14. Screening Gender Medicine

Health and the Gendered Body in Recent US-Based Medical Dramas and Dramedies

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ABSTRACT

In recent years, awareness of sex and gender inequalities in healthcare has been gaining momentum, following a number of paradigm-shifting developments in the bioclinical and cultural fields. Although not immune to complexity, gender medicine has led to a number of positive steps towards a more nuanced understanding of healthcare inequalities based on sex and gender. The effects of those discoveries on the way popular culture represents and narrates gendered health are already visible. Yet medical dramas, which might seem like an ideal vehicle for gender medicine communication, occupy an uneasy position in relation to it. After an introduction to gender medicine from a bioethics perspective, this chapter will proceed through a number of close readings of specific scenes from recent medical dramas and other genres of seriality to examine two broad gender medicine examples: women's cardiac events, and eating disorders. Through the encounter between the medical drama format and gender medicine-related patient cases, our analysis foregrounds the importance of the question of temporality in accounting for complexity in the audiovisual representation of health and illness.

KEYWORDS

Gender-specific medicine; TV series; women's heart attacks; eating disorders; temporality.

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Gender Medicine – An Overview[2]

In recent years, awareness of sex and gender inequalities in healthcare has been gaining momentum, following a number of paradigm-shifting developments in the biomedical and cultural fields. Some significant developments, in this sense, have been the birth and consolidation of the field of gender medicine in the 21st century,[3] which places attention upon the impact of sex and gender on human pathophysiology; and mobilisations by women and queer people around the world against the abuse of power by men, most famously in the film industry, and the effects of those abuses on mental and physical health.[4] Gender medicine, itself partly influenced by the long tail of the feminist women's health movement of the 60s (Shai et al. 2021: 7), has led to a number of positive steps towards the elimination of healthcare inequalities based on sex and gender: after much lobbying and research, for example, it is now common knowledge that part of the reason why women die of coronary heart disease at a much higher rate than men is due to treatment and assessment bias, as well as failing to account for the different symptomatology of this pathology between the sexes (Khamis et al. 2016: 1144-47).

Since its recent birth at the turn of the century, gender medicine has brought much needed attention to the importance of sex and gender for health and medical knowledge more generally (see, for example, Garattini and Banzi 2022). Gender medicine, which focuses, according to one definition, on the "impact of gender on human physiology, pathophysiology, and clinical features of diseases" (European Society of Gender Health and

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2 Parts of this introduction have been adapted from Rosa Barotsi (2019).

3 For an overview of this process of institutionalisation in the case of Italy, for instance, see Istituto Superiore di Sanità, EpiCentro – Epidemiology for Public Health (2021).

4 The World Health Organization recognizes that "discrimination against women and girls can lead to ill health" (World Health Organization 2022).

Medicine), has led to invaluable insights regarding previously unknown differences in the way people exhibit symptoms, are diagnosed, and respond to therapies.

Although a positive step forward, gender medicine has not been immune to complexity, as the definitional work around the term itself demonstrates. Whilst some, as in the example above, define gender medicine solely in biomedical terms, others understand the latter as deeply intertwined with sociocultural health aspects: "Gender-specific medicine is the study of how diseases differ between men and women in terms of prevention, clinical signs, therapeutic approach, prognosis, psychological and social impact" (Baggio et al. 2013).

A potent example of how gender medicine has at times (unwittingly?) reinforced the gender and dimorphic biases that it was, in principle, created to address can be seen in pediatrician George M. Lazarus' description of the scene that sparked his interest in gender medicine, in his contribution to one of the first textbooks in the field, *Principles of gender-specific medicine* (2004):

> [At an outdoor concert he attended,] the girls danced, ballet-style, to the music. The boys chased and tackled each other like little football players. No one told the children how to play. They just did what came naturally and there was no cross-over behavior between the boys and girls (Lazarus 2004: 2).

This kind of medical attention to difference is similar to the one we are used to seeing employed to reinforce hierarchies of race and gender. Historically, this has been the case with the junk science produced in 18th- and 19th-century Europe and the US to justify the institution of slavery on the basis of the biological inferiority of non-white races (Epstein 2008: 36-7) or to deny women suffrage during moments when progressive political possibilities were threatening patriarchal authority (Shai et al. 2021: 7, Oudshoorn 2003: 22, Barrows in Lacquer 1987: 18). The idea of fundamental sexual differences as fixed in the body has therefore been employed many times in the recent past and present to naturalise social inequalities (Epstein 2008: 34). Finally, as trans and non-binary activists point out, a sex-segregated health system risks turning gender medicine into "two-gender medicine", which adds barriers to non-dimorphic people's access to healthcare (Snelgrove et al. 2012).

