Master Graduation Project

The results are in you are suffering from gender stereotypes: Professional role models among medical TV drama doctors

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Master Thesis
June 13, 2025

Acknowledgements

I would like to express my gratitude to prof. Simone Driessen for supervising me and guiding me through writing this paper. I am also thankful to prof. Koen Van Eijck for coaching me while coming up with this fun project. Finally I would like to thank my parents and friends for supporting me during this process, I could not have made it through without them.

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1. Introduction

TV dramas have been popular since their inception. Between 1960 and 2020 more than one hundred medical shows have been created in the USA (Painter et al., 2019). Despite their origin they have international viewership for entertainment, relaxation and education. Interestingly, medical- and nursing students sometimes watch the shows to learn about the diagnostic process and rare diseases (Żerebecki et al., 2021). Medical shows frequently spur debates about professionalism, ethics and bedside manners (Gross et al., 2012; Cambra-Badii et al., 2021). The Pitt featuring former E.R. star Noah Wyle received high ratings and praise when it premiered in 2025 (Moorman, 2023). The show has led to intense online discussion about medical shows and the medical field. Despite the involvement of medical specialists in writing, medical TV shows suffer from inaccuracies. Diseases are sometimes portrayed incorrectly. Patient demographics tend to skew younger in fiction than in reality as this appeals to the masses. Certain parts of the healthcare system are ignored, for narrative ease (Holtz, 2006). Simultaneously the profit driven, North American healthcare system is thoroughly critiqued in particular shows. Amoral romances and rivalries are often portrayed for the sake of an interesting plot (Haboubi et al., 2015; Hetsroni, 2009). Nevertheless, these shows can serve as a cathartic experience of medical situations for safe reflection.

Cultivation theory suggests that media portrayals can influence viewer expectations of the medical field (Pokhrel, 2015; Enayet, 2018; Quick, 2009). E.R. for example caused a 1,7% increase in applications to medical resident programs in the USA between 1994 and 1997 (Suxrobjonovich & Baxtiyarovich, 2025; Saleem et al, 2014; Quick, 2009). Dr. Leonard McCoy from Star Trek and Dr. John Carter from E.R. are seen as positive professional role models (Haboubi et al., 2015). In the 1970s idealised white male doctors populated television hospitals, viewers therefor expected real doctors to be the same (Quick, 2009; Painter et al., 2019). Doctors in 1950s media were portrayed as ethical omnipotent healers (Quick, 2009; Suxrobjonovich & Baxtiyarovich, 2025). Such portrayals as well as heroics can generate unattainable expectations. Modern fictional doctors on the other hand can act unethical or even criminal, resulting in distrust. (Berger, 2010; Gross et al., 2021; Quick, 2009). Dr. House for example is infamous for his terrible bedside manners. Medical shows and the medical field have evolved with human rights movements, through diversified representations. (Medical) tv shows now contain more female, minority and queer characters. Diverse characters with interesting deeper level characteristics, can serve as a gateway to foster more understanding among audiences for said minorities (Żerebecki et al., 2021).

However narratives continue to focus on female sexuality and romantic relationships rather than the medical staff's professional role (Lauzen et al., 2008; Jain & Slater, 2013). Hence the shows have a tendency to perpetuate harmful gender stereotypes. For example the idea that women only exist in relation to men and are always less than men (Lauzen et al., 2008). In various media formats women are portrayed as pretty, passive, caring and nurturing and concerned with the domestic setting

(Brooks & Hébert, 2006). These portrayals also show women as submissive and passive sexual objects. The male gaze de-humanizes women by focussing in on particular body parts rather than the entire person (Mendes & Carter, 2008; Krijnen & van Bauwel, 2022). The advent of streaming has allowed even more medical shows to be produced and be (re)-watched (Żerebecki et al., 2023). Hence it is high time to re-asses doctors in media and their gender portrayals. The core concepts be behind this project are (1) gender representation in media, (2) professionalism in the medical field and (3) Medical tv drama's and (4) Americanization of culture. These help position myself theoretically in the theoretical framework.

The first theme highlights how male and female characters have been portrayed in media so far as well as medical tv drama's in particular. The second theme describes which behaviours are expected of hospital staff, when conducting themselves properly. The third theme briefly describes the contents and relevance of these medical shows and explains how they have been researched so far. I chose these seven shows, because they helped me cover a long period of medical tv drama's, while also showing a variety in available options. (1) E.R. (1994-2009) is the highest rated and most well-known medical drama of the last forty years. (2) House M.D. (2004-2012), is cited as a good tool to teach about the diagnosing process (Haboubi et al., 2015; Jerrentrup, 2018). (3) Grey's Anatomy (2005-present), remains ever relevant as it is the longest running American medical drama. The show started in 2005 and new episodes keep coming. (4) Chicago Med (2015-present), is part of a fictional universe called One Chicago. Chicago Fire, Chicago P.D. and Chicago Med show experiences of frontline workers and first responders such as firefighters, police officers and hospital staff (Wikipedia contributors, 2025). It often portrays the chaos of emergency situations with relative accuracy (Suxrobjonovich & Baxtiyarovich, 2025) (5) The Good Doctor (2017-2024), gave a new perspective on the medical field through the eyes of autistic Dr. Shaun Murphy (Suxrobjonovich & Baxtiyarovich, 2025; Stern & Barnes, 2019). (6) The Resident (2018-2023) follows the life of rebellious former G.I. and doctor, Conrad Hawkins (Lawler, 2018). And last, (7) New Amsterdam (2018-2023) gave a critical reading of the American healthcare system (Poniewozik, 2018). Finally the fourth theme explores how the North American origin of these shows impacts their messaging.

My research question is; How have gender portrayals of medical professionals in American medical drama tv shows changed between 1994 and 2024? I conducted qualitative and quantitative content analysis to explore this phenomenon. Such a mixed-method allowed me to analyse a large sample of data broadly and deeply. Meaning I reach deep context, while drawing from a broad sample in the sense that it consists of many different shows from different eras. Such near longitudinal research has also not been used before to analyse medical tv shows. This method will be explored further in the methodology chapter. Through this research I saw historical trends in gender representations in context, which will be explained in the findings chapter. These findings shall illustrate that both genders have become more similar over time. Female tv doctors can now hold high

status positions and act quite assertive and strong. Male tv doctors characters are not afraid to show their softer side. These similarities allowed them to better perform their professional role as they need balance in behaviour. Their attitudes and behaviours need to be suitable to various situations. The doctors were relatively professional in general, all though a few stood out as particularly unprofessional. These will be highlighted in the results chapter as well. Doctors also became less professional whenever they got carried away by behaviours which suited very masculine or feminine stereotypes. Severe aggression and emotional behaviour prevented doctors from making the right decisions.

2. Theoretical framework

The first part of this chapter explores the different representations male and female characters have had in media in general. It contains examples of representations within advertisements, films and television shows and in medical tv drama's in particular. This allows me to compare past representations and gender stereotypes in media to the medical shows produced between 1994 and 2024. It also highlights the effect of said stereotypes in media on real life interactions. This section comes from a structuralist perspective. Meaning gender ideals are social constructs, which impact our behaviour and society (Brooks & Hébert, 2006). Cultivation theory suggests that people learn about unfamiliar concepts and environments through media, meaning it can be a strong educational tool. It can also help broaden acceptance towards minorities through proper minority portrayals (Pokhrel, 2015; Enayet, 2018; Quick, 2009). Social cognitive theory (Pokhrel, 2015). suggests that people learn from what they see people do in media and then copy that behaviour in real life. Medical shows and the medical field have evolved with human rights movements, through diversified representations. Tv shows now contain more female, minority and queer characters. Diverse characters with interesting deeper level characteristics, can serve as a gateway to foster more understanding among audiences for said minorities.

The chapter also highlights the effect of the changing media landscape as the media landscape looks very different now due to streaming. This has resulted in resulted in a greater diversity in products and characters as well as different viewing behaviour (Vermeire et al., 2024; Coavoux & Aussant, 2024). Algorithms now help to determine what certain viewers see as the algorithms predict what audiences might be interested in. TV is now also no longer watched according to an airing schedule, which often results in binge-watching and lowers the stakes when deciding what to watch (Sharma, 2016). The second part of this chapter explains professional and unprofessional behaviour among hospital staff. This information helps me to determine which characters are showing competence in their professional role and which ones are not. I then used it to see if there was a potential relationship between gender and their level of professionalism. Definitions about professionalism can be used to educate workers, on how to treat patients properly (Barnard, 2016; Mason et al., 2014). This then allows patients and staff to form safe bonds for high quality medical care (Bryan-Brown & Dracup, 2003; Brennan & Monson, 2014; Sutherland Cornett, 2006).

It is most important to empower patients, by informing them and respecting their decisions. Professionalism can also be used as a source of power over others as a professional reputation or job provides high status (Barnard, 2016). Further information on professionalism in the medical field can be found in chapter 2.3. The third chapter, lays out previous research about the seven sampled medical drama TV shows in particular. To highlight the relevance and theorizes on the effects of these shows on broader society. This part of the literature contains all kinds of audience studies, qualitative- and quantitative content analyses and desk research regarding medical accuracy, societal effects,

philosophy and scientific methods, medical ethics, feminism and autism comprehension. The fourth and final part of the theoretical framework explains theories about Americanization of culture. North American companies seized control of international markets by diversifying their products to a very high degree. The USA specialized in creating media due to circumstances and shared them through mass communication technology. Those products became highly popular due to their messaging and quality. Those products disperse values such as the American dream, freedom, equality, prosperity and the concepts individualism, capitalism and democracy. Increasingly affordable transportation has also allowed more people to travel, resulting in more tourism and migration. This has further globalized society, but also led to 'grobalized' non-places.

2.1 Gender representation in media

What is deemed important in the modern age often comes from stories produced by media institutions. We learn what it means to belong to certain demographics through media images, symbols and narratives. This is how we construct our identities (Brooks & Hébert, 2006). Media works as a mirror to society and hence represents our social realities (Talbot, 2003; Shamim & Rafek, 2024). While sex differences are biological, how we perform gender is cultural. Masculinity, femininity and race are social constructs. Media disseminates these ideologies, integrating them in our socialization (Brooks & Hébert, 2006; Shamim & Rafek, 2024). Social cognitive theory suggests that people learn from what they see people do in media and then copy that behaviour in real life (Pokhrel, 2015). Dispersing these hegemonic ideals potentially supports the interests of patriarchy and capitalism, as hegemonic ideals come from the 'dominant' class. Hegemony represents what is seen as 'normal' and frames certain positions as neutral, non-ideological, objective and non-gendered (Carter & Steiner, 2004). Poststructuralist scholars such as Derrida, Foucault and Lacan created a conceptual framework to analyse media beyond realism (Mendes & Carter, 2008). This framework allows us to see how media shapes reality). Cultivation theory suggests that media portrayals can influence viewer expectations of settings which they are unfamiliar with. For example the medical field, since these shows often give a look behind the scenes of that area (Pokhrel, 2015; Quick, 2009). Cultivation theory was created in 1976 by Gerbner and Gross in (Enayet, 2018).

Media gives us gender representations and thereby helps to define what a particular gender identity entails. The male identity for example has the matching ideal of masculinity. Masculinity is defined as the images, values, interests and activities which constitute a successful achievement of male adulthood (Brooks & Hébert, 2006). It is often associated with dominance, aggression and professionalism. In current capitalist societies traditional masculinity is in crisis. White collar work, civilization and women's rights threaten masculine ideals as men can no longer overtly dominate women and other men. Media aimed at threatened straight white men hence continue to idolize violence and aggression (Brooks & Hébert, 2006). Femininity, the ideal for women is often described in opposition to masculinity. It is not as contested as it does not carry the same power as masculinity in

a patriarchal society. Women are seen as less than and always in relation to men (Lauzen et al., 2008; Wilks, 2012). They are expected to be passive, nurturing, dependant home-makers and free of high-status positions. In various media formats women are portrayed as pretty, passive, caring and nurturing and concerned with the domestic setting (Brooks & Hébert, 2006). They are often portrayed as especially concerned with body image and physical appearance (Wilks, 2012).

Stereotypes show generalizations about people of certain groups (Lauzen et al., 2008). They have been described in the field of psychology as mental shortcuts for people to quickly understand each other. They can however be very harmful as they are often inaccurate and influenced by a particular agenda. Advertisements are a good way to analyse media stereotypes and hegemonic ideals as they aim to appeal to the greatest denominator. Women were for example increasingly catered to as mass consumerism developed due to their domestic role. They were responsible for household consumption, making them an interesting market (MacDonald, 2004; Krijnen & Van Bauwel, 2022). During the interwar period women's portrayals in advertisements consisted of (1) capable household managers, (2) guilt ridden mothers and (3) self-indulgent flappers. Hollywood films and melodrama's followed a similar trend by idealizing maternal love and villainizing women who did not behave as nurturing mothers. Women were either self-sacrificing- or tyrannical mothers, always associated with the domestic setting (Jangrossi, 2022). In the 1970s feminist guerilla war on sexist advertising changed female representations, to highlight independence. In the 1980s advertisers started portraying a post-feminist utopia where feminism was redundant. Women were portrayed as professional and independent yet also family focussed (Jangrossi, 2022).

In the 1980s and 1990s, marketeers idealized lifestyles and consumption. Products were framed as a gateway to freedom, independence and pleasure (MacDonald, 2004). This has largely remained the same in current day. Advertisements portray lifestyles to strive towards through implicit, underlying symbols and messages. Past advertisements often contained demeaning and inaccurate reflections of real women. Such portrayals showed submissive wives and mothers within domestic settings. Thereby playing into harmful stereotypes. Past media portrayed women as passive sexual objects. Advertisements also had a tendency to focus in on body parts rather than showing the whole person, thereby objectifying and de-humanizing them. This is a result of the male gaze, which requires viewers to sexualize women through the eyes of men (Mendes & Carter, 2008; Krijnen & van Bauwel, 2022). Simultaneously feminine sexual desire was suppressed. In current day both genders are objectified through framing. Actors are frequently employed to advertise gender-specific products. Second-wave feminism allowed women to be displayed in the workplace more often, in positions of authority and as independent beings. Minority women have unfortunately not always received the same treatment. Television portrayed women in a narrow range of roles too. They were often showed in domestic settings, as subordinates or as sex-objects. However with time more feminist friendly portrayals followed (Mendes & Carter, 2008).

The media landscape has changed a lot since the advent of streaming and increased media diversity through online content creation. It is now easier to take more risks in media creation as online dissemination channels allow for more feedback from viewers. This has increased variety in available products (Coavoux & Aussant, 2024). Netflix wants to give creators relatively free reign, to create something unique (Sharma, 2016). This is possible because they do not depend on advertisers like television does. Digital platforms for communication and entertainment work as programmable architectures to organise interactions between users. User data is often collected to then steer user behaviour through algorithms. These algorithms manage to control people's attention, by showing exactly what someone is expected to want to see (Vermeire et al., 2024). These personalized recommendations allow bestsellers, but also more niche products to reach audiences. This increased the amount of products from the 'long tail' to also be seen (Coavoux & Aussant, 2024).

Our relationship to these platforms is quite different to our relationship to television. Television is a form of one-sided communication and connection. We put our trust, time and commitment into the television and in return we expected pleasures and payoffs through storytelling. We needed to make time to see each episode when it aired (Sharma, 2016). Netflix on the other hand releases entire seasons at a time. This allows viewers to get instantly hooked. Viewers may also give the show a second chance if the first or first few episodes do not draw them in, since they are all readily available. It is also easier to move on to a different show if one does not appeal to us. Netflix has started to create their own original content as that was more affordable than continuing to purchase from other studios. Here they have also revolutionized storytelling, by creating more over-arching storylines. In television stand-alone episodes were quite common as that made it easier to keep track of the show, when missing episodes. These over-arching storylines allow viewers to be drawn in for each episode. It also allows the studios to tell more complex stories. Cliff-hangers between commercials are no longer necessary, but very helpful at the end of each episode instead (Sharma, 2016).

In past television shows women were relegated to secondary, supportive roles rather than main roles like their male counterparts. Gender portrayals have diversified since, as more women assumed leadership roles (Shamim & Rafek, 2024). Yet traditional roles remain overrepresented in contemporary media. Female characters are often portrayed as nurturing and caregiving, whereas men are assertive and dominant. Occupational diversity also remains limited. Male characters hold more high status leadership positions, whereas female characters remained in female dominated fields. Both genders continue to suffer from unrealistic body standards as well as heteronormativity (Shamim & Rafek, 2024). Female characters are more likely to have marital roles, whereas male characters have occupational ones. They also behave differently in the workplace as women are more likely to engage in interpersonal or relational behaviours rather than performing work related tasks. More progressive

portrayals of women rely more on intellect and competence rather than physical beauty or relationships to men for success (Lauzen et al., 2008).

Teenage personalities and behaviours are largely shaped by their habitus, but teenagers also seek role-models in media. Popular medical professional role-models are for example Dr. Leonard McCoy from Star Trek and Dr. John Carter from E.R.. (Haboubi et al., 2015). Media role models also aid in the development of ideas about gender roles among teenagers, especially in those who consume many hours of content. Such role models have a strong effect as these role models are often perceived as very attractive, confident and powerful. These ideas relate to the importance of appearance for women and girls, stereotypical toys, activities and occupations (Ward & Grower, 2020). Exposure to traditional gender stereotypes have been linked to negative body image and self-esteem among adolescents. Counter stereotypical portrayals on the other hand help challenge stereotypes and possibly positively change societal attitudes (Shamim & Rafek, 2021; Żerebecki et al., 2024). TV and streaming can work as socializing agents, as viewership often predicts socio-political attitudes. The internet can infamously act as an echo chamber, where similar opinions are re-peated as a result of algorithms. These echo-chambers are also known as filter bubbles (Żerebecki et al., 2021; Coavoux & Aussant, 2024).

