

# **Disappearing Ambivalence? Representations of Intersexuality in North American Medical Television Dramas**

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I was beginning to understand something about normality. Normality wasn't normal. It couldn't be. If normality were normal, everybody could leave it alone. They could sit back and let normality manifest itself. But people—and especially doctors—had doubts about normality. They weren't sure normality was up to the job. And so they felt inclined to give it a boost.

—Jeffrey Eugenides, *Middlesex*<sup>1</sup> (503)

During this century<sup>2</sup> the medical community has completed what the legal world began—the complete erasure of any form of embodied sex that does not conform to a male-female, heterosexual pattern.

—Anne Fausto-Sterling, “Five Sexes” (23)

## 1. Introduction

Medical TV dramas have been a staple of the North American television landscape since *Medic* was introduced as the first of its kind in 1954 (Tapper 393; Goodman 182). In fact, as Strauman and Goodier note, they are “one of the most popular generic conventions in television” (“Not Your” 127). Indeed, these shows have always been extremely popular with the North American viewing public and TV audiences around the world. However, although these shows have always placed a remarkable emphasis on accurately representing modern medicine—*Medic*'s producers in fact closely collaborated with the Los Angeles County Medical Association (Tapper 393)—this legacy of painting a positive or even idealized picture of medicine and its practitioners has also meant that they have mostly shied away from critically reflecting on the institution's normative function in society. Thus, medicine, rather than a social agent itself, has often taken on the appearance of a neutral and benevolent arbiter for society at large that bases its decisions purely on biological ‘facts’ without any interference from cultural norms.

However, as the above epigraph from Jeffrey Eugenides's *Middlesex* indicates, medicine's definition of what is normal is never extra-cultural or essential in and of itself, and always potentially problematic; because it brings with it the need to police normality—“to give it a boost”—whenever it is threatened by deviation. As such, this oversight—as the epigraph from Anne Fausto-Sterling's seminal essay “The Five Sexes” makes clear—can have potentially devastating consequences when it comes to these shows' representations of individuals or groups of individuals that fall out of the purview of ‘normality’ or rather normativity. As Roen puts it, “[a]typicality only makes sense, and only comes into being as something that might be erased, insofar as an imagined norm can be sustained (Roen 34). Intersex people<sup>3</sup> are one of these marginalized groups that raise the question as to what is considered normal in our heteronormative society,<sup>4</sup> and as such have been the target for surgical

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1 The same epigraph is also used by Zajko (175).

2 Fausto-Sterling wrote this article in 1993 and is therefore referring to the 20th century. Her statement nonetheless still remains relevant for the 21<sup>st</sup> century.

3 Individuals whose bodies defy definite characterization as either male or female (LeFay Holmes 15).

4 A heteronormative society privileges heterosexuality and regards it as the norm (Berlant and Warner 548).

erasure since the emergence of modern biomedicine (Fausto-Sterling, “Five Sexes”; Preves, *Intersex* 20). Since the mid 1990s the topic of intersexuality has become “a frequent topic on television and in the national print media” (Karkazis 263). Subsequently, it has also become somewhat of a trope on medical TV dramas since it was first broached on *Chicago Hope* in 1996—two years later its competitor *ER* followed suit<sup>5</sup> (Tropiano 52). This development was particularly significant because these shows not only reach a tremendous number of viewers in the US, but are also “exported across US borders and have found a loyal following all over the world” (Marchessault and Sawchuk 1).

Thus, this thesis will explore the intersection between the medical authority of medical TV dramas and their depiction of intersexuality, heteronormativity, and the resulting effects. In order to do this, I will focus on an analysis of the portrayal of intersexuality in the respective episodes of prominent shows like *Chicago Hope*, *ER*, *Grey’s Anatomy*, *Private Practice*, *House, M.D.*, and the Canadian Drama *Saving Hope*, which I will contextualize with other—less prominent—examples to demonstrate that these are not isolated examples, but rather represent broader trends within the genre. In the process, I argue that the portrayal of intersex people and other socially marginalized and medically stigmatized groups on medical TV dramas gains particular importance because of the discourses<sup>6</sup> of medical authenticity that surround them. As a result of this, medical TV dramas are shown to be emboldened with the discursive power of modern biomedicine: an effect that, as I will show, is further enhanced by the performative enactment of medical professionalism on the shows themselves. This imparts an aura of medical authority to these shows, which gives them the power to critically reflect and problematize modern medicine’s practices—both past and present. Accordingly, I argue that the depictions of intersex people as a socially marginalized, and medically stigmatized and pathologized group gains special significance because the discursive power held by these shows gives them the potential to either reaffirm their marginalized status, or to challenge it and potentially even the heteronormative system that underlies it.

Although both intersexuality and some of the medical TV dramas under consideration have been the subjects of numerous academic publications, both within and outside American Studies,<sup>7</sup> the important connection between medical authority in cultural representations of modern biomedicine and intersexuality has remained largely unaddressed.

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5 This thesis discusses nine shows that gave considerable room to discussions on intersexuality in at least one of their episodes—it excludes minor mentions of the topic.

6 Throughout this thesis, the term discourse is used in the Foucauldian sense in that it is intended to convey “not just spoken language but the broader variety of institutions and practices through which meaning is produced” (Sturken and Cartwright 102). This means that it is assumed to represent “a group of statements that provide a means for talking (and a way of representing knowledge) about a particular topic at a particular historical moment” (Sturken and Cartwright 105). It is also important to understand, as Sturken and Cartwright point out, that “[c]ertain kinds of knowledge are validated in our society through social institutions such as [...] the medical profession [...] while other kinds of knowledge may be discredited because they do not carry the authority of institutional discourse” (109).

7 Intersexuality primarily became of interest to American Studies with the publication and success of Jeffrey Eugenides’s Pulitzer Prize-winning novel *Middlesex* (Carroll 187).

It is precisely this gap in the current research on these two topics and their interrelation that this thesis strives to close. Considering the enormous reach of shows like *ER*, *Grey's Anatomy*, or *House, M.D.* and the fact that “past research has revealed that biomedical models constitute a powerful means by which knowledges and ideologies, particularly about gender, race, and other measures of ‘normal’ bodies, are produced and circulated[.]” this gap is of particular importance (Gabbert and Salud II 209). Thus, medical TV dramas can play a pivotal role in either challenging or upholding current gender norms. This fact lends added significance to the portrayal of traditionally marginalized and medicalized groups like intersex people.

As Holmes points out, “the future of intersex itself is haunted by the probability that if we do not maintain a critical framework, intersex will not simply be under erasure but will be done away with altogether” (“Straddling” 6). Consequently, the title of this thesis—*Disappearing Ambivalence? Representations of Intersexuality in North American Medical Television Dramas*—takes on a special significance in that the phenomenon of intersexuality and the challenge it represents to gender binarism and heteronormativity does not disappear or appear by itself, but rather is first diagnostically and discursively created—as an outside of gender binarism—only to then be actively erased by the same means by which it was made to signify in the first place. Therefore, the term “ambivalence” in the title has been deliberately chosen as an alternative to “ambiguity,” which is often used in connection with intersexuality and intersex bodies and risks suggesting that these bodies, as Holmes argues, “do not look like *anything*[.]” In contrast to this, the term “ambivalence” is not intended to suggest that intersex bodies are ambivalent or somehow undetermined or even indeterminable—because, as Holmes correctly points out, they are “clearly intersexed” (LeFay Holmes 15; Holmes, *Intersex* 32)—but rather to propose that gender (and with it our understanding of ‘sex’) is always ambivalent and that the ‘treatment’ of intersex individuals is used to actively make this ambivalence disappear—along with the bodies that signify it—and establish a clearly binary constellation of genders. Thus, as Giffney and O’Rourke remark with reference to Roen and Holmes, intersex bodies take on the form of “bodies as ‘events’ or ‘not-yet subjects’ (Roen) which are ‘neither discretely male nor discretely female’ (Holmes)” and as such “refuse to ‘signify monolithically’[.]” and therefore have to be ‘normalized’ in order to reinforce the “regimes of monolithisation” because their mere existence threatens to reveal the constructed character of this heteronormative system of signification (ix-x). Hence, the ambivalent character of the gender binary takes on the form of a ‘disappearing ambivalence’ and intersexuality as its signifier is first identified as an aberration and then forcibly transformed into a ‘disappearing signifier,’ which is made to have never existed in its own right in the first place through the means and rhetoric of modern medicine. Therefore, Holmes is correct when she writes that “intersexuality is not simply a disallowed form of embodiment, but also a cultural product that has come into being under erasure; first as a diagnostic category/pathologized body, and second as a reclaimed identity” (“Rethinking” 175).

Consequently, this thesis seeks to determine whether and to what extent the representations of intersexuality in the respective shows can be said to either challenge or reinforce the marginalized and pathologized status of intersex individuals and with it heteronormativity in general. Moreover, it will explore the question of whether a development in the depiction of intersexuality has occurred as a result of intersex activism and changes in the medical communities approach to intersexuality. This is accomplished by comparing early representations of intersexuality from *Chicago Hope* and *ER*,<sup>8</sup> and shows such as *Grey's Anatomy*, which aired considerably later—in 2005—but still preceded the 2006 “Consensus Statement on Management of Intersex Disorders” with those of shows like *Private Practice*, *House, M.D.*, and *Saving Hope* which followed the statement. In this statement, which was the result of a 2005 Chicago conference with “fifty invited international experts in the field (principally M.D.s), [...] only two intersex adults and no parents of affected children” (Reis, *Bodies* 156) for the first time acknowledged that

there is little evidence that infant genital surgery does what it has been assumed to do: improve attachment between child and parents, ease parental distress about atypical genitals, ensure gender-identity development in accordance with the assigned gender, or eliminate the intersex condition. (Reis, *Bodies* 156)

Moreover, the statement “advis[ed] a more cautious approach to early genital surgery” and limited it only to “‘severe’ cases” (Karkazis 237). Consequently, this thesis will explore the extent to which this drastic change in the medical communities’ approach to intersexuality is reflected in the shows. In the process, it seeks to determine whether the portrayals of intersexuality during the two periods challenge the traditional treatment paradigm and with it the imposition of heteronormative standards on the unruly bodies of intersex children—and potentially even heteronormativity itself—or whether they merely represent what Judith Butler has termed “high het entertainment” (*Bodies* 126) in that they serve the “reidealization of hyperbolic heterosexual gender norms” (*Bodies* 125).

In order to investigate these questions, I will first outline my working definition of intersexuality and its related terminology. Next, I will consider whether medical TV dramas can be said to inherit the authority of modern biomedicine when it comes to presenting medical facts and how this is accomplished in the discourse surrounding the shows—or rather their most prominent representatives like *Chicago Hope*, *ER*, and *House, M.D.* To round off this analysis, I will examine the ways in which medical authority is constructed within the narratives of the respective shows. Based on this, I will then investigate the representation of intersexuality in the respective episodes to determine the extent to which they can be said to either challenge or reinforce heteronormative conceptions of gender and relatedly sex. This analysis will be divided into two historical periods. The first starts shortly after the emergence of the intersex movement in the 1990s and prior to the 2006 “Consensus Statement.”

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<sup>8</sup> These shows aired shortly after the emergence of the intersex movement in the early 1990s, the resulting public debate and the subsequent problematization of the traditional ‘treatment’ of intersex infants by modern medicine (Karkazis 6-8; Greenfield; Reis, *Bodies* xiv).

The second period follows the “Consensus Statement” and extends until 2014. Both sections are concluded by an analysis of the implication of the period’s portrayals, in which I will also contextualize the episodes with examples for less successful or later shows to demonstrate that they are representative of the period. In doing so, this thesis utilizes the concept of heteronormativity in conjunction with Judith Butler’s conception of gender performativity, and high het entertainment. In this manner, it demonstrates that rather than unfolding the deconstructive potential of intersexuality, the portrayal during the first period is used to reinforce heteronormative standards in that the shows utilize their medical authority both to portray intersexuality as a pathological aberration, and to impose heteronormative standards onto it and the respective patient. Moreover, although the shows following the “Consensus Statement” are increasingly skeptical of the traditional treatment paradigm, they nonetheless perpetuate gender binarism and the belief that sex determines gender, and misrepresent the history of the medical treatment of intersex children. As such, these episodes—much like their earlier counterparts—can be identified as an example of what Butler calls ‘high het entertainment.’

## 2. Working Definitions of Theoretical Concepts

### 2.1 Hermaphroditism, Intersexuality, DSD and the Importance of Terminology

When discussing intersexuality—or any other marginalized group—terminology is of fundamental importance because it can either perpetuate marginalization and pathologization of intersex individuals or give them agency. Therefore, I will briefly summarize the extensive debate surrounding the nomenclature of intersexuality and explain why I have chosen to use the terms intersexuality, intersex individuals, intersex people, and intersex<sup>9</sup> as opposed to hermaphroditism or disorders of sex development (DSD).

The term “*hermaphroditism*” and its associated term “*hermaphrodite*” is archaic and “can still be found in medical writings” (Reis, “Divergence” 536). According to Reis it suffers from being “vague, demeaning, and sensationalistic” in that it “conjures images of mythical creatures, perhaps even monsters and freaks [...]” (“Divergence” 536; Reis, *Bodies* 154). The term intersex, on the other hand, was chiefly used by intersex activists starting in the 1990s and “describe[d] the set of conditions previously called hermaphroditism” and was a markedly political term used by these activists to reclaim the condition and to protest “against stigmatization and unnecessary infant genital surgeries” (Reis, “Divergence” 537). Nevertheless, this term also remained contested as “[s]ome parents [...] were uncomfortable with the intersex label for their affected children” because they thought the term denoted “a third gender, something in-between male and female” and thus ran counter to their desire of

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<sup>9</sup> Although the terms “intersexed” and “intersexuals” appear in quotations throughout this thesis I have chosen to avoid them in direct usage as intersex organizations like the Organisation Intersex International Australia object to these terms (“Suggested”).

“see[ing] their newborn babies as girls or boys, not as intersex” (Reis, “Divergence” 537; Reis, *Bodies* xv). Others rejected its use because of its potential association “with sexuality, eroticism, or sexual orientation” which for them resulted in the problem of “reconciling their child’s anatomical condition with thoughts of his/her future sexual activities” (Reis, “Divergence” 537; Reis, *Bodies* xv, 155). Moreover, the medical profession “never fully incorporated *intersex* into their vocabulary, and so the word has suffered from a lack of specificity in the medical world” (Reis, “Divergence” 537; Reis, *Bodies* 155). Therefore, a 2005 conference “hosted by the Lawson Wilkins Pediatric Endocrine Society and the European Society for Paediatric Endocrinology” devised the new nomenclature “*disorders of sex development (DSDs)*[,]” which “quickly bec[a]m[e] ubiquitous” within the medical community (Reis, “Divergence” 536; Reis, *Bodies* 153). However, as Reis points out, this new term, much like those it was intended to replace, remains “controversial and divisive” (“Divergence” 536; Reis, *Bodies* 153). Nevertheless, advocates of DSD

believe it deemphasizes the identity politics and sexual connotations associated with *intersex* and the degradation associated with *hermaphrodite* and instead draws attention to the underlying genetic or endocrine factors which cause prenatal sex development to take an unusual path. Many proponents of the name change believe that using *DSD* has the potential to create better medical care for affected children and their families because it avoids sensationalizing health conditions, allowing doctors to focus solely on therapeutic issues. (“Divergence” 537-38; Reis, *Bodies* 155-56)

However, as Reis points out, although the term ‘disorders of sex development’ might be beneficial for members of the medical profession and may “provide some relief for the parents of children born with such conditions” it has caused considerable debate and outrage among “adults who identify as intersex” as they oppose the use of the word “disorder” in connection with intersex conditions (Reis, “Divergence” 538; Reis, *Bodies* 156). In fact according to Diamond, “[t]he terminology and meaning given to DSD has been strongly spoken against by the largest international organization of intersex persons as being demeaning and insulting” (172). Thus, as Hsu points out, “many activists regard this change as an abandonment of identity politics and an act of self-pathologization” (87). This is due to the fact that the word disorder could be said to “connote[] a need for repair” which would mean that “this new nomenclature contradicts one of intersex activism’s central tenets: that unusual sex anatomy does *not* inevitably require surgical or hormonal correction” (Reis, “Divergence” 538; Reis, *Bodies* 156). Thus, Reis rightly argues that “[t]he label *disordered* marks an individual as patently impaired, a body that needs to be poked and prodded until it fits neatly into the recognizable binary categories of female and male” and as such “represents a denial of a core feminist and intersex-activist principle regarding the fluidity of sex and gender” (“Divergence” 539; Reis, *Bodies* 157). Moreover, it also “contradicts the central precept of disability politics, which asserts that difference need not be seen as inherently insufficient or defective” (Reis, *Bodies* 157). As such Reis contends that “[u]sing the word ‘disorder’ elides a crucial point that some of these surgeries, such as clitoral recession, serve primarily social rather than

medical goals” (*Bodies* 156-57). Giffney and O’Rourke go even further in their summary of the debate surrounding the new nomenclature in which they argue that

it seems that right now intersex is in deep trouble, is losing its critical edge. With the widespread shift from the language of intersex (privileging a non/normative ‘identity’) to DSD (Disorders of Sex Development), we are witnessing a return to the pathologisation and intersexualisation (Eckert) of the intersex body, a refusal of its multiplicity, messiness, unreadability (Spurgas). This biopolitical shift, largely in North American contexts, is an attempt to control, discipline, render vulnerable and manageable the intersex body, an attempt to make the edgy body less troubling, to keep it before the law (Kolbe). (Giffney and O’Rourke xi)

Consequently, for Holmes, the new terminology is indicative of the fact that “the clinical environment repeats in a new guise its nineteenth-century assertion that intersex/hermaphroditism does not really exist” (“Straddling” 6). In order to solve these problems, Reis suggests replacing the term ‘disorder’ with ‘divergence’ as this would avoid labeling intersex people “as being in a physical state absolutely in need of repair” and allow the retention of “the acronym DSD” (“Divergence” 541). An idea that is also favored by Diamond who argues that using the term ‘difference’ instead of disorder—which would also allow the continued use of DSD—might also help parents in coming to terms with their child’s diagnosis (172). However, up to this point neither Diamond’s nor Reis’ terminological changes have been widely adapted. In addition, they do not retain the emancipatory character of the term intersex, which was and to a certain degree still is seen by many intersex activists as an “autonomous self-identification, a reclamation and wresting away of meaning and power from medicine” and thus exemplifies “the movement’s trajectory [...] away from a stigmatizing and medicalized view and toward a valuing of embodied difference” (Holmes, “Straddling” 5).

As a consequence, in the absence of a universally accepted nomenclature this thesis will—in full awareness of the fact that they are neither the “final term[s], nor the most appropriate term[s]” (Holmes, “Straddling” 7)—continue to employ the terms ‘intersex,’ ‘intersexuality,’ ‘intersex individual,’ and ‘intersex people’ because they are both widely used both by activists and scholars and represent “powerful term[s] whose historical, social and political import remains *critical* as a tool for interrogating heteronormative and bio-normative presuppositions about proper embodiment” (Holmes, “Straddling” 7). The following two sections of this thesis will investigate the question of how society has traditionally reacted to intersex birth, how this reaction has been criticized by intersex activists, the extent to which this has resulted in a change to the traditional treatment paradigm, and how intersexuality and society’s reaction relate to queer theory and its project of critiquing gender binarism and heteronormativity.

## 2.2 Medicalization of Intersexuality and the Construction of the Gender Binary

According to LeFay Holmes, “intersexuality refers to a physical and/or chromosomal set of possibilities in which the features usually understood as belonging distinctly to either the male OR female sex are combined in a single body” (15). As such, intersexuality is used as “an umbrella term that describes incongruity between external genitalia, internal reproductive anatomy, hormonal levels, and chromosomes” or rather aberrations from our traditional understanding of the congruence of these features (Reis, “Coming” 373). There is a whole range of different intersex conditions with a multitude of different causes whose major communality lies in the fact that they “in some way violate the commonly understood biological differences between males and females” (Karkazis 9; cf. Holmes, *Intersex* 31). Therefore, Holmes argues that irrespective of any biological definition, intersex on “a cultural level [...] is a category that results from particular scientific and medical commitments, commitments linked to larger social means of ordering and organizing sexuality” (*Intersex* 31).

Although the term “ambiguous” is often used in both medical and social science texts to describe intersex conditions and genitalia, LeFay Holmes opposes this formulation, because she believes it to be “a misnomer because there are presentations of intersexuality in which genitals appear quite clearly as one or the other of the two recognised sexes” (15; Holmes, *Intersex* 32). In addition to the formulation’s imprecision, she also rejects the term “ambiguous” because it “implies that intersex genitals do not look like *anything*” and thus reinforces the pathologization of intersex bodies and reinforces gender binarism (LeFay Holmes 15; Holmes, *Intersex* 32). Instead LeFay Holmes argues that “[t]he fact that they are neither male nor female makes them clearly intersexed rather than confused or incomprehensible” (15; Holmes, *Intersex* 32).

As Lucal points out, “the prevalence of intersexuality is difficult to determine, partly because of the lack of agreement about what constitutes this condition” (522). Nonetheless, it is estimated that “1 in 500 to 1 in 2,000” children are considered intersex at birth (Warnke 127). However, as Warnke points out, “these estimates increase if one includes infants with ‘unacceptable’ genitalia: for example, infants whose penises are considered too small or whose clitorises are considered too large” (Warnke 127). Nevertheless, despite the fact that this means that intersex births—without including infants with ‘unacceptable genitalia’—are more common than for example “cystic fibrosis”—which according to Lucal occurs in “[a]bout 1 out of 9000 people”—there is a comparatively remarkable lack of awareness with regards to intersexuality (Lucal 522).

Traditionally, doctors assign intersex infants to “either male or female sex” and then “carve the external genitalia or internal organs to create the anatomy appropriate to that sex” (Warnke 127). The treatment is then supplemented with hormones “to ensure continuing conformity of the body to the assigned sex and their families usually receive counseling to help with proper, gender-based psychosocial rearing” (Warnke 127). In the context of this medical paradigm, it is assumed that “a true sexed identity does exist—and that it must be restored”

and thus “[g]enitals are described as being ‘unfinished’ or ‘incomplete’ and surgery offered as simply finishing a process of development begun in the womb” (Carroll 193). Even though modern medicine allows doctors “to determine chromosomal and hormonal gender, which is typically taken to be the real, natural, biological gender[.]” this does not mean that this evidence is always the determining factor for the sex assignment; instead “biological factors are often preempted in physicians’ deliberations by such cultural factors as the ‘correct’ length of the penis and capacity of the vagina” (Kessler 12). As such, these procedures are undertaken to ensure compliance with the heterosexual norm in that what ultimately determines the child’s gender is based on whether the genitalia of a presumed male will be “capable of penetration” (Kessler 106), and that of a presumed female is able to have “intercourse with a ‘normal-size’ penis” (Kessler 58). These cultural underpinnings are also revealed by the peculiar fact that modern medicine views intersexuality “as pathology, rather than as a neutral form of difference” in spite of having itself established that “intersexuality is a naturally occurring, statistically stable instance of sexual/anatomical variation” (Holmes, *Intersex* 20). As such, the medical rationale “testifies to [...] the discursive gymnastics required to sustain a two-sex model” that Hird already identified in the work of John Money—the father of the traditional treatment paradigm for intersexuality (Hird 350). Hence, Kessler notes that

medicine [...] in the face of apparently incontrovertible evidence—infants born with some combination of ‘female’ and ‘male’ reproductive and sexual features—physicians hold an incorrigible belief that female and male are the only ‘natural’ options. (Kessler 12-13)

A fact that is further exhibited in modern medicine’s narration of the way in which it surgically “corrects” intersex deviation. As Kessler points out, the fact that “intersexed genitals would be immutable were it not for medical interference” is ignored in modern medicine’s reflections on the topic, and instead “they think of, and speak of, the surgical/hormonal alteration of such ‘deformities’ as natural because such intervention returns the body to what it ought to have been if events had taken their typical course” (Kessler 31). Thus, the procedure is conceived in terms of converting “[t]he non-normative [...] into the normative, and the normative state is considered natural[.]” which in turn is predetermined by the “culturally indisputable gender dichotomy” (Kessler 31). Consequently, Kessler stresses “that genital ambiguity is ‘corrected,’ not because it is threatening to the infant’s life but because it is threatening to the infant’s culture” (Kessler 32). A point with which Karkazis would concur as she stresses that these surgeries have “the effect of limiting human variation and expressing a disdain for atypical bodies” and are not based on any “functional limitation” of “[i]ntersex embodiments” themselves, but instead are based on the fact that these bodies represent “corporeal configurations that violate cultural standards” (Karkazis 10). The oddity of the conclusion that intersexuality is pathological in nature is made even more striking if one considers that “the intersexed condition does not necessarily in and of itself pose a threat to the baby’s immediate or even future health” and is nonetheless traditionally conceived as “a ‘medical emergency’” that “warrant[s] rapid and radical surgical intervention” (Carroll 191-92). As such the traditional

medical approach to intersex births is based on conceiving intersexuality as pathological and itself performatively and surgically underscores the pathologization of intersex individuals.

The traditional medical treatment of intersexuality has been heavily criticized by intersex people<sup>10</sup> (Preves, “Sexing” 540); and organizations like the Intersexual Society of North America have “lobbi[ed] to abolish all unnecessary surgery<sup>11</sup> and ensure that what surgery is still performed is with the full understanding and consent of the intersexual individual involved” (Hird 352). Much of this criticism of the traditional and in many instances still practiced treatment paradigm, as Carroll points out, was and is based on the fact that

Such interventions [...] constitute medically unnecessary cosmetic surgery on a subject unable to give consent, and given that such initial surgeries are often a prelude to lifelong medical interventions, whose side effects can include irreversibly impaired sexual function. (192)

Before this criticism the treatment paradigm, which was based on the practice and research publications of John Money, “enjoyed almost unprecedented acceptance and adherence for decades” (Reis, *Bodies* xiv). The origins of this criticism and with it the intersex movement can be traced to “the 1990s, [when] intersex adults who had received surgery as infants came forward speaking about their sense of mutilation” (Greenfield). The development was further precipitated by the revelation that one of Money’s most prominent cases—the “John/Joan” case<sup>12</sup> (Rosario 2)—which he had used to bolster his claim that “young children could safely be assigned any gender with surgical ‘reinforcement’ was revealed to be a failure” (Greenfield).

These efforts by intersex organizations and support groups have generated considerable public attention and have had a tremendous—though not universal—impact on the medical community and its stance on intersexuality. As a result, “Intersexuality has moved from the margins of cultural awareness to the mainstream of popular culture via news media and popular programming, and to the center of much debate in queer and feminist theory” (Holmes, *Intersex* 22). Consequently, according to Reis, “Money’s findings have been discredited, and the injunction to ‘wait until puberty and see’ that is gaining acceptance surely obviates much heartache” (*Bodies* xiv). As such, Fausto-Sterling in 2000 already reported that “[t]he revelation of cases of failed reassignments and the emergence of intersex activism have led an increasing number of pediatric endocrinologists, urologists and psychologists to reexamine the wisdom of early genital surgery” (“Revisited” 21). The movement has in fact been so effective that in 2005 in an unprecedented move “medical professionals and advocacy groups worked

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10 It should be noted that although the majority of intersex activists oppose early childhood surgery, as Holmes notes, there are also those that “favor[] surgical intervention” even if this stance “is less popular with intersexed persons themselves than it is with their families and medical care providers” (*Intersex* 16). Nevertheless, even among these supporters “most report that the surgery was *right for them* but *not*, necessarily the right course of action for *all* intersex persons” (Holmes, *Intersex* 16).

11 It is important to note that although the intersex movement is critical of surgically assigning a sex to intersex children they “are not suggesting that children be raised without a gender identity” (Holmes, “Rethinking” 160). Thus, as Holmes further points out, “Suggesting that early cosmetic surgery should be postponed is not equal to arguing that children should be raised as radical gender experiments. The necessity of a clearly defined social role is not at issue” (“Rethinking” 160).

12 For a detailed summary of the case and its implications see Rosario pages 2 to 6.

together to reconsider medical care for those born with intersex diagnoses” which resulted in the 2006 “Consensus Statement on Management of Intersex Disorders” (Karkazis 237). This statement included a revised stance on early childhood surgeries, which included important provisions that meant to curtail “vaginoplasty in infants with short or absent vaginas” and allowed “clitoral surgery only in ‘severe’ cases” (Karkazis 237). Moreover, it also resulted in the change in the medical terminology—from “hermaphroditism” to “DSD”—discussed above (Karkazis 237). Additionally, it recommended

integrating psychosocial support and professional mental health care for persons with intersex diagnoses and their families at all stages of development; advocating honest and complete disclosure with patients and their families; considering the potential for fertility for all infants; curtailing genital exams and medical photography [...]. (Karkazis 237)

In addition to this, in 2013, a report on torture “the Special Rapporteur to the United Nations’ Human Rights Council called on member states to end laws allowing ‘forced genital-normalizing’ surgeries on intersex people” (Greenfield).