As these examples suggest, an approach to healthcare that takes difference into consideration must be particularly careful to bring to light is-

sues such as inherent bias, access, communication, language, and cultural competence. The risks of a pure logic of difference that does not take into account sociopolitical factors but presumes to be based on purely biological ones (under the false assumption that biological factors are in some way completely separate to the sociopolitical context) are immense (Hamberg 2008). We know, for example, that women with cardiovascular problems may tend to underreport basic symptoms such as chest pain for social reasons (Richards et al. 2002); that women have a higher rate of orbital fractures, which might be explained as a result of domestic violence (Goldberg et al. 2000); and that lesbian women have a higher rate of breast cancer, which might be explained by their higher reluctance to visit doctors for regular checks out of fear of being mistreated by medical staff (Epstein 2008: 270). The numerous social factors that result in health differences between men and women are often overlooked in gender medicine (GM) research. As Shai et al. report, for instance,

> GM publications quote observational studies according to which women suffer from more cardiac sequelae after acute coronary syndrome (ACS). However, a recent study demonstrated that gender roles, such as being the primary provider, employment, and household responsibilities, rather than sex, are those associated with prognosis after ACS [...]. Searching for these variables and their significance to health, instead of using sex as a proxy for their values, would benefit personalized medicine (Shai et al. 2021).

Gender Medicine and Medical Dramas

The institution of gender medicine is, in many ways, a step towards healthcare equality. But as the examples above demonstrate, it can only function as such if it does not take its role as self-evident, and its assumptions as objectively inviolable. In other words, the mere fact that such a thing as gender medicine exists does not hinder sociocultural bias against women, non-binary and non-cis people from continuing to influence its conclusions. The concept of *difference*[5] is a particularly potent example of this – as a strictly

[5] In the contemporary debate, an author who insists on interrogating the complexity of 'difference' is Italian feminist, journalist, and philosopher Ida Dominijanni. Dominijanni understands 'sexual difference' neither as a mere biological marker nor a solely cultural construction, but rather as the socio-symbolic trait that inherently defines human exist-

biomedical category, it involves great risk from a social-justice point of view. Conversely, as a biopolitical project, it can lead to complex and nuanced discussions regarding issues such as self-determination, minority rights, and state policy. *How* we think about and visualise difference is, in that sense, of immense importance in the era of gender medicine.

As Kara Keeling points out, our bodies often exceed the schemas available to represent them (Keeling in Halberstam 2018: 88). The ways in which representations organise social reality can be rigid and prescriptive, for example in the way in which they describe female and male bodies as opposite to and complementary with each other. But they can also be disturbed and changed by those who do not see themselves reflected in them. It is therefore crucial to understand how that relationship functions and evolves, as changes led by different interest groups – new discoveries by the biomedical community, the fight against misrepresentation by different social groups reforms that promote equal access to healthcare by institutions – impact our collective visualisations of health and illness.

We suggest that gender medicine is compromised by the incomplete project of an interdisciplinary dialogue between the biomedical field and areas of thought that include feminist science studies, gender and queer studies, media and cultural studies, and philosophy. The absence of meaningful communication between these fields disallows gender medicine from acquiring an expanded view of itself as part of larger social structures (Shai et al. 2021: 8). It has long been recognised that cultural representations of medical practices and institutions and their reception is a fundamental part of understanding the relationship of medicine and healthcare to the societies they are embedded in and which they help shape (Lupton 1994, Gilman 1988). But there has been very little research into how visual culture has reflected, promoted or understood the recent gender medicine developments.

Within that visual culture, and especially popular visual culture, medical dramas should offer themselves as particularly fruitful vehicles for gender medicine communication. Medical dramas are one of the most popular televisual genres; they often feature medical doctors on their screenwriting teams; and research has confirmed their influence on the public's perception

ence. According to Dominjanni, 'sexual difference' emerges from multiple dimensions: the social and the psychic dimension, cultural and unconscious processes, symbolic and imaginary realms. See Dominijanni (2012).

of medical assistance (Rocchi 2019: 72, 74). The hypothesis we are testing out in this chapter is that the basic format of the medical drama does not necessarily align well with the type of communication required for visualising the insights of a gender medicine that addresses the complex associations between sex, gender, and health (Shai et al. 2021: 8). Through the encounter between the medical drama format and gender medicine-related patient cases, our analysis foregrounds the importance of the question of temporality in accounting for complexity in the audiovisual representation of health and illness.