Surprisingly viewers were found to be quite open to watching novel content as they want to learn about different cultures, philosophies and religions (Żerebecki et al., 2023). They also seem more open to watching a large variety of products through streaming, as the investment has become smaller. Here viewers display a cosmopolitan attitude by engaging with content from various countries (Coavoux & Aussant, 2024). Tv shows are a safe way to cathartically explore novel concepts from a distance. Viewers often seek friendship, love and justice in their shows, no matter who the characters are. They like characters who are smart, courageous, friendly and helpful. Portrayals should be positive yet realistic, meaning the characters do need challenges to overcome (Żerebecki et al., 2023). At the same time streaming platforms have higher numbers of minority characters including in casts. If they have nice deeper level characteristics, they can serve as a gateway to foster more understanding among audiences who are less open to said minorities (Stern & Barnes, 2019). Examples of such characters might include Will from Will and Grace or for example Mitchell Pritchett from Modern Family. These characters are atypical enough to change the stereotype, but typical enough to represent the entire group (Żerebecki et al., 2021).

They are also complex enough to be relatable to general audiences (Żerebecki et al., 2023). How well a character is received does not merely depend upon surface level characteristics. It goes beyond demographics towards personality, attitudes and experiences of fictional characters (Żerebecki et al., 2024). Typical demographics which matter to audience include gender, race, ethnicity, occupation and sexuality. When audiences care about a character they engage in character liking,

perspective taking, character emulation or even treating them like real-life people (Żerebecki et al., 2024). Biographic resonance theory suggests that similarities in life events, changes, struggles, events, places, and conversations with other people are likely to cause more resonance among audiences(Żerebecki et al., 2024). Demographic similarity makes viewers statistically more likely to be immersed in a story as it makes characters more likely to experience similar situations and life events as the audience (Żerebecki et al., 2024). Deeper level similarities have an even stronger effect on identification than demographic similarity. Similar biographies allow for reflection among media audiences. Hence it may be helpful to write female characters in a slightly more masculine manner as that would avoid stereotypes and allow them to be more realistic. It could make them more relatable to men and women, as they are now actual people rather than an idealized fantasy. Recognizability of characters also depends on consistency in writing, as inconsistent portrayals make characters less relatable (Żerebecki et al., 2024).

Medical drama Grey's anatomy has been researched quite extensively from a feminist perspective as it features two successful professional women, Dr. Meredith Grey and Dr. Cristina Yang (Wilks, 2012; Enayet, 2018). The show was created by Shona Rhimes, who is a successful African American female television writer. She is known for intentionally blind-casting her television shows to grant equal opportunities to actors of all backgrounds. The show also features quite a few inter-racial relationships, which according to Shonda were simply bound to occur due to her blind-casting process. Interestingly race issues are never really brought up in those romantic relationships, as though in this universe they do not exist. The issues in the hospital take the main stage instead. The characters all act like heroes, no matter their race or gender (Warner, 2015). These heroics made heavy viewers expect real doctors to be heroic too (Quick, 2009). However main character Dr. Merdith Grey and her love interest Dr. Derek Shepherd are both white, which may have been a conscious decision to insure acceptance from white audiences (Warner, 2015).

The show tackled the issue of abortion multiple times through the perspective of Dr. Cristina Yang and Dr. Amelia Shepherd (Wilks, 2012; Jangrossi, 2022). The first time Dr. Yang accidentally ended up pregnant from her husband Dr. Owen Hunt. She tells him about the situation and he tries to convince her to keep the child. He explains that since it is his child he should get a say in the matter too. She disagrees as she feels children deserve parents who actually want them and she does not want children. Her career is more important to her. After seeking comfort with her best friend Dr. Grey, she decides to undergo the abortion anyway. Dr. Hunt then begrudgingly supports her decision. The procedure is portrayed as a very traumatic experience for her. Dr. Shepherd later in the show also accidently gets pregnant from Dr. Hunt, while they were married. He again tries to convince her to keep the child. She explains that she had a traumatic experience pregnancy in the past, which resulted in her losing the child. Due to this experience she never wants to go through pregnancy again. She gets the abortion and they get divorced. This is also a result of other marital problems. Finally she gets

pregnant again, from Dr. Atticus Lincoln who handles the situation much better. He explains he'll support no matter if she keeps the child or not. He is most concerned for her well-being (Jangrossi, 2022).

The show hybridizes elements of all three waves of feminism, but predominantly features elements of third wave feminism. Dr. Grey and Dr. Yang fulfil traditional roles by maintaining traditional romantic relationships, simultaneously they frequently prefer each other's company and advice. Dr. Grey in particular settles down by starting a family, but she maintains her career as well for she feels she does not need to choose (Wilks, 2012). Men and women are sexualized in the show to an equal degree. Researchers were surprised to find that interactions between doctors and patients in Grey's Anatomy do not differ greatly depending on the gender of the doctor nor patient (Pokhrel, 2015). While patients spent a bit more time speaking to female doctors compared to male doctors, the contents of these interactions were very similar. Male doctors had a tendency to make positive partnership language and ask more questions of a medical and psychological nature. They also got partnership statements and medical information from patients as a response. Female doctors tried to create a positive interpersonal climate and be good listeners. Both genders provided emotional support through statements, counselling on lifestyle etc (Pokhrel, 2015). While the behaviour of male and female doctors has been compared in Grey's Anatomy, it has not been investigated yet in medical TV drama's as a whole. Hence this paper lays out the behaviours of male and female doctors in seven different shows between 1994 and 2024.

2.2 Professionalism in the medical field

To assess how portrayals of female doctors in media contribute to overall female representation in media it is important to find out how professional these characters are in their field of work. This information will be used in following sections to asses how (un)professional characters are, to see if they are helpful representation. The following section establishes a baseline of what is seen as professional behaviour in the medical field and the workplace at large. It also discusses the effect that a professional role can have on an individual's experience as well as the people around them. Professional standards have traditionally functioned as protection of economic and political interests of members of the field. They also aided in demonstrating their elevated social status (Barnard, 2016). Professionalism has been instrumentalized by company presidents, CEO's, senior administrators and department heads to encourage productivity, sticking to budgets and institutional superiority. Professionals are socially held in a higher esteem than technicians, blue-collar workers and businessmen as such careers are seen as a calling rather than a job. Hence professionals are expected to be altruistic and self-sacrificial (Bryan-Brown & Dracup, 2003). Professionalism is of the utmost importance in the medical field as it generates trust. Constant displays of altruism, excellence, skilfulness, dutifulness and accountability make patients more likely to seek care (Brennan & Monson, 2014).

Doctors are responsible for patient welfare, patient autonomy and social justice. There is an emphasis on ongoing improvement of access to quality care. They are also responsible as expert members of the public to advocate on various subjects (Bhugra, 2024). Medical personnel is held to professional standards to generate patient trust. Patients often feel vulnerable in seeking help. Patients are vulnerable in three different ways. The first is inherent in the human condition as we are all susceptible to illness and death. Second they deal with socially created vulnerability, which results from unequal or discriminatory socio-political arrangements. Finally they deal with the aggravation or exacerbation of vulnerability, which is the shame that can arise from paternalistic or demeaning efforts to help (Barnard, 2016). When we turn to medical professionals for help in our time of need we are in an involuntary state of dependence as we are temporarily physically and mentally impaired. Healthcare professionals should hence avoid exploiting and increasing our vulnerability. They should instead aim to reduce our vulnerability by alleviating symptoms, protecting us from socio-political vulnerability and enhancing our capacity for self-determination. In a sense to be professional means to be trustworthy (Barnard, 2016).

Professionalism in the medical field is often described as character traits and attitudes rather than behaviours, which makes them difficult to study, teach and learn (Barnard, 2016; Mason et al., 2014). In Western cultures it is also seen as a theoretical concept in constant flux. The school of Rehabilitation Sciences Professionalism Charter proved quite helpful in providing good practices. The charter implies that professionalism entails providing high quality, safe and effective care. This requires well-educated staff, who treat patients with dignity and respect. Compassion, sensitivity and person-centred care are of the utmost importance. Professionalism needs to be approached from three different levels; the individual, inter-personal and societal or institutional. On an individual level good practices of behaviour can be innate or learned. Inter-personally, it is important to know which behaviours are appropriate to certain contexts. On a societal or institutional level professionalism is rooted in ideology. Professionalism is the ability to make wise decisions in different contexts, based on experience. Role models can also aid in learning good practices (Mason et al., 2014).

Three settings should be monitored to maintain high quality healthcare; (1) scientific, (2) therapeutic and (3) professional. The scientific field should continue to innovate to develop treatments. In a therapeutic setting systematically applied procedures, knowledge and skills, accountability and clear communication increase patient welfare. Finally on an organisational level ethics should be maintained (Sutherland Cornett, 2006). Medical professionalism entails; honesty and integrity, empathy and compassion, altruism and respect for others, trustworthiness and dependability, initiative taking, proper judgement, confidentiality, ability to keep relationships appropriate, professional presentation, co-operation, organised working methods, effective communication, self-awareness, reflexivity and clinical reasoning (Mason et al., 2014).

Professionalism can be analysed in six different contexts; (1) doctor-patient relationships, (2) interprofessional relationships, (3) patient centred care, (4) integrity and accountability, (5) pursuing excellence and (6) ethical stewardship of medical resources (Barnard, 2016). Patient-relationship skills develop over time. Such relationships require active listening, genuine interest in people, respect, recognizing needs, patient advocacy and maintaining boundaries. Proper interprofessional relationships entail appropriate boundaries and appearances, addressing gaps in individual knowledge, respecting colleagues, avoiding derogatory language, maintaining patient confidentiality and respecting system rules and procedures. Patient-centred care requires empathy and compassion, promotion of patient autonomy and respect for patient preferences and decision-making. Actions should benefit the patient even in cases of conflict of interest. Integrity and accountability involve maintaining patient confidentiality and appropriate patient relationships and disclosing and taking responsibility for medical errors. To pursue excellence one needs to adhere to national evidence-based guidelines and individualize for particular patients. Finally fair and ethical stewardship entails doing no harm and delivering care equitably in a culturally sensitive manner (Barnard, 2016).

2.3 Medical tv drama's

TV dramas have a massive international audience. More than one hundred medical shows were created in the USA between 1960 and 2020 (Painter et al., 2019). They are a popular source of entertainment, relaxation and education. Interestingly, medical- and nursing students sometimes watch the shows to learn about the diagnostic process and rare diseases (Żerebecki et al., 2021). Medical shows frequently spur debates about professionalism, ethics and bedside manners (Gross et al., 2012; Cambra-Badii et al., 2021). Despite the involvement of medical specialists in writing, the shows suffer from inaccuracies. Diseases are sometimes portrayed incorrectly. Patient demographics tend to skew younger in fiction than in reality as this appeals to the masses. Certain parts of the healthcare system are ignored, for narrative ease (Holtz, 2006). Amoral romances and rivalries are often portrayed for the sake of an interesting plot (Haboubi et al., 2015; Hetsroni, 2009). The profit driven, North American healthcare system is not safe from critique in medical tv shows. These shows serve as a cathartic experience of medical situations for safe reflection.

(1) E.R. is the highest rated and most well-known medical drama of the last forty years and ran from 1994 till 2009. The show has been analysed regarding medical accuracy and societal effects through qualitative content analysis and desk research (Lepofsky et al. 2004; Suxrobjonovich & Baxtiyarovich, 2025). It was also part of some audience research among students in a USA university (Quick, 2009). It featured a large ensemble cast, with protagonists Dr. Mark Greene, Dr. Doug Ross and young Dr. John Carter who initially serves as an audience insert (Fienberg, 2025; Staff, 2024). This cast is diverse in ages, genders, ethnic backgrounds, sexualities and even physical abilities (Lepofsky et al., 2004). E.R. took inspiration from previous shows such as Dr. Kildare, Marcus Welby M.D. and St. Elsewhere. These shows featured a dynamic where young doctors learned from older

doctors. E.R. adopted similar relations by using fictional teaching hospital County General as their setting (Lepofsky et al., 2004). The show provides a look behind the scenes which many people never get in their life, by featuring the emotional and ethical issues hospital staff deal with (Quick, 2009; Suxrobjonovich & Baxtiyarovich, 2025). Actual physicians consulted on scripts and shared real cases which inspired story lines (Lepofsky et al., 2004). The show likely became so successful due to how realistically it portrayed the American healthcare system.

It shows healthcare through a perspective of crisis, this became part of actual healthcare discourse at the time. To provide healthcare in this show means to create order in the chaos. Crisis often refers to instability or on the edge, where immediate decisions are necessary. In E.R. doctors deal with crisis on three levels; bodies, medical networks and the social relations in the city of Chicago Lepofsky et al., 2004). (1) Bodies often appear bleeding, breaking, tearing and falling apart. Medical technology is then used to restore said body again. Sometimes the efforts are in vain, because the patient damages themselves again afterwards. The show is not afraid to show their characters in an unfavourable light, this is a great departure from previous omnipotent healers (Painter et al., 2019). Previous shows such as Dr. Kildare and Marcus Welbey M.D. portrayed doctors as gentle healers, with wonderful emotionally supportive bedside manners (Suxrobjonovich & Baxtiyarovich, 2025). (2) Characters in E.R try to bring stability to the medical network by dealing out their own justice, sometimes resorting rudeness or violence. E.R. doctors are willing to break rules and lie for their patients as the healthcare system works against them. (3) The city of Chicago is a metaphor for urban chaos, with dangerous diseases, criminality and homelessness. The doctors at County General try to treat victims of these sides of the city. The chaos gets represented through intense movement and ever changing action (Lepofsky et al., 2004). The camera frequently spins around patients while they are being treated by a large team at a rapid pace.

(2) House M.D., which ran from 2004 till 2012 is cited as a good tool to teach about the diagnosing process (Haboubi et al., 2015; Jerrentrup, 2018). The show was simultaneously critiqued regarding Dr. House's poor bedside manner as his character was based on the rather antisocial and drug addicted Sherlock Holmes (Holtz, 2006). House M.D. was used for audience studies regarding medical accuracy through quantitative surveys among hospital doctors and health board members in Wales (Haboubi et al., 2015). Qualitative content analysis was combined with interviews to assess opinions among medical industry professionals (Holtz, 2006). The show was also used to test how effective it was as an educational tool among 213 students in Germany through exposure to the show and quantitative surveys (Jerrentrup, 2018). House M.D. was part of desk research regarding medical accuracy in medical shows in general (Suxrobjonovich & Baxtiyarovich, 2025). The show was also analysed from a more philosophical perspective through qualitative analysis regarding scientific methods and patient treatment (Rich et al., 2008). Finally House M.D. was analysed regarding medical ethics through quantitative content analysis (Wicclair, 2022).

He frequently quarrels with his boss Dr. Lisa Cuddy. At the same time she gives him quite a lot of freedom. Lab coats are mandatory in their fictional Princeton-Plainsboro teaching hospital, but Dr. House is allowed to wear T-shirt, jeans, sneakers and a blazer (Holtz, 2006; Mason et al., 2014). He is the epitome of a misunderstood genius or perhaps a savant. More importantly, he is a rule-breaker. He ignores informed consent, lies to- and patients and staff, uses drugs, breaks doctor-patient confidentiality, ignores DNR's (do not resuscitate orders) and searches patient's homes for clues after breaking in (Holtz, 2006; Rich et al, 2008). Strangely the doctors do all the work. They perform tests, look after patients and seemingly have endless treatment resources (Holtz, 2006). The show represents everything wrong with the healthcare system; waste, insubordination, superiority complexes and business oriented mindsets (Holtz, 2006). The show has a tendency to over-represent rare diseases (Suxrobjonovich & Baxtiyarovich, 2025). This could be a result of Dr. House being a 'diagnostician' or diagnostic specialist. He specializes in infectious diseases and on cases nobody else can figure out (Holtz, 2006). A typical episode follows the timeline of a medical case from presentation, to testing and treatment.

Most of House's patients are under the age of 40. This is quite unrealistic as the real medical system treats mostly geriatric patients. It adds to the mystery however, thereby playing into his Sherlock Holmes-style investigations (Holtz, 2006; Wicclair, 2008). Dr. House uses deductive reasoning to find out what is wrong with his patients, thereby representing Foucault's modern physician (Rich et al., 2008). Patients are often in perfect health, before being struck by some life-threatening issue. Cases often present in an a-typical manner where indicators remain invisible on tests at first (Holtz, 2006). He usually leaves it up to his team to actually interact with his patients (Holtz, 2006). In reality he is applying what is known as 'le regard', where a doctor distances themselves from the patient to properly observe the disease (Rich et al, 2008). He tries to reach complete objectivity by removing himself from the situation physically and sometimes mentally by using drugs. Dr. House dehumanizes patients and fellow staff to distance himself from them (Rich et al, 2008). This allows focussed deductive reasoning.

