This is partly due simply to the dominance of American cultural products (particularly in the context of residing in Canada, where American products are in overabundance), especially when it comes to commercial and mainstream television. It is also because much of the specifics of the genre of medical TV shows were solidified in the US (Turow) and is the source of many of the most popular medical TV shows ever produced, even on a global scale (Epstein; Gardner; Spencer). Additionally, the focus on American TV shows naturally follows with a focus on the development of medicine and healthcare in the North American context. As the following sections will show, this is especially relevant in a discussion of the entrenchment of medical epistemic authority in the 20th century, and as with many other aspects of history, the history of medicine in the US spills over and is constantly relevant to a similar discussion of

medicine in Canada. Thus, when referring to the medical system throughout this study, I am sometimes specifically referring to the US medical system, but often more broadly referring to the systems of organized Western medicine which evolved through Enlightenment ideologies and approaches to knowledge construction (Porter; Spray).

As I continued to do research for this study, it became clear just how much the medical system was and is involved with and preoccupied by medical TV shows. The more I read, the more it became clear that the object of this study was not just these shows in isolation. Rather, it was the medical system itself, with the medical TV show as a cultural product emerging from the sheer dominance of the cultural and epistemic authority of Western medicine through the 20th century. As such, the first section of this study will provide an intertwined history of the medical TV show with the history of modern medicine. It will delve into the visual cultures of both TV and medicine, as well as other ways the institutions of medicine and television have worked symbiotically with each other over the past eighty years. The section following that will consist of an overview of the scholarly work which I hope to apply to my own study, drawing primarily from literary and cultural disability studies. Much of the scholarly study of medical shows has emerged from the field of medical science research, providing a very narrow, albeit telling perspective (in the sense of revealing how the medical profession itself views these shows). Bringing in new texts to the study of medical TV shows will provide new insight into the cultural weight these shows hold in contemporary society. Finally, the remaining sections of this work will involve close readings of various episodes from the series *ER* (1994-2009) and *Grey's Anatomy* (2005-present). These

analyses will reveal in detail how medical shows and their portrayals of disability and illness reinforce individual messages which accumulate to collectively uphold the epistemic authority of modern medicine. Ultimately, what this study will reveal is that scripted television shows emerged in the mid-20th century as the *ideal* format for the dissemination of propagandistic messaging about the medical system, with the ideologies of both industries aligning and coalescing in various subtle but significant ways.

1.3 On Close Reading as Methodology

To illustrate this project's claims about medical shows, medical epistemic authority, and the institution of medicine, I intend to select episodes from *Grey's Anatomy* and *ER* which draw from across the shows' many seasons in order to conduct close readings of the textual, narratological and visual choices made in the progression of the shows' narratives. In the past few decades, there has been significant criticism of the methodology of close reading, especially in relation to its origins in New Criticism, a conservative and reactionary school which emerged after World War II. A well-established practice, both in academic literary scholarship and in pedagogical practices, close reading has been criticized for its inclination to strip literature of its historical, social and political contexts, in favour of a closed analysis of literary aesthetic properties (Hines 32). Nonetheless, many of these criticisms ignore how close reading has been utilized in actual practice, particularly when employed as a methodology by those embracing very different ideologies than those embodied by New Criticism (James). Indeed, in his book *Aesthetic Nervousness,* Ato Quayson makes a sustained argument for

the value of close reading when reading disability in various literary texts. For Quayson, close reading for disability in a text can achieve two effects:

> One is to make more prominent the active ethical core that is necessarily related to disability and that hopefully helps to restore a fully ethical reading to literature. The other is that from using disability to open up the possibility of close reading, I hope to encourage us to lift our eyes from the reading of literature to attend more closely to the implications of the social universe around us. (31)

This project intends to follow in the spirit of Quayson's formulation, where close reading allows for a comprehensive understanding of the subtleties of the place of disability and illness in medical TV shows, where as a methodology it is employed, "not so much to establish the autonomy of the text as to convey the subtle relations that secure the place of disabled characters within the literary-aesthetic domain" (35). This is a fully contextualized close reading, situated within a complex understanding of the historical, political and social implications of the specific aesthetic and structural components of medical TV shows under scrutiny for this project.

As my strategy for selection, I chose episodes which were to me the most emblematic or illustrative of the specific tropes or patterns which I identify as collectively contributing to the ideological project of the medical TV show. These episodes will thus most acutely serve to reinforce the epistemic and cultural authority of modern medicine through their depictions of disability and illness. To review, select, and analyse these episodes, I accessed them through the two streaming websites which host *ER* and *Grey's Anatomy* in Canada, Amazon Prime and Netflix, respectively. Through my close readings, I will incorporate the relevant ideas and theories outlined in the following sections,

drawing from literary and cultural disability studies, the medical humanities, as well as visual communication, media, and television studies.

2. The Medical TV Show & Modern Medicine: An Intertwined History

When in 1954 the NBC show *Medic* first made the TV airwaves, it was marketed with headlines which declared that it made "no compromise with truth" (Turow 44). The show would go on to become the first hit primetime medical show to air on American network television. Its creator, James Moser, had spent two and a half years "stalking" the hallways of the Los Angeles County Hospital as research for the show, endeavoring to create the most realistic portrayal of medicine possible (53). Once the show went into production, its authenticity was additionally rigorously enforced through the perspectives of medical professionals belonging to the Los Angeles County Medical Association, who through a deal made between themselves, the network, and the production company, had absolute final signoff and veto power over every single script of the short-lived show. As Joseph Turow notes in his comprehensive book on medical TV shows, *Playing Doctor,* medical consultants on these early medical shows not only supervised the scripts for accuracy of medical facts, but also for the show's portrayal of medicine and doctors overall (59). What Turow also notes, is that while the medical professionals pushed their specific view of the field of medicine on the shows' writers and producers, the disagreements which emerged were limited to conflicts between writing good narratives and the accuracy of medical terminology or procedures, and not the supremacy of medical knowledge or the power of the institution itself. As mostly affluent, middle-aged white men, the creators of these shows resoundingly endorsed portrayals of the system as

uniquely positive, modern and cutting edge, as they belonged to the demographics which most benefited from the unequal distribution of the modern marvels of the medical system during the mid-century (26, 68).

Through its detailed account of the history of the medical TV show, Turow's book emphasizes the instrumental role the institution of modern medicine played in the establishment of the formula that came to rule the development of the TV medical show, a formula which he argues has hardly changed since the first episodes of *Medic* back in 1954. Although *Medic* was short lived as a show, it still managed to establish many of the elements of the doctor show formula which are still familiar to viewers of these shows today: a primary, if not exclusive focus on doctors; a setting mainly focused within the walls of a hospital; a focus on acute illnesses which are resolved often within a single episode; and the centrality of the infallibility of medical knowledge itself, featuring themes which "both glorified establishment medicine and placed heavy responsibilities on it" (42). The actual role of institutionalized medicine in establishing and propagating these shows cannot be underestimated. As Turow argues, the authoritative control organizations such as the American Medical Association (AMA) had over the earliest shows ensured the development of a formula which had the overt stamp of approval of the AMA[1]. While the control the AMA had over the earliest shows began to wane over the decades as network executives and producers became more confident in their

[1] In fact, the AMA introduced a system of oversight for medical TV shows which included "a written statement noting its cooperation at the end of each episode," (Turow 88) in exchange for the right to review each script with the intention of preserving medical authenticity and a positive representation of doctors and medical practice.

portrayal of the genre, there continued to be medical experts and consultants who had significant authority over scripts, sets, actors' portrayals and more. Most recently, following the success of *ER* which was created by Michael Crichton, a graduate of Harvard medical school and a former medical intern, medical shows have had real-world doctors working on the creative production side of the shows, as writers, producers, and directors. In this sense, *ER*, and the shows which followed its precedent, "went further in ensuring the profession's [institutionalized medicine] legitimation by choosing writers who were themselves physicians" (Turow 346).

Possibly the biggest shift in the medical TV show formula over its almost eight decades of refinement is the primary focus of the narratives transitioning from the patients to the doctors themselves. For the first few decades of their existence, while the main stars and recurring characters were doctors, episodes of these shows would primarily follow the patient or patients introduced at the beginning of the episode. This would include the introduction of not only the medical concern they came in with, but often also emotional and social problems which accompanied them, all of which the dependable and familiar doctor characters would help to resolve. In shows such as *Ben Casey, Dr. Kildare, Marcus Welby, M.D,* and more, the doctors would remain relatively flat characters over the seasons, with the patients given more screentime to develop a storyline and a certain degree of characterization. Beginning in the 1980s with *M*A*S*H,* the formula went through what Turow calls "undoubtedly the most fundamental change in the doctor-show formula over the decades" (368). Instead of focusing on the problems of patients coming to the hospital for medical treatment and the issues surrounding their

lives, medical series began to focus on the lives of the doctors, who were for the first time revealed to be flawed, less-than-idealized human beings struggling to make the best of a flawed system and their high-pressured lives.

This representation of doctors shifted their portrayal as unassailable heroes to a portrayal of them as hero-victims, where the doctors struggle admirably against forces working against their righteous drive to save human lives. A critical consequence of this shift, and something that is still observable as a feature of today's medical shows, is that the focus on doctors as the hero-victim inevitably made patients one of the "forces" that work against them (Turow 340). In order to provide more opportunities for characterization of the doctors in a roughly forty-minute episode, the development of the patients' backgrounds and struggles were significantly reduced, making them much more static and shallow representations than they had previously been. As Turow notes in an overview of an early episode of *ER*, a patient's backstory and his interaction with the doctors, which in previous decades would have been given an entire hour to develop, takes place over no more than one minute. Additionally, this one minute serves to reinforce a message about one of the medical professionals in the show, and not about the patient character himself (369). In the effort to make doctors seem more human, the humanity of their patients had to be dramatically curtailed. This shift will be shown to have significant implications for the portrayal of medicine, disability, and illness in the section of close readings of shows which adopted this newer formulation of the genre.

This shift in the formula marked the beginning of a period of unparalleled proliferation of the medical TV show. Since *ER* first aired in 1994, over 80 shows

featuring doctors as main characters and which take place in medical settings have aired on American television alone ("List of Medical Drama Television Programs"), many of which have become consistent international hits, such as *ER, Grey's Anatomy, House, the Good Doctor* and more[2]. While part of this success is contributable generally to the increase of TV viewership globally, especially with the advent of streaming platforms (Rocchi), the specific success of medical TV shows is often seen as attributable to the increase in popular concern about healthcare and its provision, medicine's control over life and death, as well as the continued increase of medicalisation throughout society (Gauthier; Henderson; Turow). Put simply, the medical industrial complex touches everyone's life in some way or another, and medical TV shows provide a place for viewers to explore and in some ways understand, though in limited ways, how some of these processes work. We therefore see again that it is impossible to separate the fictional depictions of medicine and healthcare from the real-world systems they represent. It is important then to present some of the history of the development of medicine in the 20th century, in order to fully understand what these shows do as a function of popular culture.