As researchers have pointed out, medical drama patient narrative arcs generally have to conclude within the confines of a single episode, and have to additionally compete for screen time with at least one other patient case, to accommodate the larger narrative arcs of the medical ensemble cast and their relationships. This is the paradox at the heart of the medical drama, according to some researchers: that "the very qualities that contribute to uniquely compelling enactments of medical scenarios also threaten to undermine their objective accuracy" (Goodman 2007). There is therefore usually not enough room for complexity and nuance in the presentation of many medical cases, whilst patient characters don't have enough time to develop into three-dimensional figures the way the medical doctors who are the protagonists of the series do. Additionally, the disease narrative arc remains largely within the confines of something along the following lines: symptom – diagnosis no.1 – crisis – diagnosis no.2 – resolution (cure or death).

As we will see in our examples, we find more nuance and complexity in the depiction of pathologies when the patient is one of the doctors who form part of the protagonist ensemble cast, since "the overriding narrative concern" of the genre is to foreground the relationships between the lead characters (Hart 2016). In this chapter, we will also try to suggest that it is not surprising that other formats and genres, such as dramedies, often do a better job of presenting medical cases where the recent lessons of gender medicine are more adequately addressed. This, as we'll see, comes down at least partly to the fact that we are not meant to identify with the medical gaze, but with that of the patient/(co-)protagonist, who is therefore programmatically and already a fully realised three-dimensional character when they encounter patient-hood.

Women's Heart Attack: *Grey's Anatomy* (ABC, 2005-) vs. *Crazy Ex Girlfriend* (The CW, 2015-2019)

We will base our analysis on episodes of two shows, *Grey's Anatomy* (ABC, 2005-) and *Crazy Ex Girlfriend* (The CW, 2015-2019), as examples of the ways in which popular culture has attempted to visualise the changing awareness surrounding women's heart attack symptoms in both the medical community and patients themselves. As noted in the introduction, heart disease in women constitutes a sort of prototypical case of gender medicine research and communication: it has been more than thirty years since researchers first concluded that symptomatology and therefore diagnosis, prevention and treatment of heart disease in women and men can differ significantly in ways that had been previously ignored (see Cutter 2012: 2). For instance, research demonstrating that low-dosage aspirin for primary prevention of cardiovascular events does not work for women (while the risks remain the same for both sexes) has been circulating at least since 2006 (Berger et al. 2006), and it has been at least ten years since the American Heart Association begun releasing attention-grabbing informational videos in which recognisable TV stars attempt to deconstruct the fallacy that women don't get heart attacks ("Just a little heart attack" 2012;[6] "A man's world," 2014[7]). Even though awareness that women are also vulnerable to heart disease has therefore been increasing over the past decades, it seems that the differences in the symptomatology of cardiovascular events in women is still struggling to become mainstream knowledge.

Our example from *Grey's Anatomy* stages the ongoing struggle, even within the medical community, to take into account the specificities of heart attack presentation in women, who may experience symptoms that are typically less associated with cardiac events, such as fatigue and indigestion. As we will see, the episode also tackles the intersectional complexities of medical bias when issues of gender, race and mental health are compounded.[8]

In episode 11, Season 14 of *Grey's Anatomy* (2018), "(Don't Fear) the Reaper", Miranda Bailey (Chandra Wilson), Grey Sloan Memorial Hospital's

[6] https://www.youtube.com/watch?v=_JI487DlgTA.

[7] https://www.ispot.tv/ad/7FWj/go-red-for-women-ceiling-crasher (Thank you to Thomas Scherer for this reference).

[8] This bias is still confirmed in recent large-scale research into doctors' notes (cf. Markowitz 2022).

chief of surgery, realises she's having a heart attack. Her symptoms include indigestion, nausea, and stomachache. Reluctant to let her husband and colleagues know, she rushes to the emergency room of a different hospital. When her electrocardiogram comes back normal, the doctor insists her heart is fine and immediately begins a different line of questioning: "Any big stressors in your life?" Bailey, in the no-nonsense tone she is known for, promptly replies: "Do not go down that road with me: The road where a woman shows up in an ER with physical symptoms, and you decide that it must be that she's not able to handle all her feelings. No, this is not about anxiety. My secret heart doesn't need fixing. My actual heart needs fixing."