However, this does not mean that this change has been universal or even that the new medical approach to intersex births has been adopted by the majority of North American hospitals. As Rubin pointed out in 2012,

Although Money’s work has been questioned in recent years, many clinicians continue to follow his guidelines, viewing intersex infants as corporeally unintelligible at the moment of birth, only to immediately transport them into intelligibility through surgical, medical, and psychosocial normalization. (Rubin 902-03)

Similarly, Holmes in her 2008 book *Intersex A Perilous Difference* points out that “In the absence of an identifiable disease, this medical and surgical management continues to be performed at all the major children’s hospitals in Canada and is performed in hospitals across the United States” (42). A statement that is corroborated by Greenfield in her 2014 article in which she states, “The few figures that exist reinforce the doctors and medical literature that describe the surgeries as continuing.” This also has to do with the fact that the “Consensus Statement” was not very specific and, as Dr. Charlotte Boney—a critic of “clitoral reduction surgery”—points out, “didn’t go far enough. It leads you to believe surgery is a viable option” (qtd. in Greenfield). Furthermore, according to Karkazis the statement “demonstrate[s] an unwillingness (or inability) to think about intersexuality in terms other than biomedical (and pathological)” (4). This in turn is said to show that “[f]rom the physician’s point of view, gender assignment or surgical techniques are controversial, but the existence of intersex bodies and the need to treat them are not” (Karkazis 4). As a result the statement, according to Karkazis, reflects the “ambivalence” that predominates the medical community stance on genital surgery in that in it

The authors acknowledge that there are minimal systematic surgical outcome data about genital surgery [...], that orgasmic function may be harmed by surgery, and that there is little support for the belief widely held among physicians and others that surgery performed in the first year of life relieves parental distress about atypical genitals [...]. (Karkazis 134)

Nevertheless, the statement still allows for surgery in cases of “girls with severe virilization” (Lee et al. qtd. in Karkazis 134), but “the authors fail to provide a rationale for why, given the problems they noted, it is still advisable or acceptable to consider surgery for girls with greater genital virilization” (Karkazis 134). Nevertheless, Karkazis acknowledges that there has been considerable change in some areas, most strikingly with regards to “feminizing surgery on males with a small phallus” which has become far less common (Karkazis 135). Moreover, she notes “Clinicians are [...] moving away from the wholesale idea that sex-specific genitalia are necessary for ‘proper’ gender-identity development” (Karkazis 135). However, this does not mean that the medical profession is about to abandon the “profound belief in the inseparability of genitals and gender,” but rather the connection is maintained and surgery is still recommended in some cases—such as in the case of infants who have been assigned to the female sex (Karkazis 135). However, what has changed is the rationale behind such procedures; it used to be performed to guarantee ‘correct’ “gender-identity formation[,]” whereas it is now performed under the guise of enabling “psychosocial well-being[,]” which according to this rationale necessitates “looking ‘normal’” (Karkazis 135). Consequently, it is said to “give the girl a chance at an otherwise unattainable normal life” (Karkazis 135). Thus, despite evidence showing the potentially harmful effects of such surgeries, they are still recommended under the conviction that this will allow the patient to live a ‘normal’ life (Karkazis 135). A premise that Anne Fausto-Sterling already debunked in her 1993 article “The Five Sexes” in which she pointed out that “there are few empirical studies to back up that assumption,” and that studies conducted “between 1930 and 1960, before surgical intervention became rampant” show that most intersex children “who grew up knowing they were intersexual [...] adjusted to their unusual status” (“Five Sexes” 24). Nevertheless, in spite of this evidence and decades of protest by intersex organizations, early childhood genital surgery continues to be practiced. This is in part also due to the fact that “Consensus Statement”—because it merely represents treatment guidelines—did not include any “enforcement or oversight mechanisms” (Karkazis 274). Consequently, Karkazis concludes that the statement ultimately “exists as little more than an ideal on paper” (274).

As should now be clear, the “unruly—even heretical—bodies” of intersex individuals question and trouble the gender binary as “[t]hey do not fall naturally into” it and, as Fausto-Sterling argues, “only a surgical shoehorn can put them there” (*Sexing* 8; “The Five” 24). Thus, in order to “maintain” and reinforce the binary divisions of gender, society “must control those bodies that are so unruly as to blur the borders” (Fausto-Sterling, *Sexing* 8). As Preves points out, these procedures and their continuation are “founded on the belief that intersex is pathological” rather than on conclusive evidence of their effectiveness (“Sexing” 524). Therefore, according to Preves, the medical treatment of intersex children can be considered to be what “Irving Zola first labeled [...] *medicalization*” in that it “view[s] a natural phenomenon in a medical framework where the medical view is seen as the authoritative, if not hegemonic, view [...]” (“Sexing” 532). Moreover, she notes that “Once a phenomenon is seen through

this medical lens, medical treatments may seem logical” (Preves, “Sexing” 532). This also explains why these procedures are often designated as preventative in that “intersex is also seen as potentially disease causing, as evidenced by the emergency gonadectomies performed to prevent cancer” (Preves, “Sexing” 524-25). However, as both Preves and Reis make clear, the motivation for such procedure is cultural rather than medical (Preves, “Sexing” 524; Reis, “Coming” 375). Accordingly, Holmes argues, “the medical procedures meant to fix intersex are actually only imperfect measures to render it invisible” (“Rethinking” 174). As such, they are carried out not “for the sake of preventing stigmatization and trauma to the child [...] [, but] [r]ather, these elaborate, expensive, and risky procedures are performed to maintain social order for the institutions and adults that surround that child” (Preves, *Intersex* 11-12). As Preves observes, “[b]odies that are sexually ambiguous challenge prevailing binary understandings of sex and gender. Individuals who are intersex have bodies that are quite literally queer” (“Sexing” 523). Along the same lines Kessler remarks, “In the acceptance of genital variability and gender variability lies the subversion of both genitals and gender” (132). Thus, as Carroll remarks, “[i]ntersexuality demonstrates both the indeterminacy of ‘sex’ as a category [...] and the normative violence to which deviant bodies are subject” and argues that “the medical and surgical management of intersexed bodies can be considered symptomatic of a heteronormative imperative” (187). Consequently, intersexuality is of major interest to proponents of queer theory—which “affirm[s] the indeterminacy and instability of all sexed and gendered identities” and “undertakes an investigation and a deconstruction of these categories” (Salih 9)—as it signals the internal ambivalence of gender binarism and reveals the extreme measures that have to be undertaken to maintain it. These questions of the interrelation between queer theory and intersexuality and of queer theory’s value for a critique of intersexuality’s marginalized and pathologized status will be addressed in the following section.

### **2.3 Intersexuality and the Ambivalence of the Sex/Gender Binaries**

As pointed out above, intersexuality is of major interest to proponents of queer theory as they set out to question the traditional “‘sex’/‘gender’ binary [...]”<sup>13</sup> and the underlying heteronormative assumptions that there are only two clearly distinguishable genders that are naturally attracted to each other (Hird 348), as well as the accompanying idea that “sex equals penis-in-vagina intercourse, [and] that ‘family’ constitutes a heterosexual couple and their children” (Clarke et al. 120). Thus, they challenge a system of heteronormativity in which heterosexuality does not only appear to be the most coherent form of sexuality, but in which it is also privileged (Berlant and Warner 548). In this context, heteronormativity represents “the perceived reinforcement of certain beliefs about sexuality within social institutions and policies” (Clarke et al. 120). However, as Berlant and Warner point out, it is “more than

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13 In which sex was understood to be rooted in biology and gender represented “the practices of femininity or masculinity in social relations” (Hird 348).

ideology, or prejudice, or phobia against gays and lesbians” and other non-normative groups (554-55). In fact they argue that

it is produced in almost every aspect of the forms and arrangements of social life: nationality, the state, and the law; [...] medicine; and education; as well as in the conventions and affects of narrativity, romance, and other protected spaces of culture. (Berlant and Warner 554-55)

One of the most prominent critics of the sex/gender distinction and its heteronormative roots has been Judith Butler, who asserts that “[t]here are no direct expressive or causal lines between sex, gender, gender presentation, sexual practice, fantasy and sexuality. None of those terms captures or determines the rest” (“Imitation” 725). According to Butler, “[t]he presumption of a binary gender system implicitly retains the belief in a mimetic relation of gender to sex whereby gender mirrors sex or is otherwise restricted by it” (*Gender* 6). Consequently, Butler criticizes the distinction between sex and gender because, according to her, it is merely established to conceal the fact that both are “effects of a specific formation of power” (*Gender* viii). Therefore, for Butler, gender is not the cultural expression of a prediscursive, biological sex; instead it should be seen as the “very apparatus of production” that brings about the idea of an objective ‘sex’ that precedes culture in the first place (*Gender* 7). Hence, Butler considers “*gender* [...] [to be] *a kind of imitation for which there is no original*” (“Imitation” 722). Indeed gender performatively produces the semblance of its own originality (i.e. sex) (Butler, “Imitation” 722). In her opinion, this reveals that “gender is always a doing, though not a doing by a subject who might be said to preexist the deed” (Butler, *Gender* 25), for as she points out, “subject-formation is dependent on the prior operation of legitimating gender norms” (Butler, *Bodies* 232). This also implies that

[t]here is no ‘proper’ gender, a gender proper to one sex rather than another, which is in some sense that sex’s cultural property. Where that notion of ‘proper’ operates, it is always and only improperly installed as the effect of a compulsory system. (Butler, “Imitation” 722)

Nevertheless, this does not mean that Butler considers the seemingly biological category of ‘sex’ to be mute, but rather that she views it as a result of the cultural norm of gender, or as she writes in *Bodies That Matter*, “Sexual difference [...] is never simply a function of material differences which are not in some way both marked and formed by discursive practices” (1). As Salih points out, this is not the same as saying that “there is no such thing as the material body, but that we can only apprehend that materiality through discourse” (74). Thus, for Butler, rather than being “a simple fact or static condition of a body[,]” ‘sex’ is a cultural and “regulatory norm[.]” which brings forth its own production “through a forcible reiteration of those norms” (*Bodies* 1-2). Therefore, Butler argues that “the regulatory norms of ‘sex’ work in a performative fashion to constitute the materiality of bodies and, more specifically, to materialize the body’s sex, to materialize sexual difference in the service of the consolidation of the heterosexual imperative” (*Bodies* 2).

However, since this materialization—and the performative reiteration of gender in general—is based on heteronormativity, it naturally produces and necessitates an outside, or as

Butler puts it “a domain of excluded and delegitimated ‘sex’” of which intersexuality is a part (Butler, *Bodies* 15-16). As such, intersex bodies according to Butler “provide the necessary ‘outside’ if not the necessary support, for the bodies which, in materializing the norm, qualify as bodies that matter” (Butler, *Bodies* 15-16). Therefore, Butler notes that “The normative force of performativity [...] works not only through reiteration, but through exclusion as well” (Butler, *Bodies* 188-89). However, this also means that intersex has the potential of troubling heteronormativity and thus “gives us a way of understanding the taken-for-granted world of sexual categorization as a constructed one, indeed, as one that might well be constructed differently” (Butler, *Gender* 110).

Nonetheless, Butler emphasizes the fact that transgressions of the gender binary and their cultural representation are not always and necessarily subversive of it and its heteronormative underpinnings. Hence she observes that

heterosexual privilege operates in many ways, and two ways in which it operates include naturalizing itself and rendering itself as the original and the norm. But these are not the only ways in which it works, for it is clear that there are domains in which heterosexuality can concede its lack of originality and naturalness but still hold on to its power. Thus, there are forms of drag that heterosexual culture produces for itself [...]. (*Bodies* 126)

An example of such a non-subversive practice is what Butler—with reference to the drag performances in the movie *Paris Is Burning*—has termed “high het entertainment” (*Bodies* 126) in that they serve the “reidealization of hyperbolic heterosexual gender norms” (*Bodies* 125). Butler conceptualizes “high het entertainment” as cultural products in the “narrative trajectory” of which “the anxiety over a possible homosexual consequence is both produced and deflected” (*Bodies* 126). This according to her “provid[es] a ritualistic release for a heterosexual economy that must constantly police its own boundaries against the invasion of queerness [...]” (Butler, *Bodies* 126). Moreover, Butler argues that “this displaced production and resolution of homosexual panic actually fortifies the heterosexual regime in its self-perpetuating task” (*Bodies* 126). Similarly, I will redefine the term ‘high het entertainment’ to encompass the narrative production of intersexuality as a violation of an “idealized gender dimorphism” (Butler, *Undoing* 65), which threatens to expose the norm’s constructed character, but which is narratively deflected rather than given the chance of fulfilling its subversive potential and thus ultimately results in a reification of heteronormativity. Hence, such narrative representations of intersexuality similarly constitute a “ritualistic release” (Butler, *Bodies* 126), which further fortifies the normative status of gender dimorphism rather than displace it. This may, for example, be achieved by portraying intersexuality as a pathological and extremely rare disorder of sex development or by perpetuating the belief in modern medicine’s ability to see through the supposed ambivalence to discover the patient’s true gender identity—thus mitigating the dangerous indeterminacy of intersexuality by reintegrating it into the norm. Or it may be accomplished by exempting either past or/and present medicine from seemingly mistaken gender assignments by presenting these procedures as the sole result of the misguided decisions made by overwhelmed parents. Furthermore, it is also represented in stories that

perpetuate the idea of ‘mistaken gender assignments’ in the first place, which ultimately suggest that there could have been a correct decision were it not for the outdated methodologies used in the past or the panicked and often ill-advised decisions of parents.

For the following analysis, Butler’s theorization of gender performativity has two important implications. First, rather than viewing intersexuality as an aberration of biological ‘sex,’ it will be discussed as a violation of the cultural norms underlying our current understanding of ‘sex,’ which via the regulatory mechanism of biomedicine—or in this case its cultural reproduction—is forcibly made to comply with these norms. Second, although the common understanding of the category ‘sex’ is presumed to be a cultural product of our gender system in the course of this thesis, I will nonetheless continue to differentiate between ‘sex’ and ‘gender’ in order to reflect the differentiation and relation between the two that underlies certain presumptions in the episodes at hand and culture at large. However, this does not mean that this thesis shares this belief, but instead that ‘sex’ should be explicitly understood as a special formation of power—on the basis of cultural presumptions of gender—that is connected to certain physiological properties of human bodies and is enforced on those that do not comply with its prescriptions.

Using these concepts, this thesis will demonstrate that the portrayals of intersexuality in the respective medical show do not contribute to a problematization of heteronormativity, or in many cases even just a questioning of the pathologization of intersexuality. Instead, even the shows aired after the “Consensus Statement,” which are openly critical of the traditional treatment paradigm, are shown to utilize their medical authority to reinforce heteronormative standards and the idea that sex determines gender. Therefore, all of the portrayals under consideration will be shown to represent high het entertainment. However, preceding this analysis, the following section of the thesis will first demonstrate that medical TV dramas inherit the medical authority from the institution they depict and how they themselves discursively reinforce this authority, which is later shown to be used to reinforce gender binarism and heteronormativity.

### 3. Origins and Construction of Medical Authority in Medical TV Shows

#### 3.1 Medical Authority and the Reception of Medical TV Shows

In Western society, medicine, its practitioners, and the hospitals in which it is practiced have a special status in that they are given and are perceived to possess the unequivocal authority to define what constitutes an illness and how it may be remedied. This authority is the result of a process that took place “in the 19<sup>th</sup> and early 20<sup>th</sup> centuries, as medical discourse, hospitals, and medical education transformed into institutions built on scientific standards that elevated the authority and prominence of physicians” (Rich et al. 221). Thus, as a result of this process,

medicine has [...] obtained well-nigh exclusive jurisdiction over determining what illness is [...]. In the sense that medicine has the authority to label one person’s complaint an illness and another’s complaint not, medicine may be said to be engaged in *the creation of illness as a social state which a human may assume*. (Freidson 205)

Although Freidson concedes that “the layman may have his own ‘unscientific’ view of illness diverging from that of medicine[,]” he maintains that “in the modern world it is medicine’s view of illness that is officially sanctioned and, on occasion, administratively imposed on the layman” (206). According to Freidson, this is the part of medicine’s status as “a profession” which grants it “the official power to define and therefore create the shape of problematic segments of social behavior” (206). Similarly, Gabbert and Salud II—with reference to Anthony Giddens—assert that “modern Western biomedicine” is exemplary of an “expert system” in that in it “people depend on the technological expertise of strangers” (211). In this expert system of medical knowledge “[d]isease is defined as deviancy from an idealized model of health and is explained by focusing on physiological processes and biochemical mechanisms” (Gabbert and Salud II 211).

Michel Foucault termed this specialized medical knowledge and examination that accompanied it the “medical gaze” (Downing 34), and according to Rich et al., it “indicates a mode of medical perception that enables the physician to look through the patient to recognize the disease” (222). As Foucault writes, “The eye becomes the depositary and source of clarity; it has the power to bring a truth to light that it receives only to the extent that it has brought it to light [...]” (*Birth* xiii). By means of this medical gaze, the doctor is said to be able to, “communicate directly with the disease rather than with the patient, who is understood now in his or particularities only so that these may be abstracted and contextualized” (Rich et al. 222). To accomplish this, the medical gaze “partitions the body into its components and essays an anatomy of disease” (Downing 34). As such, the gaze makes its objects “stand out against a background of objectivity” (Foucault, *Birth* xiv). As Jones and Porter point out, the medical gaze does not “predetermine[e] everything that happens[,]” and is also not “a reductive mode of perception,” but rather it is “productive of individuality, uniqueness, [and] particularity” (35). This also means that the gaze is not a mode of neutral observations, but rather it establishes that which it observes and constructs relations of power around it or as Foucault puts it, “the gaze that sees is a gaze that dominates [...]” (*Birth* 39). Thus, the medical gaze has established

its “sovereignty” and came to possess “[s]o many powers, from the slow illumination of obscurities, the ever-prudent reading of the essential, the calculation of times and risks, to the mastery of the heart and the majestic confiscation of paternal authority” among others, and so became “the eye that knows and decides, the eye that governs” (Foucault, *Birth* 89). Moreover, Foucault notes that the medical gaze,

was no longer the gaze of any observer, but that of a doctor supported and justified by an institution, that of a doctor endowed with the power of decision and intervention. Moreover, it was a gaze that was not bound by the narrow grid of structure (form, arrangement, number, size), but that could and should grasp colours, variations, tiny anomalies, always receptive to the deviant. Finally, it was a gaze that was not content to observe what was self-evident; it must make it possible to outline chances and risks; it was calculating. (*Birth* 89)

Furthermore, Foucault notes that “the medical gaze embraces more than is said by the word ‘gaze’ alone. It contains within a single structure different sensorial fields” and thus becomes a specific mode of observing that is “endowed with a plurisensorial structure. A gaze that touches, hears, and, moreover, not by essence or necessity, sees” and that in contemporary medicine is complemented with various medical instruments—from the stethoscope to x-ray and MRI scans—that aid it in its task (Foucault, *Birth* 164).

According to Freidson, the medical evaluation that underlies this process is, similar to the way that “the judge determines what is legal and who is guilty” in that the physician holds the authority to ascertain “what is normal and who is sick” (206). Consequently, he defines illness “as a type of deviation, or deviance, from a set of norms representing health or normality” (Freidson 207). Consequently, he maintains that “the concept of illness is inherently evaluational [*sic*]” and thus the practice of medicine represents “a moral enterprise like law and religion, seeking to uncover and control things it considers undesirable” (Freidson 208). However, as he points out, unlike law and religion, medicine “is believed to rest on an objective scientific foundation that eschews moral evaluation[,]” and its conception of illness thus appear to “constitute a physical reality independent of time, space, and changeable moral evaluation” (Freidson 208). Along the same lines Karkazis argues that

Far from existing outside culture, biomedicine is a cultural entity that not only has unparalleled discursive and practical powers to define and determine what it is to be normatively human but also to withstand alternative constructions and challenges to its version of normativity [...]. (5)

This, as Freidson rightly points out, not only has medical implications as “[i]n human society, naming something an illness has consequences independent of the biological state of the organism” (208). Thus, he concludes:

Illness as such may be a biological disease, but the idea of illness is not, and neither is the way human beings respond to it. Thus, biological deviance or disease is defined socially and is surrounded by social acts that condition it. (Freidson 209)

This medical authority is also transferred to the fictional representations of modern biomedicine in medical TV dramas, which—in combination with their movie counterparts—have been an essential source of medical information for US Americans “[s]ince the early

twentieth century (Reagan, Tones, and Treichler 1). These shows as Turow notes are “very much in style on television” (1). This according to Turow is partly the result of the fact that these programs give viewers an inside look into a part of their daily lives to which they normally have very limited access (1-2). Namely, “[t]hey show the struggles around prognoses and treatment options that patients would likely not hear about from their own ‘providers.’ And, in playing out the characterizations and plots, they offer perspectives that viewers can apply to their personal lives” (Turow 2). Therefore, these programs constitute “a pool of powerful images from which Americans draw their understanding of health care” (Turow 2). The continuing relevance of these TV shows as a source of medical information for the US public is also demonstrated by the fact that, as Cummins and Gordon point out, “a 2002 Kaiser Family Foundation poll [showed], [that] 49 percent of adult US Americans cited TV as their primary source of health information” (122). The immense trust US American television audiences place in these shows has also been shown by “[n]umerous studies [that] have noted [...] the ways in which viewers use entertainment programs as a basis for their knowledge about medicine[,]” thereby demonstrating their trust in the medical accuracy and authority of these shows (Strauman and Goodier, “The Doctor(s)” 32). One survey on the impact of the immensely popular medical TV drama *ER* showed that

about one in three [viewers] said that information they picked up from watching this fictional show helped them make real health care choices or decisions. About one in seven said they had contacted a doctor because of something they saw in the show. (Holtz 5)

Moreover, Holtz notes that medical shows have also been proven to have an educational effect in that “[a]t least twice during the long run of *ER*, health education researchers worked with the show’s writers to insert relatively unknown medical facts into the plots[,]” and combined these with national surveys to measure the impact this information had on viewers (Holtz 6). In one of these studies, the effect of the inclusion of the “morning after pill” was studied, and the survey “indicated that awareness of this sort of emergency contraception rose from about half of *ER*’s viewers before the episode aired to two-thirds of them a week after the show” (Holtz 6). The medical authority of TV dramas is further underscored by the fact that as Turow points out, “[t]he Centers for Disease Control and Prevention (CDC) Web site proclaimed that ‘88 percent of people in America learn about health issues from television’” (363). Moreover, it is further underscored by the CDC’s conclusion that “[w]e believe that prime-time and daytime television programs, movies, talk shows and more are great outlets for our health messages” (Turow 363). If this were not enough the CDC also created the Sentinel for Health Awards to promote and honor “exemplary achievements of television story lines that inform, educate and motivate viewers to make choices for healthier and safer lives” (Turow 366). This not only reveals the significant effect that these shows can have on the medical knowledge of their audiences, but also the tremendous trust viewers place in these reenactments of modern biomedicine.

This trust is also nurtured by the fact that the physicians on these shows, as Cohen and Shafer point out,

personify every quality a patient could want: brilliant diagnostic abilities, an unlimited fund of knowledge in all medical subspecialties, and Hollywood-style good looks. In a world of time and economic pressures, these doctors are able to address every concern and comfort nearly everyone around them. (211)

As a result of this tendency which Cohen and Shafer link to “commercial appeal and rating” the medicine practiced on these shows is marked by “quality care and understanding” (211). Similarly, as Makoul and Peer note, “the doctor shows tend to glorify physicians and their healing power, portraying them as unrelenting advocates for their patients” (245).

However, the public trust in the medical accuracy of these shows is not the sole result of their inheritance of the legacy of modern medicine, but is also due to a public discourse that surrounds these shows. In this context, *ER* used the fact that its creator Michael Crichton was a physician and that it was the first show to employ medical professionals as writers as a promotional tool to convince viewers of its accuracy—a practice that has been continued by all the later shows discussed in this thesis (Turow 345-46). The show’s medical credentials were further underscored by the fact that “*Newsweek* put the *ER* cast on its cover on 31 October 1994 with the caption, ‘A Health-Care Program that *Really* Works’” (Annas 40).

However, the fact that *ER* is not the only show to place such an emphasis on medical accuracy is underscored by an interview David E. Kelley, the creator of *Chicago Hope*, gave to *USA Today*, in which he remarked “that he aimed to make the show the most realistic drama ever seen on TV” (Turow 339). It is further emphasized by Holtz’s discussion of the popular medical TV drama *House, M.D.*, in which he notes that viewers “trust that the diseases, symptoms, tests, and treatments will contain essential elements of reality” (4). Moreover, the show’s creators are aware of these expectations, and they themselves emphasize the importance of medical accuracy for the show’s production; an assessment which Holtz bases on an interview he conducted with Lawrence Kaplow, one of its producers and writers, in which the former remarked: “Absolutely. Otherwise you become a fantasy. Sure, we take liberties, but those liberties are still factually based” (Holtz 4). In order to achieve this level of accuracy and authority in the viewers’ eyes, the show’s writers—in a manner similar to those of *ER*—“not only [...] consult with experts and browse the medical literature for strange and interesting cases, and there are also medical experts on staff, including writer David Foster, M.D.” (Holtz 7). Additionally, the writers of *House, M.D.* also consult with medical experts of “the Hollywood, Health & Society program of the USC Annenberg Lear Center” to further ensure the accuracy of their program (Holtz 8-9). As if this were not already enough to convince its viewers of its medical authority, the show also “provid[ed] links to [medical] online resources from the official *House* Web site” (Holtz 9). According to Goodman, this focus on medical accuracy has also resulted in the recognition of “the pedagogical value of the genre” by some educators who have started to “use video clips during lecture to illustrate and amplify concepts they are trying to convey” (182).

All of this shows that viewers greatly trust in the medical information that medical dramas provide to them and that the creators of the show invest substantial resources to maintain and nourish this trust. As a consequence, medical TV shows are imparted with significant medical authority that is normally reserved for the modern biomedicine from which it is inherited. This puts them in a position to make authoritative statements about the medical conditions they depict. However, it is not only the discourse of medical authority that surrounds these shows' production that is responsible for their perceived medical authority, but also the way in which medical authority is enacted on them. It is precisely this aspect that will be briefly considered for each show in the following section of this thesis.

### **3.2 Narrative Construction of Medical Authority in Medical TV Dramas**

#### **3.2.1 *Chicago Hope* and the Professionalism of High-Tech Medicine**

The producers of medical TV shows do not limit themselves to projecting an image of medical authority, but also construct and reinforce this image through its narrative enactment on the shows themselves. Consequently, these shows focus on “[w]ell-articulated terminology and appropriate descriptions of illnesses, preventions and cures [...] [as well as] accurate suturing and graphic body depictions” so as to convince “viewers that the producers and actors kn[o]w the world they portray[]” (Turow 367).

This tendency can be observed in *Chicago Hope*—the first show under consideration in this thesis. The show premiered simultaneously with *ER*—which will be discussed below—and ran into serious trouble when it was forced to compete with the latter during the 1994 to 95 season and only managed to “c[o]me to its own” when it was rescheduled in January of 1995 (Annas 41). Nevertheless, despite only being able to garner “a little more than half of *ER*'s audience, this was enough to rank it in the top 30 TV shows” of that season which Annas describes as “a solid achievement for any serial drama” (41). Moreover, according to Annas, in the course of its first seasons it took “on many of the major bioethics issues of our day, including euthanasia, [...] the separation of Siamese twins, experimentation (with malaria) on an AIDS patient, [...] [and] sex change operations [...]” (41).

The importance of this is, for example, demonstrated by the fact that *Chicago Hope* already establishes its reputation for cutting-edge medicine within the first minute of its pilot episode when the first treatment shown begins with a patient being fixated and inserted into an MRI machine. In the same scene the viewers can also already see the high-class character of the “wealthy research hospital” in which the show is situated (Jacobs 25), as the MRI machine is actually adorned with potted plants around it (Kelley, “Pilot”). According to Jacobs, this hospital also supposedly boasts “the best surgeons in the world” (25). Chiefly among them are the “two middle aged star surgeons Jeffrey Geiger [...] and Aaron Shutt [...]” who make “\$2 million plus a year [...]” (Annas 41).

The medial prowess of the doctors Dr. Jeffrey Geiger and Dr. Aaron Shutt is further underscored when they are called in to a procedure that Dr. Thurmond—an older colleague of theirs—is performing because Dr. Thurmond is apparently having trouble keeping his hands steady due to his old age and consequently is endangering the lives of his patients. However, instead of just showing the doctors Geiger<sup>14</sup> and Shutt as they storm into the OR, they are first depicted as they meticulously scrub their hands and arms (Kelley, “Pilot”); this further underscores the show’s focus on medical accuracy. When the two doctors enter the OR, the patient has suffered cardiac arrest and Dr. Thurmond is trying to resuscitate him. After they have been informed of the current situation, the two doctors immediately take charge of the operation and to perform a lifesaving procedure (Kelley, “Pilot”). Consequently, in the first four minutes of the show’s first episode, the audience gets to watch as the doctors perform a complicated medical procedure in which they cut and saw into the patient (Kelley, “Pilot”). This scene is not only permeated by complex medical terminology and the view of them performing the procedure, but showcases a multitude of medical surgical equipment and machines that monitor the patient’s vital signs. However, most strikingly, the doctors are able to accomplish what Dr. Thurmond could not thereby reviving the patient, and are even shown to start singing during this procedure, which further underscores how routine such situations are for them. Therefore, according to Vandekieft, the show’s practitioners are representative of “the heroic archetype” even if they are given “human shortcomings” (230). At the conclusion of the procedure the audience is even given a view of the patient’s beating heart on a monitor—as the physician would see it—as they insert a camera to get a closer view of the patient’s heart (Kelley, “Pilot”). All of this takes place in a state-of-the-art operating room.