While the genre of the medical TV show was still being honed and crafted by the production companies associated with the major US television networks, the institution of medicine itself was in a state of constant change and evolution. The history of modern

[2] During its peak, *ER* was the most watched TV show in North America, averaging 30 million viewers per week during the 1996/97 season. Since it began streaming on Hulu (US), it has been in the top 4 shows overall for the streaming service (Gardner). *Grey's Anatomy* has had even more consistent success, continuing to average over 15 million viewers per episode, and according to Netflix, is the second most popular streaming show in the world (Epstein). During their own peak seasons, *House* and *The Good Doctor* were also some of the most widely watched television shows in the world ("'House' Is World's Most Popular TV Show"; Spencer).

medicine is vast and complex, especially when considered alongside its social, political and cultural contexts. Medical advances through the latter half of the 20th century consolidated a mainstream narrative of medical history as "a narrative of great men and their selfless devotion to research" (Cartwright 129). Nonetheless, this narrative conceals much of the social, cultural, economic and political changes that the institution of medicine was a critical part of throughout its development. While it is impossible for the length of this study to discuss the entire history of medicine, the following paragraphs will outline the relevant aspects which emerge as important to both the understanding of medical TV shows and the representations of disability and illness within them.

Prior to the 19th century, medicine was not considered a particularly respectable field, or one with any sort of scientific legitimacy. Many popular medical treatments of earlier eras did more harm than they did good, and physicians and doctors regularly had to compete with other professions which claimed to be custodians of human health, such as homeopathy, street medicine vendors and more. Especially in the US, the practice of medicine was not a regulated profession (Pickstone 305). This began to change when medical practitioners decided "to hitch their profession's star to the rising success of science" (Turow 20), specifically, to Enlightenment science and the scientific method. As a part of the increasingly legitimized field of scientific medical research and practice were new frameworks of diagnostics and etiologies, systems of classification which were created to organize human bodies and to solidify boundaries between the created categories of normalcy and aberrance. Entire groups of people were subsumed into the logics of Enlightenment science and its drive to "objectively" classify, naturalize, and

standardize all living things. Alongside these new classifications came new industries of rehabilitation, treatment, and control, addressing what was considered abnormal, now under the medicalised terminologies of disability, pathology, aberration and illness (Braddock and Parish). As medicalisation has become a dominant factor in our lives, the consolidation of medicine's power has been concentrated around the most marginalized and oppressed groups. This inevitably takes form through the enforcement of Western liberal capitalist values and ideals and as a means of social control (Lupton 96–97). Many of the medical advances made at the end of the 19th and early 20th centuries emerged from military and/or colonial milieus, further emphasizing medicine's development of its power as a form of social control and epistemic dominance (Pickstone 306).

It is important when considering this history of medicine to centre how disability and illness have been shaped by the expansion of the institution of medicine, through medicalisation and the pervasiveness of the medical model of disability and illness. In the centuries prior to the ascendency of medical science, disability and illness were defined by specific impairments, often attributed to supernatural, spiritual, or moral causes. This is not to say that disability and illness were not significantly regulated as they are today through medical control, but only that this was done more explicitly through culturally and non-scientifically based terms, for example through community control (such as prisons or community exile), custodial institutions (such as asylums or schools for the deaf and/or blind) (Braddock and Parish), or for a smaller number of disabled people, freakshows and exhibitions (Garland-Thomson, "Extraordinary Bodies"). As medical science gained ascendency, disabled and sick people were increasingly targeted for

regulation, and became understood exclusively through the eyes of medical pathology and medical model concepts of deficit and abnormality.

One of the ways through which medicine was increasingly able to pathologize disabled bodies was a rapidly developing system of medical technologies, all intended to be able to better measure, observe, and ultimately control the human body and its processes. These technologies, including x-rays, stethoscopes, electrocardiographs and more, increasingly encouraged a scientific and medicalised understanding of human bodies, in many ways solving the mystery of certain forms of embodiment while also bringing into the fold many conditions that previously had not been considered medical or pathological under the purview of the medical gaze. Another consequence of this proliferation of medical technologies and devices was the direct consolidation of medical epistemic authority. As Cartwright argues, doctors were no longer limited to the methods of observation generally available to anyone, such as visual observation and manual examinations of the body. New technologies allowed doctors and researchers to see *into* the human body, revealing things unobservable to the unaltered human senses. These advances, "did wonders to increase the legitimacy of 'regular medicine' in the eyes of the rest of society as well as to encourage people's dependence upon physicians" (Turow 21).

2.1 Crossovers & Symbiosis

In many ways, the emerging medium of television was the ideal format for institutional medicine to consolidate its image for the purposes of cultural consumption. Television and medicine overlap with each other in significant ways, including their respective relationships to visuality, seriality and didacticism. They also share an

investment in preserving established systems of power, which over the decades have proven to be fruitful for both industries in complex and symbiotic ways. For instance, returning to Cartwright's discussion of medicine's visual culture, it is important to note the significance of medical research's drive to define the boundaries of life and death alongside the oft stated purposes of medical shows to showcase the drama of life and death (Turow 138, 177). By exploring this drama through a medicalized context, medical TV shows reinforce the cultural perception that medical science is the exclusive framework through which the concepts of life and death are constituted and determined. Through this comparison, the uneasy similarities between the institution of medicine and its representation through television narratives begin to emerge. In her overview of the medical TV show, Marta Rocchi notes that the portrayal of medicine in popular culture has mostly found success in TV shows, with other media such as film, radio and books consisting a very small fraction of the overall content (70). As will be seen in the following paragraphs, this is arguably because of the unique qualities of television which complement aspects of medical culture itself.

On the surface it may seem that television's connection to visuality is fairly obvious and straightforward, as television is an audio-visual medium (Bignell). When considered alongside medicine's relationship with visuality though, new perspectives emerge and the visuality of television can be examined in a new light. The history of medical scientific research has long been intertwined with the history of photography and film. While their respective histories have often been written as more divergent into the 20th century, Cartwright argues that this is an erroneous framing, illustrating how the

emergence of the modern cinema of entertainment and medical scientific research have been significantly influential on each other. Film was especially critical in the establishment of medical research which examined living processes, including physiology, as the study of life had previously been paradoxically reserved to studies of dead animals or human bodies (Cartwright; Kirby). Thus, film was able to vivify the body in ways previously inaccessible to science, a context which becomes particularly interesting when considering the medical TV show's fixation with representing life and death. Indeed, as Cartwright argues,

> [T]he cinematic apparatus can be considered as a cultural technology for the discipline and management of the human body, and… the long history of bodily analysis and surveillance in medicine and science is critically tied to the history of the development of the cinema as a popular cultural institution and a technological apparatus. (3)

While the human stories portrayed by these shows are compelling, it is arguably the visual performance of medicine's rituals of preserving, extending, and containing life and death which is made into some of the most enthralling parts of medical shows, and indeed is what make them unique amongst other TV formulas. This can be seen especially when examining disability in medical dramas, where narratives are driven by doctors deciding whose life (and death) has value in relation to the limits of medical science and the provision of healthcare.

Many of the techniques of visual storytelling in medical TV shows parallel the use of visual methods in medicine which serve to document medical phenomena. For instance, since their inception medical TV shows have relied heavily on the use of x-rays, and more recently MRI and CT scan images, as part of the visual aspects of narrating the

trajectory of a patient's story. These medical tools often serve as visual accompaniment to a climactic narrative point where a doctor determines a diagnosis. Additionally, these shows depend significantly on the visual disturbance of shocking human bodies, often embodied by patients with uncommon or particularly visual disabilities, emphasizing the specific way that visuality reinforces stereotypes (Fahmy and Alkazemi). Garland-Thomson has discussed at length the relationship between disability and staring ("Ways of Staring"; *Staring: How We Look*) and the way many of these shots are framed reveals a dependence on shock value and the thrill of spectacle, harkening back to the aesthetics of disability freakshows (Wegner). Still, this aesthetic framing is done in a truly modern sense, with a medicalised lens applied, and so every non-normative body we encounter through these shows is an invitation to pathologize, categorize, and visualize as in need of fixing. Thus, medical TV shows, with their emphasis on a medicalised form of visuality, invite viewers to engage in a form of staring that is packaged as a legitimate medical gaze, reinforcing disability stereotypes through the medical model and medicine's authority in the process.

On the other side of this invitation to stare at the exterior of extraordinary human bodies (to use Garland-Thompson's term), medical TV shows today increasingly invite us to stare at the interior matter of the human body, to examine it in bits and pieces. This occurs in the context of extended shots of surgeries, amputated limbs, crushed internal organs, excessive blood and more. When medical TV shows in the 1990s moved away from directly involving AMA representatives and official medical bodies in their consultation process for the accuracy of their shows, they embraced other techniques for

signaling authenticity to their viewers. These were notably almost all visual techniques, with the new claims of authenticity in these shows largely stemming from stylistic changes to the way these shows were filmed and edited, as well as their visual content. Thus, when *ER* first aired, one aspect of its new-age realism and accuracy stemmed from the show's unprecedented portrayal of bodily gore, showing blood, guts, body cavities, and more visceral aspects of the human body than had ever been seen on medical TV shows in previous decades (Turow). This unprecedented portrayal of the insides of the human body mimics medical science's centuries-long obsession with visualising the interiority of the human body, where the body's truths are constantly conceptualized as being held just beyond our own ability to see them with the naked eye (Cartwright). This logic of medical research extends into popular culture so that when we are shown the insides of the human body on TV, we are left with an increased sense of having seen something realistic and authentic, that is, the truth of the human body which is typically withheld from our own observation but for the revealing nature of these shows.