The scene is staged as an argument between two Chiefs of Surgery, one of whom is also a patient: Dr. Bailey, a Black woman, and Dr. Maxwell (Mark Moses), Chief of Surgery of the Seattle Press Hospital, a middle-aged white man who, we're told, has studied at Yale. Despite Dr. Maxwell's attempts to appease the patient, Chief Bailey insists on educating him (and us) about his blind spots regarding women's heart disease symptomatology: "Apparently your teachers didn't get the memo that women's heart attacks don't manifest the way they do in men. They're not all chest-clutching, vomiting, 'Help, my arm is numb,' boom, floor drop." Dr. Maxwell is shown to ignore Dr. Bailey's requests and insists on asking her about her stress levels and any medication she's on. At this point, the spectators are shown a flashback montage sequence of stressful events in Bailey's personal and professional life. As spectators of this debate, our willingness to believe Bailey might momentarily take a hit at this point: is Dr. Maxwell right to suggest that a highly successful person in this profession might be experiencing too much stress for their own good?

The news that Bailey also takes statins and antidepressants to manage an obsessive-compulsive disorder appears to further convince Dr. Maxwell (and perhaps some of the audience) that Bailey's issues stem from her mental health. This prompts Bailey to ask for a second medical opinion, as she realises her mental health diagnosis reinforces Maxwell's biased medical opinion of her condition. She retorts: "Yes, I have obsessive-compulsive disorder. I am not ashamed of that, but it's not my story. It's just one piece. And if you continue to look at just that one piece, if you check the mental illness box and refuse to look at anything else, then I'm not gonna live long enough to finish the rest of my story". Unsurprisingly perhaps, Maxwell appears to concede to Bailey's request for a second opinion, only to send a psychiatrist to follow up with her. At this point, undeterred, Bailey gives us an

explicit lesson in gender medicine, complete with stats: "Sixty-three percent of women who die suddenly from coronary heart disease had no previous symptoms, and women of color are at a far greater risk, so if I were consulting on the patient you describe, I would take into consideration statistics that would never even occur to people who look like you." The episode does not provide a conciliatory resolution, forcing Bailey to enlist the help of her colleagues Dr. Maggie Pierce (Kelly McCreary), a young Black doctor, and her mentor Dr. Richard Webber (James Pickens Jr.). Together they attempt to force Maxwell's hand by emphasising the importance of new protocols and non-conventional approaches to women's health, but it is the physical demonstration of heart attack symptoms Bailey eventually experiences in front of him that convinces Maxwell to allow her colleagues to rush her to the operating room for a life-saving procedure.

This example from *Grey's Anatomy* is interesting to compare with an episode from a different series that, although in some sense as far from the medical drama genre as possible, was born at least in part with the goal of discussing women's health issues. The musical dramedy *Crazy Ex Girlfriend* is, in fact, infamous for tackling underdiscussed aspects of women's mental and physical health in ways that have sometimes attracted accusations of didacticism (Pape 2019).

In episode 12 of season 4 "I Need a Break", which aired in February 2019, about a year after "(Don't Fear) the Reaper," the protagonist's best friend and sidekick, Paula Proctor (Donna Lynne Champlin), a woman in her early 50s who works as a paralegal and is studying for the Bar whilst raising two teenagers and doing pro-bono case work for incarcerated women, shows up for work understandably exhausted. As everyone insists on telling her how terrible she looks, she fires back with assurances that she's fine and all she needs is another cup of coffee. She exhibits symptoms that include excessive sweating and fatigue, which prompt the people around her to make a series of assumptions about what the issue might be: her work friend, drawing on her own experience, suggests she is going through menopause, her husband that she is working too hard. Finally convinced that she needs to visit her gynecologist, Paula wastes no time and asks him to prescribe her something that helps with menopausal symptoms so she can get back to work. The doctor (Kunal Dudheker) insists she tell him precisely what her symptoms are, at which point she lists the fatigue, hot flashes and sweating, along with achy arms and vomiting. To her surprise, the doctor asks her to describe the vomit ("kind of white and milky"). In

a light-hearted tone the doctor then replies, as he picks up the phone to the ICU:

- Doctor: "Well, I'll tell you what. It is possible that you're starting to go through menopause, but I think you're also having a heart attack."
- Paula: "Ha-ha."
- Doctor: "Nope, not ha-ha. Not a ha-ha thing. [On the phone] I have a patient here who needs to go to cardiac ICU immediately."