This theme of medical accuracy is also underscored in the show’s introductory sequence in which the audience sees the members of the cast wearing a variety of medical garments and equipment, such as face mask, special operating glasses, while they examine x-ray images, administer drugs, rush into the OR, and perform operations in operating rooms furnished with a wide assortment of medical equipment (Kelley, “Pilot”). If the predominance of medical technology, imagery, and the performance of remarkable lifesaving surgery discussed above were not enough to demonstrate that the show depicts cutting-edge medicine, the pilot episode also features the successful separation of Siamese twins. This is accompanied by discussions among the doctors that serve to foreground the impossibility of this undertaking in rooms that are literally plastered with scans of the twins produced by virtually every type of medical imaging technology imaginable (Kelley, “Pilot”; Turow 339). The complicated nature of the procedure is also emphasized by the fact that the two teams of doctors undertaking the procedure are seen as they rehearse it multiple times to avoid mistakes (Kelley, “Pilot”).

In addition to this procedure, the doctors are also shown to successfully perform open-brain surgery to remove a tumor using state-of-the-art equipment, and again the audience is

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<sup>14</sup> When it comes to naming the characters in the specific shows, I will follow the conventions the shows practice themselves.

granted a view of the exposed brain over the doctor's shoulder (Kelley, "Pilot"). Thus, as Annas notes, "the show's real action centers on the preparation, performance, and consequences of major experimental cardiac and neurosurgical procedures" (42). To further underscore the competence of its doctors, *Chicago Hope* portrays its patients as "demanding/annoying" and as "[a]nxious/afraid" who are dependent on their doctor's help—a tendency that as will be shown below is characteristically present in most of the shows under consideration in this thesis (Makoul and Peer 254-55). The medical expertise of the shows' practitioners is also underscored by the fact that they "rarely face[] medical uncertainty" and that their "medicine promise[s] care and kindness within a science that always knew the problem and *how to fix it*" (Koch 68).

### 3.2.2 *ER* and the Benevolent Wisdom of the Emergency Room

Although *Chicago Hope*, as Turow points out, "managed to stay in prime time for six years," *ER* continually outshone it and "quickly climbed to the top of the ratings, reaching peak Nielsen viewership numbers of 47.8 million viewers in 1998" (331). Moreover, the show "also garnered a record 122 prime-time Emmy Award nominations and was the longest-running doctor show in U.S. television history when it ran its final episode in 2009" (Turow 331). In addition, the show has been beamed to television sets "in more than 66 countries around the world" (Mensah 139).

The difference between the high tech medicine of *Chicago Hope* and that of the County General Hospital of *ER* already becomes startlingly apparent in the pilot episode of the latter. At the beginning of the episode, the audience is greeted with a pitch-black picture that is only illuminated when a nurse opens the door to the room in which Dr. Mark Greene—one of the show's principal characters—is resting on a hospital bed during his nightshift in the emergency room. The nurse starts calling his name in an increasingly loud voice, thus awakening him and informing him that he has a patient. After asking if the intern can accommodate the patient, only to be informed that he has to do it himself, Dr. Greene inquires what time it is and is informed that it is five o'clock. After being informed that the patient is his colleague Dr. Douglas "Doug" Ross, Doctor Greene gets out of bed and stumbles along a corridor towards the reception to pick up Dr. Ross, who is inebriated (Crichton). Within this first minute of the pilot, the viewer already gets a sense of the emergency department in which the show is set. This department is the exact opposite of the high-tech, natural light flooded, spacious and almost spaceship like hospital on *Chicago Hope*. In contrast, the equipment in this emergency room looks dated and the corridors are narrow, crowded and filled with equipment and illuminated by fluorescent light. Annas points out that the difference between the hospitals on the two shows can be explained by the fact that *ER* unlike *Chicago Hope* is not set in "a rich private hospital," but instead is situated in "a public hospital" (41). However, the rundown character of the emergency department and its equipment, as well as the focus on fast emergency care as opposed to meticulously rehearsed high-tech medicine should not be taken as an indicator

that *ER* is any less focused on medical accuracy. In fact, these features of the show underline the show's dedication to portraying an accurate picture of emergency care. In fact, the set was intended to enhance the show's realism as it boasted a "real ceilings, real equipment provided by medical supply companies [...]" (Annas 40). Although Annas also notes that "[t]he show is not really about a public hospital's emergency department[,]" but instead about the personal lives of its principal characters, this does not mitigate the effect this faux realism likely had on its viewer's perception of the medicine practiced on the show—as several studies have demonstrated (40).

After this short introductory scene, the audience learns that a building has collapsed, and thus shortly afterwards, the first patients from the collapse start to arrive and start being brought into treatment rooms, and the viewers are treated to their first emergency operation of the show after less than six minutes (Crichton). In this scene, another difference between *Chicago Hope* and *ER* becomes apparent in that the emergency department on *ER* unlike its high-tech counterpart on *Chicago Hope* does not focus on extremely complicated experimental procedures, but rather is tasked with saving patients who are, more often than not, in life-threatening conditions. This is already demonstrated by the fact that the first patients being brought into the hospital are all either unresponsive to the nurses and doctor's questions or even receiving cardiopulmonary resuscitation (CPR) upon admission (Crichton). This is further underscored by the gore that permeates the first episode with half torn off limbs, open fractures, several patients with gunshot wounds, motorcycle accident victims, patients vomiting blood due to damage to their lungs, multiple patients in cardiac arrest, and other patients who are either dying or dead on arrival (Crichton).

Even the first few minutes of the show are characterized by a remarkable onslaught of medical terminology and procedures ranging from EKG's, x-rays, ultra sound, complete blood count, electrolyte panel, to CPR, and even the surgical reattachment of a torn-off hand. In addition to this, the doctors are also shown to diagnose numerous less severe cases, suture cuts, deliver a baby, diagnose ectopic pregnancy, perform tests in the laboratory, and explain diagnoses, such as lung cancer, to patients with the help of, e.g., x-ray images (Crichton). According to Goodman, this is exemplary for *ER* in that the show "regularly depicted the wounded and bleeding body, and the jargon used to describe and treat such cases, with new levels of explicitness and detail, setting a standard that would be followed by such currently popular programs as *House* and *Grey's Anatomy*" (182). The medical prowess of the doctors is most strikingly demonstrated when Dr. Benton performs a procedure on "a ruptured aneurysm" despite being as Dr. Susan Lewis remarks "just a resident." However, as he informs the colleague, "The guy's already ruptured his belly. He's puffed up like a balloon and he's bleeding to death internally. I gotta do him. I'm his only chance." Subsequently, Dr. Benton is shown as he successfully keeps the patient alive until other more experienced doctors are free to finish the operation (Crichton).

However as Turow points out, “*ER*’s creators wanted people to believe in the power of modern medicine. Right from the start, though, they announced there would be no guarantees” (Turow 343). This stance already becomes apparent in the pilot episode when Dr. Lewis informs a patient with a potential diagnosis of lung cancer “Mr. Parker, if there’s one thing you learn in my job, it’s that nothing is certain. Nothing that seems very bad and nothing that seems very good. Nothing is certain. Nothing” (Crichton; Turow 343). Nevertheless, according to Koch the doctors on *ER* “rarely faced medical uncertainty[,]” but rather struggled with “economic and hospital bureaucracies” that threatened their otherwise remarkably uncomplicated practice of medicine in which they “always knew the problem and *how to fix it*” (68).

They also demonstrate extreme dedication. This is for example demonstrated when Dr. Lewis is asked whether she is married, to which she replies “No, I’m a doctor[,]” thus indicating that she does not have time for much else, or when Dr. Peter Benton complains to nurse Carol Hathaway that “We work [...] 90 hours a week, 52 weeks a year. For that we are paid \$23,739 before taxes” (Crichton). It is further underscored by the fact that the doctors repeatedly express surprise when they notice that the weather outside has changed. However, it is most strikingly exemplified by Dr. Greene’s rejection of a job offer that would have entailed significantly better pay, additional benefits, and more free time because he thinks it is not as worthwhile as his work in the ER (Crichton). This sentiment is probably best summed up when Dr. Greene reassures the young medical intern John Carter by saying “People come in here and they’re sick, dying and bleeding and they need our help. Helping them is more important than how we feel. But it’s still a pain in the ass sometimes” (Crichton). This is also reflected in Strauman and Goodier’s analysis of the show in which they conclude that

Although *ER* promotes a view of physicians as selfless heroes acting in the best interests of their patients, the show also offers story lines in which physicians are uncertain, racist, mistaken, and uncaring toward each other, staff, and patients. However, it still can engender faith in some individual physicians who, although fallible, act in the best interests of their patients. (“Not Your” 128)

Thus, whereas *Chicago Hope* can be said to represent high-tech medicine practiced by “star surgeons” the doctor’s on *ER* are representative of the benevolent character of emergency medicine conducted by “young residents” (Annas 41). This is also noted by Cohen and Shafter who argue that

The incredibly skilled staff is able to treat all comers with the most considerate of manners, rarely allowing external pressures to interfere with the instantly forged, yet remarkably intimate, doctor-patient relationship. In fact, their abilities to heal may be rivaled only by their degree of compassion. (211)

This, according to Burger, sets *ER* apart from later medical dramas like *House, M.D.*, which foreground the prowess of their medical practitioners (Burger 355). Indeed, *ER* “focus[es] on doctors’ humanity rather than their infallibility” (Burger 357). Nevertheless, according to Makoul and Peer, like *Chicago Hope*, *ER* also constructs most of its patients as “crazy/irrational (13.3 percent), anxious/afraid (10.8 percent), demanding/annoying (10.1 percent), or unconscious/dead (10.1 percent)” in order to underscore the authority of its doctors (253-

54). Therefore, patients on both shows are presented as “trouble and troubled” (Makoul and Peer 258).

### 3.2.3 *Grey’s Anatomy*: It is All about the Competition

In terms of success, “ABC’s hit medical melodrama *Grey’s Anatomy*” is remarkably similar to both *Chicago Hope* and *ER*, and thus reaffirms the popularity of medical dramas among the US television audience (Long 1067). The show “premiered in the spring of 2005” and has “consistently been among the 10 most-watched television series” ever since “garner[ing] audiences as large as 21 million, and spawned a spin-off series, *Private Practice*, which premiered in 2007” (Kuorikoski 47). As Hallam points out, “*Grey’s Anatomy* became the top-grossing US network show of 2005 and has won many awards for writing, acting and direction, including a Golden Globe in 2007 for best drama series” (60). Moreover, the fifth season of the show attracted “more than 15 million viewers” and thus competed with the likes of *House, M.D.* “to displace *CSI: Miami* [...] as the top of the US Nielsen ratings in February 2009” (Hallam 60). The show’s popularity is also exemplified by the fact that in “[...] 2006 nearly thirty-eight million viewers chose to forego post-Super Bowl celebrations in favor of tuning in to a much-hyped episode of [...] *Grey Anatomy*” (Long 1067). According to Hallam, this means that it “has become one of the most successful TV shows of recent years<sup>15</sup>” (60).

However, in some important ways *Grey’s Anatomy* is very different from the two predecessors discussed above. Most strikingly, its producers do not try to sell it primarily as a medical drama. According to Tapper, the show’s creator, “Shonda Rhymes, consistently eschews the importance of medicine in her show, saying that it is really ‘a relationship show with surgery in it’” (398). An evaluation with which Tapper concurs as he states that “the residents seem, at times, far too occupied with themselves to even notice that there are patients in the hospital” (398). Similarly, Strauman and Goodier argue:

Though most of the show is set on the surgical floor of the hospital, medicine is not the primary focus of the show. Each episode is marked by two or three extraordinary cases [...] which primarily serve to underscore the relational tensions between and among the characters. As the doctors struggle to understand and treat a patient’s condition, they are forced to grapple with lessons that parallel their personal lives. (“Not Your” 129)

In this manner, the plot of the show revolves around the experience of five young surgical interns—chief among them the show’s central character Meredith Grey—at the Seattle Grace Memorial Hospital, as they eagerly compete against each other for the best surgical assignments and the attention of “their attending physicians and resident physicians” and desperately search for love (Czarny, Faden, and Sugarman 203). The plot of the show is complicated by the fact that Meredith’s mother—a renowned surgeon—is suffering from

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15 Although these numbers are considerably smaller than those of *ER* a direct comparison of the popularity would be problematic as the number of channels has “multiplied” since *ER* aired, and some viewers have switched to “online or [...] digital video records[,]” which are not recorded in standard rating systems as those used by the Nielsen Company (Turow 5).

Alzheimer's, which causes her daughter to "struggle to balance the demands of a surgical career with the challenges in her personal life" (Strauman and Goodier, "Not Your" 128). Thus, according to Strauman and Goodier, "[t]he show highlights and often blurs the lines between the personal and professional relationships among Meredith and her fellow interns [...]" ("Not Your" 128). As Hallam points out, *Grey's Anatomy* with its focus on "surgical heroics, sexual shenanigans and a chat between friends over a quick caffè latte" as opposed to the "traumatised bodies and graphic realism and debated controversial ethical issues" that predominated medical dramas in the 1990s represents an "escapist drama for credit-crunch times, for people weary of bleak realities and depressed by reality TV" (60). Thus, Hallam concludes that the show "is not that kind of drama designed to shock us or to engage us with the social and political realities of working life such as *ER*[,] but instead its "unique selling points are to have a woman playing doctor and a multi-racial cast" (60). The latter is the result of the color-blind scripting and casting method used by the show's creator Shanda Rhimes in which character descriptions only included references to gender (McDowell qtd. in Long 1067). Moreover, the rather lighthearted character of the show more often than not gives it an appearance that is closer to sitcoms like *Friends* and *Sex and the City* than its more serious predecessors in the medical genre (Hallam 60). This is further underscored by the fact that "at the beginning and end of each hourly episode, Meredith delivers a dose of edifying platitudes in a voiceover accompanied by soft rock music and a rosy glow of smug self-satisfaction[,] which Hallam describes as "offer[ing] us the kind of moralising homilies that we might expect to find in a women's magazine problem page [...]" (60). Nonetheless, these voiceovers are not without function as they

provide a synopsis of the episode's main themes as the interns are presented with three or four patients that they have to treat, at least one of them with a rare condition. In time-worn generic fashion, each serves a plot function: one will be a 'bizarre case' that provides black humour, one will be a surgical challenge and one will provide the 'human' element. (Hallam 60)

The show's special character is also emphasized in its introductory sequence—which precedes all episodes with the exception of the pilot and which, unlike those of the medical dramas discussed so far, does not purely highlight the medical character of the show by depicting various types of medical equipment, which it also does. Instead, this medical equipment is juxtaposed with articles of stereotypical feminine clothing. Indeed, it begins with a shot of a person in medical clothing—supposedly a doctor—with sterile shoe covers over their shoes and then pans over to reveal a pair of fashionable red high heels. Similarly, the next shot shows a surgical tray with a sterile drape on it, onto which a gloved hand places an assortment of scalpels, surgical clamps, and an eyelash curler. The latter is then picked up by a hand with painted fingernails and used to curl that person's eyelashes. Moreover, this is then followed up by a sequence in which a black evening dress is contrasted with a surgical gown, an I.V. with the pouring of a Martini and ultimately ends with the view of a hospital bed with its curtains closed in which two people rub their feet together, and the camera pans down to

reveal the same pair of red heels that were shown at the beginning of the sequence (Stanton and Werksman).

However, this does not mean that *Grey's Anatomy* places less emphasis on medical accuracy, in fact the medical expertise of its doctors is highlighted throughout the show's narrative. As Tapper points out, it is indeed "very much a show about medicine, beloved as such by millions of people, medical and premedical students included. And just like her predecessors, Ms. Rhymes employs medical consultants to furnish the program with 'realistic' patients and scenarios" (398). Furthermore, Tapper argues that "[v]iewing *Grey's*, a general fascination with both disease and medical intervention is obvious. [...] The technology and technique of medicine are celebrated [...]" (398). In fact, the first 15 seconds of the show's pilot are dedicated to a dream Meredith has in which the viewers get their first view of a seemingly complicated surgical procedure while she gives a synopsis of the show's premise, "The game—they say a person either has what it takes to play or they don't. My mother was one of the greats. Me, on the other hand—I'm kind of screwed" at which point the patient in the dream dies—as is indicated by the characteristic beep and the view of a monitor displaying vital signs or rather the lack thereof—and Meredith awakes (Rhimes, "A Hard"). This focus on medicine is continued when Meredith gets to the hospital, and she and the other interns are welcomed to the hospital, where the audience and the interns get their first view of the state of the art operating room. Moreover, when the first patient suffering from multiple seizures arrives after a mere five minutes, the show demonstrates that it does not have to hide behind its predecessors when it comes to the use of medical terminology as Dr. Miranda Bailey—the resident in charge—instructs the interns: "Izzie, 10 Milligrams diazepam I.M. [...] A large-bore I.V. Don't let the blood hemolyze" (Rhimes, "A Hard"). This becomes even more intense when Dr. Burke—the attending cardiothoracic surgeon—instructs "Dr. Bailey, let's shotgun her" which Dr. Bailey translates for the interns by remarking "That means every test in the book—C.T., CBC, chem-7, tox screen" and then assigns them different duties (Rhimes, "A Hard"). In the meantime the audience gets to witness several highly stylized surgical procedures that play out in the background while the interns inform Dr. Bailey of their progress. In addition to this, medical scans and medical equipment permeate the environment at the hospital much like they do on the other programs.

Moreover, the interns are shown as they diagnose and attempt to treat other patients (Rhimes, "A Hard"). The fact that these doctors only attempt to treat rather than successfully treat their patients—at least at the beginning of the show—underlines a crucial difference between the doctors in training on *Grey's Anatomy* and the doctors on other shows. As Tapper notes, "While the doctor's craft—its utility and capabilities—seems elevated, the doctors themselves are fallen figures" (398). Therefore, similar to *ER* the show portrays the doctors on the show as fallible human beings (Burger 357). However, as the above quote by Tapper makes clear, this fallibility does not translate into a challenge to medicine's authority, but rather underlines their status as doctors in training, humanizes them, and underscores that

even these doctors in training still have a lot to learn before they can truly practice the medical gaze. Indeed, as the season progresses, the interns on the show become gradually more secure in their position, make significantly fewer mistakes, are entrusted with increasingly complicated procedures, and their fallibility is mostly limited to their personal lives (Stanton and Werksman). In the final episode of the season, one of Meredith's opening voiceovers clearly shows how deeply the belief in medical authority and ability is embedded into the show when she remarks: "Secrets can't hide in science. Medicine has a way of exposing the lies. Within the walls of the hospital, the truth is stripped bare" (Stanton and Werksman).

The interns on *Grey's Anatomy* are shown to be in constant competition with each other because their performance determines who will get to "scrub in" for the most interesting surgeries (Rhimes, "A Hard"). Thus, according to Tapper, the show portrays "patients as extensions of the doctor by other means. First, these patients are bodies for practice. The residents jump all over each other for the chance to scrub in on complex or 'hot' surgeries" (398). In addition to this, the patients are "bodies to behold, circus freakery to entertain and be judged by the rarity and grotesqueness of their ailments" (Tapper 398). The first procedure—an appendectomy—is thus performed by the intern Dr. George O'Malley while the viewer gets to observe. This surgery is similar in style to those shown on *Chicago Hope* and *ER* in that it is highly stylized, but it differs because, unlike the doctors on those shows, Dr. O'Malley makes a mistake that endangers the patient's life so that Dr. Burke is forced to step in to remedy the situation (Rhimes, "A Hard"). However, despite being inexperienced Meredith and her fellow intern Dr. Christina Yang are able to diagnose the seizure patient as having an aneurism, a case that the new attending physician Dr. Derek Shepherd had been unable to diagnose. Thus, Meredith gets to assist in the complicated procedure because as Dr. Shepherd tells her "on your first day, with very little training, you helped save her life. You earned the right to follow her case through to the finish" (Rhimes, "A Hard"). Thus, the show's viewers can observe another highly stylized surgical procedure in which an extreme amount of medical equipment is utilized and which includes close-up shots on the patient's brain as it is operated on. However, even in these highly stylized operations, the show sets itself apart from its predecessors in that they are overlaid not just with soft rock music, but also with a voiceover by Meredith in which she reflects on her experience and sums up the lessons of the episode. In a manner similar to the other shows, patients on *Grey's Anatomy* are also shown to be troubled, as is demonstrated by the fact that Meredith's patient has a nurse execute an emergency protocol that notifies Meredith just because she is bored and is unable to watch the beauty pageant in which she was originally scheduled to partake (Rhimes, "A Hard").

All in all, although *Grey's Anatomy* has a distinctly different character from that of its predecessors, it nevertheless still places considerable emphasis on medical authority, and on convincing viewers of its medical accuracy by using medical terminology, presenting medical machinery and equipment, highly stylized recreations of surgical procedures, and the use of medical imaging technology such as x-ray, MRI, and CAT-scan.

Moreover, like its precursors, it also portrays patients as largely ignorant of their conditions and often as a cause of trouble for the diagnostic process. Much like *ER* it also—particularly at the beginning of the show—foregrounds the fallibility and inexperience of the young interns on whose experience and constant competition with each other it is primarily focused. Nonetheless, this portrayal of the fallibility of the interns does not undercut the show’s underlying belief that medicine can uncover the truth.

### **3.2.4 *Private Practice*: A Special Kind of Practice**

If *Grey’s Anatomy* was distinctly different from its predecessors, its spinoff *Private Practice* took this trend to the next level and, according to David Hinckley of the *NY Daily News*, might even be said to “reinvent[] the concept of the doctor show” in that it focused on portraying its “seven doctors” and their receptionist as “a family[,]” albeit a rather dysfunctional one. Hence, according to Turow, *Private Practice* “was unusual for its conceit that it was a typical contemporary medical practice treating all sorts of patients” (377). Thus, unlike the shows discussed so far, *Private Practice* is not situated at large hospitals in Seattle or *Chicago*, but rather a “dramatically more casual” private clinic called “Oceanside Wellness Center, a hip medical co-op in Santa Monica, Calif. [...]” (Keck). The show is based on the premise that Dr. Addison Forbes Montgomery, “a top-notch surgeon”—who was previously part of the team of doctors on *Grey’s Anatomy*—has decided to leave “Seattle to heal her broken heart in Los Angeles, where her best friend has founded a private wellness clinic” (Stanley). Accordingly, the show is “about a pediatrician, psychiatrist, and obstetrician sharing a medical business”; and unlike earlier shows, it “did imply and even sometimes show, that its doctors had established knowledge of their patients over time” (Turow 377). Moreover, according to the show’s creator Shonda Rhimes, it is “really centered on the moral and ethical dilemma that doctors face in practice, or in the medical world” (qtd. in Turow 377). Moreover, Rhimes emphasizes that “[i]n every episode [...] they [the doctors] ‘deliberate’ about the episode’s central moral dilemma around their office’s kitchen table” (qtd. in Turow 377). In the process, according to Hinckley, “[t]he patients aren’t pawns or victims, but people who challenge the doctors [...]” Also unlike its parent show, it was not received kindly by reviewers when it first aired (Keck). Alessandra Stanley of *The New York Times* for example commented that Dr. Montgomery’s “new colleagues collectively offer one of the most depressing portrayals of the female condition since ‘The Bell Jar[.]’” Nevertheless, *Private Practice* was able to amass enough of a following to sustain a six-season run from 2007 until 2013 (Hughes).

However, this does not mean that *Private Practice* is less focused on presenting itself as being medically accurate than its predecessors. This already becomes evident in the first scene of the pilot—which is still set at the Seattle Grace Hospital—in which Dr. Richard Webber accosts Addison about her resignation, telling her, “I don’t want to hear this again. Working at a private medical co-op, moving to L.A. This is not my Addison. My Addison is a world-class neonatal surgeon. My Addison lives to cut” to which she replies, “Your Addison

would've been promoted to chief of surgery. So stop 'addisoning' me. I want a change, I need a change, and this is how I'm gonna do it. In L.A., at that practice, with those people" (Rhimes, "In Which"). Thus, already at the outset of the show Addison's medical expertise and skill are underscored.

This focus on presenting the doctors on the show as experts is continued when a patient suffers a stroke during a sperm donation, and the staff at the practice rushes him to a hospital, where Dr. Sam Bennett informs the doctors at the hospital of the treatment the patient has received thus far, remarking "All right, he's had three rounds of epi and a 200 lido bolus. Defib times 5 on scene" (Rhimes, "In Which"). Nevertheless, despite their efforts, they are unable to save the patient as the doctor at the hospital informs the patient's girlfriend: "He's been down too long. No point to make it a show" (Rhimes, "In Which"). Similarly, the co-op's psychiatrist Dr. Violet Marianne Turner with the help of the pediatrician Dr. Cooper Freedman proves her skill when she diagnoses and consoles a patient who experienced a mental breakdown at a mall (Rhimes, "In Which").

This focus on the expertise of the show's doctors is further continued when Addison delivers her first baby at the practice. This scene not only highlights the medical accuracy of the show, but also its special character. Indeed, it is not only Addison who is involved in the procedure, which follows a "holistic birth plan[,] but also Dr. Pete Wilder, who specializes in alternative medicine and William 'Dell' Parker the practice's receptionist and midwife (Rhimes, "In Which"). This dualism is already clearly visible in the birthing room, which although it boasts the usual medical equipment that viewers have come to expect in a hospital room on medical TV dramas—such as monitors that display vital signs of both mother and unborn child—is also furnished with a sofa, several tables with candles and lamps on them, as well as plants and curtains that give it the appearance of a bedroom rather than a hospital room (Rhimes, "In Which"). However, although the show places emphasis on being different, this does not mean that it places any less emphasis on the medical prowess of its characters. This, for example, becomes evident when there are complications during the delivery. In fact it is Pete—who up to this point has never been named as a doctor, but rather as an alternative medicine specialist—is the first to notice that there is something wrong with the patient and has them halt the delivery telling Addison that "She's short of breath with JVD" to which she replies in surprise: "I thought Eastern medicine was your thing?" upon which he informs her: "I have a lot of things. Now she is short of breath with JVD. Do you want to double check or trust me" (Rhimes, "In Which")? Thus, Addison consults the printout of the fetal heart rate monitor and remarks "The baby's in distress" and informs the patient that she should not push for now. However, the patient loses consciousness and Addison instructs the others to "Get her on high-flow oxygen" and call an ambulance as the patient is "going into congestive heart failure" (Rhimes, "In Which"). However, Addison soon learns that the ambulance will not get there in time. Thus, she is forced to perform an emergency C-Section even though the conditions at the co-op are less than optimal in that "It's not sterile" and she

lacks the necessary surgical equipment, or “extra blood” or appropriate anesthesia (Rhimes, “In Which”). Nevertheless, Addison decides that she has no choice, and she and Dell collect the necessary equipment while Pete treats the patient “so she won’t feel any pain.” Thus, Pete uses his knowledge in acupuncture to block the patient’s pain receptors and the viewers get to observe the show’s first highly stylized surgical procedure in which they not only safely deliver the baby, but also save the mother’s life (Rhimes, “In Which”). This scene not only highlights Addison’s surgical skill, and the show’s dedication to medical accuracy—by utilizing the genre’s typical features of close-up shots of surgical incisions with the accompanying display of blood, medical monitoring technology, and terminology—but also highlights its alternative character by giving close-up shots of Pete’s acupuncture technique and showing how he despite Addison’s doubts is able to successfully block the patient’s pain receptors (Rhimes, “In Which”).

### **3.2.5 *House, M.D.*: Untangling Medical Mysteries**

The immensely popular medical drama *House, M.D.* has not only attracted considerable critical attention during the course of its eight-year run from 2004 to 2012 (Koch 67), but has also been the subject of numerous publications regarding its medical accuracy. According to Strauman and Goodier, it “focuses primarily on medicine and the scientific method, using everyday interactions, observations, and relationships to uncover the clues for solving the case” (“Not Your” 129). The show depicts the “eccentric medical genius” Dr. Gregory House and his team of specialists at “the fictional Princeton-Plainsboro Teaching Hospital in New Jersey” (Włodzik 231), as they are tasked with solving cases “that have baffled other doctors” before them (Burger 355).

Even in the title sequence of the pilot, the connection between *House, M.D.* and modern biomedicine and the medical gaze is unmistakably made by showing a stylized scan of a human skull that fades away to reveal the face of Dr. Gregory House, who is seemingly scrutinizing the image; his face is then overlaid with the title of the show (Shore, “Pilot”). Thus, the viewer is given the illusion of observing House from the other side of an x-ray illuminator while House is analyzing the scan—i.e., practicing the medical gaze. In the opening credits<sup>16</sup> of the other episodes, the emphasis on medical imaging is even more prominent. These credits not only feature the same CAT scan sequence, but also highly stylized models of human skulls with their brain exposed to the observer, animations suggestive of neural networks, x-ray images of a human torso, other scans of the human skeleton, and numerous drawings of different parts of the human body (Learner, Friend, and Shore, “Skin”). As Włodzik correctly points out, the prominence of medical imaging in the opening scenes “point[s] to the significance of reasoning in the formula of the show” (231). However, even more importantly, it emphasizes the importance of medical imaging technology in the show, and connects it to the legacy and

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<sup>16</sup> Which are used for all episodes except the pilot.

authority of modern biomedicine. Indeed, the title sequence seems to suggest to the viewer that this show, unlike other medical dramas,<sup>17</sup> is about serious, i.e., high-tech medicine. The importance of medical equipment and medical knowledge is further emphasized by its excessive use throughout the pilot episode and the entirety of the show's eight seasons. In this spirit, the patient is not only subjected to a routine blood test, but also to a CAT scan, a contrast M.R.I, experimental treatment with steroids, neurological tests to confirm that she has not suffered any brain damage as a consequence of the seizure and cardiac arrest that resulted from the steroid treatment, and finally an X-ray (Shore, "Pilot"). Thus, while most regular patients might only be subjected to one or two of these tests, the extreme cases that House treats are regularly subjected to a whole series of expensive and sometimes dangerous tests. The importance of medical technology is further underscored by the fact that:

the episodes, rarely if ever, give attention to illness prevention or out-patient treatment; instead the show revolves around the state-of-art medical equipment and visualizing techniques that make the final diagnosis possible. (Włodzik 233)

Thus, these medical technologies "serve as the ultimate evidence" and the basis for the team's differential diagnostic process (Włodzik 233).