Dr. House represents a modern doctor in a postmodern world. Movements in the 1960s and 1970s increased stakeholder participation in medicine (Rich et al, 2008). Dr. House on the other hand is very paternalistic in his approach to medicine. He always feels he knows best and claims he does not give the patients what they want, but what they need (Wicclair, 2008). His fellow staff members function as diverse post-modern foils. They give female- and African American perspectives on the healthcare system and frequently raise concerns about Dr. House's distanced, authoritarian scientific method. In true postmodern fashion they describe medicine as more of an art than a science or a combination of both. Dr. House himself is also postmodern in the sense that he is very flawed. Postmodernism questions romanticized one-sided depictions of people in power (Rich et al, 2008). Despite its flaws the show is well-liked among medical students (Jerrentrup et al., 2018). This could be a result of

House M.D. playing into fantasies they might have of breaking rules as a reaction to difficult patients and coworkers (Enayet, 2018).

(3) Grey's Anatomy remains ever relevant as it is the longest running American medical drama, it therefor continues to develop. The show started in 2005 and new episodes keep coming and older episodes keep re-airing, with a growing ensemble cast (Today, 2024). The show has a tendency to play into current events in the medical field. For example episodes about the Covid-19 pandemic and the changes in abortion laws (Jangrossi, 2022). Grey's anatomy was extensively researched regarding medical accuracy and societal effects through desk research, qualitative content analysis of season 1 and desk research combined with interviews with industry professionals (Suxrobjonovich & Baxtiyarovich, 2025; Enayet, 2018; Berger, 2010). It was also part of multiple feminist media studies, which assess medical accuracy as well through qualitative and quantitative analysis (Jangrossi, 2022; Wilks 2012; Pokhrel, 2015). Finally it was part of an intersectional study employing desk research (Warner, 2015). It has been praised for its accuracy in use of medical terminology (Suxrobjonovich & Baxtiyarovich, 2025). Simultaneously the characters are intentionally flawed as they were meant to represent ordinary people, doing extraordinary things (Enayet, 2018). Interestingly these portrayal did not make patients view physicians in a more negative light (Berger, 2010).

The show initially follows the experiences of Dr. Meredith Grey and her fellow residents, learning to navigate the hospital environment. They learn about themselves and life through their time spent at their fictional teaching hospital in Seatle Washington (Enayet, 2018). The start and end of each episode features a voice-over narration by Meredith herself. She shares her thoughts on certain topics and gives the audience life-lessons (Enayet, 2018). She first learns how to survive in the competitive and hierarchical hospital environment, surrounded by cut-throat surgical staff. The characters learn to cooperate and even dare to defy authority for the sake of their patients (Enayet, 2018). Dr. Grey tries to live up to her mother's legacy as a surgeon and learns to appreciate the importance of friendship. Ambitious Dr. Yang prioritizes her career above everything else. They become best friends and call each other their 'person' (Wilks, 2012). Over the course of the first season they befriend their fellow interns; initially abrasive Dr. Alex Karev, caring Dr. Izzie Stevens and shy Dr. George O'Malley. The rather strict senior resident Dr. Miranda Bailey oversees them during their internship. The show puts an emphasis on the responsibility of the patient themselves as well. Dr. George O' Malley in particular learns the hard lesson not to make promises to patients. They also learn about good bedside manner and how to stand up for themselves (Wilks, 2012; Enayet, 2018).

(4) Chicago Med started in 2015, continues to get new episodes. It is part of a fictional universe called One Chicago. Chicago Fire, Chicago P.D. and Chicago Med show experiences of frontline workers and first responders such as firefighters, police officers and hospital staff using an ensemble cast (Wikipedia contributors, 2025). It often portrays the chaos of emergency situations with

relative accuracy (Suxrobjonovich & Baxtiyarovich, 2025). The show has not received as much academic attention, likely due to how recent it is. Hence it may be relevant to analyse the show to see how it compares to predecessors. Chicago Med has only been studied through desk research (Suxrobjonovich & Baxtiyarovich, 2025).

(5) The Good Doctor, which ran from 2017 till 2024, gave a new perspective on the medical field through the eyes of autistic Dr. Shaun Murphy (Suxrobjonovich & Baxtiyarovich, 2025). He struggles to become a surgeon and cope with social situations. We frequently get a real look into his mind through graphics on the screen, which show his thought process (Stern & Barnes, 2019). The premise was based on a popular tv show from Korea (Nevins, 2018). It is a counter-narrative to negative news stories stigmatizing ASD (Autism Spectrum Disorder). Fictional media rarely features autistic protagonists or even side-characters, yet media psychology research found that fictional narratives potentially increase empathy and decrease stereotyping and prejudice towards marginalized groups (Stern & Barnes, 2019). The show has received attention for its portrayals of autism and has been analysed through desk research, quantitative content analysis of season 1 and audience studies (Suxrobjonovich & Baxtiyarovich, 2025; Cambra-Badii et al., 2020. The effects watching the TV show were compared to the effects of a lecture on ASD (Autism Spectrum Disorder) to see which fostered the most understanding (Stern & Barnes, 2019).

Undergraduate students were found to know and understand more about autism from watching the Good Doctor than they did after listening to a seminar on the same topic. They also became interested in learning more about ASD to understand autism and Dr. Murphy more fully. When tested they associated autism with more with positive traits than those who listened to the seminar (Stern & Barnes, 2019). This is probably not a result of idealisation of autism as the show frequently features negative traits associated with ASD as well. Dr. Murphy can lose his composure over unexpected things in unexpected ways. He frequently suffers from over-stimulation and anxiety due to disturbances in his routine. The show was found to be potentially useful in teaching about bioethics as it frequently features bioethical dilemma's (Cambra-Badii et al., 2020). Dr. Murphy's objective perspective and very open communication patients are always informed of upsides and downsides of any procedure. He sometimes unfortunately comes off as brusque due to his savant syndrome (Cambra-Badii et al., 2020).

(6) The Resident during its run from 2018 till 2023 gave a more standard perspective on the medical field through the eyes of rebellious former G.I. and doctor, Conrad Hawkins (Lawler, 2018). Finally (7) New Amsterdam which ran from 2018 till 2023 gave a critical perspective on the American healthcare system in particular. Protagonist Dr. Max Goodwin is the head of titular hospital New Amsterdam. He tries to provide healthcare against all odds (Poniewozik, 2018). He frequently faces issues due to financial constraints as the hospital is a private for-profit organisation. The Resident and

New Amsterdam have not been studied from a media perspective yet and only Grey's Anatomy has been researched from a feminist perspective. Hence it was high time to assess the rest of the shows from such a perspective too and compare them to seek historical trends.

2.4 Americanization of culture

It is also important to address that these shows come from the USA and hence inherently carry North American ideals, norms, values, aesthetics and culture. North America holds a soft global power through products, technology and media (Craig et al., 2009). This is a result of North America becoming a global industrial powerhouse during and after WII (Berghahn, 2010; Catley, 1997). The economies of previous European superpowers were harmed significantly during and after the war as everything needed to be rebuilt. Russia, the European Union, Japan, India and China became the new global superpowers as a result of the turmoil (Catley, 1997). The USA did not however accept its role as a global superpower as it did not want to replace the superpowers that came before. Colonialism during the Enlightenment and the mass production of the Industrial Revolution made the British- , the French- and the Japanese empire, the Soviet Union and Nazi Germany powerful united nation states. They had the largest industrial economies and hence competed over world power. While the USA and Canada helped end WWII, the USA was not willing to continually be involved in international matters. It was instead only willing to intervene when it was deemed in the interest of their own national security, not to uphold global peace (Kagan & Council on Foreign Relations, 2021).

The North American economy flourished during and after WII, resulting in moguls, popular products and mass entertainment from Hollywood. Typical popular products, services and lifestyles made their way to Europe and Asia through global trade. For example Coca-Cola, Levis, McDonalds and Disney (Craig et al., 2009). These companies often created other popular products as well resulting in powerful oligopoly's. Companies such as Coca-Cola, Unilever, PepsiCo, Proctor and Gamble and Nestle have a large hold on the international grocery market (*These 11 Companies Control Everything You Buy*, n.d.). Similar developments occurred in the media landscape. News Corp, Disney and AOL/Time Warner publish most news. News Corp, which owns Fox news has already been accused of only representing the right-wing conservative agenda of the Murdoch family (Law et al., 2002; Warf, 2007). The CNN effect suggests that news stations to shape political outcomes and foster consent for elite policy preferences (Oswald, 1994; Robinson, 2001). Transnational companies such as Time-Warner, Sony Pictures, Fox and Disney distribute media globally (Wasser, 2009). Recently these companies have undertaken many mergers. Disney is infamous for diversifying its business to a point where they even own real estate (Hallman, 2023).

The medical tv shows I analysed were all filmed in the USA and Canada by local production companies. Smaller companies often cooperated with large ones such as Warner Bros, Fox, Universal Television and Sony Pictures Television. North American values, ideas and customs have been

globally distributed through popular media products (Craig et al., 2009). American productions promoted values such as the American dream, freedom, equality, prosperity and the concepts individualism, capitalism and democracy (Ibbi, 2013; Catley, 1997). Hollywood vertically integrated their studio system for market control. Studios were able to force entire packages of films onto movie theatres, rather than individual blockbusters. This guaranteed continuous profits (Scott, 2001). Stars were re-used as part of a formula. Production was standardized while the films or products were differentiated to keep audiences interested. Thereby guaranteeing reliability and quality. An example of such efficiency is the series of horror films released by Universal in the 1930s by re-using stars and sets, but telling a new story every time. Standardization can still be seen in the formula's used to create blockbusters (Scott, 2001). In the 21st century entire cinematic universes and endless sequels, pre-quals, midquels, spin-offs and re-boots became the norm. This is all a reaction to the seven economic properties of the cultural industries as nobody knows what will be a success (Caves, 2000).

Various studios settled in LA as there are many different landscapes available and the weather is often suitable for filming outside (Scott, 2001). The first film studios in the USA left New York and Chicago for better weather around 1910 (Bordwell et al., 2003). Real estate costs were also relatively low in the area at the time. Particular camera technology was also available there. The widespread adoption of the English language, Hollywood storytelling and the family-friendly censorship in films likely contributed to international success. Storytelling in Hollywood films was based on Aristotelian narrative construction, inherited from 19th century plays. This is the three-act structure, though the structure was subverted more in the 1960s and 70s (Scott, 2001). Hollywood sold America to the world as a utopia. Yet it could be argued that more critical films and television shows are being created now too. The process of Hollywoodization lead film industries in Asia to adopt the production style, costume design or even names of popular Hollywood productions (Ibbi, 2013). Studios do bear in mind international markets as international distribution allows them to re-cooperate production costs. However they focus most on domestic audiences, as it needs to be distributed domestically first (Sharma, 2016). The medical shows I looked at in particular were first distributed through US-based television networks, before ending up on streaming as well as foreign television channels.

The cultural proximity of countries was found to be the most significant factor in how likely a country is to adopt products, media and values from abroad. Countries with open economies are also more likely to make such adoptions. Especially smaller countries such as Belgium, Ireland, Austria, Switzerland, Netherlands and Norway have adopted North American media products. This could be a result of their rather small domestic media landscapes as well as their multi-lingual nature (Craig et al., 2002). Although the USA has had an undeniable influence on these small nations, it could be argued we are seeing the effects of globalization rather than mere Americanization. North American values are not adopted without question. The reaction to such values depends on which nation is receiving them (Roudometof, 2015). We are not being homogenized into a single global culture, it is instead

becoming more diverse, complex and multicultural (Shimemura, 2002).This is a result of international media, migration and global trade. Japan and North America have held a special relationship since WWII. The two nations now share a surprising amount of products and media. Japan for example has an interest in Hollywood movies, McDonalds, Nike sneakers and GAP clothing. Japanese people also visit North America frequently as a travel destination (Shimemura, 2002).

North America on the other hand has adopted Japanese manga's, anime, video games, fashion and sushi. Hence this relationship is two-sided, not one-sided as often suggested (Roudometof, 2004). It could also be argued that popular chains such as McDonalds do not blindly implement their business models abroad. If they did they would be more likely to fail. Hence McDonalds alters their menu and formula slightly everywhere to comply with national regulations and suit local tastes (Shimemura, 2009). Similar things occur when media is created for the international market. The local and global always interact, this phenomenon is also known as glocalization. It results in both homogeneity and heterogeneity (Khondker, 2004; Roudometof, 2015). Slight local flavours are adopted to share with a wider audience. What is global and what is local blends into something new (Wasser, 2009). Media is now sometimes made by cross-border media production companies cooperating. It is also common for Hollywood productions to include people from abroad to play major roles and tell their stories. Scripts are also meant to be as inoffensive as possible, to appeal to the broadest possible audience (Ibbi, 2013). Fusion kitchens are another popular example of said phenomenon (Shimemura, 2002).

The phenomenon of glocalization has also been deemed grobalization instead for it mainly results from the ambitions of nations, corporations and organisations to impose themselves on particular geographical areas (Ritzer, 2003). They want their power, influence and profits to grow. It exists between the areas of something and nothing as it is part of the non-places, 'nonthings', nonpersons and nonservices associated with empty and inauthentic globalized products such as Disney world. Disney world is a non-place as it is not real. Disney souvenirs are non-things as they refer to nothing. Cast members are nonpersons as they do not present as themselves. Finally queuing is a form of nonservice as it is self-service and very uncomfortable. Products such as Disney world have little to say and hence appeal to many. Examples of 'grobalized' products include travelling concerts of Persian artists and music and a travelling van Gogh exhibit. Similarly souvenirs, have become 'nonthings' as they are mass produced. Store clerks also behave like non-people as they try to be as neutral as possible. Finally local cuisine might be watered down to be more neutral too, thereby resulting in inauthentic tourist non-places (Ritzer, 2003).

3. Methodology

I investigated portrayals of doctors in American medical tv drama's, using a mixed qualitative and quantitative method (Bryman, 2016). Such a mixed-method allowed me to look at a relatively large sample of data broadly and deeply. This near longitudinal research has also not been used before when investigating medical tv shows. I sought historical trends in gender representations, while maintaining deep context for said representations. This study sampled episodes from (1) E.R. (1994-2009), (2) House (2004-2012), (3) Grey's Anatomy (2005-present), (4) Chicago Med (2015-present), (5) The Good Doctor (2017-2024), (6) The resident (2018-2023) and (7) New Amsterdam (2018-2023). While Scrubs is very popular and influential Scrubs it was left out of this study as it is a medical comedy, rather than a drama. My qualitative method was inspired by the Visual-Verbal Video Analysis method (Fazeli et al., 2023). This framework was created for short-form video content, but can also be relevant for longer-form media. In this case it can be helpful for analysing dealing with doctor-patient and staff interactions in the medical context. Their professional interactions and decisions in the transcripts were my primary unit of analysis. However their interactions the private sphere sometimes gave me insight into their character.

Visual-Verbal Video Analysis consists of six stages (see Fazeli et al., 2023). The first stage is the collection, analysis and reviewing of the data. Here I chose which episodes to look at and how. The second stage consists of rigorous transcription of the data, to allow transparency (Bryman, 2016). While my order was slightly different, the third step is choosing units of analysis. Mine were inspired by sociological and medical literature, but also steered by the data itself. The fourth step is to extract and code the data. Here one can look at the characters, purpose of the content and other technicalities. For example character traits, visual characteristics, messages, emotions and discourse. Speech and body language can be important emotional indicators here. Music, light or colour and camera angles can also give an insight into the message the creator was trying to convey. Hence I made sure to note when camera angles were unique for a particular purpose. Fifth one needs to organize, describe and interpret said data to make sense of it. Finally one reports their findings (Fazeli et al, 2023).

I first explored a smaller sample of the data qualitatively to broaden my quantitative code-book describing (un)professional behaviour in the medical field as well as gender stereotypes. One episode was meant to give a general overview of the kinds of interactions that occur in these shows. Qualitative analysis could highlight in which situations certain behaviours occur thereby making the case more generally applicable. I created Word transcripts of seven episodes, which describe what characters say, wear and do. This helps to make the method reliable and valid as the method is now reproducible. (Bryman, 2016). These transcripts allow me to quote characters exactly and provide proper context for the quotes I chose to illustrate my findings. I later coded those transcripts using Atlas.ti. I first started with an open-coding, to sort out the data in general categories. After that I looked for more specific patterns. During this process I kept a journal to write down any thought's and

theories that came up. I also employed memo's in Atlas.ti, to make sense of my code-groups. This helped me create code-trees to get an overview of how the concepts connect and increase dependability (Bryman, 2016).

The entire sample was then also coded quantitatively using a code-book and Excel, to be analysed in SPSS. Here I looked for behaviours which exemplify medical (un)professionalism or match or subvert gender stereotypes. I recorded the name, gender, sexuality and ethnicity of the doctors I was observing and their behaviours. This allowed me to see if particular characters have deviant tendencies which do not represent the fictional doctor population. Doctor House for example to misbehaved a lot as he is a drug addict, infamous for his terrible bedside manner. I coded both professional and unprofessional) behaviour in a medical setting as it is sometimes easier to spot mistakes than proper behaviour. My qualitatively revised codebook can be found in table C 1 Medical professionalism in Appendix C: Quantitative codebooks. I also coded gender stereotypical behaviours using a code book. This allowed me to see how stereotypical these characters are and the kinds of roles they play. The qualitatively revised gender stereotypes can be found in Table C 2 Codebook gender stereotypes in Appendix C: Quantitative codebooks.