We can make a couple of inferences based on this dialogue: from the doctor's reaction, we are meant to understand that the association between Paula's symptomatology and risk of heart attack is established knowledge in his field. From the patient's point of view, instead, the episode stages "common knowledge," as expressed by Paula and the people around her, as including (probably accurate) assumptions about menopausal symptoms – but not about women's heart attack symptoms. This is in opposition to the *Grey's Anatomy* episode, which stages an internal debate between two groups of doctors (on one side, a team of three white men, on the other, a group composed of two Black women and a Black man). In that debate, spectators are led to one of two conclusions: either that knowledge about these types of symptoms is not fully consolidated within the field; or that medical bias disallows this information from being taken seriously within parts of the medical community, affecting diagnostic ability to the detriment of women, and especially women of colour.

It is our contention that, as opposed to the medical drama format, where medical cases are typically presented, debated and resolved within the span of more or less a single episode, other genres, such as dramedies in the case of *Crazy Ex Girlfriend*, have the advantage of being able to develop character arcs over a much longer period, within which issues of mental and physical health can be nestled. This leads, naturally, to a kind of temporality of illness that allows for a much more nuanced and complex representation. It is not a coincidence, therefore, that the *Grey's Anatomy* episode we analysed earlier uses the vehicle of the doctor-patient who is a member of the ensemble cast in order to allow for that complexity to emerge. What we know about Bailey and her character, and what we are allowed to remember with her during the flashback scenes, helps us, as spectators, to better understand the force of her advocacy for her own health crisis. Having characters that spectators know and love experience these health crises is undoubtedly a much stronger tool in raising awareness about the importance of gender medicine. If this

much is true of heart attacks, with their relatively circumscribed temporality of presentation, it is even truer of eating disorders, which can be classified as chronic, and which require a multidisciplinary therapeutic approach. As we will see in the next section, we found very similar patterns in the choice of character-vehicles for eating disorder cases in medical dramas.

Medical Dramas and Eating Disorders

Eating disorders (EDs) constitute an emblematic example of how gender medicine issues are weaved into the narrative in medical dramas: the genre tends to reinforce the gendered construction of such disorders, by which patients are usually women and, furthermore, it appears to support our argument that nuanced representations of such medical issues almost always involve members of the doctors' ensemble cast. This transposition of EDs onto the medical staff curiously corresponds, as we will see, with a higher rate of men who manifest ED symptoms. Additionally, cases where a doctor is shown to suffer from an ED display more accuracy in the peculiar temporal dimension of such disorders. Time plays a key role in cinematic representations of eating disorders, especially because EDs require a long, multi-therapeutical approach, since they are mostly chronic illnesses subject to relapse, and in conflict with the daily routine of food intake. A comparison of medical, psychological, and sociological explanatory models of eating disorders shows that anorexia, bulimia, binge eating, and chronic dieting do not have a single cause, but this is not the sense one gets from watching most medical dramas that address them. As we will see, not eating is most often depicted as a tantrum, and in ways that stigmatise the patient. While there are some examples of male binge eating and bulimia in medical dramas, there are – to the best of our knowledge – no cases of male anorexia patients in this genre. Even though statistics show that anorexia, in particular, afflicts mostly women, the focus on a single affected constituency not only marginalizes afflicted minorities, but also hinders understanding of the complex and multifaceted nature of the disorder, on both an individual and social level. As recent studies have shown,[9] men, who are increasingly affected by EDs (especially vigorexia, ortorexia, and anorexia), are often underdiagnosed, as the stereotypical idea that they are only girls' problems persists.

[9] See Bartel (2020).

Furthermore, dysmorphia and EDs are present in queer communities where they can overlap with dysphoria, therefore making a sex-gender lens on the diagnosis and treatment of EDs even more crucial.[10]

In the four medical dramas we selected for our analysis of the portrayal of EDs – *The Good Doctor* (ABC, 2017-), *Chicago Med* (NBC, 2015-), *New Amsterdam* (NBC, 2018-2023), and *Holby City* (BBC One, 1999-2022) –, we encountered the persistence of gendered stereotypes in the patient narrative arcs, and less damaging and more nuanced depictions of such disorders only in cases where a doctor/co-protagonist is the person living with the condition.