House's medical authority is further highlighted when his colleague and friend Dr. James Wilson asks him to consider a case that he was unable to diagnose and refers to him as "a renowned diagnostician[.]" and his boss Dr. Lisa Cuddy, Dean of Medicine and the hospital's administrator, remarks, "[t]he son of a bitch is the best doctor we have" (Shore, "Pilot"). His reputation is further emphasized by the fact that Cuddy seems unable to fire him despite the fact that his "billings are practically nonexistent[.]" he "ignore[s] requests for consults[.]" and is "six years behind on [...] [his] obligations to the clinic" because, as she informs him: "[his] reputation is still worth something to this hospital" (Shore, "Pilot"). Ultimately, Cuddy is only able to force House to live up to his obligations by revoking his authorization to perform medical procedures (Shore, "Pilot"). In addition to his own medical prowess, which is continually confirmed by the fact that "he saves patients no one else can save" (Burger 355), according to Wilson, he also has "three overqualified doctors working for [...] [him]" (Shore, "Pilot").

Moreover, the show also utilizes "highly stylized recreations [of medical procedures]<sup>18</sup> and super-realistic computer animations" in which the camera seems to fly into the patient's body to illustrate a diagnosis or to show the progression of an illness and its symptoms (Serlin 241). Similar to the use of "close-ups in the series[.]" these animated sequences "could be interpreted as creating the impression of a penetrating medical gaze [...] that pierces through the skin and sees the purified and aestheticized body at work" (Włodzik 233). In the pilot, for example, the camera seemingly flies into a patient's nostril, past her brain, into one of the

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17 Which as Włodzik remarks "usually are more relationship oriented (231).

18 These replace the "snippets of actual filmed surgery" that other shows like the famous *ER* have used in the past to illustrate a procedure (Serlin 241).

arteries, and then through her bloodstream only to then be replaced by an CAT scan image of her skull, which then fades away to reveal House's medical gaze upon it (Shore, "Pilot").

In contrast to other medical shows, the protagonist of *House, M.D.* has a very peculiar way of dealing with his patients in that he tries to avoid contact with them at all costs (Tapper 397). Thus, according to Strauman and Goodier,

House's distrust of all things personal (i.e. outside of the realm of biomedicine) both upholds traditional images of biomedical competence and counters the overly positive images of television physicians of the past by casting the doctor as a wholly human and often unlikable character. ("Not Your" 130)

This is, for example, demonstrated in the pilot episode, in which House does not directly interact with the patient, but instead uses his team as a mediator (Shore, "Pilot"). This is also exemplified in House's response to a question by Dr. Eric Foreman, a member of his team, "[s]houldn't we be speaking to the patient before we start diagnosing" to which House replies by asking whether she is a doctor and then informing Foreman and the rest of his team: "Everybody lies" (Shore, "Pilot"). Dr. Allison Cameron, another member of the team, further elaborates on this by remarking, "Dr. House doesn't like dealing with patients" to which Foreman retorts, "Isn't treating patients why we became doctors" to which House responds by sarcastically commenting: "No. Treating illnesses is why we became doctors. Treating patients is what makes most doctors miserable" (Shore, "Pilot"). When Foreman questions this by remarking, "So you're trying to eliminate the humanity from the practice of medicine[.]" House further responds that "If we don't talk to them, they can't lie to us, and we can't lie to them. Humanity's overrated" (Shore, "Pilot"). According to Włodzik, this approach to patient care with its focus on distrust "aptly summarises the gist of the plot, as both patients and their bodies are liars and his role as a doctor is to find out the truth about them" (235). In the pilot episode, House only changes this approach to dealing with the patient after she has decided to refuse further treatment and experiments, which prevents him from verifying his "perfect" diagnosis (Shore, "Pilot"). Even then House enters her room for the sole purpose of informing her of his diagnosis and to convince her to accept his treatment (Shore, "Pilot"). However, rather than accepting his diagnosis based on his word alone, she demands visual proof of the tapeworm in her brain—House's perfect diagnosis—before accepting further treatment. Rather than yielding to his authoritative statement "[w]hen you're all better, I'll show you my diplomas[.]" she continues to question it by pointing out his previous incorrect diagnoses (Shore, "Pilot"). Ultimately, House is only able to change her mind when Dr. Robert Chase, another member of House's team, suggests using an X-ray to diagnose the patient, which proves House's "perfect" diagnosis, allows his team to reassert their and his medical authority thereby reinforcing his exceptional diagnostic skill and the ability of his team (Shore, "Pilot"). Thus, as Włodzik rightly puts it, House "is depicted as a mythical medical hero able to come up with the correct diagnosis at any time" (231).

Inspired by House's example, his team also withhold information from their patients and only informs the patient—in the pilot episode—which treatment they are performing and

of their current diagnosis after repeated questions (Shore, “Pilot”). This represents a general tendency in *House, M.D.*, i.e. patients are generally assumed to be medically incompetent and a danger to themselves, as well as an obstacle to the diagnoses and their own treatment. As a result, they are either not consulted prior to treatment, are only given partial information, and are lectured if they should dare to question their doctors or modern medicine in general. This is, for example, exemplified when House reprimands a mother who has withheld asthma medicine from her son due to her concerns regarding “children taking such strong medicine so frequently[,]” by informing her: “[y]our doctor probably was concerned about the strength of the medicine too. She probably weighed that danger against the danger of not breathing” and then lecturing her on asthma only to conclude: “Forget it. If you don’t trust steroids, you shouldn’t trust doctors” while leaving the room (Shore, “Pilot”). This is exemplary of the show’s tendency to portray patients “as separate from their bodies, unable to understand their complicated signals and in a desperate need of a professional medical intermediary” (Włodzik 234). As a result of the patients’ ignorance of the messages that their bodies are sending, they and their bodies “are forced to confess their illness, using any available means from diagnostic technology to moral blackmail” to which House and his team are seemingly justified “[d]ue to the usual critical state of their patients” (Włodzik 233). In this context, House’s “political incorrectness and bitter sense of humour” are excused by “his devotion to finding a cure[, which] justifies all his wrongs and sharpens his sense of vocation as a doctor” (Włodzik 234).

Consequently, House embodies the ideal practitioner of Foucault’s “biomedical model” in which “doctors are supposed to be competent, caring,<sup>19</sup> omniscient, and omnipotent managers in the production of health” (Gabbert and Salud II 210). However, as Gabbert and Salud II point out, doctors—including House—“make mistakes, guess, or are simply incompetent” and thus subvert[] the ideological model in real life” (210). Nevertheless, even though House does make mistakes and does base his medical diagnoses on educated guesses, he is never portrayed as incompetent, and his mistakes appear to be a natural byproduct of his diagnostic process, or as Strauman and Goodier put it:

Notably, even when House’s diagnosis is wrong, his process is proven correct. House often defends his decisions, arguing that by finding out what something is not (and often worsening the patient’s situation), he and his team are closer to figuring out the mystery. (“The Doctor(s)” 38)

This diagnostic process is by and large shown to be remarkably successful in that “he loses very few patients given the ‘unsolvable’ cases he and his team often confront” (Burger 355). Strauman and Goodier even go so far as to argue that “House’s accuracy as a diagnostician and scientist provides a firm foundation for his role as the ultimate authority figure” (“The Doctor(s)” 38). Moreover, the fact that his “technocratic evidence-based” practice of medicine, as Włodzik puts it, “enjoys improbably high rates of success on the show” further underscores

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<sup>19</sup> As has already been noted, for House caring is limited to curing the patient and for the most part excludes direct interaction with the patients. In fact, it has been noted both by other characters on the show and its critics that House seems to be “more interested in the puzzle of diagnostics than in the patients themselves (Burger 357).

his medical authority and “inspir[e] an unswerving belief in progress and [the] power of medical knowledge” in the show’s viewers (237).

### 3.2.6 *Saving Hope: A Healthcare Service that Transcends Death*

The Canadian medical TV drama *Saving Hope* represents a novelty because, until its introduction in 2012, “there ha[d] been no long-running English-language medical show set in Canada” (Jubas 138). This had meant that “[f]or Canadians whose exposure to healthcare is limited to the family doctor’s office, the fullest pictures of healthcare might be provided on television, and those pictures are likely imported” (Jubas 136). Although Jubas notes that the Québécois show *Trauma* might represent an exception from this rule, she notes that while it “is broadcast across Canada [...] [it is only] available in French [...]” (144). *Saving Hope* is very successful in Canada where it “is averaging 1.6 million viewers a week,” which according to Stinson is “impressive [...] in that it easily surpasses the one-million-viewer mark that is a somewhat arbitrary standard for major success in this country [...]” Moreover, according to Stinson it is “also consistently winning its timeslot.” As a consequence, the show was renewed for a fourth season, which will “begin production in summer 2015 in Toronto” (Yeo). However, in the US where it initially aired on NBC, the ratings were “more tepid” and the show even failed to compete with reruns of old shows on other networks (Stinson). Consequently, NBC canceled the show mid season (Dowling). However, in 2015 the show is set to return to US television on ION Television (Yeo; Dowling).

The show is set at the fictitious “Hope Zion Hospital” and is “built largely around the travails of Alex Reid [...], a young surgeon who deals weekly with assorted medical problems in a manner typical of hospital procedurals [...]” (Stinson). It is similar to most of the shows discussed so far—with the exception of *Private Practice*—in that it presents its viewers “with the usual hard-to-diagnose cases, action sequences involving crash carts and intense music, and doctors who are equally part brilliant, beautiful and horny” (Rackl). However, *Saving Hope* distinguishes itself from its competitors through its “supernatural element” (Stinson). As such, the show not only follows the actions of the doctors at the hospital, but also features the disembodied spirit of Dr. Charlie Harris as he wanders the hospitals corridors where he “encounter[s] the occasional spirit of a dead patient” (Hale) while “his body lies in a hospital bed hooked up to machines” (Rackl). Alex—“his bride-to-be”—in the meantime “divides her time between checking up on him and doing her usual rounds” (Rackl). According to Hale, this means that *Saving Hope* “combine[s] a doctors-in-love medical soap opera modeled on ‘Grey’s Anatomy’ with something completely different, a paranormal ghost story with elements of ‘A Gifted Man’ and ‘Ghost Whisperer.’”

The remarkable dedication of the doctors on *Saving Hope* can already be observed in its opening scene in which Dr. Alex Reid and Dr. Charlie Harris are seen in a taxi on their way to their wedding and their taxi is hit by another car (MacRury and Brebner).

In this scene according to Turchiano,

Forever in healer mode, both rush out to help the injured driver of the other car, despite the cut on Charlie's head that turns out to be the much more serious injury. Suddenly what should be the happiest day of their lives becomes the worst, as Charlie is rushed to the very hospital at which he works.

However, before Charlie collapses Alex notifies an ambulance and Charlie provides medical assistance to the driver of the car that crashed into them and reinflates her lung (MacRury and Brebner). Indeed, according to Turchiano, this scene demonstrates that

the doctors of NBC's new Canadian medical drama import, *Saving Hope*, is that they have questionable judgment. They may be noble, and they may always put their medical board code ahead of their own well being, but they are human like the rest of us, and that means they will make mistakes.

Nevertheless, although Turchiano is correct in noting the problematic nature of their actions, their behavior still underlines their dedication. Moreover, when Charlie is brought into the hospital, this gives the show an opportunity to highlight both its dedication to medical accuracy and the skill of its physicians. Interestingly this also includes the unconscious Charlie who diagnoses himself in a voiceover as having "an epidural bleed" a diagnosis that Alex repeats only moments later (MacRury and Brebner). In addition to this, the scene is saturated with medical terminology and equipment. While they are treating him, he is no longer in his body, but rather is observing the situation from the outside and commenting on his experience "This is how it happens. You leave it all behind. [...] Everything you love... Everything you know... [...] You belong to the hospital now. And all you can do... Is Hope" (MacRury and Brebner). At this point, a transitional image of a hospital corridor—with the name of the show superimposed upon it—that stretches far into the screen and at whose end a pair of brightly gleaming doors is visible (MacRury and Brebner). In this manner the audience is introduced to the show's subplot that revolves around the disembodied experience Charlie is having while he is in a coma.

After this sequence, the show jumps back 12 hours to show the events that occurred before the crash. This starts with Charlie giving a lecture in which he poses the question about "management of soft tissue sarcomas in the upper limbs amputation or limb-sparing surgery?" to the other doctors at the hospital. A question to which none of the doctors, whom he addresses by name, can give a satisfactory answer until he reaches Alex, who initially tries to deflect the question by replying "I'm a general surgeon, not an orthopedic surgeon." However, Charlie presses her for an answer by remarking "Yes, but you are a doctor, aren't you?" at which point Alex remarks "I would save the arm" and when asked why, continues "Because if the tumor doesn't metastasize, the survival rate is 75%" an answer that Charlie rejects by saying "Yes, but if it does, if it goes systemic, the patient's 5-year survival rate is zero" (MacRury and Brebner). After which Alex inquires, "How can you be so sure of yourself, Dr. Harris?" to which he replies, "Because that's my job, Dr. Reid" (MacRury and Brebner). This already establishes how the show portrays modern medicine.

This portrayal is similar to that of *House, M.D.* in that it presents medicine as a science that is based in fact and can uncover the truth or at least establish a certain degree of certainty in its diagnoses by means of its medical gaze. However, it also strongly differs from *House, M.D.* in that its doctors are remarkably dedicated to their patients and treat them with the utmost respect, and thus unlike House are not solely dedicated to treating their illnesses, but also their general well-being. This can already be observed when Charlie talks to the patient on whose case his lecture centered. In this scene, he not only describes the procedure to the patient, but also reassures him that everything will go well by telling him “Don’t be nervous. Just, uh, solving a problem here” (MacRury and Brebner). This approach can also be observed in Alex’s treatment of a patient “with nonspecific abdominal pain” in which she also keeps the patient informed about every step of the diagnosis by telling her “Okay, we need to get some blood work done, and then if that’s okay, we’re gonna get you a C.T. And see if something’s up with your appendix. Easy.” Furthermore, she also tells the patient not to worry as “[t]he test will show us what’s going on” (MacRury and Brebner). In fact, this trust is also evident when she talks to the doctor whom she was helping with the case “Take it slow. Listen to the patients. Trust the facts” (MacRury and Brebner). The doctor’s dedication to their patients is also emphasized when Dr. Joel Goran is introduced as he—in his normal street clothes—is seen rushing in a victim of a bus crash who was “[e]jected through the windshield approximately 10 feet” with “a penetrating chest wound and a second pneumothorax” (MacRury and Brebner). While he is rolled in on top of the patient whose chest wound he is compressing, he screams commands to the other doctors such as “Full trauma team. Get me to the O.R.” before he greets Alex by her first name and tells her “You look like a million bucks, by the way. Whoo!” while the audience can hear the reactions to his commands by the hospital staff in the background (MacRury and Brebner). This operation gives the show another opportunity to emphasize its medical accuracy as Alex and Charlie—similar to the doctors on *Chicago Hope*—are shown while they meticulously scrub their hands and arms before surgery. Furthermore, the audience witnesses the surgery in the state-of-the-art operating room, which is equipped with numerous medical devices, and is treated to the same highly stylized surgical recreations that have become a staple of the genre. For example, as Alex makes her first cut the viewer is given a detailed view and can see the blood flowing. Likewise, they are presented with close up shots of Alex’s hands while she sutures the patient’s liver (MacRury and Brebner).

This focus on medical accuracy and expertise is continued after the show returns to the present and the viewer gets to observe Charlie—who is hooked up to multiple machines that monitor and maintain his vital signs—as he is treated by his colleagues. In this process, Charlie is subjected to an MRI scan—the results of which the viewers get to observe on a screen (MacRury and Brebner). In addition to these procedures the viewers are also treated to an emergency delivery, Charlie’s resuscitation and “craniotomy” which Charlie explains to the viewers:

In case you're wondering, during a craniotomy they drill holes in your head. And that's about it. See, most patients don't understand how physical surgery is. The body is tough. You gotta crack a few bones, poke a few holes, and really get in there. And it works, most of the time. (MacRury and Brebner)

While he is saying this his body can be seen as it is hooked up to multiple machines and the viewers can observe as Dr. Shahir Hamza drills wholes in Charlie's skull.

All in all, *Saving Hope* is similar to *Chicago Hope* because it focuses on medical accuracy and on portraying doctors dedicated both to their patients' physical and psychological health that even surpasses that of the doctors on *ER* and stands in stark contrast to the dehumanized medicine of *House, M.D.* In addition to this, the show introduces a spiritual element as Charlie meets patients that are either in a coma like him or who have just died, talks to them and thereby helps them in their transition to the afterlife. In this manner, the health care offered by the show's doctors and their dedication to their patients even extends beyond death.

In conclusion it can be said that medical TV dramas are imbued with a significant degree of medical authority, which they further enhance by producing narratives that support it. Thus, the manner in which they represent intersexuality gains special validation in the eyes of their viewers as a result of this medical authority. The following sections will hence analyze how the respective shows utilize their medical authority to either challenge or uphold the marginalized and medicalized status of intersexuality.

#### **4. Representations of Intersexuality before the 2006 “Consensus Statement on Management of Intersex Disorders”**

##### **4.1 “A Vagina Would be Far Easier to Construct Surgically”: Intersexuality in the *Chicago Hope* Episode “The Parent Rap”**

In 1996 the US medical drama *Chicago Hope*<sup>20</sup> in its episode “The Parent Rap” was “[o]ne of the earliest” if not the first to depict an intersex birth and portray modern medicine's reaction to it (Tropiano 52). Therefore, this episode forms the natural starting point and baseline for the upcoming analysis of representations of intersexuality on medical TV dramas, particularly for those before the 2006 “Consensus Statement on Management of Intersex Disorders.” Thus, this early depiction is crucial in that it marks a reference point from which the developments in the portrayal of intersexuality can be discerned. Consequently, the following section of

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<sup>20</sup> According to Tropiano, *Chicago Hope* also dealt with intersexuality in a later episode entitled “Boys Will Be Girls,” in which it supposedly “explores intersexuality from the patient's point-of-view” (52). However, although Tropiano is correct in that the episode deals with a child whose sex was surgically assigned shortly after birth, the case in question does not technically deal with intersexuality—understood as an individual who at birth defies society's conception of being clearly male or female—but rather similar—if not almost identical—to the case of David Reimer, the child in question was assigned to the female sex after a “botched [...] circumcision” (52). Consequently, the episode will not be covered in detail within the scope of this thesis.

this thesis will closely examine the representation of intersexuality on *Chicago Hope* and its successors to establish in how far they can be said to either challenge or reinforce heteronormative notions of gender and relatedly sex, as well as sexual orientation.

The episode's portrayal of intersexuality starts with what at first appears to be a standard, if not a cliché, scene of a child being born in a hospital with an anxious husband filming as his annoyed wife delivers their first child—in fact, as is indicated by the recording square and the erratic camera movements, the scene is initially viewed through the father's camera (Arkadie, Charno, and Levin). This is further underscored by his narration “This is Doctor Sutton who is going to deliver the next generation of a long line of Broussards, this is Nurse Camile Shutt, and this is Gail” (Arkadie, Charno, and Levin). Even before the child is born, the father's preference for a boy already becomes apparent as he announces “We gonna call him ‘Clay’” even if his wife interrupts him and raises the possibility of the child being female in which case she would name it “Adeline” (Arkadie, Charno, and Levin). However, as the parents soon learn, things are not that simple when Dr. Sutton after successfully delivering the child wants to proclaim his/her<sup>21</sup> ‘sex’ and falters after starting with “Congratulations Mr. and Mrs. Broussard you have a beautiful baby” at which point the mother inquires whether there is something wrong with the child and the father simply asks “It's a boy, right? A little baby boy,” thereby once again underscoring his deep desire for a male heir (Arkadie, Charno, and Levin). However, Dr. Sutton casts an uncertain and worried look at the equally worried Nurse Shutt before handing her the child and upon further inquiry by the mother admits that he “Can't tell” (Arkadie, Charno, and Levin). The dramatic nature of this birth of a child that defies gender norms, but is nonetheless completely healthy is further stressed by the fact that the triumphant upbeat music that began to play as the child was born quickly loses its momentum and ultimately dramatically fades, as Dr. Sutton is unable to make a clear gender pronouncement (Arkadie, Charno, and Levin). With this dramatic setup, the show has already begun to pathologize intersexuality because the shocked reactions by Dr. Sutton and Nurse Shutt suggest to the viewer that intersex births are both a very rare and a tragic occurrence. This perception is further underscored by the parents' reaction and change in the background music.

This tendency is continued in the next scene in which Mr. Broussard accosts Dr. Sutton remarking: “No I don't understand. What do you mean you can't tell what sex it is? You skipped that part in medical school? Boys have penises, girl's don't. It seems real simple to me, Doctor Sutton. It's not that hard to tell the difference” (Arkadie, Charno, and Levin). At this point, a frustrated Dr. Sutton interrupts him by saying, “Mr. Broussard, your child has what is called ambiguous genitalia. It is possible for an enlarged female organ to be

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21 Throughout this thesis, Anne Fausto-Sterling's conventions of “*s/he* and *his/her*” will be used whenever a character either does not clearly identify as either female or male or in the case of infants is too young to make such an identification in the first place (“The Five” 20). As such, this convention aims to represent those whom our heteronormative language “refuses” to signify, namely everyone “who is clearly neither male nor female or who is perhaps both sexes at once” (Fausto-Sterling, “The Five” 20).

indistinguishable from a small male organ, and the opposite.” This leads a bewildered Mr. Broussard to inquire “Small? How small?” and after being informed by Dr. Sutton “Small” results in him protesting “No, Dr. Sutton, my family name goes back 250 years now I’m the only son, I’m supposed to carry that name” (Arkadie, Charno, and Levin). However, before the argument can reach a resolution, they are interrupted by Nurse Shutt, who urgently calls them back into the delivery room. In this scene, the importance both Mr. Broussard and Dr. Sutton place on the size of the genitalia for determining the child’s ‘sex’ and for his/her successful performance of that gender already becomes blatantly obvious.

When they are back in the delivery room Nurse Shutt informs Dr. Sutton “We started a pitocin drip, but she won’t stop bleeding” (Arkadie, Charno, and Levin). Thus, in order to save Mrs. Broussard’s life, Dr. Sutton has to “perform a hysterectomy[,]” which means that “she will not be able to have other children” (Tropiano 52). This, of course, upsets her husband even more as he desperately “wanted a son to carry on the family name” (Tropiano 52). This becomes evident in his reaction to Dr. Sutton informing him of the consequences of the lifesaving operation that he performed on Mrs. Broussard. First, he inquires “And what about the baby’s sex?” only to be informed by Dr. Sutton “We don’t know, the test results haven’t come back yet” to which he responds “So, eh, I have a he/she for a kid and now you say my wife will never have another child? You can’t say that” (Arkadie, Charno, and Levin). Dr. Sutton responds by remarking that “your child is not a ‘he/she’” at which Mr. Broussard responds “Then tell me I have a son, give me some good news” (Arkadie, Charno, and Levin). At first this scene might be seen as evidence that Dr. Sutton does not want to make a pronouncement regarding the child’s ‘sex’ until he has clear scientific proof on which he can base his decision. However, if related to the previous scene it becomes clear that Dr. Sutton has already made up his mind that the child does not possess a phallus of sufficient size to qualify as male.

This becomes even more evident when Dr. Sutton has presented the results of the tests to Mr. Broussard. In this scene Dr. Sutton sits behind his desk in his office with huge open books in front of him—in which he has presumably read up on the issue—while Mr. Broussard stands in front of it. The scene starts with Mr. Broussard—who has presumably just been informed of the results—asking “But it could be done?” to which Dr. Sutton responds “A vagina would be far easier to construct surgically” (Arkadie, Charno, and Levin). This causes Mr. Broussard to protest: “You just said that the tests show it’s a boy, now I’ve already explained to you what it means to me to have a boy” (Arkadie, Charno, and Levin). However, Dr. Sutton rejects Mr. Broussard’s objection by remarking:

The surgery to make your child male would be prohibitive; your son would have a non functioning penis. As he got older he might be able to have a pump surgically implanted in order to achieve an erection, but... although he’d be able to have sex, he may never achieve orgasm. In addition, most likely his testicles will develop a malignancy that could prove fatal. [...] As a girl, your daughter would be sterile; she would have to take hormones for life, but would be able to enjoy a full sex life. (Arkadie, Charno, and Levin)

This furthers Mr. Broussard's desperation who thus lashes out at Dr. Sutton: "You sit there giving me these choices. How are Gail and I supposed to decide for this child? How are we supposed to know what to do to give this child a normal life?" (Arkadie, Charno, Levin). Consequently, this scene further underscores that Dr. Sutton had already made up his mind before receiving the lab results on the basis of the child's genital size and that his conviction stands firm in spite of seeing them. Accordingly, the patient's genital anatomy is seen as determining his/her future gender identity. Additionally, unlike the parents who in accordance with "some psycho-medical texts, are depicted as worried, fearful, confused, not able to cope, and wanting things 'fixed'" (Roen 23), Dr. Sutton is presented as the calm informed voice of reason that only wants the best for the child and is seemingly annoyed with the father's demand for a son that stands in utter conflict with medical dogma (Arkadie, Charno, Levin). Thus, he presents Mr. and Mrs. Broussard with the choice of either perform a "prohibitive" procedure to "make your child male[,] but would likely result not just in an inability to achieve orgasm and include the risk of testicular cancer, or the supposedly unproblematic option of surgically assigning the child to the female gender, which would result in his/her sterilization and dependence on hormones, but would entail the ability of "enjoy[ing] a full sex life" (Arkadie, Charno, and Levin). Consequently, the show is representative of modern medicine's tendency to assign intersex children to a gender on the basis that "phalloplasty would require many surgeries" as opposed to the presumably "relatively simple surgery [...] needed to create a vagina" (Karkazis 131). However, as Karkazis argues "multiple surgeries for vaginoplasty are common because of complications like scarring and stenosis (where the vaginal opening closes)" (Karkazis 131). Moreover, Dr. Sutton's claim that surgical assignment to the female 'sex' would enable her to "enjoy a full sex life" does not hold up when compared to the experiences of intersex women who have undergone such operations (Arkadie, Charno, and Levin). As Karkazis points out, "mounting evidence shows that women who have had genital surgeries have problems with sexual function and sensation, and in some cases are inorgasmic" (Karkazis 131). Therefore, instead of constituting a criticism of the medicalization of intersex children, the episode affirms it (Preves "Sexing" 532). According to Tropiano, it "effectively dramatizes the dilemma parents of intersexed infants face" (52). However, none of the characters on the show consider the third possibility—which is favored by intersex activists—namely "to simply wait until the child develops rather than predetermining its gender" (Tropiano 52). Thus, the parents are deprived of having this choice. This also means that the audience is not given this option or information about the problematic nature of early childhood surgery on intersex children either and thus, like the parents, is forced to accept Dr. Sutton's recommendation—which after all is supported by his medical authority.

However, before the parents ultimately yield to Dr. Sutton's authority, they consider another option namely "giving the baby up for adoption" (Tropiano 52; Arkadie, Charno, and Levin). Both Dr. Sutton and the audience find out about this when a concerned Dr. Sutton confronts the parents about the fact that they have not seen their child since it was born.

In response, he is informed by the distraught couple that they “can’t see the baby” because as Mrs. Broussard explains, “We went over and over this, every choice seems cruel. We’re sorry this happened,” and Mr. Broussard adds: “There is only one thing we can do and it will be the least hurtful all the way around,” thereby informing Dr. Sutton that they have decided to give the child up for adoption (Arkadie, Charno, and Levin). Nevertheless, Dr. Sutton has not given up and tries to convince the parents to change their mind by telling them that “this child does not deserve to be given up on.” To this Mr. Broussard responds, “Even if we could learn to accept this, our child as a girl, she’d have no reproductive organs” (Arkadie, Charno, and Levin). To this Dr. Sutton replies:

That is what I am trying to tell you. A person is so much more than chromosomes and reproductive organs. There are men and women so many more than you would guess, who are unable to have children. I see them in my practice every day and they are no less masculine or feminine for it. [...] Any child you’d have would have trouble figuring out who they are, what they are. That’s what growing up is all about. [...] This is an opportunity some people never get. The chance to love a child of their own. Don’t give that up! (Arkadie, Charno, and Levin)

Although this speech could easily be mistaken to be in support for intersex rights and tolerance as he argues that “A person is much more than chromosomes and reproductive organs[,]” the viewers soon learn that this does not mean that this tolerance entails accepting deviation from the social standards of “masculine” and “feminine.” This becomes clear at the end of the episode when, on his way out of the hospital, Dr. Sutton stops by the Broussard’s room to observe the happy parents with their child and the mother hands the child to the father who says “Adeline Lily Broussard you are one beautiful little girl” (Arkadie, Charno, and Levin). This implies that they decided to have the surgery performed to make her a girl (Tropiano 52). The cheerful tone of this resolution is further underscored by the fact that the happy music that was originally interrupted when Dr. Sutton was unable to identify the child’s gender has now resumed indicating that the tragic birth has now reached its happy resolution (Arkadie, Charno, and Levin).