The sample consisted of episodes from seven different shows and totals 18 hours of content. The sample is between the minimum 12 and maximum 18 hours required for saturation in qualitative content analysis. It is also above the minimum for quantitative analysis as requires about 12 one-hour episodes. This is meant to equal around one season of a tv show. These 18 hours also allow me to watch at least two episodes per show, preventing bias. I tried to avoid special event episodes, cross-overs, season openings and finales as those might differ significantly from regular episodes. This division gave me about an equal part of each era as can be seen in Appendix A: Sample medical tv show episodes. I created the sample by making an overview of the number of episodes and how they were divided across the seasons and calculated an equal distance between them. That way the episodes come from the start, middle and end of each show, but are simultaneously somewhat randomized. In the beginning only E.R. was on, whereas in more recent years Chicago Med, the Good doctor, The Resident and New Amsterdam were all on television simultaneously as can be seen in Figure B 1 Timelines medical tv shows in Appendix B: Timelines medical shows.

These shows give me an insight into the changes in portrayals of medical professionalism and gender stereotypes in the past 30 years between 1994 and 2024. Sharing my exact sample and code-book makes this study relatively replicable (Bryman, 2016). The total hours I sampled of each show depends on their relative size. Hence I watched the most hours of Grey's anatomy and the least of New Amsterdam. The calculations can be found in table 3.1 below. House M.D. and The Good Doctor feature controversial protagonists, whom employ unconventional methods. Hence a smaller sample size for both shows also seems appropriate. I observed the behaviours of a relatively small sample of

207 main- and recurring doctors and 87 patients. The dates of the episodes were slightly too far apart to use them for any kind of regression (Bryman, 2016).

Hence I looked for correlations and compared means to seek differences among different demographics instead. I first determined the level of diversity of the shows by looking at the demographics of the doctor and patient population. I used SPSS to calculate the percentages of different demographics in all shows and in the individual shows. I then created masculinity-, femininity-, professionalism- and unprofessionalism- scores by adding up the points received for each behaviour in the code-book for the masculine-, feminine-, professional- and unprofessional behaviours and dividing it by the number of episodes each doctor featured in. So for example all the instances of a character showing a feminine behaviour were added up to become part of a femininity score. I then divided it by the number of episodes the character was int to somewhat prevent a skew for doctors who feature in more episodes than others. I then conducted tests of correlation between the scores for masculinity, femininity, professionalism, unprofessionalism and demographic information to find demographics tendencies. Finally I ran several compare means to see if there are significant differences between groups within the doctor population and seek trends over time.

Table 3. 1 Calculation sample size medical tv shows

	Name tv show	Runtime		Total Seasons	Total Episodes	Length episode		Total hours	% of total hours	Analysis hours	Episodes for analysis
		Start	End			Min	Max				
1	ER	1994	2009	15	331	45		248	24%	4,33	6
2	House M.D.	2004	2012	8	177	41	49	121	12%	2,11	3
3	Grey's Anatomy	2005	Present	21	438	43	53	314	30%	5,47	8
4	Chicago Med	2015	Present	10	184	40	44	123	12%	2,14	3
5	The Good Doctor	2017	2024	7	126	41	44	86	8%	1,50	2
6	The Resident M.D.	2018	2023	6	107	43	45	77	7%	1,34	2
7	New Amsterdam	2018	2023	5	89	43		64	6%	1,11	2
	Total			72	1452			1032	100%	18,00	25

While the development of medical shows has been covered extensively until the 90s and 00s, more recent medical drama tv shows have not received nearly as much attention. Hence my research question is; How have gender portrayals of medical professionals in American medical drama tv shows changed between 1994 and 2024? Three sub questions guide this research. (1) What kinds of roles do male and female doctors play? This question highlights possible stereotypes I might find. (2) How do male and female doctors interact? Such interactions could show if dynamics have improved to make them more equal. (3) What are the differences between male and female doctors? These differences could highlight levels of professionalism and hence how the characters measure up as role models. This should aid in finding a historical trend over the last 30 years. I expected male and female

doctors could play more and more similar roles. There are now likely statistically more women playing doctors than before and doctors are expected to behave in a perhaps more masculine way to fulfil their position. The dates of the episodes were slightly too far apart to use them for any kind of regression (Bryman, 2016).

Hence H1 is; The number of female doctors in medical tv drama's has increased. I determined the amount of women in these shows and the level of diversity by recording the demographics of the doctor and patient population. I recorded gender, ethnicity/race and sexuality of the doctors by researching said information online. I also recorded the gender and ethnicity/race of patients just by observing them (the languages they speak, how they identify themselves when interacting with people and what they look like). I then used SPSS to calculate the percentages of different demographics in all shows and in the individual shows. Male and female doctors may have become more similar in their characterisation meaning H2; Female doctors have become more masculine over time and H3; Female doctors have become less feminine over time. Simultaneously H4; Male doctors have become more feminine over time and H5; Male doctors have become less masculine over time. I created a masculinity- and femininity score by combining the aspects in my codebook, adding them up and dividing them by the number of episodes doctors feature in, to prevent a skew towards doctors who feature in more episodes than others. I then used correlations to compare if femininity and masculinity were correlated with a particular gender. This would tell me if women were statistically more likely to be feminine and if male doctors were statistically more likely to be masculine. I then used compare means to see changes over time, by comparing the mean masculinity- and femininity- of each show and each year of each gender and both genders combined.

Here I also created a mean comparison for minorities to see how stereotypical and damaging their portrayals were. I expected H6; Doctors who belong to sexual and/or ethnic minorities to behave in a more stereotypical manner than doctors who belong to the majority. I controlled for this factor by creating a means comparison of masculinity- and femininity scores which such a layer as well. I similarly expected that doctors who belong to such minorities would be written as less professional than their majority counterparts. Meaning H7 is; Doctors who belong to sexual and/or ethnic minorities are behave in a more unprofessional manner those who belong to the majority and H8 is; Doctors who belong to the majority behave in a more professional manner than those who belong in sexual and/or ethnic minorities. To control for this and see if the shows feature proper diversity I compared professionalism- and unprofessionalism scores of minorities and majorities with a layered compare means.

I expected that rebellious male doctors would appeal to audiences and therefor play more fast and loose with ethical standards and regulations than female doctors, who need to be rule-abiding due to scrutiny. Hence H9 is; Female doctors live up to medical ethical standards more than male doctors.

To test this I calculated a professionalism- and unprofessionalism score. The professionalism- and unprofessionalism scores consist of the instances doctors behave professionally or unprofessionally according to my codebooks. These are again adjusted by dividing them by the number of episodes each doctor appears in to prevent a skew towards doctors who are in more episodes than others. I then used correlations to compare if professionalism and unprofessionalism were correlated with either gender and with femininity and masculinity, to see if there was a relationship between the stereotype a character might represent and their level of unprofessionalism or how they measure up as a professional role model. Those who score high on unprofessionalism do not follow ethical standards. Hence I compared the unprofessionalism scores of male and female doctors to see who is most rule-abiding. Here I also compared the shows using layers, to seek changes over time.

At the same time I expected male doctors to perhaps jump in at the last minute with unexpected cures and risky heroics. H10: Male doctors contribute more to curing patients than female doctors. Here I used the professionalism score and compare means to see if male behaved statically more professional than female doctors. Those who score high on professionalism help cure patients in various ways. Here I again compared the different shows as well through layers to seek changes over time. Finally I expected that representations of male and female doctors have changed over time, to appeal to new audiences. This would mean an increase in diversity among doctors. Hence H11 is; Representations of male and female medical professionals in American medical drama tv shows have become more diverse. I tested this by comparing the level of diversity among doctors per show.

4. Results

4.1 Qualitative results

After transcribing and coding seven episodes of the seven different medical shows I found behaviours which had to do with three different themes; gender ideals, medical professionalism and social issues. The following section will explain what these themes mean and highlight examples of in which contexts such behaviours occur. After this analysis I realised that nurses received quite a bit of positive attention in E.R., Chicago Med and The Resident. This quite a departure from previous television shows. They are portrayed as capable and irreplaceable healthcare workers in these three shows. While other shows ignore them a bit as doctors do all of the healthcare tasks, they are not used as a way to make a joke. Overall diversity has increased in the sense that there are more and more ethnically diverse doctors. They also have more varied sexualities. Despite more women playing main-characters women continued to be a minority as doctors. Hence it is an improvement, but not a large departure from the past white male-populated hospitals of the 1970s (Shamim & Rafek, 2024, Quick, 2009; Painter et. Al, 2019). Many nurses were female, all though with time more male nurses were portrayed on screen. The patient population also looks quite diverse, various ethnicities and sexualities.

I found that male and female doctors have become more similar in their portrayals. Female doctors stood up for themselves and male doctors sometimes showed their sensitive side. Examples of such occurrences will be explored in section 4.1.1. They were also equally professional, however any character who displayed extremes ran a risk of behaving in an unprofessional manner. Those who got carried away by their often stereotyped emotions and behaviours started crossing boundaries, thereby not living up to professional expectations of the medical field (Barnard, 2016; Bryan-Brown & Dracup, 2003; Brennan & Monson, 2014; Sutherland Cornett, 2006; Mason et al., 2014). Instances of professional and unprofessional behaviour will be expanded upon in section 4.1.2.The shows also feature discussions of various complex social issues. Most of those were discussed from a very North American point of view. In that sense the shows perpetuated North American ideals, norms, values, aesthetics and culture as expected (Craig et al., 2009). How these were represented will be explored in section 4.1.3.

4.1.1 Gender ideals

Interestingly, findings show more behaviours which suited masculine ideals than feminine ideals. This could be a result of the association professionalism still has with masculinity (Brooks & Hébert, 2006). Female doctors also had a tendency to portray these masculine behaviours in order to fulfil their professional role. Both male and female doctors were assertive, brave, calm and collected, confrontational, competitive, contrarians, direct and dominant. They also displayed logic, promiscuity, rationality, tough love, strength and problem solving skills. Though most did not have rugged

appearances nor want to resort to violence. In most of the shows I looked at female doctors continued to be a minority. Grey's Anatomy was the only exception, hence it seems the women adapt to a male dominated field. Simultaneously male doctors were not afraid to show their more feminine side especially when dealing with sensitive matters. In those cases they were caring, co-operative' and they listened (Brooks & Hébert, 2006). Most characters were somewhat romantic and sometimes distracted by romance too. They also got emotional from time to time. Some even had feminine hobbies. Only women were particularly concerned with appearance and pretty. They were willing to wear very impractical clothing at times in order to suit beauty ideals. How these codes interconnect can be seen in Figure D 1 Code network Gender Ideals in Appendix D: Code networks.

The shows featured quite a few women in leadership roles, thereby continuing a trend of women's emancipation (Shamim & Rafek, 2024). Female leaders such as Dr. Cuddy (House M.D.), nurse Goodwin (Chicago Med) and Dr. Bailey (Grey's Anatomy) have a tendency to display some toughness to enforce important boundaries. Dr. Cuddy for example would get very hard on Dr. House whenever he came up with another dangerous plan. She frequently employs humour to snap him back into reality. Nurse Goodwin on the other hand is very serious whenever boundaries need to be enforced, but she also has a warm quality about her when she needs to look after her staff. In the particular episode I looked at Dr. House came up with the idea to perform an autopsy on a patient who was still alive as this was the only way to treat her. Patient Andie was suffering from two types of cancer, which would be fatal either way. However since she requested treatment for as long as possible Dr. House comes up with a very unconventional method to deal with her unconventional and difficult illness. This would give her another year to live. Dr. Cuddy made sure to highlight the severity of what House was planning to do. As can be seen in this funny quote below:

> "Dr. House peeks his head into Dr. Cuddy's office. He finds her sitting behind her desk.
>
> Dr. House: Is it still illegal to perform an *autopsy* on a living person?
>
> Dr. Cuddy: Are you *high*?" (House M.D. Season 2 Episode 2: Autopsy, 2005)

Dr. Cuddy is very direct in this interaction and takes power in order to maintain control of the hospital. She plays into humour here, because she knows Dr. House responds best to such witty interactions. At the same time her phrasing hints at an underlying issue which is Dr. House's well-known drug abuse. She might wonder here if he came up with this dangerous idea, because he is in a mentally compromised state. After this interaction they sit down and discuss the situation intensely to insure they make the right decision. Thereby again highlighting Dr. Cuddy's competence as a hospital leader.

Dr. Yang (Grey's Anatomy) similarly breaks all sorts of gender ideals as she is direct, competitive and actually frequently lacks empathy. She is extremely career oriented to a point where her ambition can endanger patients or at least make her unpleasant to work with at times. Hence she is the opposite of a household manager (Jangrossi, 2022). She also never wants children, which was part of a few of her storylines. When confronted with difficult cases she gets excited, but to a degree where she dehumanizes patients. She can therefore be considered somewhat negative representation, especially in the beginning of the series. Her character illustrates what happens when women have "too much ambition for their own good".

Dr. Grey (Grey's Anatomy) displays a lot more empathy for patients and suits feminine ideals more. She was caring, emotional, supportive, warm, friendly, romantic, concerned with appearance, listened, co-operated, wore impractical clothing and sought connection. Dr. Grey and Dr. Bailey eventually decide to build families, thereby being both professional and family focussed. This is why the show is considered part of third wave feminism (Wilks, 2012). Previous shows like E.R. also showed the private lives of the characters somewhat. On that show female characters engaged in all sorts of relationships, but were less concerned with having children. The male characters did start families, thereby playing into the stereotype that men can have both a professional career and a family (Brooks & Hébert, 2006). As they take care of the breadwinning while women handle childcare. Another frequent trope is the characters starting a family by the end of the tv show. They switch jobs and move elsewhere after marrying their love interest. This could be related to the effects of the privatized healthcare where medical professionals get overworked. The job is a calling, meaning they do not have time nor energy for much else (Bryan-Brown & Dracup, 2003; Ibbi, 2013; Catley, 1997). It also shows that families and relationships are still prioritized over careers.

Grey's Anatomy has a tendency to objectify the cast equally. Both men and women get framed as promiscuous, with a focus on their appearance in particular scenes. This is a departure from the male-gaze which only puts a sexual emphasis on women. The characters also discuss their intimate lives with colleagues, rather than keeping such information private. These female characters are no longer passive sexual participants, with suppressed desires (Mendes & Carter, 2008; Krijnen & van Bauwel, 2022). Dr. Bloom (New Amsterdam) strikes a nice balance between feminine and masculine tendencies. She can be direct, strong, brave, assertive and quite humorous while remaining friendly, caring and empathetic. These are generally the traits seen in television doctors nowadays based on what I found. In the passage below she goes out of her way to make an underage patient Gianna feel safe, while her father is undergoing surgery. This could be seen as a stereotypical portrayal since she is playing a slightly maternal role (Jangrossi, 2022). However her other portrayals make her a relatively balanced character. She is not afraid to confront colleagues when necessary. She decides to keep her company while she waits for her father to come back as Gianna explains she is scared to be alone:

"Dr. Bloom: Hey, I was just about to head out. *I wanted to see if you needed anything*. Oh.

She looks at Gianna and notices she is looking rather *sad*, hidden behind her Sandstorm comic book. Hence Dr. Bloom quickly drops her bag, to console Gianna.

Dr. Bloom: Are you okay?

Gianna breaks down and starts to *cry*.

Patient Gianna Morales: I'm scared. I don't like being… *alone*.

Dr. Bloom: You wanna know a secret? *I don't like being alone either*.

This piques Gianna's interest and calms her down slightly.

Dr. Bloom: What do you say, you and I, *we keep each other company until your dad gets back*?

Gianna nods." (New Amsterdam Season 1 Episode 7: Domino Effect, 2018)

After this interaction she sits down in the hospital bed next to Gianna and chats with her, till Gianna falls asleep on her shoulder. This suggests her tactic to make Gianna feel safe was effective. Male doctors are not afraid to show their sensitive side either. Hence my findings were quite in line with previous findings regarding Grey's Anatomy. Interactions between doctors and patients of both genders are not significantly different in contents (Pokhrel, 2015). Dr. Greene (E.R.) and Dr. Ross (E.R.) are both portrayed as caring and somewhat concerned with the domestic sphere. Dr. Ross generally behaves in a more masculine way in the sense that he is more promiscuous than Dr. Greene for Dr. Greene is married (Mendes & Carter, 2008). Neither are afraid to speak their minds. At the same time they are quite sensitive towards whomever they are treating. Dr. Frome (New Amsterdam) and Dr. Charles (Chicago Med) both show more vulnerability and sensitivity than the average doctor due to their role as psychiatrists. In Dr. Frome's case it is also possible he is less afraid to show his more feminine side because he is openly gay. Dr. Halstead (Chicago Med) is also never afraid to open up, especially to whomever he is romantically interested in. He is simultaneously very protective of whomever he is dating (Lauzen et al., 2008; Brooks & Hébert, 2006).

Dr. Shepherd (Grey's Anatomy) is also quite soft and caring most of the time, but Dr. Murphy (The Good Doctor) and Dr. Glasmann really put stereotypes on their head. Dr. Murphy behaves in a slightly unconventional manner due to his autism. This means he is never afraid to display emotion, all though he does manage to remain professional towards patients most of the time. He frequently requires emotional support from fellow staff which they seem quite willing to give to each other. Dr.

Glassman in particular is like a father figure to him. This is especially visible in this scene where Dr. Murphy experiences an autistic breakdown due to romantic issues as well as childhood trauma. As we can see in the quote below Dr. Murphy is in severe distress, to a point where he starts to hurt himself. Dr. Glassman helps him ground himself, tells him he can do anything he sets his mind to and promises him he'll always be there for him. He goes even further by saying he is proud of Dr. Murphy, a phrase that some parents are not even able to utter. They hug for a bit, before Dr. Murphy needs to leave for a surgery:

"Dr. Glassman: Shaun?

Dr. Murphy: I wanted to be honest. Carly said she wanted me to talk to her. Lea said not to tell what happened. Lea was right.