In *The Good Doctor* (02x05) and *Chicago Med* (05x04), two anorexic female patients both arrive at the hospital in critical condition caused by being severely underweight after a life-long struggle with anorexia. The woman in *The Good Doctor*, Louisa (Reiko Aylesworth), needs to have life-saving heart surgery but she is too frail and debilitated. After failing to force-feed Louisa, Dr. Browne (Antonia Thomas) pushes for an experimental deep brain stimulation surgery. Following a debate on the multiple risks of this operation, including changes in her personality that could damage her emotional connection with her child, the committee and Louisa decide to go ahead with the surgery.

Throughout the episode, the anorexic character is presented exclusively as a mother and wife. We know nothing about the "biography of her symptom" (Nicastro 2022a) except that being pregnant was the only time she was able to force herself to eat, by looking at the ultrasound and visualising the food nourishing the baby instead of her. Both the family and the medical staff appear to ascribe her with the full responsibility of her eating behavior ("how hard can it be to eat" says the son) while at the same time reducing anorexia to a purely organic problem located in the brain.[11] When she wakes up after the surgery, her very first words are "I'm hungry," confirming the success of the experimental medical procedure, to everyone's relief. But when she hugs her child something has changed: alone with Doctor Browne, the woman confesses this troubling perception. Despite "the successful surgery" we don't know whether Louisa has lost the capacity to feel.

[10] See Sauer (forthcoming).

[11] We don't want to undermine or deny the psychiatric dimension of eating disorders but simply underline the mono-dimensional depiction of them that most medical dramas provide.

In *Chicago Med*, we find a similar stigmatization of the female anorexic patient, Allison (Morgan Weed), whose corporeality is morbidly exposed to us and the doctors, with the camera often dwelling on Allison's bony, frantic body. The first scene closes with the nurse covering the patient with a sheet in a way that anticipates her death at the end of the episode. When Dr. Choi (Brian Tee) asks the head of psychiatry for his support, the latter seems to detect from a distance that Allison is a "difficult" case of anorexia: the door of her room is open, and we see the woman lying in bed in the background. The psychiatrist approaches her in a grotesquely aggressive way, inquiring about the latest trendy weight-loss tricks in the online anorexia communities. When she protests and asks to be released from the hospital, he opens the bed rail and invites her to leave to prove that she doesn't have the strength to do so. The patient appears to trigger a sadistic behavior in all the doctors except Dr. Charles' medical intern, Sarah Reese, who is shaken by the patient's drive to "kill herself".

Both Louisa and Allison's narrative arcs end with a resolution in which the subtext is that the price to pay for their "choice" is extremely high: in one case, death, in the other, the ultimate sacrifice for a mother to make, that is, to keep herself alive but lose her affection for her son, and therefore her sense of motherhood. For a woman who has been presented to the audience as nothing other than a wife and a mother – no other information about her life or psychological history is given to us – this sacrifice is also meant as the ultimate punishment, and is intended to make us consider whether this is a fate worse than death.

Both *Chicago Med* and *The Good Doctor* feature adult women – one in her 30s, another a mother in her 40s – highlighting the fact that eating disorders do not only affect teenagers but are often chronic conditions that last well into adulthood. Yet both patients are infantilised, and the general tenor of the episodes seems to suggest that there is a personal responsibility or choice involved in "reducing" oneself to a state of poor health through disordered eating

By contrast, *New Amsterdam* (season 3, 2021) presents the experience of a man who has been dealing with binge eating since he was a child. Dr. Iggy Frome, one of the doctors in the ensemble cast, is caught in the act by a colleague who herself had addiction problems in previous episodes. The story was included in the script thanks to Tyler Labine – the actor who plays Dr. Frome – who suffers from body dysmorphia and binge eating (Heldman 2021). Dr. Frome's story is explicitly dealt with in the second

episode of the third season, but it is preceded by several episodes where he is shown to eat compulsively. Additionally, the episode dedicates a significant amount of time to discussions about Dr. Frome's childhood and complicated relationship with his father, who constantly berated him for being "fat and weak". Although the psychological aspect is simplified and reduced to a mere "chain of cause and effect", there is an attempt to delve behind the surface of his behavior and to treat it as an addiction, not as a choice, or as gluttony. Similarly, in the British medical drama *Holby City* (season 22, 2021-2022), John Hudson (Trieve Blackwood-Cambridge), is a Black doctor who suffers from bulimia. As in the case of Dr. Frome, there is no final resolution in Hudson's narrative arc, and the development of both these characters is allowed to follow the temporality of their disorders, which is characterised by chronicity and relapse.