ER was also a pioneer in the use of the Steadicam camera in television shows, a technology which had previously been used almost exclusively in cinema (Butler 244). This technique was able to provide interest to an otherwise boring conversation about a diagnosis or treatment regimen between doctors, by following them as they walked from one place to another through the busy hospital. This helped to convey a sense of movement and excitement in relation to the plot while also conveying a sense of space in the setting (in this case, mostly of a hospital) that would otherwise be lacking from static camera shots (Bignell 160–61). This technique further contributes to a sense of realism,

as "[the camera] moves with characters who move through the space of the scene… giving a sense of the whole space. These… present an extended experience of time and space that suggests privileged observation of a real world as it is lived" (Bignell 161). Seeing as these shots are mostly employed to follow the movement of the doctors through the hospital, this technique contributes to the viewer's identification with the doctors, as we move with them through the hospital as the narratives progress. Doctors are portrayed as dynamic, in constant movement, and proactive, whereas patients are usually portrayed as static and passive: lying in bed, lying in an MRI machine, or lying on a surgical table. This visually constructs a system where doctors are hypercompetent professionals with the knowledge and skill to justify their behavior, even when this behavior is shown to be neither professional, knowledgeable or skillful. Through their emphasis on visual medical screening techniques as visual narrative device, the shocking portrayals of the extraordinary disabled body and close-ups of bodily gore, and this particular use of the Steadicam, it is clear that medical TV shows visually mimic the medical gaze and thus, through their very construction, reinforce the epistemic authority of institutional medicine. Visuality and its relationship with medicine proves to be not just critical for the conveyance of a sense of realism and accuracy in these shows, but also in reinforcing the supremacy of medical authority in society at large.

One way in which television significantly differs from other storytelling methods such as novels or film is the dependence on serial narration. Serial narration, where a story emerges across multiple episodes, developed as a narrative strategy for television in the 1960s. Network executives and show creators were attempting to increase viewership

and sustained engagement with their products, which until then had largely consisted of episodic narratives (Murphy). TV serials were also lucrative, as they reduced costs for sets, casting and other production components, as well as being easily packaged for syndication in other countries (Bignell). One of the first American TV shows to experiment with the serial format was NBC's *Dr. Kildare* (1961-66), which went on to become one of the first medical TV show sensations. The advent of this type of narration and the success of *Dr. Kildare* is arguably not a coincidence. As Wohlmann and Harrison note in their article on disability and serial narration, the construction of series has been an essential component of medical science since the late 17th century. Many illnesses and diseases are characterized through medical discourse as staged, or in other words, serialized, and many narratives of illness and chronic disease emphasize the experience of them as a "series of dramas" (68). Thus, the television serial narrative format echoes the narration of illness as it is constructed in the real world itself. Wohlmann and Harrison argue that serial narration can provide a more complex and nuanced representation of chronic illness in television, especially when the disease does not follow the traditional narrative structures of exposition, climax, and conclusion. This seems to especially be the case in medical TV shows portraying illness or disability when it occurs in the recurring doctor characters. As two examples amongst many, this can be seen in the serialised portrayal of physician's assistant Jeanie Boulet's experience with HIV across seasons 3 to 5 of *ER* or in Dr. Arizona Robbins' grappling with the effects of a leg amputation throughout season 9 of *Grey's Anatomy*.

Various publications have explored the early relationship between the creation of scientific medical knowledge and of seriality. One article notes how during the 19th century, scientists moved towards a qualitative method of organizing the massive amount of scientific data that was accumulating through the establishment of scientific journals and serials, embracing overtly literary methods to make sense of the varying and often disconnected advances being made across the natural sciences (Csiszar). As Cartwright emphasizes in *Screening the Body*, medical science did not develop in a vacuum, rather it was constantly influenced by the surrounding cultural norms and ideologies. Thus, Vasset notes the similarities between medical and literary publications in the 18th century, with many early medical researchers adopting literary styles common at the time to qualitatively illustrate their findings, including the common usage of serialized narrative structures (1). As such, the appropriateness of the television serial for the narration of medical stories emerges in multiple ways, fitting with a centuries-long tradition of how medical researchers narrate the nature of illness and pathology itself. Rather than a creative and personalizing approach to narrating the harsh objectivities of medical science, as is often advertised as the draw of medical TV shows (Turow), the narrative structure of these series in fact conforms to the established traditions of medical research. This parallel between the narratological nature of seriality in both television and medicine provides both with inherent benefits when combined into the medical TV show: the shows benefit from an endless array of illnesses which are often already characterized by seriality, making for good plotlines which can span any number of episodes, while institutionalized medicine benefits from the popular consumption of mainstream,

fictionalized narrations of illness and medicine which vary quite little from the accepted ideological framings of illness and medicine structured by medicine in the real world.

As indicated by much of the medical scholarly discourse, there is a persistent view of medical TV shows as didactic in nature, imparting varying degrees of knowledge about medicine and the medical system to viewers. Even in a show like *Grey's Anatomy*, often described as closer to a soap opera in terms of its tone and content[3], there is a persistent view that viewers are, or should be, learning something. There is little doubt that institutional medicine has always seen medical TV shows as a means of educating the general public about medical conditions and healthcare (Turow; Hoffman, Shensa, et al.; Beck). The rise of the cinema had already convinced doctors and scientists of the usefulness of fictional narratives in dissemination scientific and medical information to the general public (Kirby). Today, medical shows are even seen as an important tool in medical school curriculum, apparently revealing popular ideas about healthcare and attitudes towards medicine and doctors themselves (Hoffman, Hoffman, et al.; Goodman; Stanek et al.). Television was an ideal medium for the dissemination of medical information, largely due to its own originary conceptualization as an important venue for public messages and civic engagement (Bignell 54). This intended didacticism has heavily influenced the shape and appearance of medical shows to this day, even when the shows do not purport to be particularly accurate or realistic.

[3] Shonda Rhimes, the show's creator, described *Grey's Anatomy* as, "unique because we're definitely a relationship show, with some surgery thrown in for good measure" (Rhimes, as quoted in Turow 371).

The intended didacticism of these shows relates significantly to the impression of their realism. Initially, the AMA supervisors were concerned about misinformation and realistic representations of illnesses they felt the general public didn't know enough about, insisting on accuracy in order to avoid inciting panic or complacency. Through the 1990s and into today various disease organizations, such as the American Cancer Society, realised the potential for their cause in having a popular prime-time medical show feature an illness for the purpose of awareness raising and public education (Turow 207–08). These consultants influenced and guided accurate descriptions of symptoms, testing and treatment protocols, and recovery probabilities, amongst other medical science-oriented concerns. As such, the realistic portrayal of an illness or disease was often reduced to an accurate dissemination of objective information about it, rather than a realistic representation of the subjective experience of living with said condition (Hether et al.; Hoffman, Shensa, et al.). This aligns with what has historically consolidated as evidence of a realistic portrayal of modern medicine and healthcare in a medical TV show, where for decades medical procedures, doctors' behaviours, technological devices, and treatment protocols have been much more heavily scrutinized for accuracy than any representations of patient experiences or other subjective experiences of healthcare. These representations are of course further limited by the fact that while television has often liked to consider itself a tool for public service, it is still heavily governed by market demands, meaning the producers of a show will only feature medical topics they feel will make for entertaining TV (Henderson; Turow). Thus, as was seen earlier, a very specific and narrow version of realism emerges within these shows.

3. Literary Disability Studies & Scholarly Writing About Medical TV Shows

Considering their enduring popularity over the past eight decades, there has been a significant amount of academic scholarship about medical TV shows, not to mention the copious amounts of newspaper articles, blog posts and other media content about them. Nonetheless, sifting through this content reveals a concentration of analysis around certain topics. With the shift in the medical TV show formula which took place during the 90s, where patients became secondary to the doctors themselves in terms of character and narrative development, it would be easy to forget the roles patients play in the modern medical TV show. Indeed, it seems that they have been all but overlooked in much of the scholarship about these shows, where doctors, individual illnesses, procedures, and various other aspects of these shows receive much more attention than the sick, injured and disabled patients. A large amount of scholarly writing about medical TV shows emerges as concern by medical professionals, mostly doctors and nurses, as to how these shows accurately or inaccurately portray medicine and its practitioners (Czarny et al.; Ouellette et al.; Serrone et al.), while in contrast, very little has been written about medical dramas using disability studies frameworks.

The field of literary disability studies provides a necessary addition to an examination of these understudied aspects of medical TV shows, although relatively little has been written about these shows directly applying literary or cultural disability studies frameworks. Nonetheless, the texts discussed below provide a useful entryway into discussing how disability and illness are constructed within medical TV shows. One common tactic in the texts below and in many others in disability studies is to centre the

lack of discussion of disability as worthy of analysis in and of its own right. Thus, the dearth of discussion of the representation of the disabled and sick patients in these shows itself becomes something worth examining. Additionally, the texts discussed below emphasize the need not to examine literary texts and their representation of disability as isolated from the real-world experiences of disabled people. They reject simplistic conceptualizations of the relationship between representation and reality and instead describe a complex interplay between material embodiment, semiotics, literary tradition, personal experience, social and political marginalization, history and more. While the field of literary disability studies is constantly expanding, this study will primarily draw from three foundational texts with crucial theoretical concepts to be applied to the analysis of medical TV shows for this study. These include *Extraordinary Bodies* by Rosemarie Garland-Thomson, *Narrative Prosthesis* by David Mitchell and Sharon Snyder and *Aesthetic Nervousness* by Ato Quayson.

In *Extraordinary Bodies,* Garland-Thomson engages in one of the earlier attempts to bring disability studies into the humanities and specifically literary and cultural studies. Garland-Thomson draws on feminist theories which interpret the body as a cultural text, which is "interpreted, inscribed with meaning—indeed *made*—within social relations" ("Extraordinary Bodies" 22 emphasis in original). Through seeking to understand how physical disability operates through cultural and literary representations, the book reveals several ways what Garland-Thomson describes as extraordinary bodies are framed alongside and through different ideological and aesthetic framings, including freakery and sentimentalism. As part of these ideological and cultural constructs, Garland-

Thomson defines the useful concept of the "normate", which she positions as the mutually constitutive figure alongside the disabled figure. This term:

> [N]ames the veiled subject position of cultural self, the figure outlined by the array of deviant others whose marked bodies shore up the normate's boundaries. The term normate usefully designates the social figure through which people can represent themselves as definitive human beings. Normate, then, is the constructed identity of those who, by way of the bodily configurations and cultural capital they assume, can step into a position of authority and wield the power it grants them. ("Extraordinary Bodies" 8)

The concept of the normate is especially useful when examining how disability and illness in modern medical TV shows functions in relation to the non-disabled doctor characters. It is also useful when applying Quayson's formulation of a close reading methodology, where it is crucial to examine the entirety of a text for how disability is constructed throughout, and not just where the disabled characters themselves appear. Garland-Thomson's analysis is additionally of particular use to this study as it is not limited to so-called "high literature", including texts such as photography, brochures and popular fiction which emphasize the visual nature of representations of physical disability, as well as its operation through more mainstream constructs.