Dr. Glassman: Uh, take a breath. Sit down.

Dr. Murphy: I can't. I have surgery in a few minutes and I can't focus and… And I feel sick, and *is everyone going to leave me?*

Dr. Glassman: What? What? *What are you talking about?*

Dr. Murphy: *My dad didn't want me*.

Dr. Murphy hits the top of his head as he states this.

Dr. Murphy: *My mom chose him over me. Carly now hates me. Lea will get tired of me*.

Dr. Glassman: Shaun. Shaun.

Dr. Murphy: *You'll get sick of me*.

Dr. Glassman: What? Shaun.

Dr. Murphy: *I do everything wrong*.

Dr. Murphy hits his head again.

Dr. Glassman: Shaun, look at me for a second.

Dr. Murphy: Everyone will go away! I make people upset!

Dr. Glassman: Hey, hey, Shaun!

Dr. Glassman throws down his papers.

Dr. Glassman: Oh, my god, Shaun!

Dr. Murphy*: I make them angry! I make them hate me!*

Dr. Glassman: *Shaun, look at me, look at me, look at me right here*. Right here. Look at me here.

Dr. Murphy calms down a bit, still breathing rapidly and wringing his hands with tears in his eyes.

Dr. Glassman: *Don't ever say that about yourself. Don't ever say that! You hear me?*

Dr. Murphy calms down further.

Dr. Glassman: *You're gonna get through this*. You're gonna do the surgery and you're gonna get this done.

Dr. Murphy: How?

Dr. Glassman: How? Because *you're an extraordinary doctor*. That's how. And that's what you do. That's what you do.

Dr. Murphy's breathing speeds up.

Dr. Glassman: Hey, hey, hey, hey, hey.

Dr. Murphy's breathing slows down a bit.

Dr. Glassman: *I could not be more proud of you. You hear that? And I could never get sick of you.*

Dr. Murphy sighs and hugs Dr. Glassman.

Dr. Glassman: *You're not getting rid of me, pal, okay?* I'm right here. Right.. right here. Okay? I got you." (The Good Doctor Season 3 Episode 11: Fractured, 2020)

In the interaction Dr. Glassman shows some real emotional intelligence. Once he realises something is wrong with Dr. Murphy he tries to convince him to take a seat so they can discuss it. When Dr. Murphy explains he cannot sit down, because he has responsibilities to tend to Dr. Glassman instead tries to snap him out of his panic by drawing his attention. He asks Dr. Murphy to look him in the eye, so he can comfort him and tells him to breathe calmly. Once he gets Dr, Murphy's attention he opens up emotionally and shares how much he cares about Shaun, as this seems to be the best way to help him through these issues. Extremely masculine characters would never display such emotional availability and vulnerability. Dr. Murphy also helps normalize feeling overwhelmed and needing help from time to time, thereby again changing the stereotype of what it means to be a man and a professional Lauzen et al., 2008; Brooks & Hébert, 2006). He also promises he is never going to leave

Dr. Murphy, thereby tackling the abandonment issues Dr. Murphy is struggling with due to his childhood trauma.

4.1.2 Medical professionalism

Overall the doctors behaved quite ethically. A variety of codes demonstrates proper and professional behaviour in the medical field. The doctors did everything in their power to provide 'safe, high quality and effective care'. They addressed their gaps in knowledge, advocated for patients, aimed for equality and alleviated symptoms. They were also ambitious, showed appropriate behaviour in specific contexts and avoided patient exploitation to the best of their abilities. The doctors showed bravery, a certain amount of caring and empathy as well as clinical reasoning skills. They co-operated and showed compassion and friendliness. They complimented colleagues when appropriate in order to motivate them. The doctors were also willing to compromise, confide in colleagues or employ a bit of deception when needed. Certain situations also warranted them to interrupt colleagues while at work. They frequently came up with creative solutions such as a drug-free operation (The Good Doctor), live autopsy (House M.D), zip-tie sutures (Chicago Med) and a donation chain (New Amsterdam). The doctors tried their best to protect doctor-patient confidentiality and educate patients to increase their agency. Their communication with patients and colleagues was generally effective, leading to proper leadership.

They try their best to ethically steward medical resources and hold colleagues accountable. How these codes interconnect can be seen in Figure D 2 Code network Medical professionalism in Appendix D: Code networks. The doctors were usually honest and employed humour in order to make patients feel more comfortable and create a safe environment. They often had an interest in patients as people and learned from them. The doctors were frequently better at looking after others such as patients and colleagues than they were at looking after themselves however. For example by not having a work-life balance They often tried to work 'without aggression, anger or judgement all though this was not always achieved. After these mistakes they were usually self-aware enough to self-reflect and improve their behaviour, especially if they were held accountable by colleagues. At the same time they frequently offered help. They usually had an organized working method, prioritizing patient comfort, rights and wishes. The doctors usually 'fraternized' with each other in order to survive in the stressful medical environment. This often involved quite a bit of positive teasing. They usually wore practical and professional clothing and aimed for preventive care.

The doctors tried their best to be rational and realistic, while remaining respectful towards patients. They sometimes struggled to respect colleagues and subordinates however. Certain doctors were even willing to risk their reputation for the sake of patients and stood up for themselves when needed. Hence they were extremely altruistic, patient centred and accountable (Brennan & Monson, 2014, Barnard, 2016). They frequently displayed excellence, skilfulness and dutifulness, thereby living

up to professional expectations (Brennan & Monson, 2014). They also managed to alleviate symptoms and protect patients from socio-political vulnerability thereby enhancing their ability for self-determination. (Barnard, 2016). Finally they applied procedures, knowledge and co-operated to the best of their abilities (Mason et al., 2014).

Certain doctors were abusive towards subordinates, aggressive, distant and distracted by romance. Such doctors often display a lack of empathy. A few struggled with addiction and drugs, others frequently broke boundaries rather than maintaining them, by for example fighting out private matters at work or resorting to violence. Such doctors held inappropriate conversations at work and showed inappropriate behaviour in particular contexts. Some held biases, others delivered care inequitably. Certain doctors dodged their responsibilities, others had a god complex, where they thought they could perform any dangerous procedure. Some doctors communicated ineffectively leading to confusion and concern. Some doctors interrupted colleagues for no good reason or kept secrets from supervisors. One doctor in particular was cowardly and 'left a patient behind' in a dangerous situation, to fend for themselves. Hence they did not provide safe care. As mentioned before not all doctors look after themselves as they should. And working too much. They can also be very rude to colleagues and disobey orders for selfish reasons. While fraternizing and teasing are nice, pranks pulled on colleagues often went way too far. Some were too ambitious, leading to 'sucking up to superiors'. Sometimes showmanship also got the best of them. They would try to impress important people by delivering care inequitably and 'wasting medical resources.

After my analysis I realised that unprofessionalism seems to arise mostly when the doctors lean too far in one direction or the other. When they act too feminine they risk getting walked all over whereas if they act in a manner which is too masculine they run the risk of stepping on others instead. Whenever this happens they get too carried away by their emotions to make the right decisions. For example when Dr. Greene (E.R.) is struggling to work with the rather abrasive Dr. Swift (E.R.) they end up arguing while trying to treat a car crash victim. They manage to resolve it calmly once they are outside of the E.R, but they let their aggression, dominating behaviour and confrontational nature get the best of them. After their discussion however they also realise that they both wanted what was best for the patient in their own way. Dr. Greene uses this as a learning opportunity as Dr. Swift motivates him to do better. As can be seen in this example most protagonist or recurring doctors did learn from their mistakes, often during the run of the episode. They would go out of their way to correct their mistakes. Non-recurring doctors however could be terrible simply to be an antagonist. Such characters would never take the time to reflect on their behaviour.

Dr. Benton (E.R.) can get rather grumpy when he does not get his way. For example when Dr. Carter uses the E.R. as his second choice for an internship. He lets Dr. Carter (E.R) write his own recommendation for it as an act of revenge. Dr. Bailey (Grey's Anatomy) has a similar tendency to let

her emotions get the best of her. While she is beloved for her toughness, she can go too far when telling off interns. In the quote below she first scares them and then calls them 'Rosemary's babies' for apparently chasing away other residents. Dr. O'Malley also crosses a boundary here by hugging Dr. Bailey without her consent. He let his softer side get the best of him. The quote below also show tendencies which Dr. Yang (Grey's Anatomy) and Dr. Reese (New Amsterdam) share. They are ambitious to a point where they might become unethical. In Dr. Yangs case this means she is willing to suck up to superiors to get her way. In other scenes she is also willing to step on others to get ahead.. Dr. Reese instead made the mistake of putting a psych patient in danger, because she was convinced her exposure therapy method would cure him. They show what happens when women have too much ambition for their own good:

> "Dr. Yang: Yeah. Which *surgeon are we having to suck up to* today?
>
> Dr. Bailey jump scares them from behind.
>
> Dr. Bailey: That would be *me*.
>
> Dr. Stevens: Dr. Bailey?
>
> Dr. Bailey: I've been gone two weeks, two weeks, and *you ran off two residents*? I've got people phoning me screaming, telling me *my interns are Rosemary's Babies*. Nobody wants you. *Do you think I have time for this? I am pregnant*. I'm supposed to be on bedrest. I'm supposed to be growing a human being. I'm supposed to be calm. Do I look calm to you? *Did I raise you fools to be pariahs?*
>
> Dr. O'Malley pushes the other residents aside, steps forward and hugs Dr. Bailey. " (Grey's Anatomy Season 2 Episode 16 It's the End of the World, 2006)

Dr. Bailey simultaneously shows another 'terrible tendency', which is to be a workaholic. This could be a result of the North American mindset towards work-life balance. In the USA it is normalized to work a lot of overtime in order to show commitment to a certain occupation (Bryan-Brown & Dracup, 2003). This tendency could be even stronger in the medical world as medical careers are seen as a calling rather than a job (Bryan-Brown & Dracup, 2003). Such callings in North American culture require intense commitment (Ibbi, 2013; Catley, 1997). Dr. Bailey is willing to go to work while pregnant and very close to giving birth. In fact she goes into labour a few minutes later in the episode, while still giving instructions to fellow staff. She shares this tendency to overwork herself to a point where she harms herself with Dr. Goodwin (New Amsterdam) and Dr. Bloom (New Amsterdam). Dr. Goodwin was willing to postpone his own cancer treatment to help patients in need of organ donations. He together with Dr. Sharpe created a very creative donation chain to insure everyone

would find a match and receive or give an organ. Dr. Bloom on the other hand has been shown to abuse Adderall in order to continue working to a point of exhaustion.

Good fellow coworkers are willing to step in however. Dr. Halstead (Chicago Med) for example tried to insure Dr. Manning (Chicago Med) would take a day off after being involved in a shootout. While she irresponsibly carried on with her work, he motivated her to take some rest. He turned out to be right as she ended up with a concussion from hitting her head on a car door. She slammed into the door while dodging the crossfire. This concussion also made her act out of character, where she became too aggressive for her own good, which resulted in a very difficult situation regarding a child abuse victim. She almost chased the patient away from the hospital by offending the patient's caretaker. Just like other characters on Grey's Anatomy, Dr. Karev and Dr. Stevens are quite involved in work romances. While this does not need to be a problem in particular as there is no power imbalance between them, they were willing to engage in intimate acts at work. This is the point where it crosses the line.

Dr. House (House M.D.) crosses the line most frequently. He distances himself from patients and fellow staff by insulting and dehumanizing them. He is also often unwilling to speak to the patients himself. He instead leaves this up to his team to avoid having to deal with feelings. Simultaneously he claims these behaviours are part of his deductive treatment method, which requires rational objectivity (Rich et al., 2008; Holtz, 2006). In order to theorize in complete concentration he frequently abuses drugs such as Vicodin. He became addicted to Vicodin due to an injury to his leg. In his interactions with patients he can be extremely paternalistic, thereby decreasing patient agency (Wicclair, 2008; Barnard, 2016).

Dr. Bell (The Resident) is quite the opposite of Dr. House. While he can be tough in setting boundaries and perhaps too profit oriented at times, he develops into a very kind and understanding doctor. He is very respectful of fellow staff, which is especially notable in the episode I looked at. During the episode he discovers that their beloved hospital custodian Simon Ortiz is sick. He goes out of his way to treat Simon and takes the time to check in on him, since they are close friends. Simon unfortunately passes away despite their efforts. Dr. Bell decides to clean the operating room himself this time, to honour Simon. In the quote below Simon tries to push Dr. Bell away as he deems the treatment unnecessary, but Dr. Bell manages to continually convince and comfort him with humour. In their interactions he highlights how much he values Simon as a friend and a worker, rather than being a very distanced leader. Dr. Hawkins tries to convince Simon that he is worth their time and effort, as he is a very valuable worker and person. He says Simon deserves the best the hospital has to offer:

"Custodian Simon Ortiz: Is all this really necessary?

Dr. Hawkins: *Nothing's too good for Chastain's longest serving employee*.

Custodian Simon Ortiz: Can I get a 65' Mustang instead?

Dr. Hawkins: You can buy it yourself, you're winning that lottery."

(The Resident Season 2 Episode 16 Adverse Events, 2019)

Here Dr. Bell demonstrates his emotional intelligence by putting himself in Simons shoes to know how to convince him, without coming across as paternalistic (Brooks & Hébert, 2006; Barnard, 2016). He therefor focusses on what Simon might be looking forward to after undergoing treatment. In this episode it is revealed that they frequently buy lottery tickets together and they bond through fantasising about what they might do if they win. This suddenly puts them at an even level, even though Dr. Bell is the CEO of the hospital and Simon Ortiz is the hospital custodian. It is also clear in their interactions that they do not feel a power imbalance, because Simon is a lot older than Dr. Bell and knew him when he was still a medical resident. He jokes that Dr. Bell was as green as grass when he started and hid from his attending in the custodial closet back then.

4.1.3 Social issues

These shows shed light on many relevant social issues. A lot of these issues were quite particular to the USA. Thereby granting attention to the concepts of the American dream, freedom, equality, prosperity, individualism, capitalism and democracy (Ibbi, 2013; Catley, 1997). The shows do not shy away to the downsides of capitalism and the USA democratic system. The episodes got into the effects of religion, migration, capitalism and the privatization of healthcare, mental health and drug addiction. These religious issues are frequently related to USA religious organizations. The effects of capitalism and privatization of healthcare are strong there too. Drug addiction is also a common problem, partially due to income inequality and lack of a social safety net. The codes I found instances of abuse, addiction and drugs, autistic meltdowns, autistic traits issues regarding big pharma and bribery, the chaos of North American Emergency Rooms, child abuse and -marriage, parentification, cult brainwashing, the dangers of fast food, gun violence, immigration issues, infertility, low nurse wages, 'mental health problems and trauma, privatized healthcare, student debt, unfair distribution of healthcare and the dangers of wealthy hospital patrons. How these codes and issues interconnect can be seen in Figure D 3 Code network Social issues in Appendix D: Code networks.

Dr. Lewis (E.R.) was very sensitive when discussing attempted suicide with the girlfriend of one of their patients. Their patient Donald Costanza attempted to commit suicide by driving his car into a ditch. Girlfriend Amy was very distressed. Dr. Lewis noticed signs of abuse so she allowed Amy to make up her own mind about leaving Donald (Barnard, 2016; Sutherland Cornett, 2006). By the end of the episode she changed her mind and stayed with Donald, despite his emotional manipulation. Dr. Lewis did not say anything about it at that point, as it is not up to her to involve herself in such

matters. She did suggest all kinds of help for Amy while Amy was contemplating what to do however. In the quote below she first re-assures Amy and then lets her open up about her feelings towards Donald. Hence she provided empathy and compassion as expected of a medical professional (Mason et al, 2014). Donald is a gambling addict and emotionally manipulative, as he threatened to commit suicide if Amy broke up with him. He actually did it too after she broke up with him. Hence Dr. Lewis offers to find Amy a therapist. When she declines she does not push on and instead try to honour her wishes.

Dr. House (House M.D.) went about euthanasia very neatly too. He was treating nine-year-old Andie, who suffered from two types of cancer. Since she only had one year left to live if treated, he carefully asked her if she was sure she wanted to undergo the treatment at all. He explained that the treatment would be very uncomfortable, thereby decreasing her quality of life. In that conversation he explains to Andie that she does not need to go through all this pain for her mother, if she does not want to. He hereby motivates her to choose freedom and individualism, playing into North American ideals (Ibbi, 2013; Catley, 1997). When she decides that she does want treatment he honours her wishes. Dr. Goodwin, Dr. Sharpe, Dr. Kapoor, Dr. Frome and Dr. Reynolds (New Amsterdam) come up with a brilliant idea to deal with a lack of available organs. They create a donation chain through intense cooperation to insure everyone receives or gives an organ. Basically the family members of patients in need of an organ donate an organ, but to a stranger rather than towards their own family member. This way the organs actually match, whereas with a direct donation they would not.

Dr. Murphy (The Good Doctor) and Dr. Reznick (The Good Doctor) tackle drug abuse very well. They never show any judgement towards their patient for suffering from addiction. During the process they do everything they can to keep them safe and respect patient Kerry's wishes. They come up with a plan to conduct a drug-free operation in order to treat their patient without letting her relapse. Before deciding on this procedure they also lay out all of the alternatives as those might have been safer. When the patient decides on this plan, they respect her wishes as long as it goes well. Dr. Park (The Good Doctor) was a lot less understanding when confronted with drugs. He treats patient Luka, who turns out to be a drug mule. Luca suffers the consequences of being a drug mule when the drugs get stuck in his belly. Since Dr. Park used to be a police officer he gives patient Luka a very hard time for getting involved in drug trafficking. He thereby created an unsafe environment (Barnard, 2016). Dr. Browne shows a lot more understanding and tries to help him get away Scott free, since the drugs did not end up with any users anyway.