Consequently, as Preves points out, the way in which *Chicago Hope* represents intersexuality in this episode is “[a]n example of the medicalization of intersex” in that it depicts “the birth of a healthy intersexed infant” which immediately causes the “delivering physician [...] [to] consult[] a pediatric endocrinologist and urologist to ascertain the baby’s sex” (“Sexing” 532). Thus, the doctors on *Chicago Hope* “treated the infant’s sexual ambiguity a medical emergency and, in the end, opted for a female gender assignment and genitoplasty due to the small size of the infant’s phallus” (Preves, “Sexing” 532). What is even more remarkable is that, as Preves points out, “[t]he necessity of surgical intervention was never discussed, it was simply presumed” (“Sexing” 532). Similarly, the surgery to feminize the infant is presented as absolutely unproblematic and the most humane solution to this ‘emergency’ despite the empirical evidence to the contrary, which—much like the possibility of not performing surgery—is not given any consideration in this episode. Moreover, the parents’ inability to deal with the situation and accept their child unless s/he is clearly gendered

via surgical intervention is exemplary of a tendency Roen identifies in the psycho-medical literature on intersexuality, namely that “the parents of an intersex child may not cope unless the child is surgically altered” (Roen 23). This according to Roen serves two functions:

First, it presents the idea of surgical intervention as something that parents may seek for their children, not as something that they resist. Second, it presents surgical technologies as a solution to problems, namely the problems of parental anxiety and of the child not being accepted by those around them. (24)

Finally, there is no mention of intersex support groups anywhere in the episode. This may not be too surprising given the fact that the intersex movement was in its infancy when the episode aired, but is nonetheless problematic.

All in all, *Chicago Hope* utilizes its medical authority to reinforce the pathologization of intersexuality and to present surgical intervention as an unproblematic solution to parents’ anxiety, which will ultimately allow them to accept their child and thus ensure their and its happiness. At no point in the episode are the heteronormative underpinnings of this presentation questioned, or is the prospect of not performing surgery even considered nor are the negative long-term effects of feminizing surgery discussed. Instead, not performing surgery is effectively ruled out because the show uses the parents’ reaction to suggest that they and by extension society will only accept the child if it is surgically assigned to a clear binary gender identity. Non-intervention is further ruled out as it and intersexuality is innately connected to disease, i.e. cancer, and death. Thus, intersexuality is presented as an extremely rare and problematic condition that requires medical intervention to ensure a happy, i.e. binary, outcome.

#### **4.2 “Seems That Barbie is a Boy”: Intersexuality in the *ER* Episode “Masquerade”**

In 1998, two years after its contemporary *Chicago Hope*, *ER* also discussed a case involving intersexuality in its Halloween episode “Masquerade” during its fifth season. However, unlike the case on *Chicago Hope*, the action on *ER* does not revolve around the birth of an intersex infant and the resulting choice faced by its parents, but instead portrays the doctor’s reaction to discovering that an 11-year-old girl that was brought in after an automobile accident is intersex—or to be more precise that she has Androgen Insensitivity Syndrome or AIS<sup>22</sup> (Corbin and Sachs). In addition to this, the episode aired at a point in time when the intersex movement and its associated support groups were better established than in 1996 when *Chicago Hope* discussed the issue and thus caused a considerable reaction by intersex activists that will be part of the upcoming discussion. Indeed, several AIS women addressed the producers of *ER* in emails to express their dismay with one—identified as “AIS 28 year-old”—writing: “Your representation of AIS was worse than insensitive...it was sensationalistic and ethically irresponsible” and accusing them of having “just continued the legacy of deceit, secrecy and

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<sup>22</sup> The show itself refers to her condition by the outdated terminology Testicular Feminization, which is deemed to be demeaning by AIS women (Corbin and Sachs; “*ER* Episode”).

shame” (“*ER Episode*”). Another woman—“*AIS 44 year-old (1)*”—remarked that she had “real mixed feelings about the handling of the subject” noting, “It’s great that it’s [the discussion of AIS] out there. It could have been soooo [*sic*] much better. I still think it sucks” (“*ER Episode*”). In the following analysis, I will explore what made the portrayal of intersexuality in the episode so problematic and in which ways it can be said to have perpetuated the medicalization and pathologization of women with AIS and intersexuality in general.

The episode’s representation of intersexuality begins in the OR with one of the surgeons inquiring about the age of the girl on whom they are operating. During this procedure Dr. Benton discovers what he terms an “infrarenal mass” to which the other surgeon remarks “Looks like a lumbar node,” a suggestion that Dr. Benton rejects saying: “No it doesn’t feel right. It’s too rubbery.” At this point another unnamed surgeon notes that “There’s one on this side too. Could be lymphoma” leading Dr. Benton to order a biopsy and Dr. Elizabeth Corday is asked to “run this specimen down to pathology.” When Dr. Corday returns with the results, she initially quizzes the other surgeons on the biopsy results only to reveal to her shocked colleagues that it revealed “Seminiferous tubules” and inform them that “You biopsied two testicles. It seems that Barbie is a boy” (Corbin and Sachs). Consequently, from the outset the biopsy is presented as an indication that “Barbie is a boy” regardless of her own gender identity and thus the episode perpetuates the problematic notion that sex (i.e. biology) determines gender. Furthermore, the shocked reaction by the other physicians serves to emphasize the supposedly rare character of Barbie’s condition, and Dr. Corday’s comment pathologizes her and intersexuality.

This theme is continued when the doctors inform the parents of their findings. Initially, their presentation is focused on the details of their finding; nonetheless, it already includes some problematic elements as well as redeeming aspects. Indeed, Dr. Dale Edson informs the worried parents that “When we explored the retroperitoneum, we discovered two small masses” (Corbin and Sachs). When the anxious mother inquires what kind of masses they found he informs her that they did a biopsy “that revealed testicular tissue” at which the mother exclaims, “What does that mean?” to which Dr. Edson replies “Barbie has a condition called testicular feminization. Genetically, she’s a male with XY chromosomes. But during development, the fetal tissue was resistant to testosterone and the external genitalia developed as female.” At this point the mother in disbelief protests “There’s gotta be a mistake” only to be informed by Dr. Edson “No mistake. The vagina’s nothing but a blind pouch. No uterus or ovaries. She’ll need to be on estrogen replacement therapy” (Corbin and Sachs). When the father inquires, “My little girl has testicles?” Dr. Edson responds: “Actually, we had to remove them because of the high incidence of malignant transformation.” After hearing this, the father asks, “She’s a boy?” to which Dr. Corday informs the parents “The genetics don’t matter. You’ve raised her as a girl. Barbie is a girl. It’s what she looks like. It’s her identity. Nothing will change that,” at which point Dr. Edson inserts: “But you have to understand that she’ll never menstruate or bear children.” At this point the mother starts crying and Dr. Corday tells them: “Obviously this has come as a

shock. You'll need time to adjust. Barbie's recovering. We'll refer you to a genetic counselor. They'll help you decide when and how to tell her." At which both doctors leave the room. As soon as they have stepped outside Dr. Edson tells Dr. Corday: "Nice job. [...] Of course you forgot to mention they'll have to change Barbie's name to Ken" to which she responds with a disapproving look (Corbin and Sachs). This scene is problematic for many reasons. For one thing, Dr. Edson uses the outdated terminology "Testicular Feminization," which an AIS woman—identified as "*AIS 49 year-old*"—in her email to NBC noted to be "obsolete, inaccurate and stigmatizing" instead of the widely accepted term "Androgen Insensitivity Syndrome" ("*ER Episode*"). Moreover, although the explanation Dr. Edson delivers is technically correct, the serious tone of his explanation suggests that there is something seriously amiss with Barbie, and his choice of words emphasizes Barbie's 'otherness' and questions her femininity when he remarks that "The vagina's nothing but a blind pouch. No uterus or ovaries" (Corbin and Sachs). Thus, Dr. Edson chooses to emphasize Barbie's difference from 'normal' women rather than the similarities such as the fact that—as "*AIS 45 year-old*" pointed out in her email—she like other women was "feminized by her own hormones" in fact as, she further notes, AIS women might actually be seen as "ultra female" as they unlike other women have a reduced or no reaction to androgens and thus are more feminine—at least in terms of hormones ("*ER Episode*"). As if this were not enough to contribute to the stigmatization of AIS women and intersexuality in general, he justifies their decision to remove Barbie's testicles with the supposed risk of testicle cancer. However, as Greenfield informs her readers the cancer risk for patients with Complete Androgen Insensitivity Syndrome is "probably similar to the chance of a normal woman developing breast cancer" (Greenfield). Thus, by the same logic all women should receive mastectomies at an early age in order to circumvent the mere possibility of breast cancer. He also creates the impression that Barbie needs "estrogen replacement therapy" as a result of her condition and not due to the unnecessary procedure they performed (Corbin and Sachs). In fact, as "*AIS 40 year-old*" points out in her email to NBC:

The timing of this surgical procedure is controversial and the cancer risk is so minute before adulthood that many believe that it is an infringement [*sic*] of the patient's rights to have this operation forced on them without informed consent, apart from the fact that they then have to undergo a chemically-induced puberty via HRT, rather than via the natural female hormones from their testes. ("*ER Episode*")

Thus, although Tropiano is correct that "the fate of the child's gender is unknown" (52) the same cannot be said for her sexual anatomy, which is surgically adjusted to approximate the norm under the guise of a preventative procedure. This is done without consulting either the patient or her parents prior to the procedure and despite the fact that there was no immanent danger to her health. Although Dr. Corday's comment that "The genetics don't matter. You've raised her as a girl. Barbie is a girl. It's what she looks like. It's her identity" might be seen as redeeming it is immediately undermined by Dr. Edson comment "she'll never menstruate or bear children[,]," which serves to emphasize her supposed difference from femininity (Corbin and Sachs). It is further undermined by her earlier comment that "Barbie is a boy" (Corbin

and Sachs). However, the most troubling aspect of the episode is Dr. Edson's comment that "you forgot to mention they'll have to change Barbie's name to Ken." This like Dr. Corday's earlier statement perpetuates the idea that Barbie is not 'a real woman' or even a man in disguise—a suggestion that might also be deduced from the episode's title "Masquerade" and the fact that it is a Halloween episode, which, as "*AIS 36 year-old*" noted, might also be read to imply that "AIS patients [are] 'freaks'" ("*ER Episode*"). As "*AIS 45 year-old*" notes in her email to NBC:

you had a responsibility to counteract his cruel stupidity with some kind of epiphany on the part of Dr. Corday, a realization that chromosomes (and even undescended testes) do not in all cases a man make [*sic*], and that the real locus of gender is in the individual's sense of self, not in the organs or the chromosomes [...]. ("*ER Episode*")

Although Dr. Corday reacts to the comments with a disapproving look and her earlier comments about Barbie being a girl despite her genes might be viewed as having a corrective effect, she—as "*AIS 45 year-old*"—points out, "missed out on the very important fact that Barbie had been feminized by estrogen produced by her own body" ("*ER Episode*"), and earlier in the episode made a similar comment in proclaiming that "Barbie is a boy[.]" which might suggest that while she does not agree with the tone of her colleague she shares the sentiment (Corbin and Sachs).

The show's portrayal of intersexuality ends with a scene in which Dr. Corday comes to check upon Barbie in her hospital bed. The scene begins with Barbie asking Dr. Corday whether it is still Halloween to which she responds in the affirmative. In response Barbie expresses her disappointment at not being able to go trick-or-treating, but remarks "That's okay. The best part was making the costume anyway. Me and my mom made it together." Then Barbie asks Dr. Corday for her tiara, which she retrieves from under the bed and places on Barbie's head. When Barbie asks how she looks Dr. Corday with a smile on her face responds, "Oh, like a beautiful fairy princess" (Corbin and Sachs). This scene might be seen as an attempt to counteract the stigmatizing tone of earlier comments and express respect for Barbie's gender identity ("*ER Episode*"). However, it is so ambiguous that it is largely left to the audience's interpretation whether it constitutes an affirmation of Barbie's identity, an act of compassion, or simply an attempt by Dr. Corday to conceal the diagnosis from her patient—who throughout the episode is neither informed of her condition nor of the procedure that was performed on her ("*ER Episode*").

Consequently, *ER*'s representation of intersexuality similar to that of its contemporary *Chicago Hope* in no way contributes to the condition's destigmatization or to a criticism of the medical treatment of intersex people, not to mention of heteronormativity. Instead, the show further perpetuates the medicalization and pathologization of intersexuality. It does so by perpetuating the problematic notion that sex, i.e. biology, determines gender and emphasizing the rarity of intersexuality despite contrary scientific information. Furthermore, it accomplishes this using outdated and stigmatizing terminology and portraying Barbie's condition as a medical emergency that requires immediate intervention—regardless of the fact that her

intersexuality poses no imminent risk to her health. This is further underscored by the fact that her testicles are removed under the pretext of cancer prevention despite scientific evidence that suggests that such an operation is premature at this age and cancer a mere possibility. Interestingly, unlike *Chicago Hope*, *ER* does not suggest that the procedure is undertaken to alleviate the parents' distress, but is instead justified under a faux medical rationale. This focus on intersexuality as disease causing also serves to further medicalize and stigmatize it and Barbie. Similarly, the fact that the episode is called "Masquerade" and is a Halloween episode might be interpreted to imply that Barbie is only masquerading as a girl and that AIS women and other intersex individuals are 'freaks'. Moreover, the episode repeatedly suggests that Barbie is a boy and should be labeled with a male name in total disregard of her gender identity. It is further accomplished by placing particular emphasis on her difference from other women rather than on her similarity to other women or the fact that she is hormonally closer to the feminine ideal than most other women. Although the show at various points tries to suggest that Barbie's intersexuality should not be seen as undermining her femininity, these attempts are all circumvented by other remarks or undermined by earlier statements of a contrary nature. Lastly, similar to *Chicago Hope*, the producers of *ER* failed to provide any reference to intersex support groups or other resources on the subject ("*ER* Episode").

#### **4.3 "Do I Have to be a Boy Now?": Intersexuality in the *Grey's Anatomy* Episode "Begin the Begin"**

In January 2006, after eight years of being absent from North American medical TV dramas<sup>23</sup> and seven months before the publication of the "Consensus Statement on the Management of Intersex Disorders," intersexuality made its return as a topic on *Grey's Anatomy*—probably as a result of the media coverage surrounding "The 2005 Chicago Consensus Conference" that resulted in the "Consensus Statement" (Reis, *Bodies* 156). The episode in question is called "Begin the Begin," and given the fact that it aired a decade after *Chicago Hope's* "The Parent Rap" and eight years after *ER's* "Masquerade[.]" it should not be surprising that this episode is strikingly different in many respects from its predecessors. However, there are also some similarities; for one thing similar to *Chicago Hope* the parents of the child in question are shown to be having trouble dealing with the diagnosis (Koenig). On the other hand, similar to the depiction on *ER*, the episode does not focus on an intersex birth—like *Chicago Hope*—but rather chooses to portray the adolescent "tomboyish" teen girl Bex albeit one that is three years older than *ER's* Barbie, i.e. 14 (Hart, *Orchids* 30; Hart, "Representation" 10; Koenig). Consequently, the episode revolves around not just the parents' or doctor's reaction to the

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<sup>23</sup> At least the present research failed to uncover any significant mentions of intersexuality on US medical TV dramas between its appearance on *ER* in 1998 and its reemergence on *Grey's Anatomy* in 2006. Unless one counts the previously mentioned and excluded *Chicago Hope* episode "Boys Will Be Girls[.]" which aired in 2000 or the 2005 *Grey's Anatomy* episode "Who's Zoomin' Who?" which deals with intersexuality largely as an aside (Stanton and Werksman). This episode will briefly be discussed in the next chapter.

diagnosis, but also focuses on that of Bex—and this marks the show’s most striking difference from its predecessors (Koenig).

The episode’s representation of intersexuality begins when Dr. Addison Montgomery-Shepherd and Dr. George O’Malley join their patient and her parents in her hospital room and George introduces Addison to the case by saying, “Bex has been admitted for an ultrasound guided biopsy on an enlargement of a pelvic lymph node” (Koenig). Addison asks George to perform a blood test, which reveals that Bex’s “hormone levels estrogen, progesterone are sky high.” Consequently, Addison instructs George to find out whether Bex is taking birth control pills. When George asks Bex whether she has been taking birth control medicine and if she has a boyfriend, Bex replies: “Like anybody would want to have sex with me” and that she took “like five of those pills a day” because she is “flat as a board[,]” but “nothing’s different.” Thus, as George finds out Bex took the pills to make her breast grow because as she explains she “wanted to be normal for once in my life.” When she inquires whether this “caused the tumor[?]” George informs her, “No, no. The pill wouldn’t have any effect on your lymph nodes, but the amount that you were taking is really dangerous, and it caused a pretty major hormonal imbalance” and asks her whether she has “been feeling different than usual?” to which she replies: “I feel like I always feel” (Koenig). Her desire to be normal combined with the fact that—as George discovered earlier—she has been cutting herself could potentially be linked to the subsequent revelation that she is intersex and thus contribute to the narrative that intersex children will encounter social problems unless they are surgically assigned to a clear gender. Similarly, at this point of the episode intersexuality seems to be associated with illness as much as it was on *Chicago Hope* and *ER*. Whether this will actually be the case will be the focus of the upcoming analysis.

However, the suggestion that intersexuality will condemn a child to being ostracized unless surgery is performed to ‘correct’ it is counteracted when George tells Bex about his own high school experience and ends with the statement: “You just have to get through high school. Because high school sucks for anyone who’s the least bit different. But then there’s college, and then out in the real world you’ll find where you fit in” (Koenig). Thus, the episode highlights that intersexuality and ostracism are not correlated.

In the next scene George joins Addison in the lab where she asks him to look at Bex’s biopsy, and to “[a]rrange a meeting with Bex’ parents, [...]. Oh, and find out who the on call psychiatrist is, if they’re available to join us.” When a worried George inquires whether Bex has cancer she responds, “No. It’s not an ovary, it’s a testis.” This leads George to ask “Bex is a hermaphrodite?” to which Addison responds “Yes” (Koenig). All in all, this scene is strikingly dissimilar from its predecessors—and from the depiction of intersexuality in the show’s earlier episode “Who’s Zoomin’ Who?” which will be discussed briefly in the next section—in that it largely forgoes the panicked atmosphere of medical emergency that characterized earlier depictions. Instead, Addison is very calm about the diagnosis and George, upon hearing about it, seems more surprised than shocked. This is also emphasized by the music, which unlike that

of “The Parent Rap” is upbeat and used to emphasize George’s surprise (Koenig). Similarly, Addison’s medical response to the diagnosis is remarkably measured compared to that of the doctors on previous shows: instead of emphasizing the need for surgical intervention, it is rather focused on psychological care. Additionally, unlike *ER*—and its earlier episode—there are no derogatory comments by the doctors. The only problematic aspect of the scene is that George uses the outdated, unspecific, and stigmatizing term “hermaphrodite,” and Addison, rather than correcting his usage, simply affirms that he is correct (Koenig).

This emphasis on psychological care is also stressed in the next scene, in which Addison and George, supported by the psychiatrist, inform the parents of their diagnosis. The scene begins with the parents’ shocked and exasperated reactions after hearing the diagnosis. Thus, the father pacing around the room remarks: “Let me get this straight. You’re telling me that our daughter—my daughter—you’re telling me my daughter might actually be a boy?” The mother, on the other hand, asks “That—how is that possible? I-I don’t understand. I don’t understand how that...” only to be interrupted by the father’s question: “Sh-shouldn’t this have been detected somehow?” To this Addison responds: “Externally, Bex has female genitalia. She looks like a girl. But internally, she has both female and male sex organs” (Koenig). Upon hearing this, the bewildered mother asks “So what now? What are we supposed to do? I-I don’t understand...” to which Addison responds by reminding them, “Okay, the best news is that the lymph node tumor is benign. So physically, Bex is going to be just fine but emotionally,... Psychologically, I strongly recommend therapy.” When the father remarks that Bex is “already in therapy,” Addison corrects him by pointing out, “I’m talking about therapy for all of you. This is not gonna be easy for Bex to hear, and it’s not gonna be an easy adjustment for you to make.” This leads the confused father to inquire: “A big adjustment. What kind of adjustment?” To this the psychiatrist responds by explaining that: “Many intersex people begin to identify very strongly with one sex, and it’s not necessarily the sex they’ve been raised.” Which causes the mother to exclaim: “She’s a girl. She looks like a girl. She has always been a girl.” In response the psychiatrist remarks, “The point is, biologically and emotionally speaking, she has a choice to make” (Koenig). As this scene shows, *Grey’s Anatomy* continues the trope of the overwhelmed parents that was established by *Chicago Hope* and according to Roen permeates a number of “psycho-medical texts” on intersexuality (Roen 23). However, unlike *Chicago Hope*, *Grey’s Anatomy* does not offer surgical assignment to the binary norm as a solution to the problem, but rather the doctors try to help the parents and Bex to cope with the diagnosis by offering them psychological care. Another aspect that sets *Grey’s Anatomy* apart from its predecessors (both *Chicago Hope* and *ER*) is that in contrast to these shows “Begin the Begin” does not establish or suggest a causal relationship between intersexuality and disease, i.e. cancer. Instead the disease is negotiated separately from Bex’s intersexuality because the tumor is not located in her testis, but rather in her lymph nodes and ultimately revealed to be benign. Consequently, the episode avoids medicalizing and pathologizing intersexuality. However, the therapist’s final comment suggests that the episode remains trapped within

heteronormative constraints, when he remarks that “biologically and emotionally speaking, she has a choice to make” (Koenig). As such, it seems to suggest that Bex will have to decide which gender she wants to identify with, which will, as the reference to biology suggests, also entail surgery to ensure that her body complies to the requirements of the respective gender. Nevertheless, the fact that a clear emphasis is placed on her making this decision and that her own gender identification is even considered is remarkable considering that earlier portrayals of the medical treatment of intersexuality did not ever consider the patient’s wishes: on *Chicago Hope* the operation was carried out shortly after birth in accordance with the traditional treatment paradigm, and on *ER* the doctors did not even inform the parents before performing the procedure and kept the patient in the dark regarding her condition.

Subsequently, Addison and George are approached by the parents in a hospital corridor to inform them that they are not going to tell Bex about her condition, as “She can’t handle something like this. You saw the scars” which causes George to protest: “But this could help her. You can’t not tell her who she is” (Koenig). Addison, on the other hand, tells them that “we’ll go ahead and proceed with the scheduled surgery to remove the tumor, and then you can talk to your daughter in your own time.” However, it quickly becomes clear that the parents have other plans. Thus, the father starts out by saying: “We thought, since you’re already gonna be in there we know ‘fixed’ isn’t the right word, but...,” at which point the mother takes over and remarks, “We were thinking that with the hormonal confusion, it might be easier on her to remove whatever boy parts she has.” The father concludes by stating, “Keep her more of a girl.” When Addison inquires: “Just to be clear, you’re asking me to perform sexual reassignment surgery on your daughter?” They respond in the affirmative, and when George asks whether they intend to keep Bex in the dark about the procedure the father responds, “All she’s said all her life is that she wanted to be normal. She doesn’t feel normal” and the mother suggests, “Why can’t we just put an end to her agony?” However, Addison informs them: “Well, first of all removing her male sexual organs may not do that. In fact, it could do just the opposite” (Koenig). When the mother protests “But her hormones...” George quickly responds that they “Can be controlled with oral medication,” and Addison puts an end to the discussion by remarking: “To do surgery and alter her body permanently is... well I just would never do that on someone who’s unaware of the procedure, and you’re gonna be hard pressed to find a surgeon who will” and walks away (Koenig). After she has left, George tells them: “Bex will learn the truth someday. H-how do you want her to find out?” before he also walks off. While he says this, Bex is seen watching them through a window in the door (Koenig). Thus, this scene once again highlights the episode’s comparatively progressive character. This becomes apparent in Addison’s vehement declaration that surgery will not help Bex to become normal, but might actually have the reverse effect.

In this manner, she formulates a veiled criticism of the surgical reassignment of intersex children, which is suggestive of the problems of such procedures and the idea of creating ‘normalcy’ that Roen has described as follows:

There are a few problems here. First, what the parents envisage probably does not account for the effects of medicalization on the child [...]. The parents’ picture of a normal, healthy child probably does not include repeated hospital visits, genital scarring, and profound mistrust of adults in medical contexts. Second, the process of embodied becoming may not actually be so strongly determined by surgeons and parents as they imagine: the child may become whomever they become despite, rather than because of, the medical intervention. (22)

Moreover, Addison’s refusal to perform a gender reassignment on Bex without her knowledge and consent highlights the ethical issues of self-determination and informed consent that are completely absent from both *Chicago Hope’s* and *ER’s* discussion of intersexuality. Additionally, George’s suggestion that Bex’s hormones can be medically regulated and do not require surgical intervention highlights the fact that the procedure, which the parents requested, is not medically necessary. George’s final question “H-how do you want her to find out?” and the fact that Bex watches them through the window further highlights the problems associated with the secrecy surrounding intersexuality (Koenig). As Preves points out, “for intersex individuals the lack of open discussion of their intersex status results in feelings of shame and isolation” (“Sexing” 541). However, there is also a problematic aspect to this scene. Namely, the fact that Addison suggests that “I just would never do that on someone who’s unaware of the procedure, and you’re gonna be hard pressed to find a surgeon who will” (Koenig). This is a problem because, as both Greenfield—for the US—and Holmes—for Canada—point out, these procedures are still widely performed on young children throughout North America (Greenfield; Holmes, *Intersex* 42). In contrast to this reality, the episode suggests that early childhood surgery on intersex children is a non-issue because supposedly almost no surgeon would perform such a procedure. Consequently, Addison’s statement is not only misleading, but might actually discourage viewers from critically engaging with the issue since it has seemingly already been resolved. Moreover, there is not even a mention of the long-standing tradition of performing such surgeries without the patient’s consent, which can be viewed as a whitewashing of medical history by omission.

This focus on the problem of secrecy is also continued in the next scene when Bex asks George whether he told her parents that she took the birth control pills or if she is dying because she has noticed that her parents are acting strangely. This is also expressed when she tells her parents: “Mom, dad, this is really freaking me out.” Thus, she asks George, “I’m having surgery to remove a tumor that’s compressing my ovary, right, George?” However, George hesitates and when Addison pressures him to answer the question exclaims, “What, am I just supposed to lie to her?” at which point Addison asks him to leave the room. This causes Bex to protest: “No, wait. Tell me what’s wrong with me. What is wrong with me?” Consequently, her parents are forced to tell her the truth. At the end of their explanation Bex says: “And I’ve had it my whole life. Oh, my God. Does this mean...does this mean I could

be a boy?” at which she smiles and whispers to herself “Yes” and the scene fades to black (Koenig). When the action returns the parents confront George in the hallway, and he is dismissed from the case. There are several interesting aspects to this scene. Most importantly, Bex is actually informed about his/her intersex status—even if reluctantly and thus is given agency over her own body. Thus, unlike *ER*, where the doctors informed neither the parents nor Barbie before removing her testes and it is only suggested that Barbie will be informed about her intersex status at a later point, and *Chicago Hope* where there is no discussion of informing the patient and the surgery is carried out before this would even be possible, the writers of *Grey’s Anatomy* make the argument that the patient should be able to give informed consent. Moreover, Bex’s frightened reaction upon being kept in the dark about her diagnosis highlights the associated problem of shame that has historically been the result of the taboo surrounding intersexuality.

The episode’s discussion of intersexuality ends with a scene in which George talks to Bex in her room. In it Bex thanks George for forcing her parents to tell her about her condition. In this conversation Bex also asks George: “do I have to be a boy now?” to which he replies, “No. No.” This leads Bex to ask, “But I can if I want to?” to which George responds by saying “Yeah, you can, if you want.” Following this, Bex asks George to cut his/her<sup>24</sup> hair short. At this point, Meredith’s voiceover begins and sums up the lessons of the episode. In it she remarks: “Who gets to determine when the old ends and the new begins? [...] It’s not a day on a calendar, not a birthday, not a new year. [...] It’s an event, big or small, something that changes us. Ideally, it gives us hope... A new way of living and looking at the world.” During this voiceover, a smiling Bex is seen, as s/he looks into a mirror while George cuts his/her hair. At this moment Bex’s parents walk in looking shocked at first, but then the mother looking serious takes the scissors and continues cutting Bex’s hair and both she and Bex are seen smiling (Koenig). In this final scene there are several noteworthy aspects. For one thing, unlike the representations of earlier shows the doctors in “Begin the Begin” do not try to impose a gender identity and accompanying sexual anatomy on Bex, but rather leave it up to Bex. Moreover, the parents are—unlike those on *Chicago Hope* and *ER*—shown to be able to cope with the situation without requiring surgical intervention—even if they originally demand it—and support Bex in his/her decision. Hence, as Hart argues, “*Begin the Begin* offers the possibility of accepting the horror of a hermaphroditic child, as he or she is, without having to ‘fix the problem’” (Hart, *Orchids* 30; Hart, “Representation” 10). However, the final sequence in which, according to Hart, “Dr O’Malley and Bex’s parents help[] Bex to cut her long, feminine hair off in order to realise or play with her (potential?) male gender identity” in contrast to Hart’s assertion remains thoroughly within heteronormative boundaries and confines Bex and intersexuality within these boundaries (Hart, *Orchids* 30; Hart, “Representation” 10). In fact, the episode makes it blatantly clear that while Bex will

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24 The personal pronouns his/her and s/he are used from this point on since it is no longer clear whether Bex identifies clearly as either male or female.

likely identify as male as is not only suggested by the fact that s/he has George cut his/her hair, but also by his/her joy at hearing that s/he could be a boy earlier in the episode, and his/her tomboyish appearance. Although it might at first, as Hart points out, “not entirely make sense from Bex’s initial position about desiring ‘boobs’ and a boyfriend that she would want suddenly to be a boy,” the episode suggests that his/her original desire for having bigger breasts and a boyfriend is largely if not exclusively a result of his/her desire to fit in and be like the other girls (Hart, *Orchids* 30-31; Hart, “Representation” 11). Therefore, the episode implicitly suggests that Bex has always felt like a man and connects this to the fact that s/he has testes and as such reasserts the idea that sex determines gender. At no point is there any doubt that Bex will clearly identify as either male or female. Moreover, Hart criticizes that “Bex’s intersex condition is never clearly defined” (Hart, *Orchids* 30; Hart, “Representation” 10-11). As she points out,

[This] [...] distinct lack of clarity and correct information, even from a biological point of view, means little has been done to help audiences understand what intersex is or how it actually works. Nevertheless, there has been an attempt to highlight the most sensational aspects of the controversy of non-disclosure and surgery surrounding intersex. (Hart, *Orchids* 31; Hart, “Representation” 11)

Moreover, much like its predecessors “Begin the Begin” does not mention intersex activism and support groups at all.