It is worth describing in more depth how Garland-Thomson positions disability alongside various American ideologies, as many of these are also reflected in how disability is constructed in American medical TV shows. Indeed, some of the disability studies scholarship that does engage with medical TV shows has explicitly considered them through the analytical framework of freakery extrapolated in *Extraordinary Bodies.* Although freakshows and their aesthetics have been analysed from various perspectives, Garland-Thomson's is particularly useful as it is positioned alongside the normate. When

considered as mutually constitutive figures, the way medical TV shows construct doctors and patients emerges as a constant discourse between social constructions of normative, economically productive figures and the disruptive socially Othered figures typically represented by patients. Gesine Wegner's analysis of the spectacle of freakery in medical TV shows provides useful insight into how the aesthetics of the American freakshow have evolved through modern cultural production. Her article also draws attention to Garland-Thomson's assessment of freakery as a source of entertainment and wonder, where its frequent presence in medical TV shows is easily explained by television's exigencies as a visual spectacle.

The other concept outlined by Garland-Thomson which is relevant to an analysis of medical TV shows is sentimentalism. *Extraordinary Bodies* provides a meticulous analysis of how the images and bodies of disabled people have historically been used to shore up the ideologies which support American nationalism. As products of mainstream American network television production, medical TV shows are heavily invested in the project of American nationalism and its concomitant ideologies. The appearance of disabled figures in these shows often serve to reinforce these values. *Extraordinary Bodies* identifies the aesthetics of freakery as essential to the construction and reinforcement of these values, as well as a complementary aesthetic category of sentimentalism. Sentimentalism, while on its face quite different from the freakshow, is similar in that both "appropriate disabled figures in the service of individualist ideology" ("Extraordinary Bodies" 81). Sentimentalism employs disability in a spectacle for the purposes of generating sympathy, casting it into similarly restrictive aesthetic boundaries

which limit disability to an object of pity and a marker of innocence, powerlessness, and suffering. Both aesthetic categories appear to various extents through medical TV shows and are useful in understanding their construction of disabled figures through the framework of American nationalism and to a broader extent, Western liberal ideology. The relevance of these categories is evidenced further through the relationship they have to the real experiences of disabled people, as ideology and its derivative aesthetics translate to material consequences in the real world. Garland-Thomson describes how the eugenicist concepts of degeneracy and insufficiency which have surrounded disability in the past few centuries are dependent on the values of autonomy and productivity inherent to the project of Western liberal individualism, which are directly reinforced through the representation of disability as either freakish or sentimental ("Extraordinary Bodies" 35).

Mitchell and Snyder provide another useful foray into literary disability studies with their book *Narrative Prosthesis*. They pay special attention to the role disability plays in initiating the narrative process. The authors identify how literary narratives are replete with disability and its frequent appearance often serves to "inaugurate the act of interpretation" through the text. They observe that the marginalization and oppression of disabled people has happened alongside the constant circulation of their images through cultural texts. They argue that:

> [L]iterary efforts to illuminate the dark recesses of disability produce a form of discursive subjugation. The effort to narrate disability's myriad deviations is an attempt to bring the body's unruliness under control… disability's representational "fate" is not so much dependent upon a tradition of negative portrayals as it is tethered to inciting the act of meaning-making itself. (6)

This is a particularly important framework of analysis when considering the sheer quantity of disability and illness in medical TV shows, where every episode is driven by the narrative action initiated by the constant presence of disabled figures. In addition to narrative prosthesis, Mitchell and Snyder describe what they refer to as the materiality of metaphor. This describes how disability uniquely operates when utilized for metaphorical purposes in literary texts, where the use of disability as metaphor provides a material and corporeal grounding for such metaphorical speculation within a text. Another critical perspective in their book for the purposes of this study is their conceptualization of how other disciplines interact with literary production. They argue "that imaginative literature takes up its narrative project as a counter to scientific or truth-telling discourses. It is productively parasitic upon other disciplinary systems that define disability in more deterministic ways" (1–2). This claim becomes troubled in an interesting way when considered in the context of the medical TV shows, which strive in multiple ways to replicate and reinforce the medical gaze and to portray themselves as closely aligned with medical knowledge and ideology.

The final major text of literary disability studies to be considered for the purposes of this study is *Aesthetic Nervousness* by Ato Quayson. In previous sections I have already described how Quayson's formulation of a methodology for close reading will be usefully applied to this study. This book is additionally useful in how it positions the role of close reading in revealing disjunctions between content and narrative structure in the representation of disabled figures. The analysis reveals how closer attention to the conventions of genre, characterization, and narrative alongside the unusual position

disabled characters often occupy in a text reveals disjunctions and contradictions. This occurs throughout the entirety and at all levels of the text, beyond just the parts where a disabled character appears. Quayson also provides a comprehensive list of tropes of literary disability representation, which include tropes which occur frequently in medical TV shows, such as: disability as null set and/or moral test, disability as inarticulable and enigmatic tragic insight, or disability as hermeneutical insight. His descriptions of these tropes provide a useful orientation to how they function in a format such as the medical TV show. *Aesthetic Nervousness* provides this study with an interpretive orientation for literary analysis, which emphasizes the need to pay attention to every aspect of a text in relation to the construction of disability.

4. Close Readings

Beyond their genre-specific status as medical TV shows, their decades long runs, and their immense popularity, on the surface *ER* and *Grey's Anatomy* seem to have little in common. Their creators had very different intentions in mind; Michael Crichton was a Harvard medical school graduate, wanting to create the most realistic and exciting depiction of the medical system to air on TV with *ER*, and Shonda Rhimes wanted to create a show about relationships with the added high stakes action of the main characters being surgeons in *Grey's Anatomy* (Henderson; Turow 345, 371). While both shows have been immensely commercially successful, *ER* carried with it a tone of prestige, being nominated for endless awards and written about extensively by medical professionals praising its unprecedented accuracy (Henderson), while *Grey's Anatomy* has frequently been compared to soap operas and critiqued for the absurdity of many of its medical

plotlines (Burkhead; Serrone et al.). Emphasizing this difference in tone, *ER* often dealt with social issues and the provision of medicine in ways *Grey's Anatomy* never would, featuring storylines about poverty, abuse, police brutality, sexual violence and more throughout its run, whereas *Grey's Anatomy* has focused more on romantic affairs, sexual escapades, and emotional medical cases in a hospital which seemingly never has a shortage of funds, resources or personnel. Their respective structures reflect these differences; *ER* often featured many patients per episode, sometimes only for a few seconds each, with chaotic pacing and framing throughout the ER department itself, while each *Grey's Anatomy* episode features much fewer patients, with more time taken up by the doctors while they were not directly working on patients. Nevertheless, despite their significant differences in tone, content and structure, both make similar statements about medical knowledge, medical practice and the role of medicine in society at large, as well as related claims about disability and illness. When analysed for how they each utilize disability to serve these ends, similar tropes of representation emerge, revealing narrow categories of possibility for how disabled embodiment appears throughout.

Both shows fully embrace the shift in the formula which transferred most of the dramatic action to the doctors, rather than the focus being on individual patients as had been common in the previous decades of medical TV shows. It is worth commenting briefly on one episode of *ER* which was hailed as ground-breaking when it aired, which was unique to the show in that the entire episode focused on one dying patient, with the episode's narrative framed entirely from his perspective ("Time of Death"). In this episode, Ray Liotta stars as Charlie Metcalf, a middle-aged man who passes out in the

ER, dying from end-stage cirrhosis. While the ER's doctors and nurses do appear in the episode, they are secondary to Metcalf's perspective as he lies on a gurney, coming to terms with his life and impending death in real time. We learn about his estranged son, his alcoholism, and subsequent criminality that stemmed from unresolved grief over his wife's death. The viewer journeys with him through various states of consciousness as he slowly slips away over the 40-minute episode, with results that are evocative, emotional, poignant, and sometimes surrealist. For the first time in *ER*'s 11 season run, this episode humanizes the various alcoholic and street involved figures who have cycled through the show, making them real people with complex stories that have in one way or another led them through the double doors of the ER. This episode demonstrates the narrative potential of focusing on patient perspectives, something usually ignored by medical TV shows in favour of the nuanced portrayal of doctors and their issues.

For this study, the focus of the analysis is on the superfluous number of disabled patients who pepper these shows and who remain understudied in the scholarship on medical TV shows. Nonetheless, over the many seasons of *ER* and *Grey's Anatomy* the recurring main characters of the show experience a plethora of disabilities themselves, either themselves or through their family and loved ones. The disabilities written for doctor characters differ significantly from those assigned to patients or their families. Through both shows, certain disabilities reappear repeatedly, largely due to their usefulness for narratives and character development, meaning that despite their serialized nature over several episodes, they remain static representations of the disabilities they purport to represent. For instance, both *Grey's Anatomy* and *ER* feature plotlines about

doctors with brain cancer. Brain cancer seems to be a popular trope due to a symptomology that allows novel narrative arcs, including hallucinations and behavioural changes, which allow for intrigue and conflict to build over multiple episodes, culminating in a dramatic diagnostic scene. Brain cancer is then treated as an illness which is either quickly cured or ends with death, allowing for a tidy ending to a dramatic plotline that forces a doctor to grapple with their own mortality. Similarly, both shows feature a character who experiences a traumatic leg amputation. Through both plotlines, the amputation serves as a short-term exploration of coming to terms with a new disability, and the exigencies of their intensive jobs in the context of newly limited mobility and pain. Amputations are seemingly chosen for similar narrative reasons as brain cancer, as they either result in the character being unable to cope with the demands of their job, thus leaving the show, or are quickly rehabilitated to the normate through their almost flawless adoption of prosthetics.

The final trope of disabled doctors I will discuss here is more nuanced and illustrates most vividly the ways disability in doctors is used to reinforce values of individualism and productivity under capitalism, especially along the lines of race and gender. Considering the dearth of recurring Black female characters, it seems significant that each show introduces long-term disabilities to two different Black women on these shows. While the characters on these shows are occasionally shown in a home setting, most of the development of their disability's narrative happens in the hospital. Thus, the extended representation of HIV, OCD and heart disease happens almost exclusively in the context of how they negatively affect the ability of these Black women to perform labour.

Sarah Orem provides an insightful analysis of one of these characters, Miranda Bailey from *Grey's Anatomy,* played by Chandra Wilson. She notes that while the successful surgeons of *Grey's Anatomy* are hardly working class, much of the way Dr. Bailey's disability is narrated draws from stereotypes about working class Black women, their labour and productivity. While ignoring the reality that capitalism often is what *produces* disability in people of colour, the narrative of Black disabled women in these shows "presents disability in black women as a threat to American capitalism" (Orem 170).