In the medical dramas we have selected as our case studies on eating disorders, it is the doctors, and specifically male doctors, who receive enough time and attention for the psychological and the socio-cultural aspects of disordered behaviors to unfold. Additionally, the doctor-patients are affected by two issues that are usually less visible (and less often represented in cinematic narratives) than anorexia, namely bulimia and binge eating. But these two forms of eating disorders are also the most widespread, and people affected by them can often have an apparently functional life, as in the case of Dr. Frome and Dr. Hudson.

Medical dramas usually take place in a hospital. Yet limit cases, such as the famous *In treatment* (HBO, 2008-2021), whose setting is a psychoanalyst's office, seem to offer an alternative temporality of patient arcs. The first season of *In Treatment* features the story of a teenager, Sophie (Mia Wasikowska), who starts therapy with Dr. Paul Weston (Gabriel Byrne) because she needs an expert's opinion for an insurance report detailing her recent suspicious bike accident. Sophie is a very precocious gymnast whose issues with anorexia will only emerge gradually towards the end of the season/therapy, as her eating disorder is intertwined with the complexity of her relationship with her parents, her trainer, and her peers. Not surprisingly, the series reflects the difference between how eating disorders are treated in a hospital (where people usually arrive in an emergency situation) and in a therapeutic setting. The series format, which is structured around recurring weekly sessions with the same group of patients for the entire season, adopts a temporality that allows us to slowly understand Sophie's eating disorder as part of a complex and three-dimensional character. Today we

know that eating disorders benefit from a multi-therapeutical approach that considers physiological and social aspects (Woodruff et al. 2020). Medical dramas would benefit from giving more space to such a perspective, as well as providing a more diversified representation of patient groups in terms of gender and race. This is of course neither an easy task nor the only one – of equal importance, for instance, would be to begin to address the recurring fantasies of people affected by eating disorders, such as those concerning a body or identity that is not (yet) the "right" one.[12]

Conclusions

As one of the most popular television genres, medical dramas have rightfully attracted investigations into their power to reflect as well as popularise ideas around health and illness. Recent medical dramas famously tackle important bioethical and political subjects, such as racial bias in the diagnostic process, euthanasia, body donation, discriminatory blood donation criteria, and, more recently, the repeal of Roe v. Wade. Over the past few years, series such as *The Good Doctor* have reflected a paradigm shift from paternalistic medicine (the exemplary case of which is *House, M.D.*, Fox, 2004-2012) to patient-centred medicine. At the same time, recent research has demonstrated that consumption of medical-themed media such as medical dramas, as opposed to other genres of entertainment, can skew gender-based disease perception in ways that reflect gendered stereotypes (van Driel et al. 2018).

In this chapter, we suggested that the format of the medical drama is often less capacious than expected when it comes to representing the complexities of gender medicine in its patient arcs. Ultimately, this was shown to boil down to a question of temporality. Other formats and genres, such as dramedies, or the "sex education" sub-genre that has recently been flourishing,[13] often do a better job of presenting medical cases where the recent

[12] See Nicastro (2022a), Nicastro (2022b) and Lemma (2010).

[13] This can be said to include series such as *Sex Education* (Netflix, 2019-2023) and *Big Mouth* (Neflix, 2017-2024), as well as the Argentinian multi-platform miniseries *4 Feet High* (2020). Other recent examples include Jessie Kahnweiler's short comedy webseries *The Skinny* (2016), which she made with the explicit goal of raising awareness about eating disorders, especially those that are less commonly represented on screen. Kahnweiler, who suffers from bulimia, wanted to move out of the clinical space and into that of daily life, the ordinary and yet invisible environment of eating disorders. As an alternative to

lessons of gender medicine are more adequately addressed. This, as we saw, comes down at least partly to the fact that, in such cases, we do not identify with the medical gaze, but with that of the patient/(co-)protagonist, who is therefore programmatically and already a fully realised three-dimensional character when they encounter patient-hood. In fact, the medical drama examples that allow for a similar level of complexity to emerge were shown to unfold in the longer temporal narratives that focus on members of the ensemble cast, therefore drawing on the potent melodrama narrative tools that form such a big part of the genre's popularity.

compulsively conclusive ED narratives, she stresses the undulating temporalities of EDs by calling the first episode of her series "Relapse."

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