In conclusion, it can be said that “Begin the Begin” constitutes the most respectful and unproblematic representation of intersexuality to air before the publication of the “Consensus Statement.” Hence, unlike its predecessors, it not only focuses on the reaction of Bex’s parents and doctors, but actually involves Bex his/herself in the decision-making process. Furthermore, the episode challenges the idea of a correlation of intersexuality and ostracism as well as the suggestion that ‘normalizing’ surgery could protect intersex children from this fate. Unlike earlier depictions—those of *ER* and an earlier episode of *Grey’s Anatomy*—this episode does not feature derogatory and discriminatory comments by Bex’s doctors. Similarly, although it continues to present parents as being overwhelmed by their child’s intersex diagnosis, it rejects the idea of resolving this anxiety by surgical means and rather focuses on psychological care for the parents and their child. Moreover, the episode takes a clear stance against the idea that surgery will enable intersex children to clearly identify with one gender and thus enable them to live a ‘normal’ life. Instead, it emphasizes that the reverse might be the case. Unlike *ER* and *Chicago Hope*, it also does not associate intersexuality with disease, but rather treats the two issues separately and thus avoids medicalizing and pathologizing intersexuality. In addition to this, it also makes it clear that surgical intervention should only be undertaken with the patient’s knowledge and consent, and that it should be the patient’s own gender identification that should determine the direction of such a procedure. In doing so, it also argues that there are alternatives to surgical intervention and highlights the problem of shame that often results from the secrecy surrounding the treatment of intersex children. However, there are also several problematic aspects in the episode. Chief among them is the fact that it suggests that surgery

on intersex children is extremely rare and that most physicians would refuse to perform such procedure. Relatedly, the fact that it makes no mention of the history of such surgeries in recent North American history is problematic since this omission deprives the show's audience of an opportunity to reflect critically on this history and effectively constitutes a whitewashing of medical history. It also remains rather vague on Bex's intersex and does not give any detailed information on intersexuality in general, thus missing a chance to alleviate some of the misconceptions surrounding intersexuality and intersex people. Additionally, "Begin the Begin," much like earlier portrayals, reintegrates intersexuality into heteronormativity by suggesting that Bex will clearly identify as either male or female—in fact it seems to suggest that Bex has always identified as male—and will opt for the respective surgery without allowing for the possibility that Bex might identify as neither or might clearly identify, and choose not to undergo surgery. Lastly, similar to its predecessors, the show also uses outdated and stigmatizing terms in its treatment of intersexuality and makes no mention of intersex activism and support groups. Consequently, "Begin the Begin" might actually constitute, as Meredith suggests it in her voiceover, "A new way of living and looking at the world" at least when it comes to the representation of intersexuality in medical TV dramas, albeit one that remains clearly within the confines of heteronormativity, continues several of its predecessors' problematic tendencies, and introduces several new ones.

#### **4.4 Implications of the Representations before the "Consensus Statement"**

In the course of the previous three subchapters, this thesis has demonstrated that there are several tendencies that are characteristically shared by most and sometimes all representations of intersexuality on medical TV dramas that aired before the publication of the "Consensus Statement." For example, cancer is a topic that is shared by most of the episodes during the period. On *Chicago Hope* the risk of testicular cancer is used to rationalize surgery and to justify Dr. Sutton's decision to assign the child to the female gender (Arkadie, Charno, and Levin). Along the same lines *ER* utilizes the risk of cancer to justify the removal of her testes without either her parents or her own consent (Corbin and Sachs). Cancer is also mentioned in the *Grey's Anatomy* episode "Who's Zoomin' Who" in which intersexuality played a minor role (Stanton and Werksman). However, tests reveal that what the doctors originally suspected to be a tumor pressing on their adult male patient's bladder is an ovary, which is described as "a quirk of nature" and surgically removed with the patient's consent (Stanton and Werksman). In the *Grey's Anatomy* episode "Begin the Begin," the issue of cancer is also present, but (unlike on *Chicago Hope* and *ER*) it is explicitly separated from Bex's intersexuality and not used as a justification for gender reassignment surgery (Koenig). However, the fact that both *Grey's Anatomy* episodes disassociate intersexuality from cancer and disease does not mark a total shift in the representation of intersexuality on North American medical TV dramas before the "Consensus Statement." This is demonstrated by the 2006 *House, M.D.* episode

“Skin Deep,”<sup>25</sup> which aired a few months before the publication of the “Consensus Statement.” In this episode the 15 year old female supermodel Alex is admitted to the hospital and is ultimately diagnosed as intersex and as having cancer on one of her testes (Lerner, Friend, and Shore). In the course of this episode, cancer is not only innately linked to intersexuality, but also used to justify surgery to remove both testes and as an excuse to delegitimize Alex’s protest at having her gender identity denied—House refers to her as a “he” after the diagnosis and denies her “agency over her own body and identity” and thus further “pathologized[s] her—and by association intersexuality in general” (Whybrew 108). Therefore, the majority of episodes before the “Consensus Statement” directly link intersexuality to cancer and use it as a justification of surgical gender reassignment. Although this is not the case on *Grey’s Anatomy*, this does not signal a wholesale change for the genre before 2006, but rather marks the comparatively progressive character of the show’s portrayal of intersexuality.

Similarly, the image of shocked parents is present in all episodes that deal with intersex infants—*Chicago Hope*, children—*ER*, or adolescents—*Grey’s Anatomy*’s “Begin the Begin” and *House, M.D.*’s “Skin Deep” (Lerner, Friend, and Shore). An exception to this is the *Grey’s Anatomy* episode “Who’s Zoomin’ Who?,” which, as mentioned above, deals with an adult patient (Stanton and Werksman).

Another feature that is widely shared by all episodes during this period is that the respective patients are all diagnosed to be intersex and treated (except for “Begin the Begin” where treatment is only inferred) in the course of the episodes, and none of the episodes focus on portraying the aftermath of these treatments and their potential side effects. Instead the treatment—mostly surgery—largely appears as unproblematic, i.e. successful. Additionally, surgical assignment to a binary gender is presented as a solution to a problem caused by the patient’s intersex status. On *Chicago Hope*, it is presented both as a preventative measure against the—as the show argues—high probability of testicular cancer and as a way to alleviate the anxiety of the parents, thus enabling them to accept their child, i.e. ensuring a happy future for both them and their child (Arkadie, Charno, and Levin). *ER* similarly presents surgical intervention as a necessary means to avert cancer (Corbin and Sachs). In the *Grey’s Anatomy* episode “Who’s Zoomin’ Who” surgery—unrelated to cancer—is still used to revolve the patient’s health issues and simultaneously to prevent any threat to the patient’s masculine gender identity as is illustrated when Dr. Burke reassures his patient and friend of his masculinity by referring to his intersex status as “a quirk of nature” and telling him that he is “A man’s man” (Stanton and Werksman). Only in the episode “Begin the Begin” is the idea that surgery represents an unproblematic solution tentatively challenged. This episode foregrounds psychological treatment for both the parents and Bex, and argues that surgery will not guarantee that intersex children identify clearly with one gender. Moreover, it is suggested that surgery might have adverse effects (Koenig).

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<sup>25</sup> This episode is not covered in detail in the course of this thesis, as it has already been the subject of an article (which was also submitted as a term paper) written by the author of this thesis.

*House, M.D.*, on the other hand, presents a case in which this risk has already become a reality. Therefore, surgery is presented as a way of resolving the manifest health problems of the patient (Lerner, Friend, and Shore).

Interestingly, almost all of the episodes during this period deal with the same intersex condition, namely Androgen Insensitivity Syndrome (AIS), but they all either use outdated and stigmatizing terminology or fail to clearly identify the respective intersex condition or both. *ER* refers to the condition by the outdated and stigmatizing term “testicular feminization” (Corbin and Sachs). Similarly, on *Grey’s Anatomy* Bex is referred to as an “hermaphrodite,” a term that is outdated and largely seen as stigmatizing by the intersex community. In addition to this, the show remains rather vague in its definition of Bex’s condition, only mentioning that she “has female genitalia. She looks like a girl. But internally, she has both female and male sex organs” (Koenig). Nevertheless, Hart suggests that “From the perspective of a person with Complete Androgen Insensitivity Syndrome CAIS, it would initially appear to me that Bex has CAIS too” (Hart, *Orchids* 30; Hart, “Representation” 11). On the other hand, *House, M.D.* uses the term “male pseudohermaphroditism[.]” an outdated and problematic term for AIS (Lerner, Friend, and Shore). The only episodes that do not deal with AIS are *Chicago Hope’s* “The Parent Rap” and *Grey’s Anatomy’s* “Who’s Zoomin’ Who.” The condition on “The Parent Rap” is never clearly defined, but rather Dr. Sutton tells the father “your child has what is called ambiguous genitalia. It is possible for an enlarged female organ to be indistinguishable from a small male organ, and the opposite” (Arkadie, Charno, and Levin). Hence, the intersex condition is not clearly defined, and it is likely that rather the child is an example of the “one in 100 births” in which the infant’s body does not conform to the socially and medically defined standards for what constitutes either female or male genitalia (“How Common”). In the *Grey’s Anatomy* episode “Who’s Zoomin’ Who” Dr. Burke explains the condition by telling his friend and patient:

The chromosomal tests have revealed that your body contains DNA from two different embryos that merged in the womb at the very beginning of development. In rare cases such as yours, the condition can produce gonadal hermaphroditism. (Stanton and Werksman)

This description is very probably intended to describe what the ISNA refers to as “mosaicism involving ‘sex’ chromosomes” in which a person “has one kind of karyotype in some of his or her cells, and a different karyotype in other cells[.]” According to the ISNA, this “happens because sometimes cells divide incorrectly early in the life of an embryo” (“Mosaicism”). Whatever the case, Dr. Burke, similar to the doctors on the other shows, uses the outdated and stigmatizing term “hermaphroditism.” Consequently, most of the portrayals fail to use accurate terminology and instead use sensationalistic terms like “hermaphrodite,” “testicular feminization,” or “male pseudohermaphroditism.” Alternatively, they fail to accurately name the intersex condition.

Regardless of the terminology they employ, all of the shows that deal with intersexuality in adolescent or adult patients in some way call their gender identity into question upon discovering that they are intersex. Moreover, many of these shows suggest that modern medicine can identify the true and definite ‘sex’ of their intersex patients and that this should determine the patient’s gender identity. *ER*’s “Masquerade” represents the most striking example of this. In it Dr. Edson not only describes Barbie’s condition in a way that emphasizes her difference from other women rather than discussing her similarity to other women and the fact that hormonally she is in some ways closer to the feminine ideal, but also both he and Dr. Corday make derogatory statements that suggest that Barbie is really a boy (Corbin and Sachs). This tendency is further underscored by the fact that the episode is called “Masquerade” and its status as a Halloween episode, which implicitly suggest that Barbie is only masquerading as a girl (“*ER* Episode”). This theme is continued in the *Grey’s Anatomy* episode “Who’s Zoomin’ Who?” where after discovering that their male patient has an ovary Dr. O’Malley in shock remarks “God, an ovary” to which his fellow intern and Dr. Alex Karev responds: “Kind of gives new meaning to the term ‘metrosexual’” (Stanton and Werksman). Ultimately, the patient’s intersex status is explained away when Dr. Burke remarks that it is nothing more than “a quirk of nature” and reassures his friend and patient in his masculinity (Stanton and Werksman). Nonetheless, the episode fails to counteract the message that intersexuality is somehow abnormal and the gender identity of the patient is represented as questionable. *Grey’s Anatomy*’s “Begin the Begin” is considerably different in that Bex’s intersex diagnosis is presented as a way for Bex to escape the ostracism that s/he experienced as a girl and—as the episode implicitly suggest—embrace a male identity that is innately connected with the fact that s/he has testicles. Thus, similar to the other episodes, this episode perpetuates the idea that sexual anatomy determines gender identity. Nonetheless, the show sets itself apart from its contemporaries by even considering Bex’s own gender identification even if its discussion of intersexuality and gender identity remains vague at best (Hart, *Orchids* 31; Hart, “Representation” 11). The theme of representing intersexuality as problematic and of questioning the gender identity of intersex patients is picked up again in the *House, M.D.* episode “Skin Deep,” which April Herndon describes as “one of the most offensive and hurtful portrayals of people with intersex conditions that I’ve ever seen” in an article on the ISNA website. In this episode, House “not only denies Alex’s gender identity by proclaiming that she really is a man, [...] but also overrules her protest by using his medical authority and the seemingly incontrovertible evidence of DNA testing (Whybrew 108; cf. Herndon). As I have further noted, “In doing so, the show uses its medical authority to reinforce the idea that medicine has the ability to unequivocally determine a person’s ‘sex’ and that this defines the person’s gender identity” (Whybrew 108). Moreover, House also remarks that “[t]he ultimate woman is a man” (Lerner, Friend, and Shore), which (similar to *ER*) suggests that AIS women only masquerade as females, but are actually men and thus further pathologizes them (Whybrew 108).

On *Chicago Hope's* "The Parent Rap," the one episode that deals with a new born, things are a little more complicated. Although Dr. Sutton orders medical tests to determine the child's 'sex,' he ultimately decides to disregard their findings and uses the infant's sexual anatomy to determine its gender—as is often the case in medical decisions regarding intersex children. Nevertheless, the episode presents Dr. Sutton's decision as beneficial for both the child and its parents and thus upholds the idea that medicine can successfully identify the true gender of a child (Arkadie, Charno, and Levin).

Most strikingly, all of the episodes fail to make any mention of the intersex movement or its associated support groups. Similarly, all of the episodes considered suggest that intersexuality is extremely rare. Nevertheless, there has been a clear development during the period before the "Consensus Agreement." This finds its most dramatic expression in the fact that unlike *Chicago Hope* and *ER*, *Grey's Anatomy* does not establish a correlation between intersexuality and disease and its doctors only perform surgery with the patient's consent (Koenig). Additionally, unlike its predecessors, "Begin the Begin" highlights the problem of secrecy surrounding intersexuality. However, as the *House, M.D.* episode "Skin Deep" shows, this trend is not a universal one because it both connects intersexuality with cancer and offers surgery as an unproblematic and necessary solution (Whybrew 108-109). This notwithstanding, "Begin the Begin" also introduces a new problematic trend, namely it suggests that very few surgeons would perform gender reassignment surgery on children or teenagers without their knowledge despite evidence to the contrary and does not reflect on the medical tradition of performing such procedures (Koenig). Thus, it suggests that early gender reassignment surgeries on intersex children are not a problem because they are no longer performed and by omission even gives the impression that they have never been a serious issue. Such a portrayal deprives viewers of the possibility to critically reflect on the issue of gender reassignment surgery on intersex children.

However, despite these improvements none of the shows has thus far questioned the necessity of clearly belonging to either the female or male gender or the idea that this would be the desirable outcome of the medical treatment of intersexuality. Hence, noncompliance to heteronormativity is consistently portrayed as a problem that has to be resolved, and all intersex characters are ultimately reintegrated into the gender binary. Thus the idea that there could be anything beyond gender binarism is never seriously considered, but instead intersexuality is presented as a biological anomaly that is ultimately revealed to only mask the binary, i.e. true, gender identity of the respective patients. Consequently, all of the representations are examples of high het entertainment in that they raise the issue of intersexuality only to ultimately seemingly smoothly reintegrate it and the respective patients into heteronormativity, thus reaffirming its universality and seeming naturalness. Whether the trends that have been outlined in this section of the thesis continue after the publication of the "Consensus Statement" and which new developments occurred as a consequence will be the subject of the remainder of this thesis.

## 5. Depictions of Intersexuality after the 2006 “Consensus Statement on Management of Intersex Disorders”

### 5.1 “It is Okay to be Different”: Intersexuality in the *Private Practice* Episode “Wait and See”

The 2009 episode “Wait and See” of the *Grey’s Anatomy* spinoff *Private Practice*, which aired during the show’s second season, was the first representation of intersexuality on a North American medical TV drama that was met with almost unequivocal praise from both the intersex and the larger LGBTQI community. Accordingly, it was nominated for an award in the category of “Outstanding Individual Episode (in a series without a regular LGBT character)” —at the 21<sup>st</sup> Annual GLAAD Media Awards—even if it lost to the *Parks and Recreation* episode “Pawnee Zoo” (Gaita; “Award Recipients”). Moreover, Curtis Hinkle<sup>26</sup> from the Organisation Intersex International (OII) thanked “ABC for their sensitive portrayal of the birth of an intersex child.” According to Hinkle, it was “in total agreement with OII’s own Official Position on Health care.”<sup>27</sup> It is also the first episode of a medical TV drama to air after the publication of the “Consensus Statement.” Therefore, the following analysis will show which features in the episode might have contributed to this positive reaction, the extent to which it reflects the Statement’s changed stance on surgery and terminology, and whether “Wait and See” can be said to challenge the pathologized status of intersex people and potentially even its heteronormative underpinnings, or if it is just another example of high het entertainment that ultimately reinforces heteronormative standards.

Interestingly, the beginning of “Wait and See” is strikingly similar to that of *Chicago Hope*’s “The Parent Rap,” in that it also starts with a birthing scene in which the parents already betray a conviction that their child will be a boy and have also already given him the name “Matthew”—this time this conviction is based on the ultrasound images made during pregnancy (Blackman). Also, similar to *Chicago Hope* the mother gives birth to a completely healthy infant, but when Dr. Addison Montgomery takes a closer look at the child both she and the birthing assistant Dell look worried and when the mother asks to “hold my little boy” Addison informs her that “It’s not a boy” and to the father’s question whether it is a girl she responds “I’m not sure” to which the parents react with a worried look on their faces similar to that of Dell and Addison. The dramatic nature of this discovery is underscored by dramatic background music (Blackman). This tenor is continued in the next scene when Addison

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<sup>26</sup> It should be noted that the article in question was published on the OII’s old website, which has since been replaced. Therefore, the associated reference supplies a link to the archived version on the Internet Archive’s Wayback Machine.

<sup>27</sup> This position—similar to that of the ISNA—emphasizes that the gender binary is “not reflected in nature” but rather there are “various gradations on a spectrum with male at one end and female at the other.” It further opposes gender reassignment surgery on intersex infants and emphasizes their right to self-determination and that the child’s own gender identity should be respected by anyone involved in caring for it once it has been expressed (“English”). The reference to the position also refers to its archived version on the Wayback Machine and not the most recent version on the OII new website—<http://oiinternational.com>.

explains the situation to the worried parents by telling them: “I know this is impossibly hard, and we don’t have all the answers yet, but your baby has something like a penis, there is also a vaginal opening” at which point Dell adds, “The babies heart, and lungs, and brain are all very healthy, and that’s important for you to understand.” Nevertheless, the mother asks “But what is it” to which Addison responds, “We’ll run some genetic and hormonal tests, I’ll consult with my colleague Doctor Bennett, she’s an excellent endocrinologist. We’re gonna get you answers” at which the father remarks, “Until then what do we tell people? I mean, what do we call him, he’s Matthew, he’s supposed to be... he supposed to be Matthew.” At this both Dell and Addison look concerned. Once again the dramatic tone of the scene is underscored by the background music. Consequently, these introductory scenes—much like those of *Chicago Hope*’s “The Parent Rap”—place a particular emphasis on the anxiety that an intersex birth causes for the parents. Additionally, similar to Dr. Sutton in “The Parent Rap,” Addison promises the parents that she will be able to give them a definite answer after performing medical tests and consulting other physicians. However, unlike *Chicago Hope*, *Private Practice* places special emphasis on the fact that the child is completely healthy.

However, in the next scene the audience learns that Addison’s promise of a clear gender determination is a lot more complicated than she originally promised the parents. In this scene Addison and Dell discuss the case with Dr. Naomi Bennett. When Addison asks Naomi what she should tell the parents Naomi responds, “Well I wish I had a good answer, but the baby does have 11 $\beta$ -Hydroxylase deficiency[,]” which as Addison explains to Dell “is an enzyme deficiency that causes an overproduction of testosterone in the baby in utero that’s why the baby has both male and female sex organs.” Naomi further remarks that the “Karyotype is xx” from which Dell deduces, “so the baby is a girl” only to be corrected by Naomi who explains: “No it’s not that simple. Yes, genetically it is a girl, but in about 30% of these cases kids orient towards male[,]” which leads Dell to ask, “so we can’t tell the parents what sex the baby is?” In response Naomi asserts, “they will have to choose, and then we can surgically correct the genitalia.” This leads Addison to express concern by remarking, “Wait, you just said there’s a 30 percent margin for error.” Nevertheless, Naomi maintains her conviction that surgery is the only option and notes that “Postoperative healing is faster and it leaves the genitalia functional, all supported with hormone therapy.” However, Dell remains unconvinced and interrupts her by protesting, “Yeah, but what if they choose wrong and the baby orients the other way,” an assertion with which Addison concurs as she suggests, “Exactly we should have them choose gender now, but not do surgery. Let them raise the baby as a boy or girl and then when the baby becomes an adolescent it makes up its own mind.” Nonetheless, Naomi maintains that not performing surgery would be problematic as “[l]eaving it an it, every sleepover, every swim party or locker room is gonna be cause for panic.” At this Dell protests: “Maybe it should be whatever it is and never lop off any body parts.” At this point Dr. Archer Montgomery—Addison’s brother, Naomi’s boyfriend, and famous neurologist—comes in and comments: “Can of worms.

Some people think gender's hardwired so whatever we do is not going to change the outcome. Me, I find it freakish, lop away" at which Naomi laughs and the two kiss as the others leave the office (Blackman).

Thus, already in the first 8 minutes of the episode many of the concerns, which were often only hinted at by its predecessors, are addressed. The episode far surpasses them in its discussion of gender reassignment surgery on intersex infants. For one thing, it at least partly rejects the idea that modern medicine can identify the true gender of an intersex person by suggesting that genetic evidence might not provide a definite answer. Also, unlike *Grey's Anatomy* it does not suggest that surgeries on intersex infants are rarely performed anymore—as both Naomi and Archer clearly favor such interventions. Moreover, unlike *Chicago Hope*, it also discusses the option of assigning a gender directly after birth, but postponing surgery until the child has reached adolescence and can make an informed decision. Even more strikingly, it is also the first episode to openly suggest that, as Dell puts it, "Maybe it should be whatever it is and never lop off any body parts[,]" i.e. of not performing surgery at any point (Blackman). However, this scene also reveals several problematic tendencies of the episode's discussion of intersexuality. For one thing, Naomi's statement—which is problematized at no point in the episode—that "Postoperative healing is faster and it leaves the genitalia functional" if surgery is performed shortly after birth fails to reflect the experience of many intersex individuals who have had to struggle with the long-term ramifications of such surgeries both in regards to resulting health issues as well as genital function and ability to orgasm. Similarly, Naomi's argument that "[l]eaving it an it, every sleep over, every swim party or locker room is gonna be cause for panic" suggests that surgery would allow the child to appear 'normal' and lead a 'normal' life, whereas inaction would condemn it to ostracism (Blackman). In this respect, it actually falls behind the argument made on *Grey's Anatomy's* "Begin the Begins" that surgery and the associated secrecy might in fact have the opposite outcome (Koenig).

The subsequent scene continues this discussion when the doctors and Dell inform the parents of their findings. It begins with the parents' reaction to their child's diagnosis. Here the father remarks, "So it's a boy, but it can also be a girl" and the mother asks, "My God, what are we suppose to do? How do we decide?" To this Naomi responds by suggesting that "the odds say that your baby will most likely identify as a female, so we can do corrective surgery and give the baby the appropriate genitalia" to which the shocked father remarks "You wanna take my baby, my son, and cut off his penis?" This leads Addison to suggest that "Alternately, you can chose a gender now, raise the baby and then when he or she matures you reevaluate" to which the mother replies "And hide this for his entire childhood?" On the other hand, the father exclaims, "What do we tell him? I mean how do you even begin to explain this to a little kid?" At this Dell suggests, "That not everybody is the same and that it is okay to be different" to which the father responds, "But it's not okay! Kids are cruel. One kid sees him in the bathroom; everyone's talking and teasing him that's what kids do. That's not the life we want[,]" and the mother concludes, "We need to make this right. We need to put this

behind us, behind him, or her and make it right, but what's the best way?" This discussion is continued when the parents approach Addison to discuss their decision, and the mother informs her, "We walked past your wall of pictures. All those kids happy, and sweet and normal and that's what our baby should be." When the father asks whether this could be accomplished by surgery Addison responds, "Surgery can give your baby gender distinct genitalia, yes." To which the mother responds in relief, "And we can know. Afterwards we can stop saying 'it'," and the father remarks, "Great, so lets do that. Can we do it soon?" To which Addison responds, "I can book an OR for tomorrow. Afterward we'll supplement with estrogen so she'll be as healthy as possible." However, the parents—similar to their counterparts on *Chicago Hope*—still maintain that their child should be male and are not even convinced by Addison's assertion, "But only 30 percent of these babies orient toward male" to which the father remarks, "You said you don't know. We know!" A sentiment with which the mother concurs as she informs Addison "He's our son. Your gonna give us our son." At this Addison looks exasperated. The problematic nature of the parents' decision is further underscored by the dramatic background music (Blackman). There are several noteworthy aspects to these scenes. For one thing, they reinforce the conviction that medicine can identify the 'correct' gender of an intersex infant—despite the suggestion that there is a certain margin of error. This is not only expressed in both Naomi's and Addison's assertion of a 70% likelihood that the child will identify as female, but also in Addison's shock at the parents problematic decision to request the she surgically assign the child to the male gender—also underscored by dramatic music—which is contrasted with her own seemingly unproblematic suggestion of performing the reverse procedure. Moreover, although Addison avoids to directly confirm the parents' assertion that surgery could make their child 'normal,' she nonetheless suggests that "Surgery can give your baby gender distinct genitalia [...]" (Blackman). This stands in stark contrast to Roen's observation that "What surgery offers is, strictly speaking, not typical genitalia. The post-surgical genitalia may look *more* typical, but not necessarily entirely typical" (Roen 32). Furthermore, the episode once again fails to address the potential negative side effects of surgery such as the "likelihood of pain, shame, complications, the need for repeat surgery, and the effects of medicalization on the child [...]" (Roen 32). On a similar note, the episode fails to problematize the suggestion by the parents that surgery will allow the child to live a 'normal' life like "All those kids happy, and sweet and normal" in the pictures along the walls of the practice (Blackman). As Roen notes, in perpetuating such a fantasy of normality both parents and physicians

imagine particular kinds of subjects that they do or do not wish the child to become (not a freak; not an isolated, unhappy, dysfunctional person; preferably someone who is 'normal', well, and happy). In the process of this project of imagining the future subject, adults project onto the child their own fears and their own ideas about what is 'normal' and what is desirable. (21)

This is also expressed in the father's reaction to Dell's suggestion of telling their child "That not everybody is the same and that it is okay to be different" to which he angrily responds

“But it’s not okay! Kids are cruel” (Blackman). However, as Roen further argues, there are two problems inherent in an argument such as that raised by Naomi in the previous scene and reiterated by the parents in this scene. First, it according to her “does not account for the effects of medicalization on the child” and thus does not take “repeated hospital visits, genital scarring, and profound mistrust of adults in medical contexts” into consideration (Roen 22). Second, and this is at least hinted at in the episode, “the process of embodied becoming may not actually be so strongly determined by surgeons and parents as they imagine: the child may become whomever they become despite, rather than because of, the medical intervention” (Roen 22). In essence, the only thing that is vehemently criticized in these two scenes is the parents’ decision to have their child assigned to the male gender in defiance expert advice of the physicians.