The remainder of this study consists of close readings of three different episodes of medical TV shows, one from *ER* and two from *Grey's Anatomy.* While the introduction to this section outlines how these shows differ in tone, structure and content, the disability tropes and depiction of the medical system remain consistent throughout both shows, relying on them to varying degrees. As will be revealed through the analysis below, each trope contributes not just to stigmatized and othering depictions of disabled people, but also to the reinforcement of medical epistemic and cultural authority. Many of the themes which emerge though these episodes are also present throughout the series in episodes where disability does not feature as prominently; however, it is arguably when disability appears in these shows that they are most cuttingly visible, making clear the dependence on disability as marker of the most extreme dilemmas facing doctors and the medical system. The following is not an extensive list of thematics which surround disability in these shows. As mentioned earlier, disability is constantly everywhere in shows which take place in a hospital. Rather, they are the themes I feel most acutely represent how disability is used propagandistically to reinforce the messages about the

medical system put forth by these shows. Finally, by categorizing these episodes by these tropes, I am not implying that these episodes fit exclusively into that one category. Most of the episodes discussed here fall under multiple categories in overlapping and dependent ways and have only been primarily categorized under the category they illustrate best for the purposes of a close reading. The tropes are as follows: disability freakery and medical scientific progress; didacticism and the limits of the doctor centered formula; and disability and unruly bodies as untrustworthy/adversary to doctors.

4.1 Freakery and Medical Scientific Progress

As will also be clear with the other tropes analysed in this study, disabled figures on medical TV shows are often utilized as extreme examples of other themes which appear regularly throughout the series. In this way, the commonly occurring representation of disability as freakery is often employed as an exceptional illustration of the benefits of medical progress. For the disabled figures embodying this trope, these benefits necessarily include full or partial assimilation to the normate, which is constructed as essential for a fulfilling life. Medical progress is shown to be more than just about making people healthier and live longer; it is shown as critical to the project of normalization and as ultimate arbiter of what constitutes a good or bad life. In order to frame these patients as obvious candidates for experimentation by the well-meaning doctors, their possibilities for characterization are extremely limited. These patients are not only visually constructed as Other through videographic techniques but are also made to expend most of their limited dialogue explaining just how much they are ostracized in their lives and how much they profoundly resent their condition and its visual

manifestation on their bodies. They make self-defensive jokes about how they look and are rude in return to the doctors who make ignorant comments to them. This echoes ways the historical freakshow has been analysed as a self-protective and potentially empowering context for disabled people who were involved, where their limited control over how their bodies were spectacularized contrasted with the all-consuming social rhetoric of disability as an object of shame and secrecy (Wegner 22; Garland-Thomson, "Extraordinary Bodies"). Importantly though, in the medical TV show, disabled freaks are offered a solution to a lifetime of subversively challenging those who stare at their non-normative bodies: the hope for a cure to their condition courtesy of the never-ending drive of medical progress.

The representation of disabled people as freaks and medical curiosities in medical TV shows draws significantly from the visual culture of both medicine and television. Lisa Cartwright's analysis of medicine's visual culture notes the crossovers between medical imaging and popular culture, where the imagery of medical research from technologies such as the X-ray have been objects of fascination in popular culture since their early proliferation. In a reciprocal way, medical research has emerged within the context of society at large and is thus marked by broader culture. This reciprocity between medicine and culture contributes to a naturalized process of staring and examination, where in medical TV shows the analytical medical gaze is made interchangeable with the voyeuristic staring of the viewer. As Wegner describes in her article on freakshow aesthetics in the modern medical TV show, the display of disabled bodies as freakshow helps to explain the success of the genre. These shows rely on the

exhibition of non-normative bodies, using visual techniques which recall freakshow displays such as revealing patients hidden behind room doors or from behind a group of ogling doctors, humorous music emphasizing an absurdist interpretation of extraordinary bodies, and medical imaging techniques which confirm that these patients' bodies are as deviant on the inside as they are out. Wegner also identifies dehumanizing techniques of renaming patients and the narrative construction of disability as unbearable deviance as two other ways the freakshow is recreated in medical TV shows, both of which appear in the episodes analysed below.

As Garland-Thomson argues, the American freakshow was a pivotal location for the negotiation of the ideal American citizen and was thus a significant part of the nation-building process ("Extraordinary Bodies" 58–59). In medical TV shows, the display of non-normative bodies holds a similar purpose but filtered through the logics of the modern medical system. Thus, non-normative bodies are portrayed as in need of assimilation through cutting edge medical care and as examples of the types of embodiment which have not yet been classified and disciplined by medical progress. Medical TV shows subject disabled bodies, aestheticized as freaks-of-nature, to a disciplining process which serves to reinforce medicine's authority over the boundaries of life and death, or more accurately, what constitutes a good or bad life and death. What these shows propose is that medical progress is an ever-progressing forward march with no limits, where disabled people serve as the most vividly material illustrations of the successes and failures of this model. As medical progress is tied up with the exigencies of nationalism and the assimilation of deviant bodies into ideologies of productivity and

normativity, it becomes a national project and continuous medical development, no matter the cost, is necessary for the good of the nation.

This trope is extremely common in *Grey's Anatomy,* as the setting is cast as a more advanced and specialised hospital than the inner-city one of *ER,* and so medical oddities are more commonly interspersed throughout the narratives. These portrayals are often clearly exploitative, voyeuristic and objectifying; Wegner's analysis of these depictions clearly show how they unquestioningly replicate the qualities of the disability freakshow. Although not as sensationalised, *ER* certainly engages with this trope quite frequently as well, but with slight variations. Often, freakery is employed as a material metaphor for the chaos and overwork facing the doctors, where anyone in the ER who doesn't need medical attention is cast as invasive and distracting and thus out of place and deviant. The aesthetics of the freakshow in *ER* are often combined with a more sentimentalist representation of disability. This often occurs when a character is introduced in a way that emphasizes them as a freak, which then progresses to sentimentalism through the episode as the character is identified with a social issue and the doctors learn to empathize with their condition. These kinds of characters found throughout *ER* include people experiencing homelessness, addictions and/or mental health issues, often used for both comic relief and emotional catharsis within the same episode. These characters are often structured within the narrative in a way which serves to emphasize the boundaries between the normate and deviant bodies which are unable to be rehabilitated to normalcy through a quick visit to the ER.

The trope of disability freakery as the ultimate driver of medical progress still appears on *ER.* In an episode quite aptly titled “Freak Show,” a boy is brought into the ER after a car accident, where the doctors realise he has an extremely rare condition where his internal organs developed on the reverse side of the body than where they normally would. As news of the boy’s condition spreads through the hospital, surgeons flock to the operating room as they operate trying to save the boy’s life. They take pictures of his open body cavity and talk excitedly of the publishing opportunities, all before anyone has been able to track down this child’s family. This boy’s unusual anatomy, practically flayed out before them on the surgical table, is presented as a pivotal moment not just for the advancement of the surgeons’ careers, but for medical research and science itself. Their eagerness is thwarted when the boy succumbs to his injuries and dies. Nonetheless, to Dr. Benton and Dr. Corday there is still the possibility of an autopsy, permission for which they aggressively pursue from the father, completely oblivious to his grief. Dr. Benton only realises the horror of what they are doing and their blatant disregard to the dignity of this child’s life because the boy’s father turned out to be a childhood friend of his. The father’s justifiably angry response to the doctors’ behaviour jolts Dr. Benton out of his haze of publishing possibilities and ground-breaking case studies. While on the surface this episode presents a more ambiguous picture of medical research and the drive to integrate non-normative bodies into the logics of medical taxonomies, like many other medical conflicts appearing in medical shows, it places the blame wholly on the inappropriate behaviour of the individual doctors themselves, rather than the never-ending forward drive of medical research. The message is that these

individual doctors went about it the wrong way, rather than questioning the overall motives of the ideologies which drove the doctors to behave this way in the first place.

In *Grey's Anatomy,* episodes are often accompanied by a thematic framework which is introduced in an initial voiceover by one of the recurring characters. In an episode from season two titled "Yesterday," the show's protagonist Meredith Grey, played by Ellen Pompeo, describes in the voiceover how the insecurities we develop as kids follow us into adulthood. As usual, this voiceover describes many of the issues facing the doctors throughout the episode, as well as extends thematically to many of the patients they encounter. It is in this context that plastic surgeon Dr. Mark Sloane is first introduced, and with him the romantic and professional rivalry he has with neurosurgeon Dr. Derek Sheppard. He and Dr. Sheppard are introduced as surgeons at the top of their fields who left prestigious jobs in New York City because of a personal relationship crisis, positioning them as working in a hospital that is prestigious enough for Seattle, but still beneath their world-renowned expertise. So as Mark Sloane swaggers into the hospital, keen to impress Derek's new colleagues and to win back the woman who split the two friends apart, he sets his sight on Derek's patient, Jake.

As with many of the other episodes which appear in *Grey's Anatomy* featuring characters with extraordinary bodies, Jake Burton is introduced via descriptions of his condition before he is ever visually revealed. His parents first explain that they brought him into the hospital because he had been complaining of headaches and nausea and then Dr. Sheppard explains how his condition leads to his entire face being covered with small bony tumours. Medical discourse precedes any visual perception of this person, with the

cameras focusing instead on the doctors describing the boy and his appearance in medicalised terms. When the character is first shown, the camera is tightly zoomed in, showing us the doctors' individual faces one by one before it focuses in on the boy with a mottled and bumpy face and big smile sitting up in the hospital bed. While we have already heard the medical name of the disease, craniodiaphyseal dysplasia, the episode makes sure we know how it is colloquially referred to. Jake says, "You know if you pretend I'm a lion it helps", referring to the disease's other name lionitis. He continues, "If you pretend I'm a lion, then instead of a really messed up kid you get a talking circus animal, which is way easier to look at" (6:04). This last line, delivered as a self-defensive joke by the 15-year-old Jake in a room full of staring doctors, explicitly conjures imagery of the freakshow, linking his own disabled embodiment to a "talking circus animal". Later, Mark Sloane also calls it lionitis in a moment of excitement over the chance to see a rare case such as this in person. This concurrent use of the medical and colloquial terms for the disease, the latter of which explicitly connects the condition with animality and through the episode's dialogue, the circus, emphasizes the blending between medical science and the cultural freakshow. As such, the boundary between medical curiosity and the display of human bodies for entertainment and titillation continue to blur.