Dr. Manning (Chicago Med), went about child abuse slightly wrong. She gets a visit from fourteen-year-old patient Lindsay, who is suffering from side-effects of a miscarriage. When she realises that the forty-year-old reverend who brought her in is her husband, she starts to ring the alarm bells. She tells head of hospital Nurse Goodwin about the situation. While the two were married in a

legal manner, Dr. Manning is still eager to fight the abuse. The reverend is also intent on having children with this underage girl. Hence Dr. Manning is determined to give Lindsay her autonomy back (Barnard, 2016). She points out the hypocrisy of the reverend policing Lindsay's body when he says himself that since she is married, she is legally considered an adult. The quote below shows Dr. Manning losing her composure arguing with the reverend. She suddenly starts to call him names and yells at him. Hence her communication was no longer very effective (Mason et al., 2014). This was not the brightest idea as it motivates him to take Lindsay home with him without treatment. Her aggression is also a result of the concussion she sustained earlier in the episode. The reverend gets physical with her, which justifies Dr. Manning drawing a line, but probably not in this aggressive manner.

"Dr. Manning: I was just conferring with my patient. Lindsay regardless of what this man thinks or wants, *it is your body and your choice*…

Reverend Cray decides to grab Dr. Manning by the arm to escort her out of the room.

Reverend Cray: That has already been decided. Will you step outside with me, please?

Dr. Manning: *Sir, get your hands of - of me!*

They are now outside the room.

Reverend Cray: From the start, you have been *wilful and argumentative*.

He points his finger in her face aggressively. She argues her patient has the right to decide herself.

Dr. Manning: My patient has the right to decide how she wants to treat her cancer.

Reverend Cray: *The cancer is you*. You've been *treating Lindsay like she's a child, not a woman.*

Dr. Manning: She is a child! *She's 14! Just because you had some judge sign off on what's obviously a case of abuse*…"

(Chicago Med Season 3 Episode 10: Down by Law, 2018)

After she receives treatment for her head injury she confides in her boyfriend Dr. Halstead about her outburst. He realises this situation is very close to her heart, so he goes out of his way to fix the situation. After apologizing to the reverend on Dr. Manning's behalf and playing along with his sexist rhetoric to appease him, he speaks to Lindsay in private one more time. After informing her further about her choices she decides she would like a hysterectomy. Dr. Halstead and Dr. Manning acted as very good public educators in this episode (Bhugra). He warns Lindsay about the potential side-effects but she explains she is willing to deal with those, because this is her way to take her autonomy back.

This procedure permanently prevents pregnancy as she no longer has a uterus to grow children in. Such infertility could lead to her finally being left alone by the reverend since he seemed so insistent on having them, despite the health complications Lindsay experienced whenever pregnant. He manages to trick the reverend to get the proper paperwork, thereby misleading him for the greater good (Barnard, 2016).

Dr. Bell (The Resident), Dr. Hawkins (The Resident), Dr. Okafor (The Resident) and Dr. Pravesh (The Resident) take on big pharma throughout the entire episode I looked at (Barnard, 2016). In this episode a pharmaceutical company called QuoVadis created a 'Vagus Nerve Stimulator'. The episode sheds light on the dangers of capitalism and privatization of healthcare as QuoVadis is willing to risk people's lives for the sake of profit (Ibbi, 2013; Catley, 1997). The device is very innovative, but not safe at all. The first patient who receives the device passes away. After that the second, named Henry Barnett gets severely injured by it. Simultaneously QuoVadis tries to market the device even more, by selling it to the army for traumatized veterans. The fact that these veterans were willing to receive an implant to treat their PTSD was also a comment on how poorly veterans are treated in the USA. Dr. Bell decides to cut off their hospitals ties with QuoVadis right away. Dr. Hawkins motivates Henry's mother Zoey to go to the media about the situation, since Henry is underage. While this does not work as QuoVadis threatens and bribes her, Dr. Okafor and Dr. Pravesh, with some help from Marshall Winthrop manage to convince the army of the dangers of the device just in time.

Dr. Rhodes (The Resident) similarly takes on for-profit healthcare. He previously ran a mobile clinic in his RV to provide healthcare to remote and impoverished communities in the USA. When he gets approached by uninsured patient Marylin Spoelstra he tries everything in his power to treat her in or near the hospital, despite the fact their hospital does not actually take uninsured patients (Barnard, 2016). After she puts herself in danger he is suddenly allowed to provide treatment. He laments that the for-profit healthcare system discourages preventive healthcare for average people this way (Ibbi, 2013; Catley, 1997). Finally Dr. Frome (New Amsterdam) frequently tackles mental health problems as he is a psychologist. In this episode Dr. Frome takes on child services to help his underage patient Jemma. She shows very aggressive behaviours throughout their interactions, but he realises she is struggling with trust issues. These are a result of her past experiences. In the quote below he tells her that she needs to learn to trust in order to be with the family he arranged for her. At the same time he tells her he has faith in her and she will not mess up or push people away. He says she deserves a family.

"Jemma: *No one wants me.*

Dr. Frome is sad to hear her speak so negatively about herself and shakes his head.

Dr. Frome: Why would I say that? It's not true.

Jemma: Yes, it is.

Dr. Frome: No, it's not. Blanca wants you.

Jemma: Yeah, today she does. Someday she won't. look, I'm gonna mess it up. I always do.

Dr. Frome: No, I don't believe that. Not for a second. *I know that trusting people… is scary.* That's the scariest thing. But when it comes to family… that's just the price of admission. That's the way it goes. And *nobody deserves a family more than you do*. Nobody. Trust me.

Jemma hugs Dr. Frome." (New Amsterdam Season 1 Episode 7: Domino Effect, 2018)

Dr. Frome does not show judgement nor fear in this interaction. Instead he tries his best to put himself in Jemma's shoes to know how to help her, by insuring her of her own value (Brennan & Monson; Barnard, 2016). In their interactions he also shows an interest in her as a person as he asks what she is up to while she is working on a school project. When it falls apart he shows sympathy as he explains he finds it unfortunate that it is now broken. He also wants to know what happened so that they can prevent it from happening again. When she is finally placed in Blanca's home he gives her a new science kit, so she can create a project again. He realises this matters to her because she would like to pursue scientific education, where some experience with science could be helpful. She hugs him after he gives her the science kit, because this is one of few times someone took the time to do something for her. Here he again repeats that she deserves a home and she is worthy, to build her confidence and self-esteem back up.

4.2 Quantitative results

This section explains the similarities and differences I found between male and female fictional doctors in medical tv drama's. I coded a sample of seven tv shows quantitatively using a code-book and Excel, to be analysed in SPSS. I recorded behaviours which exemplify medical (un)professionalism or match or subvert gender stereotypes. I also recorded the name, gender, sexuality and ethnicity of the doctors I was observing and their behaviours. The first main finding is that tv shows still feature more male than female doctors on average and the division has not improved over time. However the overall the shows were quite diverse, with variation in sexualities and ethnic backgrounds among the doctors as can be seen in table 4.1 diversity among doctors. The TV shows had a skew towards male patients, but again featured a realistic level of ethnic diversity on average as can be seen in table 4.2 diversity among patients. After testing for correlations, I found no relationships between the gender and masculinity- and femininity level of characters as can be seen in table 4.3. Hence women were not significantly more likely to be feminine and men were not significantly more likely to be masculine. I also looked for correlations between people of particular ethnical backgrounds and sexualities and masculinity and femininity, since minorities are more likely to be stereotypical. I found no such correlations. Doctors who are part ethnic minorities were not

significantly more likely to be feminine, masculine, professional or unprofessional when compared to white people.

I did find correlations between femininity and masculinity and professionalism and unprofessionalism. Stereotypically feminine characters were significantly more professional as for every point they were more feminine. Masculine characters were also significantly more professional. However, they were also significantly more unprofessional. This suggests masculine characters are more likely to misbehave than feminine characters. After conducting cross tabulations I found that Nurse/Dr. Lockheart (E.R.) was the most feminine doctor of the sample with an average femininity score of 12. E.R. was also the most feminine show with an average score of 4,73. Dr. Robert Romano (E.R.) was the most masculine doctor with an average masculinity score of 21 as can be seen in Appendix F: highest scores per show. Dr. Gregory House (House M.D) was simultaneously the most and least professional doctor, thereby staying true to his morally ambiguous postmodern characterization (Rich et al, 2008). He had an average professionalism score of 50 and an average unprofessionalism score of 34. House M.D. was also simultaneously the most and least professional tv show due to the extreme tendencies portrayed by the cast. The tv show scored an average of 16 professionalism points and 8,1 unprofessionalism points.

After conducting several layered means comparisons with ANOVA tests of significance to I was able to assess to what degree particular demographics are associated with femininity, masculinity, professionalism and unprofessionalism. Most demographics showed no relation to femininity at all. Individual minorities did not show a relationship to femininity either, I only found statistical significance once I combined all doctors of non-white ethnicities together as one category. Their femininity and masculinity are significantly lower than the femininity and masculinity of white doctors. There were also significant differences in femininity between doctors of the different shows. E.R. and House M.D doctors scored 7,13 and 6,72 respectively while the other shows had scores closer to 3 as can be seen in table 4.4 Means comparison femininity among different demographics. Male characters did not behave significantly more masculine than female characters. Doctors who belonged to an ethnic minority had a significantly lower average masculinity score. They scored 2,77 on average, whereas white doctors scored 3,71 on average. Ì found significant differences in professionalism between doctors of the different shows. E.R. doctors scored 16,25 and House M.D. doctors scored 14,51 while the other shows had scores between 4 and 9 as can be seen in table 4.5 Means comparison masculinity among different demographics. This suggests big displays of professionalism have decreased over time. I did not find a statistically significant difference in professionalism among the different genders, demographics nor different shows.

4.2.1 Doctor and patient population

Table 4. 1 Diversity among doctors

Diversity among doctors								
Demographic	**All shows**	**ER**	**House MD**	**Grey's Anatomy**	**Chicago Med**	**The Good Doctor**	**The Resident**	**New Amsterdam**
Male	62,8%	65,8%	75,0%	51,8%	75,0%	61,1%	84,6%	69,2%
	130	25	15	44	15	11	11	9
Female	37,2%	34,2%	25,0%	48,2%	25,0%	38,9%	15,4%	30,8%
	77	13	5	41	5	7	2	4
Straight	91,8%	92,1%	95,0%	88,2%	100,0%	94,4%	100,0%	84,0%
	190	35	19	75	20	17	13	11
Gay	4,8%	7,9%	0,0%	7,1%	0,0%	5,6%	0,0%	0,0%
	10	3	0	6	0	1	0	0
Bi	3,4%	0,0%	5,0%	4,7%	0,0%	0,0%	0,0%	15,4%
	7	0	1	4	0	0	0	2
White	59,0%	63,2%	70,0%	62,4%	70,0%	22,2%	46,2%	53,8%
	122	24	14	53	14	4	6	7
Afro-American	20,8%	15,8%	15,0%	28,2%	0,0%	33,3%	15,4%	15,4%
	43	6	3	24	0	6	2	2
Indian	4,3%	5,3%	5,0%	0,0%	10,0%	0,0%	15,4%	15,4%
	9	2	1	0	2	0	2	2
Jewish	3,9%	5,3%	10,0%	0,0%	0,0%	16,7%	7,7%	0,0%
	8	2	2	0	0	3	1	0
Hispanic/Latino	2,9%	0,0%	0,0%	4,7%	0,0%	11,1%	0,0%	0,0%
	6	0	0	4	0	2	0	0
Chinese	3,4%	2,6%	0,0%	4,7%	0,0%	5,6%	7,7%	0,0%
	7	1	0	4	0	1	1	0
Croatian	1,4%	7,9%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%
	3	3	0	0	0	0	0	0
Other	9	0	0	0	4	2	1	2
	4,3%	0,0%	0,0%	0,0%	20,0%	11,1%	7,7%	15,4%
Total	207	38	20	85	20	18	13	13

I observed the behaviours of a total of (N) 207 main and recurring doctor characters across seven medical tv shows. These observations also contain a few repetitions of the same doctors, but this gave a good impression of what kinds of demographics received the most representation. The tv shows turned out to still have more male than female doctors on average as can be seen in Table 4.1 Diversity among doctors above. The tv shows on average featured 62,8% male and 37,2% female doctors. Hence H1; The number of female doctors in medical tv drama's has increased, was refuted. This is quite unrealistic as there are 50,9% women and 49,1% men in the USA population (US Census Bureau, 2024). House M.D. and Chicago Med were the least equal in this sense as they featured 75% male doctors and 25% female doctors. However Chicago Med features female nurses as main and recurring characters. While that does play into the stereotype that women are less able to become doctors, they are not ignored entirely. The nurses are also treated with respect in shows that heavily feature them. Grey's Anatomy had the most equal gender division with 51,8% female and 48,2% male.

The Tv shows were quite diverse in sexualities on average with 91,8% straight, 4,8% gay and 3,4% bi doctors. I recorded the sexualities of the doctors by looking this information up on forums, since fans have kept very good records of the sexualities, backgrounds and so on of tv show characters. This is quite close to the reaction to a recent poll in the USA where 85.7% of participants identified as straight, 5.2% as bisexual, 2.0% as gay, 1.4% as lesbian and as 1.3% transgender (Jones, 2025). Just under 1% fall under other categories of the LGBTQ+ umbrella such as pansexual, asexual or queer. New Amsterdam was the most diverse in sexualities with only 84% straight doctors. 15,4% of the doctors featured on New Amsterdam were bi. Chicago Med and the Resident were the least diverse in sexualities as that part of the sample consisted of 100% straight doctors.

The doctor population was also quite diverse in ethnicities as only 59% of doctors on the shows were white. The representation of white people is quite in line with the actual USA population. All though the other ethnicities are represented in different ratio's in reality. On average 20,8% of doctors were Afro-American, 4,3% were Indian, 3,9% were Jewish, 3,4% were Chinese, 2,9% were Hispanic/Latino, 1,4% were Croatian and 4,3% were of other ethnicities. The 'other' category includes Afro-American/Jewish, Afro-American/White, Iranian/Kurdish, Japanese-American and Nigerian. When the actual USA population consists of 58,9% white, 19,1% Hispanic/Latino, 12,6% Afro-American, 6,1% Asian, 2,45 multi-racial, 0,7% Native American/Alaskan and 0,2% Native Hawaiian/Pacific Islander (USAFacts, 2025). The Resident was the most diverse in ethnicities, with only 46,2% white doctors. The Resident also featured 15,4% Afro-American and Indian and 7,7% Jewish, Chinese and 'other' doctors. Chicago Med and House M.D. were the least diverse with 70% white doctors. Hence H11; Representations of male and female medical professionals in American medical drama tv shows have become more diverse, has been confirmed.

Table 4. 2 Diversity among patients

Diversity among patients								
Demographics	**Tv shows**	**ER**	**House MD**	**Grey's Anatomy**	**Chicago Med**	**The Good Doctor**	**The Resident**	**New Amsterdam**
Male	58,6%	66,7%	60,0%	61,9%	53,3%	50,0%	50,0%	50,0%
	51	18	3	13	7	4	2	3
Female	40,2%	33,3%	40,0%	38,1%	46,7%	50,0%	50,0%	50,0%
	35	9	2	8	8	4	2	3
White	63,2%	70,4%	80,0%	57,1%	60,0%	50,0%	75,0%	75,0%
	55	19	4	12	9	2	6	6
Afro-American	16,1%	11,1%	0,0%	23,8%	20,0%	25,0%	33,3%	0,0%
	14	3	0	5	3	1	2	0
Hispanic/Latino	9,1%	7,4%	4,8%	9,5%	6,7%	25,0%	16,7	12,5%
	8	2	1	2	1	1	1	1
Asian	3,4%	3,7%	20,0%	4,8%	0,0%	0,0%	0,0%	0,0%
	3	1	1	1	0	0	0	0
Jamaican	2,3%	0,0%	0,0%	0,0%	13,3%	0,0%	0,0%	0,0%
	2	0	0	0	2	0	0	0
Jewish	2,3%	7,4%	0,0%	9,5%	0,0%	0,0%	16,7%	12,5%
	2	2	0	2	0	1	1	1
Indian/Pakistani	1,1%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	12,5%
	1	0	0	0	0	0	0	1
Total	87	27	5	21	15	4	6	8

I analysed the demographics of (N) 87 different patients, whom received individual attention from the tv show characters. This helped me asses if the shows were diverse in casting overall, which gives a look into the general attitudes of the companies behind them regarding representation. The TV shows generally had a skew towards male patients as they featured 58,6% male and 40,2% female patients as can be seen in table 4.2 diversity among patients above. This is quite unrealistic as there are 50,9% women and 49,1% men in the USA population (US Census Bureau, 2024). House M.D. was the least equal in this dimension as the show featured 66,7% male and 33,3% female patients. The Good Doctor, The Resident and New Amsterdam struck the best balance with a 50/50 division. The TV shows were quite diverse overall with only 63,2% white, 16,1% Afro-American, 9,1% Hispanic/Latino, 3,4% Asian, 2,3% Jamaican and Jewish and 1,1% Indian/Pakistani. The Good Doctor

was also the most diverse in this sense with 50% white, 25% Afro-American and 25% Hispanic/Latino patients. House M.D. again was the least diverse with 80% white patients.