Nevertheless, even if the audience might initially think so, this does not mark the end of the episode’s discussion of gender reassignment surgery on intersex infants. In fact when Naomi comments that she “was surprised that you changed your mind about surgery” Addison responds, “I can help them. They [...] are desperate to change their situation for them and for the baby and you made a very good case. That surgery is the only way to really do that.” However, Naomi is concerned about the parents’ decision to have them perform masculinizing surgery as she remarks that “the odds are stacked against that[,]” but Addison responds that “the gender is not my choice, its their’s, and they want him past this, they want him better, and I can help.” Nonetheless, Dell is not the only one who remains critical of this decision as is demonstrated when Dr. Cooper Freedman—the practice’s pediatrician—questions Naomi’s and Addison’s decision by asking them “What about what the kid wants?” and when Naomi responds that “It’s a little young to make that decision” he remarks “I hope you make the right one” (Blackman). The show’s discussion concerning gender reassignment surgery ultimately culminates in Addison changing her mind about the surgery at the last minute. As she explains to the parents who ask if everything is okay with the child, “That’s just it. The baby is fine, but you, Naomi, we all wanna change the baby into a him, into something that he’s not.” To which the father responds, “So you just wanna leave him a freak?” at which the mother protests, “He’s not a freak.” Nevertheless, the father maintains, “He is if they don’t do the surgery. Please you got to do this. Give us our son” a request that Addison rejects. In response Naomi suggests to the parents, “if you want a boy you can still have a boy, you can take him home, and call him Matthew, and love him and accept him for what he is and raise him so that when the time comes, he’ll make the choice that’s right for him.” Nevertheless, the father remains unconvinced and angrily responds, “And meanwhile what? Our kid should hide, be embarrassed, humiliated, what?” He also rejects his wife’s suggestion that “We could protect him” and remarks, “What do you think it will be like, to be a six year old boy with a vagina?” to which Addison retorts “Imagine being a 20 year old woman without one.” When the father suggests that they should find another surgeon, the mother rejects this idea and tells him, “No, she’s right. We need to think about this. It is too important to just hurt him this way.”

However, the father is unwilling to accept this and remarks that “it’s a him and leaving him like this is not right” and that he “can’t take that home and hope it turns out right” before he storms out of the hospital (Blackman).

Thus, the remainder of the episode deals with the parents’ coming to terms with their child’s diagnosis without resorting to surgery. The mother informs Dell that she has decided to raise the child as male, but that she is unsure if she can raise it alone at which point Dell reassures her that she made the right decision. In the meantime, Naomi confronts the father about storming off and abandoning his wife and child by telling him: “Your wife loves you and you have a healthy child who yeah has some issues, but so what, everybody has issues.” Ultimately, the episode ends with the father returning to his wife and holding the child in his arms (Blackman). Thus, “Wait and See” ultimately lives up to the promises of its title and rejects the idea of early childhood gender reassignment surgery in favor of waiting until the child is old enough to make up its own mind. It instead promotes the idea—which is also promoted by intersex organizations—that the parents should raise the child according to a specific gender identity. Moreover, much like its parent show, *Grey’s Anatomy*, it rejects the idea that surgery is the only way to alleviate the anxiety of parents promoted by earlier shows such as *Chicago Hope* and instead suggests that parents are able to cope with their child’s intersexuality without such radical steps. However, in contrast to “Begin the Begin” where the parents are told that no surgeon would perform the surgery on their child without its informed consent and are forced to inform Bex about her condition and accept her decision, the parents in “Wait and See” are seen actively struggling both with their child’s condition, their own decision for surgery, their doctor’s refusal to perform that surgery, and the prospect of raising an intersex child and protecting it from harm. Although the parents are represented as anxious about their child’s condition and future—much like the counterparts on earlier shows, they are shown to be able to come to terms with their child’s condition without the need for surgery. Moreover, by representing the parents’ complex struggle with both their child’s diagnosis and the recommended treatment *Private Practice* counters the trope of the anxious parents that demand surgery with a more complex representation that bears a striking resemblance to Roen’s suggestion for portraying parents’ responses in which she argues that:

Parents could [...] be presented as having understandable misgivings, as needing time to work through a process of grieving before making a decision about surgery, as feeling ambivalent about the treatments on offer, and as needing more time to learn about the medical condition and the likely surgical outcomes. (25)

Relatedly, unlike *Grey’s Anatomy*, *Private Practice* does not suggest that gender reassignment surgery before the patient can consent to it is a nonissue, but rather shows doctors that are actively considering performing such a procedure and only decide against it at the last moment.

In conclusion it can be said that “Wait and See” is without a doubt the most sensitive portrayal of intersexuality on a North American medical TV drama to this point and thus deserving of the praise it received from both intersex organizations and the LGBTQI community at large even if it includes some problematic elements.

Interestingly, *Private Practice* is the first medical TV drama to completely avoid the use of outdated and stigmatizing terminology since it only uses the medical term “11 $\beta$ -Hydroxylase deficiency” and even that only once (Blackman). Similarly, it is critical of the idea that modern medicine can discover the ‘true’ gender of an intersex infant. However, it still perpetuates the notion that, while it cannot provide a definite answer in this case, it can nonetheless give a 70% accurate pronouncement of the infant’s gender identity. Moreover, unlike *Grey’s Anatomy*, it does not create the impression that gender assignment surgery is no longer performed and therefore a nonissue. Nevertheless, like its predecessors, it fails to make any mention of either intersex organizations or support groups. In contrast to *Chicago Hope*, it actually considers and ultimately favors the option of postponing surgery until the child can express its own gender identification—but nonetheless raising it in accordance with a specific gender. However, it still presents surgery on intersex infants as remarkably unproblematic—were it not for the danger of making the wrong gender assignment—and as a way of helping the child to lead a ‘normal’ life unaffected by the ostracism that it would likely suffer otherwise. In this regard, it actually fails to live up to the example of “Begin the Begin,” in which Addison had made it clear that surgery might actually produce the opposite outcome and stands in stark contrast to the life experience of many intersex individuals who have undergone such procedures (Koenig). This is also reflected in the fact that the episode neglects to mention the potentially negative effects of such surgeries or the potential impact of the medicalization of these children (Roen 22). On the other hand, its portrayal of the parents’ complex reaction is exemplary in that it not only shows them struggling with their child’s intersex condition, but they are also depicted as struggling with the decision to perform surgery and ultimately are able to accept their child without the help of surgical ‘normalization.’ Nevertheless, although this may give the audience a chance to critically reflect on these procedures, the episode fails to mention the adverse effects such surgeries can have on the lives of the respective patients. As a result, they appear as remarkably unproblematic apart from the issue of making the right decision with regards to the gender assignment. In fact, it remains unclear whether Addison would have performed the surgery had the parents not chosen to ignore her and Naomi’s suggestion of feminizing the child—which according to them and their medical evidence was the better choice. Therefore, although “Wait and See” problematizes gender reassignment surgery on intersex infants, there is a certain degree of ambivalence that suggests that such surgeries are permissible if the odds are in favor of the respective gender assignment. Thus, the episode’s stance on these types of surgeries much like that of the “Consensus Statement” permits the possibility of performing reassignment surgery even if both the episode and the Statement discourage it. Similarly, although it is remarkable that *Private Practice* is the first medical TV drama to raise the possibility of not just postponing surgery, but of actually not performing it at all and allowing the child, as Dell puts it, to “be whatever it is and never lop off any body parts.” The fact that Dell is not one of the doctors, but only a birthing assistant means that his statement lacks medical authority (Blackman). It is further marginalized by the fact that

Naomi quickly emphasizes the absurdity of such a suggestion by bringing up the increased danger of ostracization that this would entail (Blackman). Hence, the idea is only raised to be immediately discredited. Similarly, when Dell suggests to the parents that they should tell their child “That not everybody is the same and that it is okay to be different[,]” he is angrily informed by the father “But it’s not okay! Kids are cruel” (Blackman). Interestingly, the parents ultimately choose to follow Dell’s recommendation, but it is made unmistakably clear that this is only temporary until the child identifies clearly as either male or female—the possibility that it will identify as neither is never raised again. This is also emphasized when Naomi tells the parents that “when the time comes, he’ll make the choice that’s right for him” (Blackman). Thus, “Wait and See” despite its promise still constitutes high het entertainment.

## **5.2 “You Gave Birth to a Freak of Nature, Doesn’t Mean it’s a Good Idea to Treat Him Like One”: Intersexuality in the *House, M.D.* Episode “The Softer Side”**

In 2009 during the show’s fifth season, the writers of *House, M.D.* chose to revisit the issue of intersexuality in the episode “The Softer Side” after—as pointed out above—having been severely criticized for their previous attempt (the 2006 episode “Skin Deep”) by members of the ISNA (Herndon). Although this episode inspired neither protest nor praise from any major intersex or LGBTQI organization, the Blog *Intersex and the City* praised it for its accurate portrayal (“Intersex”). The upcoming analysis will show the extent to which the intersex community’s criticism of “Skin Deep” and the publication of the “Consensus Statement” have had an impact on the episode’s treatment of intersexuality. Moreover, the following analysis will show to what extent it differs from “Wait and See,” which aired only four days earlier.

Interestingly, the episode begins several years before the main action of the episode takes place. In this gloomy introductory scene the parents are informed by a doctor that their child has “a condition called genetic mosaicism[,]” but that it “can have a completely normal life” and its “ambiguous genitalia [...] be surgically repaired” to be “[m]ade to look more typical” (Friedman). When the bewildered mother remarks that “you haven’t even told us if the baby’s a boy or a girl,” he informs her, “That’s a choice you have to make” at which point the scene fades to the present where their now pubescent son Jackson collapses during a basketball game (Friedman). Cuddy introduces the case to House by telling him “Adolescent genetic mosaic, collapsed during a basketball game, presenting with persistent pelvic pain” at which House remarks, “Fun” only to be informed that “The parents haven’t told their son that he could have been their daughter. They want assurance that you won’t either” at which point House retorts “Less fun. But still” and accepts the case. In these introductory scenes “The Softer Side” already sets itself apart from its predecessors in that it is the first episode to portray a patient who was already diagnosed and treated for his intersex condition and thus the episode has the potential of discussing the possible ramifications of that treatment.

In the subsequent scene House introduces the case to his team by remarking “Our new patient. Part girl, part boy [...]” and they begin the process of differential diagnosis. In this process Dr. Eric Foreman suggests that the pelvic pain could have been the result of dehydration, an idea that is quickly rejected by Dr. Lawrence Kutner on the basis that the ER gave Jackson fluids when he was first admitted. In addition to this Dr. Chris Taub protests, “We got a kid who could mate with himself, and we’re thinking he didn’t have enough to drink? There are dozens of intersex disorders. Persistent pelvis pain could mean congenital adrenal hyperplasia, PMDS.” However, Kutner rejects this suggestion by pointing out, “Those conditions occur in intersex kids who are chromosomal XX or XY, not XX and XY. The parents recently started him on testosterone, maybe there’s something....” At which point Dr. Remy Hadley (aka ‘Thirteen’) interrupts him to inform the team that the parents have requested that they refer to testosterone as “Vitamins” and remarks: “His parents aren’t just liars. They want us to be liars too.” Alternatively, she suggests that the pain might be caused by a “blind uterus” and suggests an MRI to confirm her diagnosis only to have the idea rejected by Foreman because he believes it to be too obvious to have been overlooked by other doctors; an assessment with which House concurs calling the MRI a “waste of time[.]” Instead Foreman suggests, “He could have complications from the surgeries on his penis.” Just when the team is about to leave the room the parents burst in. The mother asks House to check for a blind uterus using an MRI and the father informs him, “Over the past 13 years, we’ve educated ourselves.” Although House ridicules them for thinking that they could contribute to the diagnosis by remarking, “Who needs med school when you’ve got Wi-Fi?[,]” he instructs his surprised team to perform an “MRI with contrast” informing Kutner that arguing with the parents would also have been a waste of time (Friedman). Interestingly, House’s team does not immediately associate Jackson’s collapse with his intersex condition, and when Taub attempts to establish a connection between the two, his suggestion is quickly disproven as medically inaccurate and irrelevant by Kutner, who instead suggests that it might be the result of the androgen replacement therapy Jackson is undergoing. Similarly, Thirteen’s suggestion that his complications might be the result of a blind uterus is rejected by both Foreman and House. Indeed, the former suggests that rather than being a result of Jackson’s intersexuality, it could be “complications from the surgeries on his penis[,]” i.e. also a result of the treatment he underwent rather than his intersex condition (Friedman; “Intersex”). This is remarkable since this makes “The Softer Side” the first episode of a medical TV drama to openly discuss the potential negative outcomes of the surgical ‘treatment’ of intersex infants. Interestingly, “The Softer Side” is also the first show to use the term “intersex” (“Intersex”). The fact that Jackson’s parents are portrayed as having informed themselves can also be seen as positive—even if intersex support groups are still not mentioned. However, this is immediately criticized by House who, as has been shown above, does not tolerate patients’ or relatives’ attempts to diagnose themselves or their loved ones. Nevertheless, although this is typical of House’s character and a general tendency in medical TV dramas, it is nonetheless problematic

because it might discourage parents of intersex children from seeking information from either other parents or intersex organizations. This is problematic because, as Karkazis notes, “In the case of intersexuality, [...] the media and the Internet present knowledge not available from other sources [...] which has been critical for fostering dialogue among clinicians and between physicians and parents” (264). Likewise, the fact that the episode is critical of the parents withholding information about his condition from Jackson is positive and its portrayal of them doing so reflects the experience of many intersex individuals (“Intersex”; Reis, *Bodies* xiv). However, it is problematic that the show places the sole blame for this on the parents instead of criticizing it as a common part of the original treatment paradigm, which focused on “providing a coherent and consistent physical and psychological gender” (Karkazis 289).

Thus, House’s team performs an MRI and disproves Thirteen’s and the parents’ theory of a blind uterus and tries to perform an endoscopy of Jackson’s penis. However, during this procedure Jackson’s heart fills with fluid and they are forced to abort the procedure to drain it. Back in the diagnostic room Taub concludes, “Pelvis plus heart doesn’t fit with any of the syndromes associated with mosaicism[.]” and Foreman suggests that his symptoms could be related to “drugs, toxin, an infection[.]” This leads Kutner to ask whether House is okay with the fact that they are “considering a diagnosis unrelated to this kid being a shemale” (Friedman). In response, Thirteen brings up the possibility that it might be related to Jackson starting hormone treatment as this “can cause autoimmune disease [...] which can cause pericardial effusion and pelvic pain. So, it is related” at which House orders them to “Start him on corticosteroids for the autoimmune, finasteride to block the vitamins” (Friedman). Thus, the episode continues to reject the idea that Jackson’s symptoms are the result of his intersexuality and instead places more emphasis on problematizing the potential negative effects of the associated ‘treatment.’ However, as the use of the term “shemale” shows, the episode continues the tradition of using derogatory terminology.

In the next scene, Thirteen informs the parents of the team’s diagnosis and the suggested treatment. In response, Jackson’s mother expresses concern that if their diagnosis is correct, it would force them to abandon Jackson’s hormone therapy which would mean that he would “stop developing, he’ll never go through puberty. [...] [T]hen he’ll never be a man” and expresses worry that they might have made “the wrong choice[.]” However, when Thirteen suggests that “maybe this is a good opportunity to tell him the truth. It might make it simpler for all of you[.]” the mother vehemently objects to this notion (Friedman). Here, the episode shows how parents might in fact continue to struggle with their original decision even years after they made it, which contradicts the idea that surgery puts an end to their anxiety and suggests that the parental response might be more complex than some medical texts suggest (“Intersex”; Roen 23, 24-25).

Thirteen then administers the treatment in Jackson’s hospital room and while doing so starts a conversation with him about playing basketball. During their discussion Jackson informs her that he is “not really that into basketball” and when asked why he joined the

team responds that his mother made him join because “she flipped out, and made me choose between basketball and hockey” when he expressed the wish to “take dance[.]” While she is talking to Jackson, Thirteen notices a rash on his hand and is thus forced to conclude that they still have not found the right diagnosis (Friedman). In this way, this scene highlights the dramatic effects that the traditional treatment of intersexuality can have on both the child and its parents as the mother “forced strict gender roles” on Jackson in accordance with the treatment paradigm and to assure herself that she made the correct choice (“Intersex”)

As a consequence of this, the team has to come up with a new diagnosis, and Thirteen suggests that Jackson might be “self-medicating with drugs and alcohol” because she is convinced that he is depressed. To confirm this suspicion, the team searches Jackson’s school and home. During their search of Jackson’s room Thirteen discovers a poem with the lines “I stand alone, my soul and me, beneath the mask that others see” and “A pain that tears and bites and will not bend. Only when I sleep will it end” from which she concludes that he could have suicidal tendencies. However, House rejects her suggestion and instead follows Taub’s diagnosis that Jackson has an infection as they found “toxoplasmosis” in his water bottle. Nevertheless, Thirteen shows the poem to the parents and suggests that they should tell Jackson the truth about his condition. However, the mother rejects this because she is not convinced that it would help him and fears it might make things worse. When Thirteen objects by telling her that “He obviously senses he’s different. He’s looking for answers[.]” she responds “Every teenager feels different. He’s sick. This isn’t the time to spring this on him” and asks Thirteen to restart the testosterone treatment alongside the antibiotics. Nevertheless, Thirteen—similar to George in “Begin the Begin”—disregards the mother’s wishes and tells Jackson that the shots she is giving him are not vitamins and that he should ask his parents what they really are. Thus, the parents are forced to tell Jackson the truth at which point Jackson asks them “So, what, am I a boy or a girl?” to which his father responds, “Some of your cells are male, and some are female.” From this Jackson concludes, “So, basically, I’m a freak” to which his father remarks, “No, no, buddy. You’re just a little different.” Despite this, Jackson is angry with his parents for withholding this information from him all his life and asks them to leave the room (Friedman). In these scenes, the episode highlights the devastating effects of the secrecy surrounding intersexuality both on the trust between Jackson and his parents, but also on Jackson’s self-image and the doubt which the sudden disclosure of his condition instills in him regarding his gender identity. The negative effects of this secrecy and the sudden disclosure are also reflected in the fact that Jackson expresses worry that he might have feelings for one of his teammates since, as he tells Thirteen, “Maybe I’m supposed to. Because if I’m really a girl...” (Friedman; “Intersex”). Moreover, to Thirteen’s horror, he informs her that the poem was a school assignment and that he never intended to kill himself, but that he is now considering it (Friedman).

However, Jackson's health deteriorates further, which causes the team to fear that he might be dying of Scleroderma. And—because Jackson still refuses to let his parents into his room—his mother angrily confronts Thirteen by telling her: “My son has a death sentence, and I can't go in there and be with him because of you.” The situation is only resolved when Cuddy tells the mother, “He's a teenager, you're his mother. This is not the time to start listening to him. Go be with him.” Ultimately, Foreman and Thirteen discover that Jackson does not have Scleroderma, and House has a sudden insight that solves the case. Thus, House walks into Jackson's room and informs Jackson, “This is all your parents' fault” and informs him and his parents that his symptoms were the result of dehydration due to his consumption of energy drinks, which also caused a strain on his kidneys. When the father inquires why Jackson has not recovered yet if it was just dehydration. House informs him, “That's where your idiocy came in” and explains that it was the contrast material for the unnecessary MRI that caused the problems and concludes, “Your son was fine when he got here. It was your freaked-out over-protectiveness that nearly killed him[,]” but thanks to his youth, he will be able to recover. Before leaving the room House tells them: “You gave birth to a freak of nature, doesn't mean it's a good idea to treat him like one.” In the final scene dealing with the case, an excited Jackson tells Thirteen that he feels “[a] little bit better” and that his mother “asked if I wanted to take dance lessons[,]” but that he is worried that he “might miss basketball.” Thirteen responds, “No reason you can't do both[,]” at which Jackson smiles and nods (Friedman). Consequently, unlike the earlier *House, M.D.* episode “Skin Deep,” “The Softer Side” does not connect Jackson's health problems to his intersex status, but rather connects it to the secrecy surrounding it, which is also shown to limit Jackson's self-expression. Instead, it promotes disclosure and honest communication about intersexuality. However, Jackson's problems are also clearly connected to his parents' attempts to inform themselves about their child's condition. This is problematic because it might discourage parents from seeking help from support groups. Moreover, the fact that House refers to Jackson as “a freak of nature” (Friedman) serves to further pathologize intersexuality as an extremely rare anomaly rather than, as LeFay Holmes puts it, “a naturally occurring, statistically stable instance of sexual anatomical variation” in other words, “just another type of body” (6). Nonetheless, his conclusion “doesn't mean you have to treat him like one” is an attempt to place further emphasis on respectful and open communication about intersexuality. This is further emphasized in Thirteen's conversation with Jackson, which suggests that the parents—to Jackson's benefit—have decided to stop enforcing strict gender roles on him, and that, in accordance with Thirteen's final comment, he will be allowed to participate in activities regardless of whether they are traditionally viewed as masculine or feminine (Friedman).

Ultimately, “The Softer Side” introduces some very important new elements. Chief among them is the fact that this is the first episode of a medical TV drama to discuss potential negative side effects of gender reassignment surgery on intersex infants and the secrecy that often follows these treatments. As such, it also reflects a shift in the discussion of intersexuality

in that it, unlike its predecessors, portrays the aftermath of the original treatment and reflects on the potentially negative outcome of these treatments. In keeping with the trend set by *Grey's Anatomy* and *Private Practice*, it also does not connect intersexuality to the patient's health problems, but rather—and this is new—discusses them as potential outcomes of the gender reassignment surgery Jackson underwent as an infant. Similar to *Private Practice*, it also paints a complex picture of the parents' struggle, not just with their child's intersex condition, but also with their decision to allow gender reassignment surgery, as well as their fear that they might have made the wrong choice and shows how this can have negative effects on their relationship to their child. Moreover, it also promotes open communication about intersexuality. Nevertheless, it still constitutes high net entertainment because at no point does it criticize the original gender reassignment operation and deflects the blame for the secrecy that followed it onto the parents rather than reflecting on the fact that this was a usual part of the original treatment paradigm. Additionally, at no point does it suggest that Jackson might identify as anything but either female or male; instead, it hints that the border between the two must not necessarily be as rigid as that imposed by his mother. Moreover, it resumes the tradition of using pathologizing terminology like “shemale” and “freak of nature” that its contemporary “Wait and See” had already abandoned and in doing so perpetuates the pathologization of intersexuality. Moreover, it also perpetuates the false notion that intersexuality is an extremely rare and pathological anomaly rather than portraying it as a natural example of human anatomical variation and thus medicalizes and stigmatizes it. Lastly, like its predecessors, it fails to mention intersex organizations or support groups. Indeed, its criticism of the parents' attempts to educate themselves about the child's condition might actually stop parents of intersex children from seeking such support.

### **5.3 Correcting the Corrected: Transsexual Intersexuality in the *Saving Hope* Episode “Vamonos”**

In 2013 the Canadian show *Saving Hope* was the next major North American medical TV drama to address the issue of intersexuality in its second season episode “Vamonos.” Although the episode did not garner much attention from the intersex community, it nonetheless is worth considering because it represents the first Canadian take on discussing the medical treatment of intersexuality and introduces some interesting new angles into the discussion. Thus, the following analysis will focus particularly on the differences and similarities between “Vamonos” and its US contemporaries.

At the beginning of the episode, the audience is introduced to Riley, a teenage female-to-male transsexual, who is about to undergo his hysterectomy/oophorectomy to complete his gender reassignment process. Riley is accompanied by his supportive mother, who even films her son for his YouTube Channel. However, before they can perform the surgery, they (as Dr. Tom Reycraft remarks) discover a “mass density here in the retroperitoneal area” on Riley's C.T. scan, which Alex fears could indicate “Desmoid tumors[,]” which could spread if they

were to cut into the mass. As a consequence, they have to abort the surgery and postpone it until they can rule out any risk of cancer. Moreover, Alex asks Riley to stop taking testosterone as it “puts you at a higher risk of certain types of cancer.” To this, a frustrated Riley remarks that going off his medication is “not an option[,]” but his mother assures Alex that they will comply with her recommendation. After consulting with “the head of radiology[,]” Alex is convinced that she can “do the surgery laparoscopically and gets permission from her superior Dr. Joel Goran, who tells her “if you promise me that you will bail at the first sign of trouble.” Nonetheless, there are complications, and as Alex informs Riley, “Things became too risky. And we couldn’t complete your hysterectomy.” In response, Riley gets angry and tells Alex, “You know what, doctor? If you’re not gonna do this for me, I’m gonna find someone on the Internet who will.” When Alex tries to calm him down, he knocks a tray with food off the table in front of him and screams at her: “Look, I trusted you! You stay the hell away from me!” After leaving Riley’s room, Alex tells the mother “80 milligrams of testosterone weekly shouldn’t affect his behavior like this” and asks her if Riley has been taking any additional hormones, which his mother denies in a defensive tone. In the next scene, Riley who is holding his abdomen in pain and his mother are seen walking down a corridor as Riley tries to leave the hospital without being discharged. When Alex stops them, Riley’s mother informs her, “He found a doctor in Aruba who’s willing to do his surgery. I’ve tried to talk sense into him. He just... he won’t hear it.” Thus, Alex confronts him and asks him, “So, Riley, this is what you want? You want some Internet hack to operate on you? This is dangerous.” To which Riley replies “No. No. No, I... I wanted you to do it, but it... I mean, it doesn’t look like that’s gonna happen. So I have to do what I have to do.” However, before he has a chance to leave the hospital, he collapses. When he is back in his room, the doctors inform him and his mother that Riley has suffered “a heart arrhythmia” which, as Alex informs them, is “A sign of steroid abuse. “Which also explains your behavior.” Riley tries to deny Alex’s allegation by blaming his behavior on the fact that she would not perform surgery and that he could have cancer, but Alex lifts up Riley’s bag and informs him “There are enough steroids in here to supply the Tour de France.” Both Riley and his mother are appalled by this invasion of their privacy, but ultimately Riley confesses that he “was trying to bulk up. I mean, it’s hard to gain muscle mass when you’re a vegan.” When Alex asks Riley where he got the steroids, he avoids the question and simply states that he got them “off some guy at my gym.” Nevertheless, Alex remains unconvinced and confronts the mother, whom she believes to be the source of the steroids. In response, the mother tells her “I know this must seem crazy to you. [...] I was just trying to be supportive. I didn’t want to mess up... again.” When Alex inquires what she means, Riley’s mother explains, “Riley was born... with both parts.” Upon which Alex asks: “he had both female and male reproductive organs?” His mother responds with a nod, leading Alex to continue, “Well, there was nothing in his medical files about a variation of sex development.” In response the mother confesses, “The doctor recommended that we wait to see which gender he grew up to identify with. But I couldn’t. I thought if I

chose, his life would be... easier. Better. And I wanted a girl, so...[.]” When Alex inquires whether Riley knows about this his mother shakes her head and tells her, “He was a baby. We had the surgery, and I just buried it. Never told him” (Pettle and Fahey).

Thus, as these early scenes show, “Vamonos” similar to “The Softer Side” and unlike any of the other episodes addresses the issue of gender reassignment of intersex children not at the point where it was originally diagnosed, but instead revisits the original decision and its aftermath several years later. In doing so, it portrays Riley as a patient who despite never having learned about his condition and the resulting operation never felt at home in his assigned gender and has decided to alter his sexual anatomy to fit his gender identity. Moreover, it also portrays a mother who deeply regrets the decision to have her child assigned to a specific gender and in order to compensate for this is willing to do everything she can—such as supplying Riley with steroids—without considering the potential negative side effects. However, in this manner, “Vamonos” repeats the problematic tendency of *Grey’s Anatomy’s* “Begin the Begin” and *House, M.D.’s* “The Softer Side”<sup>28</sup> in that it places the exclusive blame for the original procedure on Riley’s mother by suggesting that the doctors advised her to delay gender assignment until it became clear with which gender Riley identified, but that she ignored this advice. Although it can certainly not be ruled out that this has happened in some instances, it certainly does not reflect the historic norm and in many cases not even today’s treatment standards (Greenfield). Thus, it constitutes a whitewashing of medical history, which is seemingly absolved from performing such procedures and of the secrecy surrounding them. Moreover, it reproduces the trope of the anxious parents who were unable to cope with their child’s intersex condition unless surgery was performed. Strikingly, the episode’s writers do not merely use the terminology agreed upon in the “Consensus Statement” i.e. Disorders of Sex Development (DSD), but actually avoided the term which some intersex groups view as demeaning and instead employs the term “Variations of Sex Development” which intersex groups had advocated as an alternative before replacing it with Differences of Sex Development (Diamond 172). Indeed, unlike any of its predecessors, *Saving Hope* avoids using demeaning and outdated terminology and actually embraces a suggestion by intersex activists in its use of vocabulary. Nevertheless, it still remains remarkably vague about Riley’s intersex conduction.

In the following scenes Alex receives Riley’s original medical files and reviews them together with Dr. Maggie Lin, who discovers that “At 3 months old, he has a feminizing genitoplasty and is raised as a girl.” To which Alex remarks, “He also had a pelvic surgery to remove abnormal ovarian tissue during feminization. We need to confirm with immunohistochemistry. But that fibroblastic tissue is not a tumor at all. It’s 20-year-old scar tissue.” Finally, Maggie asks Alex “Are you gonna tell him?[,]” to which Alex replies,

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28 The former did not discuss the history of medicine’s treatment of intersexuality, whereas the latter placed the blame for the parents’ secrecy solely on the parents without reflecting on the fact that it was part of the traditional treatment paradigm.