Halfway through the episode, the connection between the doctors' insecurities and Jake's disfiguring condition is made clear. As Dr. Sheppard walks toward the boy's room to talk more with his parents about brain surgery to remove some of the more dangerous tumours, he hears Dr. Sloane's voice coming from inside. As Mark turns towards Derek with a challenging and taunting look on his face, Derek asks him in a hostile tone whether

he can help him with anything. In response, we hear Jake from just outside the camera's frame say, "He says he can fix my face. He says he can make me look like normal" (18:50). Immediately afterwards, rather than considering Jake and his family's perspectives on this new surgery, the scene shifts to an argument between Derek and Mark. Just as with the episode of *ER* discussed above, the fact that this surgery would make an imminently publishable case study is one of the first reasons given by Mark to embark on such a risky and experimental project. It is also positioned as part of the rivalry between Mark and Derek, both hubristic surgeons who see the most challenging surgeries, and thus patients, as tools for professional and personal advancement, and possibly as compensation for their considerable insecurities.

When we next see Jake, he is positioned in his hospital bed in front of a mirror, with Mark drawing on his face outlining where the facial structure "should be" (23:12), that is, where the tumours have grown over what would otherwise be normal cheekbones and a chin. His parents walk into the room with Dr. Sheppard, who had gone to warn them about the risks of Dr. Sloane's proposed surgery in an attempt to undermine the plastic surgeon's influence with Jake and his parents. Dr. Sheppard emphasizes again how dangerous the initial brain surgery is going to be, with a significant risk of fatal blood loss. They all argue over each other before Dr. Sloane asserts that since Jake is already undergoing anesthesia and an invasive surgery for the tumours in his brain, they might as well go in for the cosmetic surgery at the same time. His mother, with a concerned look on her face, simply says, "Honey, we just want to focus on keeping you alive" (24:10). As

the camera slowly zooms in on his face, still with Dr. Sloane's pen marks on it outlining the contours of its normative potential, Jake gives his rebuttal, saying:

> I almost died when I was 10, then again when I was 12 and then again last year. But I'm still alive, I'm still alive, I say we go for it. I know you think I'm perfect just the way I am, but that's your job to do that. But for once in my life, I'd like to think that someone else thought that. Please? Please?" (24:20)

This final utterance of Jake's (they are the character's last lines) provides significant insight into how this medical procedure is constructed within the episode's narrative. His plea to his parents, punctuated by his final "Please? Please?", structures this dialogue as that of a teenager begging his parents for permission, drawing attention to the fact that Jake is a 15-year-old boy. Jake's storyline is one example amongst many in *Grey's Anatomy* where the patient-freaks are teenagers. Thus, as older children, the medical drive to cure them or otherwise visually rehabilitate them (Jake's surgery for example is more cosmetic than it is therapeutic) to be closer to the normate is tied up in heteronormative impulses of assimilation and transforms their narratives into a coming-of-age story which they must survive in order to become full-fledged adults. In these narratives, the motivation for these teenagers to consent to the proposed dangerous surgeries is assimilationist; they're tired of being visibly disabled, labelled as freaks, and just want to be normal before they embark on life's next big adventure. As such, in the context of illness and disability, the boundaries between medical necessity and social norms are consciously and uncritically blurred within the show.

Finally, Jake is shown undergoing his brain surgery. After only a few brief seconds, well before Dr. Sloane can start the plastic surgery, Jake suffers traumatic blood loss and dies. As two of the doctors tend to his body after the surgery, Dr. Alex Karev,

known for his frequent callous remarks, says, “It’s a shame he never got his face fixed” (29:22). Despite this being framed as a distasteful remark by Dr. Yang’s reaction to his comment, the scene continues with them enlisting Dr. Sloane to perform the cosmetic surgery posthumously (with his parents’ permission). In Jake’s final appearance in the episode, his parents are brought into the room where his body is held, with only a partial view provided of his now fixed face. As his mother strokes his face, we are provided a fuller shot of it as she says, fighting back tears, that he looks peaceful. His father agrees. After they leave the room, the doctor pulls the sheet over Jake’s face, ending the scene.

The choice in this episode for Jake to die holds multiple implications for the representation of disabled people within the thematic of medical progress. Out of all the characters who get behind Dr. Sloane’s experimental procedure, the disabled teenaged boy is the one who is punished for its lack of success. Indeed, as the extended scene with Jake’s body at the end of the episode confirms, the doctors still get to perform the procedure, and Jake’s parents can feel their son is at peace once they see his posthumously surgically altered face. Jake’s death, and his body’s subsequent modification, positions him quite ambiguously within the logic of the episode’s narrative and of other episodes of *Grey’s Anatomy*. When this trope appears elsewhere, the surgeries are mostly successful, and the young disabled person is able to be assimilated into a (more) normal life through the triumph of medical progress (“Six Days: Part 2”; “Something to Talk About”). In Jake’s case, it is arguably the cosmetic nature of his surgery which condemns him to die, where the episode’s overarching theme of insecurity positions Jake as worried about the wrong things; while he was concerned with looking

normal, he should have been more like his mother with her concern over just keeping him alive. Thus, Jake's disabled body is disciplined within the show's didactic logic, where he was concerned with the wrong kind of medical progress and was punished appropriately.

Nonetheless, the surgeons' operation on Jake's face after his death introduces significant ambiguity to this formulation. The care with which the surgeons perform the surgery and his parents' reaction to seeing his modified body introduces the perception that Jake's death was a good one. He is given dignity in death through this surgery that was unavailable to him while he was alive. Jake's body is therefore disciplined in multiple ways, where he is ultimately assimilated into normalcy while simultaneously punished for wanting it in the wrong way. Most importantly though, through this narrative medical science itself emerges unscathed. Mark Sloane's experimental surgery did not fail at all, even though he was not able to perform it on a living person. Instead, it was the patient himself who failed, being unable to survive the exigencies of the normalizing drive of medical science and ableism. Dr. Sloane's surgery was still a success because while Jake didn't survive the surgery to save his life, he could still be brought into the normate in death. Dr. Alex Karev's comment that "it's a shame he never got his face fixed" emphasizes that there are two tragedies at hand: Jake's death, and how his death preceded medicine's ability to make him look normal. This final tragedy, which is the one tied up in the episode's theme of cutting-edge medical progress, is mitigated by the doctors' commitment to their profession, regardless of the patient being dead.

With the choice to have the surgery performed on a dead body that only his parents were able to see, the episode also provides a curious framing to the idea of

medical progress. As Jake dies during the initial surgery which was always known to be extremely dangerous, the value placed on the idea of medical progress for Jake lies in the hope it gave him before he went into surgery. This construction reinforces the idea that disabled figures are perpetually waiting for medicine to progress to the point where it will be able to rehabilitate them into the normate. This pernicious framing positions medical progress as *the* answer to social stigma and discrimination and disabled and sick people as eternally in debt to medicine and its drive to cure them, whatever the cost. Through its exceptionally positive framing of Jake's death and the modification of his body, this episode asserts that the hope that this surgery provided Jake with was enough, because as his mother says, he is now at peace. It doesn't matter that Dr. Sloane was unable to perform the surgery on a living person, even the spectre of medical progress is shown as enough to give hope to disabled people and to overcome their insecurities.

4.2 Didacticism and the Limits of the Doctor Centred Formula

As discussed earlier, the creators, writers and medical consultants of these shows, as well as various outside stakeholders, view medical TV shows as serving a didactic purpose. Research about the didactic benefits of these shows have provided generally mixed results about the overall effectiveness of these shows for education about various topics (Goodman; Hether et al.; Hoffman, Shensa, et al.). Regardless of their actual impact, plotlines are often clearly carefully constructed to convey a very specific message to audiences. These messages are not always overtly about medical conditions or treatments; often they include lessons about public health issues or general moral life lessons. In *Grey's Anatomy,* the narratives are often structured around a didactic theme or

moral lesson which ties the different plot points together. More often than not, these themes affect the doctors via lessons learned through their patients. What the following analysis will show is that the effectiveness of these lessons is often mitigated by the doctor centred formula. By refusing to provide further depth to the characters who supposedly embody the didactic message of the story, the narrative potential is stifled, and along with it any nuanced meaning. As such, the embodiment of these characters becomes what Quayson refers to as a cipher of the condition of frailty (82), where the disability of a patient holds very little material meaning beyond the immediate conventional implications of life and death in a medical TV drama. In this case they are not real disabilities, inserted into the narrative exclusively as a sign for the moral lesson of the episode, rather than to provide a complex embodiment to a character. This reduced meaning becomes more evident when examining the entirety of the episode in relation to the disabled characters it portrays, rather than exclusively examining the scenes in which the disabled characters appear.

Where this framing becomes relevant to the propagandistic project of the medical TV show is in how these limited messages presented through disabled characters are narratively processed by the non-disabled doctors. Since the action revolves around them, it is their interpretation of the moral or medical lessons of the episode that is privileged through the storytelling process. Episodes will often end with two or more doctors discussing the patient or their lesson learned from their experience of providing them with care. This reinterpretation of the lessons that have been conveyed to the viewer reinterprets the text once again along the lines of the medical gaze. This contrasts with a

narrative structure such as the one in the episode starring Ray Liotta from the introduction to this section, which focused exclusively on the patient's own interpretation of his life, illness, and impending death, without additional insight from the doctors.

The trope of disabled characters as part of a didactic message aligns very closely with Quayson's tropes of disability as tragic insight or as null set/moral lesson. It is also a trope which appears again and again in medical TV shows. In one episode of *ER*, viewers are reintroduced to Dr. Carter's cousin who in previous episodes had been dealing with drug addiction and an overdose. Now, the consequences of his drug use are made explicitly clear, and he is shown alone in a chair, hunched over and drooling, in the background of where his cousin and grandmother are discussing the future of his care. The message seems to be quite clear: drugs will mess up your life. But as Dr. Carter himself is emphasized as the main character in this plotline, the message becomes muddled. It seems to be instead: family members who use drugs will mess up your life. In this context the use of disability, specifically brain damage, is interesting, particularly when considered alongside the fact that several seasons later, Dr. Carter himself deals with an addiction to painkillers. This plotline is resolved in only a few episodes after he very quickly overcomes the addiction through rehab, providing a much less emphatic condemnation of the harms of drug use. The dependence then on disabled secondary characters who don't require any further character development and can be written off the show once they have served their didactic purpose comes more clearly into focus.

In the *Grey's Anatomy* episode titled "If Tomorrow Never Comes," the overarching moral theme of the episode is about procrastination. The initial monologue of

the episode lays this out explicitly; Meredith Grey says, “I don’t know why we put things off. But if I had to guess, I’d say it has a lot to do with fear” (1:19). The first plotline involves a woman who comes to the hospital with a very large tumour in her abdomen. Directly following the episode’s introduction, the immediate conclusion drawn for the viewer is that this woman has procrastinated as well. Indeed, Meredith’s voice over connects the private lives of the doctors with the patient about to be introduced, “Whatever it is we’re afraid of, one thing holds true – if by the time the pain of not doing a thing gets worse than the fear of doing it, it can feel like we’re carrying around a giant tumour” (4:45). Just as Meredith and most of the other recurring characters are shown procrastinating over dealing with their increasingly complicated romantic relationships, the show suggests that these are similar, or at least comparable, life experiences to the woman with the giant tumour.