4.2.2 Correlations

Table 4. 3 Correlations; Femininity, Masculinity, Professionalism and Unprofessionalism

		Femininity	Masculinity
Professionalism	Pearson correlation	0,388***	0,465***
	Significance (2 tailed)	<0,001	<0,001
	N	164	164
Unprofessionalism	Pearson correlation	-0,034	0,796***
	Significance (2 tailed)	0,76	<0,001
	N	84	92

*Note. Significance levels: * p< .05 ** p< .01 *** p< .001.*

I first ran multiple correlation tests in order to determine if there was a correlation between the independent variables femininity and masculinity and professionalism and unprofessionalism. This revealed correlations between independent femininity and masculinity and professionalism and unprofessionalism. Stereotypically feminine characters were significantly more professional. Masculine characters were also significantly more professional, but simultaneously significantly more unprofessional. This could be a result of the fact that particular gender behaviours suit professionalism and unprofessionalism. Certain masculine tendencies do not suit a care-taking profession very well. It also suggests masculine characters were more likely to misbehave. This could suit the stereotype of a strong and rebellious doctor.

4.2.3 Cross tabulations

After conducting multiple layered cross tabulations I found out who was the most feminine, masculine-, professional- and unprofessional- doctor of each show. I also found the average femininity, masculinity, professionalism and unprofessionalism scores for each show. These scores can be found in tables 1, 2,3 and 4 Appendix F: Highest scores per show. The table also contains the aspects that make each high-scoring doctor feminine, masculine, professional or unprofessional. The scores for gender stereotypes decreased per show. I found that Nurse/Dr. Lockheart (E.R.) was the most feminine doctor of the sample with an average femininity score of 12. E.R. was also the most feminine show with an average score of 4,73. Her supportive, friendly nature and attempts to forge connections make her a stereotypically feminine character, but not in a negative manner (Brooks & Hebert, 2006). She is a positive professional role model as her traits make her a very safe and compassionate caretaker (Haboubi et al., 2015; Barnard, 2016).

Dr. Robert Romano was the most masculine doctor with an average masculinity score of 21. His rude, direct, confrontational attitude and tendencies to dominate in public speech make him a stereotypically masculine character. He shows the worst qualities a caretaker could have, thereby

making him a bad professional role model (Haboubi et al., 2015). E.R. was also the most masculine show on average with an average score of 7,1. This suggests that E.R. was the most stereotypical. House M.D. was still quite stereotypical, but following shows much less so. These were the two oldest shows. E.R. ran from 1994 till 2009 and House M.D. ran from 2004 till 2012. This theory was also supported by a means comparison I conducted of the different years where femininity and masculinity were significantly different for each year and decrease over time as can be seen in table 4.8 means comparison femininity, masculinity, professionalism and unprofessionalism per year.

Dr. Gregory House (House M.D) was simultaneously the most and least professional doctor, thereby staying true to his morally ambiguous postmodern characterization (Rich et al, 2008). He had an average professionalism score of 50. His humour, clinical reasoning, ability to create a safe environment and willingness to advocate for patients make him a good doctor. He takes the initiative and comes up with creative treatments for the most complex cases (Mason et al., 2014). However at the same time he scored an average of 34 points for unprofessional behaviour. He has the tendency to break boundaries, disrespect colleagues and waste medical resources (Barnard, 2016). Besides that he can be paternalistic in his approach to medicine. In his mind he does not give patients what they want, but what they need (Wicclair, 2008). He can also be rather untrustworthy overall. At the same time he is well aware that he needs his team to keep him in check as otherwise he will go too far. In certain episodes he motivates them to call him out when he is crossing a line.

House M.D. was also simultaneously the most and least professional tv show due to the extreme tendencies portrayed by the cast. The tv show scored an average of 16 professionalism points and 8,1 unprofessionalism points. While the team is very knowledgeable and talented at clinical reasoning, they frequently go way too far. They are for example willing to break into people's houses, keep secrets, steal, use abusive language etc. The team might play into the savant-type in the sense that they have a very high IQ, but very low EQ (emotional intelligence). Rather than trying to understand the patients they try to push their ideas upon them (Mason et al., 2014).

4.2.4 Means comparisons

I conducted several layered means comparisons with ANOVA tests of significance to assess to what degree particular demographics are associated with femininity, masculinity, professionalism and unprofessionalism. Most demographics showed no relation to any of these scores. Hence those demographics were not especially feminine, masculine, professional or unprofessional and instead seemed rather neutral.

Table 4. 3 Means comparison femininity among different demographics

Means comparison femininity among different demographics										
		Year	**1994-2024**	**1994-2009**	**2004-2012**	**2005-present**	**2015-present**	**2017-2024**	**2018-2023**	**2018-2023**
	Significance (among all shows combined)	**Demographic**	**All shows**	**ER**	**House MD**	**Grey's Anatomy**	**Chicago Med**	**The Good Doctor**	**The Resident**	**New Amsterdam**
Genders	0,082	Female	4,03	5,25	5,50	3,81	4,50	2,00	3,00	3,25
		Male	4,59	8,39	7,07	2,92	3,00	4,29	4,29	2,75
Sexualities	0,191	Straight	4,38	7,15	7,00	3,32	3,43	3,55	3,11	2,60
		Bi	3,00		2,00	2,33				4,50
		Gay	4,87	7,00		4,25		1,00		
Ethnicities	0,027*	Non-White	3,29	4,5	3,00	3,37	4,20	1,75	3,20	2,40
	0,358	White	5,13	8,45	8,58	3,30	3,00	6,50	3,00	2,29
		Afro-American	3,34		2,33	3,30		1,00	2,50	2,00
		Chinese	2,70			4,50		4,00		
		Indian	0,58	2,50	3,00		5,00		4,00	4,00
		Hispanic/Latino	1,97			2,33				
		Jewish	2,67	4,00	4,00			1,33		
		Other	2,78	2,00			3,67	3,00	3,00	2,00
TV shows	0,037*	All doctors	4,38	7,13	6,72	3,33	3,43	3,33	3,11	2,92

*Note. Significance levels: * p< .05 ** p< .01 *** p< .001.*

I expected male and female doctors to have become more similar in their characterisation. Most demographics showed no relation to femininity at all. Meaning no demographic was especially feminine. This is quite a departure from previous studies where women behaved in a much more feminine manner than men. Previously women were portrayed as pretty, passive, caring and nurturing and concerned with the domestic setting as well as their body and physical appearance (Wilks, 2012). Now their scores are not significantly different from male doctors on average and their scores have decreased overall, which suggests both have become less extreme in their characterisations overall. Both genders can now be dominant, aggressive and professional when their job demands it (Brooks & Hébert, 2006). H3; Female doctors have become less feminine over time, has been refuted as there were no significant changes per year nor per show for female doctors. This could be because female doctors acted neutral overall, to prevent any backlash. H4; Male doctors have become more feminine over time has been confirmed

Individual minorities did not show a relationship to femininity either, I only found statistical significance once I combined all doctors of non-white ethnicities together as one category. Their

femininity and masculinity are significantly lower than the femininity and masculinity of white doctors as can be seen in table 4.4 above. They scored 3,29 for femininity on average, whereas white doctors scored 5,13. This phenomenon has not been investigated previously, but I theorize that these minority doctors are less stereotypical to make their portrayals more positive. Stereotypically masculine behaviour was statistically associated with unprofessionalism. Based on the content analysis there could be a relationship between femininity and professionalism too, but these means comparisons did not confirm it. These stereotypical portrayals can be harmful in the sense that they give the impression that there is only one way to correctly perform the social construct of gender. There were also significant differences in femininity between doctors of the different shows. E.R. and House M.D doctors scored 7,13 and 6,72 respectively while the other shows had scores closer to 3. This is likely a result of the eras they were produced in as they were created between 1994 and 2012.

Table 4. 4 Means comparison masculinity among different demographics

Means comparison masculinity among different demographics										
		Year	**1994-2024**	**1994-2009**	**2004-2012**	**2005-present**	**2015-present**	**2017-2024**	**2018-2023**	**2018-2023**
	Significance (among all shows combined)	**Demographic**	**All shows**	**ER**	**House MD**	**Grey's Anatomy**	**Chicago Med**	**The Good Doctor**	**The Resident**	**New Amsterdam**
Genders	0,543	Female	3,78	5,73	3,75	3,23	3,23	3,67		4,50
		Male	3,08	4,23	2,40	2,63	2,63	2,56	3,33	3,50
Sexualities	0,811	Straight	3,31	4,80	2,79	2,90	2,93	2,86	3,33	3,25
		Bi	5,40			4,67				6,50
		Gay	3,10	4,00		2,33		5,00		
Ethnicities	0,042*	Non-White	2,77	3,50	2,00	2,76	2,25	2,82	2,00	2,25
	0,6	White	3,71	5,43	3,00	3,02	3,18	3,60	4,00	5,00
		Afro-American	2,52	2,60	2,00	2,39		3,20	3,00	2,00
		Chinese	3,00			3,00		3,00		
		Indian	2,80	3,00			15,50		1,00	
		Hispanic/Latino	4,25			4,67		3,00		
		Jewish	3,00		2,00			2,67		
		Other	3,36	5,00			9,00	1,00		2,40
TV shows	0,021*	Doctors	3,36	4,73	2,79	2,93	2,93	3,00	3,33	3,90

*Note. Significance levels: * p< .05 ** p< .01 *** p< .001.*

H2; Female doctors have become more masculine over time, has been refuted as their masculinity level has remained relatively stable over time. This can be observed in table 4.5. Again

supporting the theory that they try to be neutral in order to fit in. Male characters did not behave significantly more masculine than female characters on average. This is quite a departure from previous studies where men behaved in a much more masculine than women. They can now also be nurturing and concerned with the domestic setting (Wilks, 2012). Rather than only being dominant, aggressive and professional Brooks & Hébert, 2006). Hence H5; Male doctors have become less masculine over time, has been confirmed. The means comparisons which can be found in table 4.5 below also support this theory as they have become significantly less masculine per year and simultaneously significantly more feminine with each passing year. The average scores for both genders combined also decreased significantly which suggests that portrayals have become more neutral with time.

Doctors who belonged to an ethnic minority had a significantly lower average masculinity score as can be seen in table 4.5 above. Hence H6; Doctors who belong to sexual and/or ethnic minorities to behave in a more stereotypical manner than doctors who belong to the majority, has been refuted. They scored 2,77 on average, whereas white doctors scored 3,71 on average as can be seen in table 4.5 above. This suggests that the white characters are more likely to show extreme behaviours, whereas those belonging to minorities are more neutral. They are not used in order to suit any gender stereotypes. There were also significant differences in masculinity between doctors of the different shows. E.R. doctors scored 4,73 while the other shows had scores closer to 3. This suggests that characters have become less extreme in their behaviours over time. Their behaviours can less easily be classified in particular stereotypes now than in the past days of E.R. and House M.D.

Table 4. 5 Means comparison professionalism among different demographics

Means comparison professionalism among different demographics										
		Year	**1994-2024**	**1994-2009**	**2004-2012**	**2005-present**	**2015-present**	**2017-2024**	**2018-2023**	**2018-2023**
	Significance (among all shows combined)	**Demographic**	**All shows**	**ER**	**House MD**	**Grey's Anatomy**	**Chicago Med**	**The Good Doctor**	**The Resident**	**New Amsterdam**
Genders	0,17	Female	8,53	15,77	5,60	5,83	11,40	10,50	11,50	11,50
		Male	10,53	13,92	19,80	5,59	11,00	7,80	9,67	9,67
Sexualities	0,21	Straight	10,16	15,06	16,84	6,01	11,10	8,94	11,53	9,82
		Bi	3,54		5,00	2,50				12,50
		Gay	5,60	8,67		4,00		6,00		
Ethnicities	0,18	Non-White	7,79	10,00	12,5	5,50	11,00	6,85	8,70	7,67
	0,224	White	11,17	17,20	17,86	5,83	11,07	15,00	14,83	12,43
		Afro-American	7,79	9,67	17,67	5,54		8,20	11,50	9,50
		Chinese	7,00	3,00		8,25		10,00	3,00	
		Indian	9,22	7,50	6,00		15,50		12,50	3,00
		Hispanic/Latino	2,50			2,50		2,50		
		Jewish	7,88	11,00	8,00			7,00	4,00	
		Other	9,75	14,00			9,00	6,00	6,00	10,50
TV shows	<0,001***	All doctors	9,79	14,55	16,25	5,70	11,00	8,76	11,53	10,23

*Note. Significance levels: * p< .05 ** p< .01 *** p< .001.*

The professional abilities of doctors who belong to minorities are not significantly different from the white majority as can be seen in table 4.6 above. Therefor H8; Doctors who belong to the majority behave in a more professional manner than those who belong in sexual and/or ethnic minorities, has been refuted. Their portrayals were not harmful as they do not perpetuate stereotypes of unprofessional minorities. There were also significant differences in professionalism between doctors of the different shows. E.R. doctors scored 16,25 and House M.D. doctors scored 14,51 while the other shows had scores between 4 and 9. This suggests big displays of professionalism have decreased over time. While I did not find a statistically significant difference in professionalism among male and female doctors, I did find a slight difference in professionalism scores between the two. Male doctors scored 10,53 professionalism points on average, where female doctors scored 8,53 as can be seen in table 4.6 above. The female doctors did not experience such a drop, meaning their abilities now come across as more level. This is quite different from theory which suggested that women would be less

professional and more concerned with the domestic setting (Wilks, 2012). This could be a result of the creative solutions male doctors tend to provide.

Table 4. 6 Means comparison unprofessionalism among different demographics

Means comparison unprofessionalism among different demographics										
		Year	**1994-2024**	**1994-2009**	**2004-2012**	**2005-present**	**2015-present**	**2017-2024**	**2018-2023**	**2018-2023**
	Significance (among all shows combined)	**Demographic**	**All shows**	**ER**	**House MD**	**Grey's Anatomy**	**Chicago Med**	**The Good Doctor**	**The Resident**	**New Amsterdam**
Genders	0,111	Female	2,09	2,00	2,25	2,04	3,00	1,00		2,50
		Male	4,57	6,23	9,92	1,95	1,75	4,00	1,33	2,00
Sexualities	0,689	Straight	3,79	5,29	16,84	2,05	2,29	3,00	1,33	3,25
		Bi	2,17		1,00	2,25				3,00
		Gay	1,29	1,50		1,25				2,00
Ethnicities	0,144	Non-White	2,10	2,33	2,60	2,24	1,67	1,25	1,00	2
	0,877	White	4,42	6,08	10,42	1,86	2,75	6,40	1,70	2,20
		Afro-American	1,89	3,00	2,50	1,60		1,00		2,00
		Chinese	4,33			4,33				2-
		Indian	1,50		1,00		2,00		1,00	
		Hispanic/Latino	2,25			2,25				
		Jewish	2,75	2,00	3,50					
		Other	1,50	1,00				1,50		2,00
TV shows	1,82	All doctors	3,57	4,89	8,11	2,00	2,29	3,00	1,33	2,13

*Note. Significance levels: * p< .05 ** p< .01 *** p< .001.*

Finally I did not find significant differences in unprofessionalism between doctors of the different shows, nor other demographics as can be seen in table 4.7 above. Hence H7; Doctors who belong to sexual and/or ethnic minorities are behave in a more unprofessional manner those who belong to the majority has been refuted. Male doctors score higher on unprofessionalism than female doctors as can be seen above. Therefor H9; Female doctors live up to medical ethical standards more than male doctors has been confirmed. Male doctors also had a tendency to come up with last minute solutions through their rebellious nature. Since their professionalism scores are higher than female doctors on average H10; Male doctors contribute more to curing patients than female doctors, has been confirmed. In conclusion representations of male and female medical professionals in American medical drama tv shows have become more similar in their behaviours. Male and female doctors now exhibit both feminine and masculine tendencies regardless of their gender.

5. Conclusion

My research question was; How have gender portrayals of medical professionals in American medical drama tv shows changed between 1994 and 2024? I found that women are still a minority among doctors. However the shows feature doctors of various ethnicities and sexualities, thereby departing from the white-straight male doctor type. Nurses were treated with more respect than in the past. My first sub question was; What kinds of roles do male and female doctors play? I found that male and female doctors have become quite similar in their behaviour. These fictional female doctors have adapted to the male dominated medical field by adopting more masculine behaviours. They display more masculine than feminine behaviours on average, though the scores are quite close to each other. Male doctors also display quite a lot of feminine behaviours, meaning in the end both genders are relatively neutral. Most doctors were relatively professional, there were no significant differences in professionalism between the different genders. The differences were the biggest between the shows themselves instead. The doctors also became less professional when they leaned too far in one direction regarding their identity. They would get carried away by their emotion and acting out, thereby not doing their job properly. The shows thereby highlight the importance of keeping a level head in medical contexts.