“Someone has to.” In the following scene, Alex comes into Riley’s room and informs him that they are ready to go ahead with “the open procedure as originally planned” because they have discovered that “The mass we discovered in your pelvis... is scar tissue from a previous surgery.” When Riley is confused and remarks, “But I... I’ve only ever had two surgeries... my-my wisdom teeth and my mastectomy” Alex tells the mother that Riley should hear the truth from her, but his mother cannot bring herself to confess the truth to Riley and asks Alex to do it for her. Thus, Alex tells Riley that “the scar tissue was from a gender assignment surgery you had as a baby. You had both female and male genitalia. You were assigned female at birth.” To which a shocked Riley responds by asking his mother, “No. No. No. You... you decided for me?” to which she replies “I was trying to protect you.” In response Riley who at this point is close to tears asks her, “How... how could you? [...] You lied to me” and when his mother asks, “What was I supposed to tell you?” Riley replies, “The truth[.]” at which point he starts crying and his mother leaves the room. Nonetheless, when Riley wakes up after the successful surgery, he asks Alex to get his mother, whom he tells that “I think it’s just gonna take some time[.]” But even at this point, the two are reconciling (Pettle and Fahey). Thus, similar to the majority of episodes considered in this thesis—with the exception of *Chicago Hope*’s “The Parent Rap[.]” *ER*’s “Masquerade[.]” and *House, M.D.*’s “Skin Deep;” all of which aired before the “Consensus Statement”—“Vamonos” does not establish a clear connection between intersexuality and illness. Instead similar to *House, M.D.*’s “The Softer Side,” the complications are revealed to be a byproduct of the original treatment, which is thus problematized. Moreover, it is clearly critical of performing gender reassignment surgery on intersex infants and instead (like *Private Practice*’s “Wait and See” and *House, M.D.*’s “The Softer Side”) argues in favor of postponing surgery until the child has identified clearly with a specific gender. However, like those episodes, it neither does it give any consideration to the possibility that the child might not identify with either binary gender nor to that of not performing surgery at all. Instead, it places a clear emphasis on the importance of clearly identifying within the gender binary and the necessity of possessing the correct genitalia to go along with that identity for its successful performance and embodiment. Consequently, the episode still represents intersexuality as an anatomical aberration that will ultimately be superseded by a clear, binary gender identification, which necessitates the appropriate body to go along with it. Thus, it remains thoroughly rooted within heteronormativity and does little to challenge it.

In conclusion, it can be said that “Vamonos” reflects many of the tendencies of the other episodes that aired after the “Consensus Statement” and a few of the episodes that preceded it. Indeed, much like “The Softer Side,” it deals with the repercussions of the original surgery rather than the discussions leading up to it. However, it goes even further than “The Softer Side” in that it portrays Riley as a person who despite being unaware of his intersex status never felt comfortable in his assigned gender and thus seeks change of his sexual anatomy to make it correspond to his gender identity.

In addition to this, it shows how his mother is struggling with her original decision and with keeping it from Riley and trying to compensate for it by attempting to do everything to help her son in his ‘transition’ to masculinity to the point where she inadvertently causes him to have heart problems by supplying him with additional steroids. Interestingly, the episode is the first to not only embrace the terminology of the “Consensus Statement,” i.e. Disorders of Sex Development, but actually uses the alternative, non-stigmatizing term Variations of Sex Development, which was originally suggested by intersex activists before it was replaced with Differences of Sex Development (Diamond 172). It also avoids using any demeaning and outdated terminology and does not connect intersexuality to disease, but rather connects the problems Riley is having to the original treatment and the secrecy surrounding it, thereby problematizing both. Likewise, it is unequivocally critical of gender reassignment surgery on intersex infants and argues for the postponement of such procedures until the child has a chance to express a clear gender identity. However, like its predecessors, it does not question the assumption that the child will clearly identify with a binary gender or the necessity of ultimately performing surgery. It rather emphasizes the importance of a congruence of anatomical sex and gender identity, and its importance for successfully performing the respective gender. Thus, it presents intersexuality as an aberration that will ultimately be reintegrated into the gender binary. Indeed, like all of its predecessors, it does not mention any intersex support groups and remains vague in defining Riley’s intersex condition. Moreover, it also—like its precursors “Begin the Begin” and “The Softer Side”—places the sole blame for the original decision to perform surgery and for withholding this information from Riley on his mother because it argues that the doctors wanted to wait until Riley could express his gender identity before performing surgery. In this way, it misrepresents the history of the medical treatment of intersex children by suggesting that doctors cautioned against early surgery rather than encouraging it and concealing the fact that secrecy was often the result of the original treatment paradigm. In doing so, it also reproduces the trope of the anxious parents unable to cope with their child’s diagnosis without surgery. All in all, although the episode problematizes the practice of surgically assigning a gender at birth, it nevertheless perpetuates the idea that a person can only be one of two genders, and that intersex people will and must decide to be either male or female without giving thought to the possibility that they may choose to be neither/both, i.e. indeterminate. Consequently, it can be said that—although the episode is certainly one of the most respectful portrayals of intersexuality ever to air on North American television—it nonetheless perpetuates gender binarism and the belief that sex determines gender, and additionally misrepresents the history of the medical treatment of intersex children. In this manner, it perpetuates heteronormativity, does little to challenge it, and is thus another example of high het entertainment.

## 5.4 Implications of the Representations after the “Consensus Statement”

Throughout this chapter, this thesis has shown that there have been substantial changes in the representation of intersexuality since the publication of the “Consensus Statement.” These changes have resulted both in an overall more respectful portrayal of intersexuality and the development of new problematic tendencies. However, ultimately all of the episodes under consideration still represent high het entertainment.

As such, unlike the majority of episodes before the publication of the “Consensus Statement,” all of the episodes that followed it ultimately argue in favor of postponing gender reassignment surgery until the child is old enough to express a clear gender identity. In this context, the doctors in *Private Practice*’s “Wait and See” originally favor performing surgery, but ultimately decide against performing surgery due to the risk of assigning the child to the wrong gender. Thus, it remains unclear whether they would have performed surgery had the parents decided to go along with their decision to perform feminizing rather than masculinizing surgery. Nevertheless, the episode ultimately suggests that the best course of action is to raise the child in accordance with a specific, binary gender identity, but to only perform surgery after it has clearly identified as either male or female. Thus, the episode’s stance on these surgeries is ambivalent and suggests that surgery on intersex infants is permissible if there is a reasonable degree of certainty among doctors regarding the child’s ‘true’ gender (Blackman). *Saving Hope*’s “Vamonos” takes a firmer stand against early childhood surgery by portraying a patient who was originally assigned to one gender (female), but who was clearly unhappy with that assignment and chose to transition to the other side of the binary spectrum (male). This stance against early childhood gender reassignment surgery is most strikingly expressed in Riley’s shocked remark “No. No. No. You... you decided for me?” when he is informed about his earlier operation (Pettle and Fahey). In contrast, *House, M.D.*’s “The Softer Side” (although critical of the potential negative side effects of early childhood surgeries on intersex children) never questions the original decision to perform surgery or suggests that it should have been postponed (Friedman). Nevertheless, this trend can also be observed in other portrayals of intersexuality on North American TV dramas which have not been considered in detail in this thesis. In a 2009 episode of the medical show *Mercy* entitled “I’m not that Kind of Girl,<sup>29</sup>” the decision as to whether to undergo surgery or not is actually exclusively left to the female teenager who is diagnosed with AIS<sup>30</sup> and ultimately decides to defy her parents’ wishes and not undergo surgery (Becker and Kucserka). In the late 2012 *Emily Owens, M.D.* episode “Emily and... the Question of Faith” the parents originally favored surgery, but changed their minds after their infant child had to undergo another procedure because they

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29 Due to their lengthy titles both this and the *Emily Owens, M.D.* episode will be referred to by the titles of their respective shows.

30 The episode does in fact not name Ashley’s condition; instead, the consulting endocrinologist Dr. Hofstadter merely refers to it as “rare recessive autosomal condition” telling them that, despite appearances, she is “genetically a male[.]” This most likely refers to a form of AIS (Becker and Kucserka).

don't want to subject him/her to surgery again. They then followed their doctor's advice to postpone surgery until the child could choose a gender identity him/herself (Sciarotta). In the 2014 "Fight" episode of the medical period drama *Masters of Sex*, which is set between the 1950s and 1960s, its protagonist, the famous sexologist Dr. William Masters, also made an argument to postpone surgery until an unspecified later date and to preserve what he viewed as the child's masculinity (Lippman).

Several episodes also problematize the potential negative side effects that might be caused by the original treatment paradigm. This trend was pioneered in the *House, M.D.* episode "The Softer Side," which discusses both the potential negative side effects of gender reassignment surgeries on intersex infants as well as the problems associated with the secrecy that often accompanied such treatments (Friedman). The same is true for "Vamonos," which problematizes both the resulting side effects of surgery and the secrecy following it (Pettle and Fahey). An exception to this is "Wait and See," which presents early childhood surgery on intersex infants as remarkably unproblematic if it were not for the danger of making an incorrect gender assignment and even presents it as a solution to the danger of ostracism the child might face otherwise—even if the surgery is ultimately postponed (Blackman).

There is also an increasing trend toward problematizing the idea that modern medicine can determine the 'true' gender of an intersex person. In "Wait and See," this takes the form of doctors only being able to make a reasonably accurate determination of the child's gender identity when they propose that there is a 70% chance that the child will identify as female (Blackman). In the case presented in "The Softer Side," the idea that medicine can determine the 'true' gender of an intersex child is not even raised, but rather the parents are asked by the doctors to choose their child's gender (Friedman). On *Mercy* Dr. Hofstadter explains to the parents that she is genetically male, but does not use this diagnosis to determine her gender identity, but instead remarks, "If Ashley chooses to keep living as a female, there is a surgery we can perform to remove her testes and what is now forming into Ashley's penis<sup>31</sup>" (Becker and Kucserka). In contrast, "Vamonos" even suggests that the original doctors suggested that Riley not be surgically assigned to a specific gender until he clearly identified with one, but that the mother disregarded this advice and chose for him (Pettle and Fahey). Although the doctors on *Emily, Owens, M.D.*, originally tell the parents that they can determine the child's gender through genetic testing, they backtrack when they discover that the child is genetically female and tell the parents that in these cases a gender prognosis is difficult due to the unpredictable influence of hormones. However, in the process, they implicitly suggest that medicine can make an accurate prediction in other cases (Sciarotta). In "Fight," Dr. Masters clearly identifies the child as male based on a blood test telling the father "It's not an 'it,' Mr. Bombeck. It's a boy" (Lippman).

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31 Although this does not override her gender identity, it still imposes the heteronormative mandate that Ashley must have the appropriate genitalia if she wants to continue living as a woman and thus thoroughly roots the episode in heteronormativity.

Likewise, most of the episodes during this period present the parents' reaction to their child's diagnosis and the prospect of treatment in a more complex manner than the majority of their counterparts—with the exception of “Begin the Begin”—before 2006. In this context, *Private Practice* shows not just how the parents struggle with their child's diagnosis, and initially favor treatment to allow it and them to lead a normal life, but also shows their anxiety about this course of action and how they ultimately are able to overcome their initial anxiety and accept the child without surgical intervention (Blackman). It also finds its expression in the reaction of Ashley's parents on *Mercy*, because they are initially shocked at their daughter's diagnosis, but the episode ultimately suggests that they learn to accept her decision not to undergo surgery (Becker and Kucserka). This is also mirrored in “The Softer Side,” in which the parents are shown to be struggling with the original decision and the fear that they might have chosen the wrong gender and even portrays how this can have devastating effects on the parents' relationship with their child. In this way, it problematizes the idea that surgery will resolve the parents' anxiety and the secrecy that was often part of the original treatment paradigm and instead proposes open communication about intersexuality as a solution (Friedman). In a similar manner, in “Vamonos” Riley's mother is shown to be struggling with the fact that she made ‘the wrong choice’ and is trying to compensate for this by doing everything to help her son's transition to masculinity even to the point where she endangers his health by supplying Riley with steroids. In addition to this, Riley is clearly resentful of his mother's decision even if he ultimately forgives her (Pettle and Fahey). This trend is also reflected in *Emily Ownes, M.D.*, where the parents originally demand surgery, but ultimately decide against it rather than have their child undergo another operation (Sciarotta). Thus, these episodes challenge the idea that surgery is necessary to allow the parents to overcome the anxiety that was triggered by the intersex diagnosis of their child. An exception to this trend is “Fight,” in which the father even refuses to hold the child until it has undergone gender reassignment surgery, which he vehemently demands because he is convinced that his child will “never be a man” since “he's going to need shots to be a real man” and which is ultimately performed without Dr. Masters' knowledge (Lippman).

Similarly, the majority of episodes avoid the use of stigmatizing and outdated terminology by their doctors. In fact *Private Practice* only uses the medical term “11 $\beta$ -Hydroxylase deficiency” once during “Wait and See” (Blackman). “Vamonos” goes even further by not only refraining from using stigmatizing terminology, but actually avoiding the controversial term ‘Disorders of Sex Development’ that was proposed by the “Consensus Statement” and instead using ‘Variations of Sex Development,’ an alternative term originally suggested by the intersex community before being superseded by ‘Differences of Sex Development’ (Pettle and Fahey; Diamond 172). *Emily Owens, M.D.* instead uses the term “intersex child” (Sciarotta). An exception to this trend is “The Softer Side” in which doctors use the stigmatizing term

“shemale,” and House labels Jackson a “freak of nature” and thus perpetuates the idea that intersexuality is an extremely rare anomaly rather than a naturally occurring variation of human sexual development (Friedman). “Fight” also uses the outdated term “adrenogenital hyperplasia[.]” but this can be seen as an attempt to accurately portray the period (Lippman).

Moreover, they also largely refrain from connecting the patient’s health problems to their intersexuality<sup>32</sup>. For example, “The Softer Side” raises the possibility of a correlation, but quickly rules it out and instead suggests that Jackson’s health problems might actually be the result of the gender reassignment surgery he underwent as a child and ultimately concludes that it was the result of dehydration (Friedman). On *Mercy*, Ashley’s intersex status is also treated completely separately from her initial health problems when Dr. Hofstadter informs the parents “first of all, there is nothing medically wrong with Ashley” (Becker and Kucserka). The same is also true for “Vamonos,” which connects the complication that results in the interruption of Riley’s surgery to the following: 1. the treatment to which he was subjected as an infant—rather than to a disease connected to his intersex status; 2. his health problems to the secrecy about this treatment and his mother’s resulting guilt (Pettle and Fahey). Likewise, *Emily Owens, M.D.* treats the infant’s health problems as being separate from his/her intersex status (Sciarotta).

A small minority of episodes even raise the possibility of not performing surgery at all, and that of the child in question not identifying as either clearly male or female, but even then these options are made to appear both unrealistic and unreasonable, or are quickly discredited. For example, on *Private Practice*, these options are not proposed by any of the doctors, but rather by the birthing assistant Dell and thus lack medical authority. Moreover, they are quickly discredited by Naomi (a doctor) or the child’s father and do not find an expression in the episode’s final resolution, which merely postpones surgery and does not question the need and inevitability of a clear, binary gender identification and subsequent surgical intervention (Blackman). On *Mercy*, the possibility of not performing surgery is not only raised, but it is actually suggested that Ashley probably ultimately choose this option (Becker and Kucserka).

In conformity with their predecessors, some of this period’s episodes discuss the danger of ostracization that children supposedly face if surgery is not performed.<sup>33</sup> Nonetheless, this is discussed differently, and the premise is questioned. “Wait and See,” for example, raises the issue and does not negate it, but rather suggests that the parents and their child will find a way to cope with this problem without the immediate need for surgery (Blackman). On *Mercy* this is not only suggested, but actually becomes a reality as Ashley’s boyfriend leaves her and tells his friends about her condition, but the episode suggests that Ashley is ultimately able

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32 Since the infant in “Wait and See” does not have any health problems, this episode is not included in this paragraph.

33 Both “The Softer Side” and “Vamonos” portray patients who have undergone surgery and therefore do not discuss the possibility of ostracism.

to cope with this (Becker and Kucserka). The parents on *Emily Owens, M.D.* also raise this question, but are told by Dr. Tyra Dupre that “It’s not the other kid’s acceptance he’ll need, it’s yours [...]” (Sciarotta).

However, the episodes following the “Consensus Statement” also retain some of the problematic aspects of their predecessors. For one thing, none of them makes any mention of intersex organizations or support groups and some, e.g., “The Softer Side” or *Emily Owens, M.D.*, even discourage parents from seeking information and support about intersexuality from any other source than the medical profession (Friedman; Sciarotta). Additionally, none of the episodes questions the necessity of performing gender reassignment surgery or the heteronormative imperative of identifying clearly with the one and only one binary gender identity. Instead, they may discuss potential negative outcomes, the fact that the wrong gender was chosen, or argue for postponing the surgery, but the efficacy and necessity of performing such surgeries is never seriously questioned. Thus, “Wait and See,” while advocating a postponement of gender assignment surgery, never considers the possibility that the child might not identify as clearly male or female, or might choose not to undergo surgery or even suggests that these possibilities might be available (Blackman). The same is true for *Emily Owens, M.D.* (Sciarotta). Although Ashley on *Mercy* chooses not to undergo surgery, it clearly suggests that not performing surgery would result in “nature tak[ing] its course. The testes will eventually descend and the testosterone will simply turn her body into a man’s” (Becker and Kucserka). Thus, although surgery is not performed, it is suggested that Ashley will clearly identify as male as s/he tells Nurse Sonia Jimenez, “I always knew [...] [t]hat there was something wrong with me. All this girly stuff that I’m supposed to like. It just always felt fake” (Becker and Kucserka). Thus, even without surgery Ashley remains thoroughly within the confines of heteronormativity. On the other hand, although “The Softer Side” is critical of the mother’s attempts to enforce strict gender norms on Jackson and suggests that the border between masculinity and femininity should be more fluid, but never considers that Jackson might identify as anything but a binary gender (Friedman). The same can be said for “Vamonos,” which—although critical of early childhood gender reassignment surgery—nonetheless does not question the idea that intersex children will invariably identify with a binary gender and that surgery should be performed after they have done so (Pettle and Fahey). Similarly, Dr. Masters in “Fight” proposes delaying surgery to a later date, but does not question that surgery will be performed, which is demonstrated by his comment “I understand the physical ambiguity is, uh, off-putting, [...] but eventually, the surgery will take care of that.” In fact, he only vehemently opposes the child’s surgery because he does not agree with the father’s decision to feminize the child. This becomes apparent when he tells the father “your son—your *son*—has a condition that can and will be corrected (Lippman). Nevertheless, the episode still makes a clear argument for postponing surgery in representing the father’s decision as wrongheaded, highlights the inhuman treatment of the infant in shocking detail, and clearly shows Dr. Masters’s frustration, shock, and anger about

the fact that the surgery was performed against his express instructions (Lippman). This is also expressed in a conversation between Dr. Masters and his research assistant Virginia Johnson, in which he clearly condemns the fact that other doctors perform feminizing surgery on the basis of “convenience” and “fear” (Lippman).

In addition to this, they also introduce several new controversial elements. Most strikingly, many of the episodes during this period deflect the blame for the negative outcome of the original treatment away from the medical profession and onto the parents. This is for example reflected in the fact that, in *Private Practice*'s “Wait and See,” the parents originally decide to ignore their doctor's recommendation, and demand that their child—against all medical determined odds—be surgically assigned to the male gender, which is only prevented when the conscientious doctor refuses to perform the surgery and the parents begrudgingly go along with this decision (Blackman). It is also partially reflected in *House, M.D.*'s “The Softer Side,” in which the harmful secrecy that followed Jackson's original gender reassignment surgery is exclusively blamed on the parents without reflection on the fact that it was an integral part of the original treatment paradigm (Friedman). This trend is continued in “Vamonos,” in which the mother is portrayed as not only having withheld the information about his reassignment surgery from Riley, but actually of having ignored her doctor's advice to postpone surgery until Riley clearly identified with a specific binary gender (Pettle and Fahey). It finds its most striking expression in “Fight,” in which (during the 1950s, in what Newitz in her analysis calls an “incredibly distorted story of how intersex surgeries happened”) a doctor tries to convince a father not to have surgery performed on his child and preserve what Dr. Masters views as its masculinity (Lippman). According to Newitz, Dr. Masters thus represents “the heroic sex doctor who never existed” because the episode portrays “the opposite of what happened in actual medical cases.” As Newitz rightly points out, “unless this father was aware of the work of (at that time obscure) sexologists like John Money, he wouldn't have known that” surgeries like the one he is demanding were “even possible [...]” In fact a more accurate historic perspective would have had Dr. Masters pressuring the parents to allow him to perform the surgery. Thus, these episodes misrepresent the history of the medical treatment of intersex children by suggesting that the secrecy about the surgery and the children's intersex condition and in the case of “Vamonos” the surgery itself were the sole responsibility of the respective parents rather than common practice in the medical profession itself.

All in all, although they are considerably more nuanced than their predecessors, the episodes that have been aired since the publication of the “Consensus Statement” are still representative of high het entertainment. As such, they continue to portray intersexuality as a temporary and problematic aberration that will ultimately be reintegrated into heteronormativity when the patients inevitably identify with a definite binary gender and thus will undergo surgery to ensure the conformity of their body to gender norms. Moreover, most of the episodes misrepresent the medical history of performing gender reassignment surgeries on intersex children and place the sole blame for these procedures and the resulting secrecy on those

children's parents while simultaneously absolving the medical profession of any culpability. Consequently, despite their promise, all of these episodes are still high het entertainment in that they not only never seriously question the need to clearly identify and perform a binary gender, but rather reinforce the preeminence and seeming naturalness of heteronormativity through their representation of intersexuality.

## 6. Conclusion

In the course of this thesis, I have shown that medical TV dramas are imbued with considerable medical authority due to the discourses of medical authority that surrounds them. As has been shown, the genres indeed place a particular emphasis on medical authenticity and accuracy. Furthermore, all of the shows that are part of this analysis—despite their various differences in foci, subject matter, and tone—have been shown to reinforce the impression of medical accuracy by placing a particular emphasis on accurate medical terminology, equipment, and highly stylized recreation of surgeries. In addition to this, they portray their doctors as exceptional practitioners of what Foucault termed the medical gaze, who are largely confronted with anxious patients, who—in turn—are normally unable to comprehend their bodies' signals. As a result of this, it has been argued—with reference to, e.g., several studies on the subject—that viewers place particular trust in these shows' portrayals of medicine and even use them as a source of medical information. Consequently, this thesis has raised the premise that the portrayal of intersexuality on these shows gains particular importance because their audiences place considerable trust in these shows' discussions of medical issues and thus may base their assessment of intersexuality and early childhood surgery on these fictional representations.

Based on this premise, this thesis, using Butler's concepts of gender performativity and high het entertainment, has analyzed the representations of intersexuality on these shows both before the 2006 "Consensus Statement" and after it to determine whether these shows challenge the marginalized and pathologized status of intersexuality and intersex people, or uphold it and its heteronormative underpinnings by further medicalizing intersexuality and thus constitute high het entertainment.

In the course of this analysis, this thesis has revealed that most of the shows that aired before the "Consensus Statement" shared many features. For example, many of the episodes explicitly mention cancer in relation to intersexuality and use it to justify surgical intervention. The sole exception is *Grey's Anatomy*, which disassociates it from cancer in both of its episodes on intersexuality. Likewise, all episodes that deal with intersexuality in children or adolescents portray anxious parents who struggle to come to terms with the diagnoses of their children. The episodes during this period are also similar in that they exclusively deal with the original diagnosis and—sometimes only inferred—treatment rather than portraying the aftermath of such treatment. Consequently, the surgical erasure of intersexuality appears to be largely unproblematic and an appropriate solution to the problems that—as these shows suggest—resulted from the patient's intersex status. The sole exception is *Grey's Anatomy's*

“Begin the Begin,” which tentatively challenges the idea that surgery is an unproblematic solution and instead suggests that psychological treatment for the patient and parents might be better suited to help them cope with the diagnosis. Indeed, it even problematizes the idea that surgery can guarantee that intersex children will identify clearly with the assigned gender and suggests that it might have the opposite effect. Furthermore, during this period, the vast majority of the episodes employ outdated and stigmatizing terminology to describe their patients’ intersex condition or like “Begin the Begin” and “The Parent Rap” remain extremely vague about the patients’ condition. Similarly, all of the episodes during this period question the gender identity of the patients after discovering their intersex status, and many suggest that modern medicine has the ability to identify the ‘true’ gender of an intersex person. In the process, these episodes suggest that sexual anatomy or DNA evidence determines gender identity. In addition to this, all of the episodes fail to mention intersex organizations or support groups, and imply that intersexuality is very rare.

Nonetheless, a clear development can be seen from the early portrayals on *Chicago Hope* and *ER* to those in *Grey’s Anatomy’s* “Begin the Begin,” which moves away from connecting intersex with disease and is critical of the secrecy that often accompanied the traditional treatment paradigm, but as the *House, M.D.* episode “Skin Deep” shows, this trend was not universal. Additionally, “Begin the Begin” also introduced a new problematic trend in that it suggested that very few surgeons would perform gender reassignment surgeries on intersex children or teenagers without their consent and thus negates the fact that such surgeries are still performed in hospitals all over North America even if their number may be decreasing. Even considering these improvements, none of the shows ever questions the necessity of belonging to a clear, binary gender and that this would be a desirable outcome of the surgical management of intersexuality. Thus, noncompliance to heteronormativity is portrayed as a problem in all episodes of this period and intersexuality consistently appears as a rare biological anomaly that will ultimately make way for a binary gender identity with the assistance of modern medicine. As such, all of these episodes represent high level entertainment because they only raise the issue of intersexuality to ultimately reintegrate it into heteronormativity and reinforce its naturalness and preeminence.

The publication of the “Consensus Statement” resulted in a considerable change in the representation of intersexuality of North American medical TV dramas that have resulted both in an overall more respectful portrayal of intersexuality, but also in new problematic tendencies. Thus, unlike their predecessors, all of the episodes that follow the “Consensus Statement” make an argument for postponing surgery until the intersex child has expressed a clear gender identity. Several episodes also discuss potential negative side effects of the original treatment paradigm. However, *Private Practice’s* “Wait and See” diverges from this trend and suggests that early childhood gender reassignment surgery on intersex infants would be unproblematic were it not for the danger of choosing the ‘wrong’ gender. The episodes during this period also began to question the idea that modern medicine can determine the ‘true’

gender of an intersex patient. Nonetheless, many of the episodes still argue that determination of gender identity is only difficult in the extreme cases that they portray, but that it might be unproblematic in other cases, and on *Masters of Sex*, Dr. Masters makes a clear gender pronouncement on the basis of a blood test—which is not surprising since this is supposed to be a portrayal of 1950’s medicine. Likewise, rather than presenting parents simply as being anxious until surgery is performed—which was the case in most of the episodes before the publication of the “Consensus Statement”—these episodes depict a more complex picture of parental reactions in which the parents are not only anxious about their child’s intersex status, but also about the prospect of surgery or having made the wrong choice, and suggest that parents can cope with the diagnosis without the need for surgery. An exception to this is the historic recreation on *Masters of Sex*, in which the father demands surgery against Dr. Masters’ advice. The majority of episodes also avoid using outdated terminology. Only “The Softer Side” and (in keeping with its historic theme) *Masters of Sex* represent exceptions to this rule. Moreover, they largely disassociate the patients’ health problems from their intersex status. Like their predecessors, some of the episodes also raise the potential danger of intersex children being ostracized, but do not use this possibility to justify surgery and show how the parents and their children are able to cope with this problem without the need for surgical intervention.

However, the episodes following the “Consensus Statement” also retain some of their predecessor’s problematic tendencies. Most strikingly, any mention of intersex organizations is still absent from all episodes and some episodes like “The Softer Side” or that of *Emily Owens, M.D.* even include comments that might discourage parents from seeking out information from nonmedical sources. In addition to this, none of the episodes question the premise that gender reassignment surgery is necessary or the heteronormative imperative that a person must clearly identify with a binary gender. Thus, they reflect the same ambiguity as the “Consensus Statement.” Moreover, they also introduce several new problematic elements. Most prominently among them, the fact that most of them deflect the blame for early childhood gender reassignment surgeries and the accompanying secrecy solely onto the parents and thereby exculpate modern medicine and distort the history of intersex management by it. Indeed, although these episodes are considerably more nuanced than their predecessors and are critical of the traditional treatment paradigm, they have been shown to still represent high het entertainment and do not seriously challenge the marginalized status of intersexuality.

Due to the limited scope of this thesis, there are several aspects that have not been considered or have only been hinted at. Nevertheless, they would form an interesting addition to the contents of this thesis. For one thing, some of the episodes such as those of *Mercy*, *Emily Owens, M.D.*, and *Masters of Sex* were only considered briefly to contextualize the statements made about the episodes central to this analysis. Nevertheless, a more detailed analysis of these episodes might reveal some interesting nuances. Furthermore, since this thesis has only focused on North American medical TV dramas and established how intersexuality

is portrayed on them, it might prove interesting to do a comparative analysis between these representations and their European counterparts, e.g., in Germany or the United Kingdom. Likewise, an analysis of nonmedical TV shows might shed some light on the question of whether these tendencies are exclusive to medical TV dramas or find their expression in other TV genres. Similarly, an analysis of literary narratives about intersexuality like *Middlesex* might prove interesting. Finally, an examination of intersex life writing might show the extent to which the fictional narratives about the medical treatment of intersexuality are mirrored in the experiences of intersex people.

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## **Ehrenwörtliche Erklärung**

Hiermit erkläre ich, dass ich meine Masterarbeit zur Erlangung des Grades Master of Arts (M.A.) mit dem Thema:

### **Disappearing Ambivalence? Representations of Intersexuality in North American Medical Television Dramas**

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