The other plotline which seemingly fits within the episode’s theme of procrastination follows Mr. Levangie, an older man with Parkinson’s disease. He has been admitted to the hospital for pain management but Meredith, encouraged by Mr. Levangie’s daughter, gets it into her head that an experimental brain stimulation treatment for Parkinson’s is the best way to help the patient. Mr. Levangie though is dead set against the idea of invasive brain surgery, even if it means he won’t be able to walk his dutiful and supportive daughter down the wedding aisle due to his body’s involuntary movements and chronic pain. Influenced by her personal experiences with her mother’s Alzheimer's disease, Meredith doggedly pursues this treatment for her patient, even approaching the head of neurosurgery, despite Mr. Levangie’s insistence that he does not

want the surgery. Eventually, Mr. Levangie agrees to the surgery and, despite the risks, is successfully cured of his more debilitating Parkinson's symptoms.

Annie, the woman with the tumour, doesn't want to be referred to as Ms. Connors, because as she says, it makes her feel "old and fat" adding, "Which I am, but why feel that way?" (6:00). The camera intermittently focuses closely on each of the interns' faces, who are all shown to be earnestly concealing reactions of disgust and horror. This plotline quite clearly aligns with Wegner's assessment of the use of freakshow aesthetics in medical dramas. Much of the plotline revolves around just how horrifying this woman's body has become, and especially how horrifying and incomprehensible it is that she would go so long without seeking treatment. Comparatively little time is afforded to understanding this woman's character, her motivations, and fears which led her to this position. After overhearing the cruel things Alex, another intern, says about her during the MRI when he thought she couldn't hear him, we are given the only bit of backstory about Annie's situation provided by Annie herself. She explains how often she had been to the hospital when her loved ones were sick, only for them to die. "All four of my grandparents, then my dad, my best friend's mom, my baby sister. They all went in – never came out. So I put it off" (18:55). What is framed as simple procrastination is evidently much more than that. This woman with severe medical trauma, who knows she will face medical discrimination because she is "old and fat", who witnesses the doctors who are supposed to be taking care of her ridiculing her behind her back, is as much a victim of the medical system as she is of any kind of "fatal laziness" (17:50). Nonetheless, in tying her experiences to the doctors who

are simply procrastinating about asking out their workplace crush, Annie's experiences are reduced to individual failings, reinscribing individualised narratives of illness and personal responsibility within the medical system. After emphasizing just how difficult and dangerous at this late stage the surgery to remove Annie's tumour will be, we are finally shown Annie's surgery. After many hours of the surgeons struggling to work with the unusual anatomy of the tumour, Annie suffers catastrophic blood loss, and dies.

Mr. Levangie's story functions as a contrast to Annie's in the context of the episode's overarching theme of procrastination. As Meredith's opening monologue frames it, fear is another motivation for procrastination, and in this case fear of the negative side effects of an invasive procedure is constructed as the motive for Mr. Levangie procrastinating his rehabilitation into the normate. With the strategic choice of the milestone of walking his daughter down the aisle, the episode draws in the logics of heteronormativity as a normalising social feature, making it even more inexcusable that he would resist this new treatment. Not only is he rewarded with a cure once he concedes to undergo the surgery, but he is shown walking down the hospital hallway arm in arm with his daughter, visually performing the future scene which vindicates the overcoming of his disability. Where Annie was unable to succeed in being cured or rehabilitated because of being "old and fat," Mr. Levangie is granted access to normativity through the drive of multiple characters' desire for him to be able to walk his daughter down the aisle.

In an interview about this episode, its writer Krista Vernoff revealed that Annie was originally supposed to survive. Ultimately, she decided she should die, stating, "The message I wanted to give was not, 'Hey it's okay to put off going to see a doctor for two

years cause it all turns out alright in the end'... I needed Annie to die so I could say all that stuff at the end about seizing the day already" (Vernoff). If, as Vernoff insists, Annie had to die in order to convey the didactic message not to delay medical treatment, a number of questions emerge. Vernoff's own interpretation of the plotline she wrote seems to orient Annie's death as punishment for her procrastination. Nonetheless, in one of the few lines Annie is given to speak about her own situation, she admits that she procrastinated because her loved ones would go to the hospital only to die. Eventually, this is the same fate Annie faces herself, essentially vindicating her fear of hospitals. As some viewers would know, delaying medical treatment is a complex phenomenon, with multiple factors including the reality of medical neglect and discrimination (Chrisler et al.; Janz; National Academies of Sciences, Engineering, and Medicine et al.; Reichard et al.), none of which are meaningfully addressed through the limited time that is provided to her character within the episode. It seems that Annie's story acts instead as a (literal) cipher for the weight procrastination holds on the personal lives of the doctors, whose plotlines are given significantly more attention than Annie's. Thus, the doctor centred formula of the medical TV shows effectively obfuscates the intended message of the episode, where it is unclear if we should avoid procrastinating in relation to medical treatment, or asking out the girl we have a crush on, or committing to the guy we've been casually sleeping around with. This can also be seen in Mr. Levangie's plotline, where his own concerns are subsumed by Meredith's identification with his daughter. The supposed message about not procrastinating because of fear, represented by Mr. Levangie's

behaviour and identified by Meredith's voice-over, is confused with her own feelings about her mother's Alzheimer's disease.

Meredith's centering of herself in Mr. Levangie's care raises another limitation of the effectiveness of the educational messages of these shows in relation to the doctor centred formula. Before Annie's character is even introduced, surgical resident Dr. Bailey warns her interns as they walk towards her room, saying "When you walk in this room you will maintain decorum. You will not laugh, vomit, or drop your jaw. Are we understood?" (4:50) With this warning, the recurring characters and those watching the episode know what to expect from this minor character before she is introduced in the episode. Before we even know her name, we know she is to be feared, pitied, and ridiculed, only just not outwardly. The first glimpse of Annie is over the shoulders of the surgical interns and from an angle where we mostly see the giant tumour, rather than her face. Through these rhetorical and visual moves, this character's illness, emotions, and life experiences are reduced to a moment of reaction centering the doctors which continues throughout the entire episode, up until she dies. As she is dying, the cameras still focus on the doctors, the patient herself visually irrelevant against the doctors' valiant efforts to save her. From this, the doctors learn something about their behaviour and lives, thanks to the disposable life lessons embodied by sick people. These are also the lessons viewers take away from the episode, because in the modern medical TV show we identify with the doctors, not the sick people. So as the viewer identifies with the doctors, we learn the same lessons they do, and Annie becomes not so much a character that learns a lesson about accessing healthcare; rather she *becomes the lesson itself*. In centering the

doctors in the lessons learned through their patients in the context of the hospital, patients are objectified as case studies, replicating the aesthetic framing of the medical gaze and research. Disabled bodies are objects for study, rather than complex human beings with experiences and learnings of their own. The body itself is endowed with meaning which replicates the epistemic drive of medical research and its need to understand and conquer the human body, only under the guise of entertaining and educational television.

4.3 Disability as Untrustworthy/Adversary to Doctors

One particularly salient trope in medical TV shows positions disability as adversarial to doctors and their ability to practice good, effective, and efficient medicine. While doctors on these shows frequently deal with belligerent or rude patients, it is disabled patients, and sometimes the disabled family members of patients, who are positioned as posing the biggest obstacle to the provision of efficient healthcare. Not only is disabled embodiment positioned as adversarial to doctors as such, but it is also often framed as deceptive, where the initial presentation or description provided by the patient must be questioned, being thus structured as untrustworthy. As with much of the representation of the problems of disability in these shows, the blame is always placed squarely on the embodiment of disabled people themselves, sometimes on the doctors' lack of sensitivity or training, but never on systemic issues or the overall structure of the provision of medicine. Thus, in a show such as *ER,* where the narrative tension often hinges on the frenetic action of an underfunded, understaffed, and overcapacity emergency department, disability as adversary emerges as manifestation of this tension, physically impeding the doctors' work where a lack of money or staff can only be

represented abstractly. Crucially, in many of these instances, the disabled-person-as-barrier is not necessarily in need of medical care. They are often family members of patients, or disabled people with insufficient support systems who rely on the ER as a makeshift social safety net. This more explicitly positions disability as adversarial not just to doctors as workers, but to medicine and its provision to society at large, which presumably doesn't include problematic disabled people.

While *Grey's Anatomy* takes place in a hospital which is generally free from these kinds of real world financial or personnel constraints, this trope still appears. This is often done for comic relief, where disruptive patients are often played in humourous ways, frustrating the doctors' efforts while releasing some of the tension built by romantic tragedies and the more serious medical issues featured through the episodes. In one episode, Dr. Meredith Grey's mother, whose Alzheimer's Meredith had been trying to hide from her colleagues, is brought into the hospital for surgery on a potentially cancerous mass on her liver. While this causes emotional distress for Meredith and the other characters who had been close to Ellis Grey, the other characters are left to deal unsuccessfully with the belligerent former doctor whose condition has her thinking it is twenty years earlier and she is the attending surgeon. The doctors' difficulty in providing her care is played to comic effect, despite Meredith's conflicting emotions ("Deny, Deny, Deny"). Her Alzheimer's, as an incurable illness and disability, is thus positioned as a barrier to providing her the medical treatment she was brought in for, impeding their productive and efficient labour.

Of Quayson's list of disability tropes, disability as untrustworthy/adversary to doctors most accurately aligns with disability as hermeneutical impasse. It also reflects quite vividly the trope of narrative prosthesis, where the disability as adversary to the doctors initiates the dramatic action. Further in line with Mitchell and Snyder's frameworks, it is interesting to examine more broadly how disability is often utilized in *ER.* As a show that was hailed for its realistic portrayal of medicine, it received many accolades for its representation of poverty and the crises related to the provision of medicine in an inner-city hospital. In this way, the proliferation of disabilities and illness in the show, especially those caused by or most frequently associated with conditions of poverty, could potentially be hailed as progressive, ground-breaking, and edgy. What the subsequent analysis reveals though is that in failing to radically disrupt how poverty and disability are represented in favour of a "realistic" portrayal grounded in the pre-established tropes of representation that would be familiar to most viewers, *ER* at best uses disabled figures as ciphers for society's failures and insufficiencies and at worst reinscribes dehumanizing depictions of disability as a freakshow or sentimental tragedy.

In an episode of *ER* titled "Don't Ask, Don't Tell," we continue to see the deleterious effects of reduced healthcare spending and the decimation of the social safety net for poor Chicagoans affecting the doctors' lives in significant ways. Through this hardship, the doctors of County General Hospital in Chicago are constructed as labouring martyrs, continuously self-sacrificing in order to serve the community to which they are ideologically committed. In order to structure this narratively, many plots depend on types of patients who are seen as getting in the way of their work of healing the deserving

injured and sick. These patients tend to include those who are old, sick and certainly dying, disabled people, homeless people, drug users, and other people who make the doctors' jobs difficult. In this episode, this kind of structuring can be seen very clearly in the main plotline which involves Dr. Mark Greene, played by Anthony Edwards. The conflict is initiated from the first scene of the episode. Dr. Greene and Dr. Susan Lewis are walking to work while he, in a frustrated and exhausted tone, rants about the new Chief of Staff, Dr. Anspaugh, and the new changes (read: austerity measures) he is implementing. At the hospital, Dr. Anspaugh brusquely describes the increase in number of patients that County General can expect, given the merger that just occurred between County General and another southside Chicago emergency department. He also announces a competition between the doctors for who can treat the greatest number of patients, with the loser having to wax his car at the end of the day.

Dr. Greene gets a slow start seeing patients, overwhelmed by administrative duties. He mentions that he hasn't had a day off in nearly nine months. Finally, he gets to see his first patient of the day, an old man who is brought in unconscious. Immediately upon assessing that this man is quite aged and came from a nursing home, Dr. Greene discloses how he already thinks of this patient as dead. He clearly considers it not worth his time to try to resuscitate this man, stating, "He seems gorked to me... I don't want to get into heroic measures if he's DNR" (10:10). But with a lack of information about the patient, and no "Do Not Resuscitate" order available, Dr. Greene is required to treat him. After very reluctantly employing resuscitation efforts, while saying things such as, "If I ever get this old, I want 'do not resuscitate' tattooed on my forehead" (13:10), Dr. Greene

declares the man dead, relieved to be able to move on to another patient. Surprisingly though, the man doesn't die, and he is moved into one of the limited available rooms in the ER. As the episode progresses, Dr. Greene is unable to get rid of this still unconscious patient who he had already tried to declare dead. It is ultimately determined that the man did in fact have a DNR order, but when the patient's son and medical proxy shows up, Dr. Greene realises he is cognitively disabled and doesn't seem to understand that his father is dying, refusing to allow Dr. Greene to take the older man off life support. The man's disability, though invisible, is signaled through his dirty clothes, his disheveled hair, as well as his habit of sucking on his fingers while Dr. Greene speaks with him. This recalls stereotypes related to the visibility of cognitive disability, which entrench this representation as a simplistic caricature. This is the conflict which shapes the episode; on a day where the doctors' have been tasked to reach a certain hourly quota of patients, Dr. Greene is "stuck" with one old man who refuses to die and his "slow" son who is unable to assist with the process of helping his father towards the end.

This plotline showcases quite clearly how the doctors on *ER* are constructed as the previously mentioned labouring martyrs; Mark Greene can't help being impatient and wanting to hurry along the dying process of this old man. He refers to the man while speaking to colleagues with dehumanising terminology, such as "gomer"[4] (14:20), or says things such as "what a joke" (23:00) during another resuscitation attempt, emphasising

[4] "Gomer" is a medical slang term which stands for "Get Outta My ER". It appears in Samuel Shem's 1978 novel *The House of God*, a satirical take on the struggles of psychiatric interns (Shem), which echoes the same physician centred perspectives of contemporary medical TV shows. The acronym, likely more familiar to medical professionals watching these shows (and writing shows like *ER)* than other viewers, emphasizes the dehumanizing treatment of patients in the ER, as well as the view of certain patients as disposable and in the way of important medical treatments.

again that to him, this patient “has got one foot in the grave” (33:54) and is therefore not worth his time and energy. He knows he can’t do anything to help him (cure him), we already know he hasn’t had a day off in almost nine months, and we also know he’s frustrated in his personal life. We are made to understand, through the doctors’ words and behaviour, how mundane death and suffering becomes to them. On a dying man’s final day, with his cognitively disabled son struggling to process what is happening, our ultimate sympathy lies with Mark Greene for having to deal with all of this when he’s already struggling. He can’t be bothered to take the time to explain what is happening to this man’s son in a way he can understand, he’s simply in the way of Dr. Greene helping patients more worth his while. The scene which most emphatically emphasises this point occurs when the son, who works several hours away at a meat processing facility, offers Mark a smoked ham as his only answer to Dr. Greene’s probing about taking the father off life support (31:00). As viewers, we are expected to recognize the absurdity of offering an entire ham to an overburdened doctor on duty in a busy ER. Dr. Greene’s reaction shows it is not a gesture of kindness and gratitude, although this is clearly what it is to the son, but rather is a tangible expression of how much trouble this patient and his son are causing him.

Disability, ageing, and any of their processes which cannot be easily streamlined into the overtaxed medical system are structured as simply things which impede the doctors’ productivity, rather than as complex expressions of human emotions of gratitude and grief. In this episode this construction is explicit, since these two men entirely prohibit Dr. Greene’s ability to see any other patients, thus impeding his ability to be

productive according to the demands placed on him by his boss and the overstressed system. So, in this instance, disability is represented exactly the way it is often by ableist society at large, as a barrier to productivity. Even though the son is employed, and indeed his employment is one of the few bits of development afforded this character besides his disability, he is still portrayed as a burden who gets in the way of productive labour. Afterall, the doctors are doing the more important work, *they save lives*, and this man doesn't seem to understand just how important Dr. Greene's job is. That is of course, as long as we don't think too much about how this man was only trying to understand that his father (his only supportive family member, we later learn) was dying.

In order for this construction to work, doctors *must* be portrayed as real, complex people and their patients *must* be portrayed in single faceted, shallow ways. This means that disability, poverty, racism, sexism and so on, often become even less than metaphors; they become part of the white noise inhibiting the doctors' ability to help the actual sick people or the cases which interest them. We are always supposed to feel bad for the doctors, and whatever emotions we feel for patients narratively serves the doctors' character development. In this case, how we feel for the old man and his son is redirected towards Dr. Greene. At the end of the episode, Dr. Greene's patient finally does die. This however occurs off screen with the patient's son nowhere to be found. Instead, all we are shown is Mark Greene's reaction when he is informed that he died, clearly frustrated as he signs the death certificate that all his efforts of the day still culminated in the patient's death (40:30). If we are inclined to think Dr. Greene is just being callous, when he reluctantly hands over his one patient chart at the end of the day, he is met with

incredulous scorn. He also has lost Dr. Anspaugh's competition, so after his long, gruelling, and emotional shift, he must stay behind to wax his boss' car (41:45). The message is that in an overtaxed system, people suffer, but the ones who suffer the most are the doctors. They are the ones we relate to, the ones who deserve better because they have chosen to be the doctors who help people most in need, rather than having chosen jobs as doctors who make lots of money and have normal schedules. Anyone who gets in their way is getting in the way of the greater good, even if those people are the ones who needed their help the most in the first place.

5. Conclusion

It can be difficult to grasp the full extent to which the medical TV show has dominated the television industry. *ER,* which ran for 15 seasons, aired a total of 331 episodes and *Grey's Anatomy* is now in its 19th season with over 420 episodes to date. During its run, *ER* was nominated for over 375 industry awards, including 122 Emmys, and *Grey's Anatomy* has also been nominated for dozens of awards over its almost two decades long run so far (*ER Awards - IMDb*; *Grey's Anatomy Awards - IMDb*). As part of their longevity and critical success, these shows have experienced some of the highest viewership of any TV series in history. At its peak during the network television era in the 90s, *ER* was averaging over 30 million households' worth of viewers per episode (Gardner). These shows are only two examples of the over 130 medical TV shows to air on US network television since the 1940s (Turow 399–402). With this level of popularity and success, clearly medical TV shows consist of a sizable portion of the landscape of television stories available for popular consumption. As cultural and literary studies tell

us, fictional and narrative representations of reality hold a reciprocal relationship with the real-world and the values surrounding various social constructions. Thus, the stories medical TV shows tell, the ways they are constructed, and the messages they convey through them, are of significant consequence to how the real-world medical system is perceived. They also refract the messages and ideologies which already exist through representational storytelling which further disseminates society's values and beliefs.

Evidently these shows hold significant cultural capital and as such exert significant influence on wide groups of viewers. While there has been significant scholarship on the messaging around specific medical conditions or procedures and how these are conveyed to audiences, less has been written about how disability and illness, or medicine as an ideological project, have been represented and constructed within these shows. This study has attempted to engage with these latter concerns as it combines literary and cultural disability studies with television studies, visual studies and the medical humanities. What the analysis here has shown is that disability is often utilized as part of recurring tropes which especially highlight the epistemic and cultural authority held by the modern medical system. As part of this process, the medical model of disability and the ableism which is an inherent part of it is reinforced and reconstituted throughout these shows. These tropes include that of disability freakery and medical scientific progress; didacticism and the limits of the doctor centered formula; and disability as untrustworthy/adversary to doctors. The medical TV show evolved in tandem with modern medicine itself, with the formula for medical TV shows evolving over eight decades as a propagandistic cultural project to reinforce the ideologies of

modern medicine, with significant input from the leaders of institutional medicine. Over these decades, the formula for these shows has changed very little; however, the most significant change to the formula, the shift of the narrative focus from patients to the doctors, has served to retrench messaging about the supremacy of modern medicine as well as medicalised and ableist discourses of disability, illness, and health.

There is no denying that a huge part of the success of medical TV shows lies in their sheer entertainment value. As the creators of these shows have often noted, their interest lies in the day-to-day encounters with life and death experienced by the patients and doctors. Nonetheless, as this study has illustrated, even the concept of life and death itself is not neutral, and medical science has been engaged now for over a century in attempts to define and redefine the parameters of these concepts. As such, medical TV shows are intimately involved in the cultural negotiation of these concepts, within which disabled and sick people are often targeted for disciplining along the boundaries of how good health, a good life and a good death are defined. Through the medical TV shows' invitation to the viewer to participate in the medical gaze, the viewer is also invited to participate in the epistemic negotiation of what kind of lives are worth living and thus are worth the efforts of the medical system and which lives consist exclusively of disposable life lessons. So as entertaining as they are, clearly the outcomes of the development of the medical TV show are much more than a successful TV show formula and an interesting setting for human interest stories. Rather, these shows are implicated in one of the most totalizing epistemic authorities of the 20th century, the institution of medicine.

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