Masculinity was represented as being assertive, brave, calm and collected, confrontational, competitive, contrarian, direct logical, rational, problem solving and promiscuous behaviour (Mendes & Carter, 2008; Krijnen & van Bauwel, 2022). Masculine characters dominated in public speech, lectured, gave out tough love, and showcased strength. Femininity was represented as friendly, caring, co-operative, emotional and empathetic behaviour. Feminine characters were concerned with appearance, pretty and distracted by romance. They had feminine hobbies, and sometimes wore impractical clothing. Professionalism was represented as honesty, humour, creating safe environments, interest in patients as people, learning from patients, looking after colleagues, self-awareness, self-reflection, offering help, organized working method, prioritizing patient comfort and wishes, fraternizing with colleagues, wearing practical clothing, preventive care, respecting patients and subordinates, risking reputation for patients and standing up for oneself (Brennan & Monson, 2014, Barnard, 2016). Unprofessionalism was represented as being abusive towards subordinates, aggressive, distant, distracted by romance, breaking boundaries, fighting out private matters at work, addiction, delivering care inequitably, dodging responsibilities, god complex, ineffective communication, interrupting colleagues, keeping secrets from supervisors, leaving patients behind, not providing safe care, disobeying orders for selfish reasons, rude to colleagues, sucking up to superiors, showmanship, impressing important people and wasting medical resources.

These professional and unprofessional behaviours could be the same no matter their gender. Male and female doctors in that sense did not display particularly different strengths. They instead

shared strengths which suited their profession overall. Whenever the doctors were unprofessional though they often learned from their mistakes. Not learning from mistakes was mostly reserved for antagonists and guest-characters rather than main characters. My second sub question was; How do male and female doctors interact? I found that the doctors usually treated each other with respect. Disrespect was mostly associated with job position rather than gender, ethnicity or sexuality. Older shows featured more disrespect than newer ones as doctors have started to act more professional with time. The doctors supported each other more rather than competing in later shows. Male and female doctors were equally good at coming up with last-minute solutions as well. My third sub question was; What are the differences between male and female doctors? The differences between male and female doctors were actually not very big. Male doctors were overrepresented as unprofessional, however both were also capable of being professional. Male doctors had a greater tendency to break boundaries and disrespect colleagues than female doctors. Both genders were capable of clinical reasoning, empathy, respecting patients, creating a safe environment and respecting patient preferences (Mendes & Carter, 2008; Krijnen & van Bauwel, 2022).

H1; The number of female doctors in medical tv drama's has increased, was refuted as the amount of female doctors remains unrealistically low. H2; Female doctors have become more masculine over time, has been refuted as their masculinity level has remained relatively stable over time. H3; Female doctors have become less feminine over time has been refuted as there were no significant changes per year nor per show for female doctors. H4; Male doctors have become more feminine over time, has been confirmed as there were noticeable changes from show to show. H5; Male doctors have become less masculine over time, has also been confirmed. H6; Doctors who belong to sexual and/or ethnic minorities behave in a more stereotypical manner than doctors who belong to the majority, has been refuted. H7; Doctors who belong to sexual and/or ethnic minorities behave in a more unprofessional manner those who belong to the majority has been refuted. H8; Doctors who belong to the majority behave in a more professional manner than those who belong in sexual and/or ethnic minorities, has been refuted. H9; Female doctors live up to medical ethical standards more than male doctors has been confirmed. H10; Male doctors contribute more to curing patients than female doctors, has been confirmed. H11; Representations of male and female medical professionals in American medical drama tv shows have become more diverse, has been confirmed.

These increasingly similar and therefor equal or emancipated portrayals and diversity in doctors could inspire women and minorities to also enter the medical field (Suxrobjonovich & Baxtiyarovich, 2025; Saleem et al, 2014; Quick, 2009). It could also make them less afraid of discrimination in a medical context they are now properly represented. Instead of being used as a joke or as a way of showing women and minorities are less capable the shows highlight how well they can perform in such a professional context. Male doctor portrayals are more unprofessional sometimes in order to make them seem rebellious. Similar portrayals might not work for female characters, because they are

still under so much scrutiny in these high career positions. The shows reflect reality relatively accurately all though it may be important for writers to include even more women. This could be a result of male-dominated writers rooms where male doctors are written and cast, because people hire people who are like themselves. Simultaneously it is interesting to note how much these shows highlight how challenging it can be to build a family while holding a medical career. Here the focus is still mostly on women, though male characters sometimes also put their duties aside for the sake of their children.

This project has made me more aware of the power streaming services hold over their customers (Vermeire et al., 2024; Coavoux & Aussant, 2024; Sharma, 2016). I created subscriptions for four streaming services on top of the ones we already owned in order to reach the content for analysis. Alternative routes towards content were closed off or made extremely expensive, hence I became dependant on streaming. Despite difficulties, my method was very suitable for seeking historical trends within context. Unfortunately the sample was still a bit too limited to seek causal relations. Hence it may be relevant to continue this research by using one episode per year per show for example. As this would allow for regressions, for even more exact statistical analysis. It could also be relevant to look into the shows made after 2015 a bit more as those could give an insight into current media messaging. In a similar vein it may be interesting to look into the most recent and popular medical tv drama The Pitt starring Noah Wyle, to compare it to what came before. The show received lots of praise for medical accuracy and realism, which has not been seen before.

While Europe and the Netherlands in particular have also known medical tv shows of their own, none have reached the cultural impact which the North American products achieved (Scott, 2001). The power the U.S.A. holds over media production remains strong and noticeable, especially in countries with a close cultural proximity (Craig et al., 2009; Roudometof, 2015). American productions promoted values such as the American dream, freedom, equality, prosperity and the concepts individualism, capitalism and democracy (Ibbi, 2013; Catley, 1997). It could also be relevant to look into interactions between doctors and nurses a bit more closely. Nurses are still frequently female, meaning there are some interesting gender dynamics at play between them and the majority male doctors. They for example have a tendency to get romantically involved with each other. Nurse portrayals in general could also be relevant to investigate as these new shows came with new nurse portrayals. They became an even bigger part of main casts in Chicago Med and The Resident.

Finally it may be interesting to conduct more audience research as there has not been a lot of audience research for Chicago Med, The Resident and New Amsterdam yet. These shows are quite different from predecessors such as E.R. and House M.D. and could hence have different effects on viewers. These shows highlight the dark sides of big pharma and for-profit more than shows that came before hence viewers could get slightly scared of healthcare. Simultaneously they are a great way to

attract attention for such issues. Medical students could also be affected by seeing these shows as particular doctors play into their fantasies of how to deal with patients (Enayet, 2018). Fictional doctors can be extremely professional and heroic, but also very abusive towards difficult patients.

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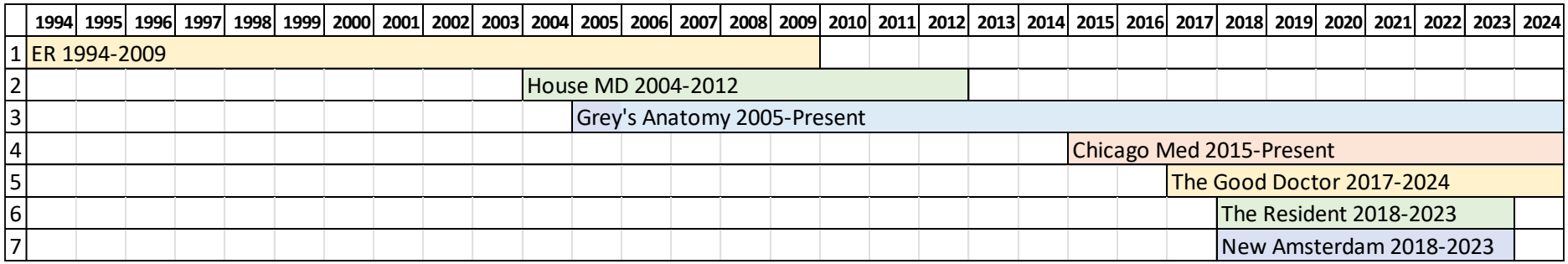
Appendix A: Sample medical tv show episodes

Table A 1 Sample medical tv show episodes

Sample medical tv show episodes									
Show	**Platform**			**No.**	**S.**	**E.**	**Title**	**Year**	**Analysis**
E.R.	HBO max	1	1	23	1	23	Love Among the Ruins	1995	Qualitative & Quantitative
		2	2	80	4	14	Family Practice	1998	Quantitative
		3	3	137	7	5	Flight of Fancy	2000	Quantitative
		4	4	194	9	18	Finders Keepers	2003	Quantitative
		5	5	251	12	9	I Do	2005	Quantitative
		6	6	309	15	3	The Book of Abby	2008	Quantitative
House	Netflix	1	7	24	2	2	Autopsy	2005	Qualitative & Quantitative
		2	8	81	4	11	Frozen	2008	Quantitative
		3	9	138	7	6	Office Politics	2010	Quantitative
Grey's Anatomy	Disney+	1	10	25	2	16	It's the End of the World	2006	Qualitative & Quantitative
		2	11	82	5	4	Brave New World	2008	Quantitative
		3	12	139	7	13	Don't Deceive Me (Please Don't Go)	2011	Quantitative
		4	13	196	9	24	Perfect Storm	2013	Quantitative
		5	14	253	12	8	Things We Lost in the Fire	2015	Quantitative
		6	15	310	14	17	One Day Like This	2018	Quantitative
		7	16	367	17	4	You'll Never Walk Alone	2020	Quantitative
		8	17	424	20	5	Never Felt So Alone	2024	Quantitative
Chicago Med	Prime Video	1	18	51	3	10	Down By Law	2018	Qualitative & Quantitative
		2	19	108	6	5	When Your Heart Rules Your Head	2021	Quantitative
		3	20	165	9	2	This Town Ain't Big Enough for Both of Us	2024	Quantitative
The Good Doctor	Netflix	1	21	47	3	11	Fractured	2020	Qualitative & Quantitative
		2	22	104	6	10	Quiet and Loud	2023	Quantitative
The Resident	Netflix	1	23	30	2	16	Adverse Events	2019	Qualitative & Quantitative
		2	24	87	5	16	6 Volts	2022	Quantitative
New Amsterdam	Netflix	1	25	7	1	7	Domino Effect	2018	Qualitative & Quantitative
		2	26	64	4	10	Death is the Rule. Life is the Exception	2021	Quantitative

Appendix B: Timelines medical tv shows

Figure B 1 Timelines medical tv shows



Appendix C: Quantitative codebooks

Table C 1 Codebook medical professionalism

Codebook medical professionalism			
Professional/ethical	**Example/clarification**	**Unprofessional/unethical**	**Example/clarification**
Avoid patient exploitation	Preventing fellow staff, the hospital and big pharma from taking advantage of patients	Exploiting patients	Chasing profit or blackmailing
Alleviate symptoms	Providing the proper treatment and medication to make patients feel better	Not alleviating symptoms	Ignoring symptoms or not properly treating them, thereby letting patients suffer
Enhancing patient agency	Inform patients to let them make their own decisions	Decreasing patient agency	Not informing patients thereby not allowing them to make their own decisions
Trustworthiness	Being truthful and maintaining privacy and ethics	Untrustworthiness	Being untruthful, not maintaining privacy and breaking ethics
Provide safe, high quality and effective care	Providing proper treatment, in a safe and organised manner	Not providing safe, high quality and effective care	Providing improper, unsafe treatment in an unorganised manner
Appropriate behaviour in specific contexts	Using polite language and showing compassion and understanding, while also being firm when needed	Inappropriate behaviour in specific contexts	Using impolite language, not compassion and understanding and not being firm when needed
Creative solutions/innovation	Finding new solutions to difficult situations	Sticking to outdated methods	Sticking to outdated techniques, because it is easier and cheaper
Systematic procedures, knowledge and skills	Knowing steps to the right procedures and applying them	Unsystematic procedures, lack of knowledge and skills	Forgetting steps of the correct procedures
Accountability	Taking responsibility and owning up to mistakes	Unaccountability	Not taking responsibility nor owning up to mistakes

Maintenance of ethics	Doing what is best for the patient and aligns with their wishes, even when this is difficult	Not maintaining ethics	Not doing what is best for the patient and aligns with their wishes, when things get difficult
Appropriate relations	Intimate relationships without power imbalances	Inappropriate relations	Intimate relations with power imbalances
Professional presentation	Wearing practical, hygienic and particularly put-together clothing	Unprofessional presentation	Wearing impractical, unhygienic or particularly un-put-together clothing
Co-operation	Properly communicating and working together with colleagues	Poor co-operation	Improperly communicating and working with colleagues, leading to conflict
Organised working methods	Proper scheduling and administration	Unorganised working methods	Improper scheduling and administration
Effective communication	Adapting medical language to allow proper understanding among patients and colleagues	Ineffective communication	Not adapting medical language to allow proper understanding among patients and colleagues
Self-awareness	Knowing yourself and the effect you might have on others	Self-unawareness	Not knowing yourself and the effect you might have on others
Reflexivity	Introspection and self-reflection	Lack of reflexivity	Lack of introspection and self-reflection
Clinical reasoning	Using proper deduction in order to determine what is ailing patients	Improper clinical reasoning	Using improper deduction in order to determine what is ailing patients
Interest in patients as people	Listening to stories patients tell and asking them questions, to make diagnosis easier and make patients feel comfortable	Disinterest in patients as people	Ignoring the stories patients tell and not asking them questions, thereby making diagnosis harder and making patients feel uncomfortable
Respectful treatment of patients	Taking patients seriously and using polite language	Disrespectful treatment of patients	Not taking patients seriously or using derogatory terms
Advocating on patients behalf	Arguing for patients needs towards colleagues, the hospital or even big pharma	Not advocating on patients behalf	Not arguing for patients needs towards colleagues, the hospital or even big pharma
Maintaining boundaries	Not involving oneself in matters which are too private nor showing abusive behaviours	Breaking boundaries	Involving oneself in matters which are too private and showing abusive behaviours

Addressing own gaps in knowledge	Studying new phenomena when necessary	Not adressing own gaps in knowledge	Not studying new phenomena when necessary
Respecting colleagues	Taking colleagues seriously and using polite language	Disrespecting colleagues	Not taking colleagues seriously or using derogatory terms
Maintaining patient confidentiality	Keeping sensitive information hidden in line with patient wishes	Not maintaining patient confidentiality	Sharing sensitive information against patient wishes
Respecting patient preferences	Giving the treatment patients request after informing them to the best of your abilities	Disrespecting patient preferences	Not giving the treatment patients request and improperly informing them about their options
Ethical stewardship of medical resources	Protecting medical resources and sharing them fairly	Wasting medical resources	Wasting medical resources
Delivering care equitably	Giving all parties equal access to care as needed	Delivering care inequitably	Giving certain parties more care than others, when they don't actually need it
Looking after oneself	Looking after one's own physical and mental health in order to continue to provide proper care	Not looking after oneself	Not looking after ones own physical and mental health in thereby decreasing the quality of care one is able to provide
Looking after colleagues	Looking after colleagues physical and mental health in order to continue to provide proper care	Not looking after colleagues	Not looking after colleagues physical and mental health in thereby decreasing the quality of care one is able to provide
Work-life balance	Taking time to rest when needed	Workaholic	Working so much that it becomes harmful
Creating a safe environment	Not showing anger nor judgement in sensitive situations	Creating an unsafe environment	Showing anger or judgement in sensitive situations
Disobedience for patient	Disobeying orders or rules for example from the medical system in order to help the patient	Disobedience for selfish reasons	Disobeying orders or rules for example from the medical system for personal gain

Table C 2 Codebook gender stereotypes

Codebook gender stereotypes			
Masculine	**Example/clarification**	**Feminine**	**Example/clarification**
Dominant	Taking control over situations and people	Submissive	Letting others control you and being powerless in situations
Aggressive	Yelling, using rude language or resorting to violence	Meek	Being quiet, polite and powerless
Rational	Using logic and deduction for decision-making	Emotional	Following instincts and using empathic abilities to make decisions
Protective	Using strength or intelligence to protect other people	Powerless	Unable to influence situations
Tough	Good at dealing with adversity	Caring/nurturing	Looking after people around you
Independent	Capable of accomplishing things without help	Dependant	Needing a lot of assistance
In workforce	Having a job and focussing on that	Domestic setting	Having a family and focussing on that
Rugged	Scruffy and strong looking	Pretty	Neat and elegant looking
Workers	Focussing on career	Mothers	Looking after children
Breadwinners	Making money	Consumers	Spending money
Active	Taking action in situations	Passive	Waiting in situations
Promiscuous	Many sexual partners	Promiscuous	Few sexual partners
Direct	Dealing with uncomfortable situations head on	Indirect	Working around uncomfortable situations
Confident	Aware of own worth and outspoken	Shy	Insecure and quiet
Problem solving	Coming up with creative solutions to difficult situations	Sympathetic	Relating to other people
Report	Building a good reputation	Support	Supporting others in need especially emotionally
Lecturing	Sharing one's own opinion in a longwinded manner	Listening	Listening to peoples thoughts and feelings
Opposition	Opposing the general consensus on a situation	Connection	Seeking to relate to other people to make them feel at ease
Assertive	Making one's own decisions and standing by them	Warm	Smiley, understanding and kind

Powerful	Being in a position of power or having physical strength	Friendly	Joking, making nice conversation and smiling to make people feel comfortable
Confrontational	Confronting people around about their behaviour	Facilitative	Working together with people to meet their needs
Competitive	Competing over important positions	Collaborative	Cooperating to work towards a common goal
Dominating in public speech	Not letting others share their opinion by speaking a lot	Quiet	Not sharing ones opinion
Task/outcome oriented	Focussing on the end-result	Person/process oriented	Focussing on the process and people involved
Brave	Willing to engage in risky or dangerous behaviours	Fearful	Unwilling to engage in risky or dangerous behaviours
Rude	Using obscenities, bringing up taboo topics and disrespecting people	Polite	Using neat language, sticking to safe topics and respecting people
Strong	Physical strength	Frail	Physical weakness
Unromantic	Bad romantic at relationships	Romantic	Good at romantic relationships

Appendix D: Code networks

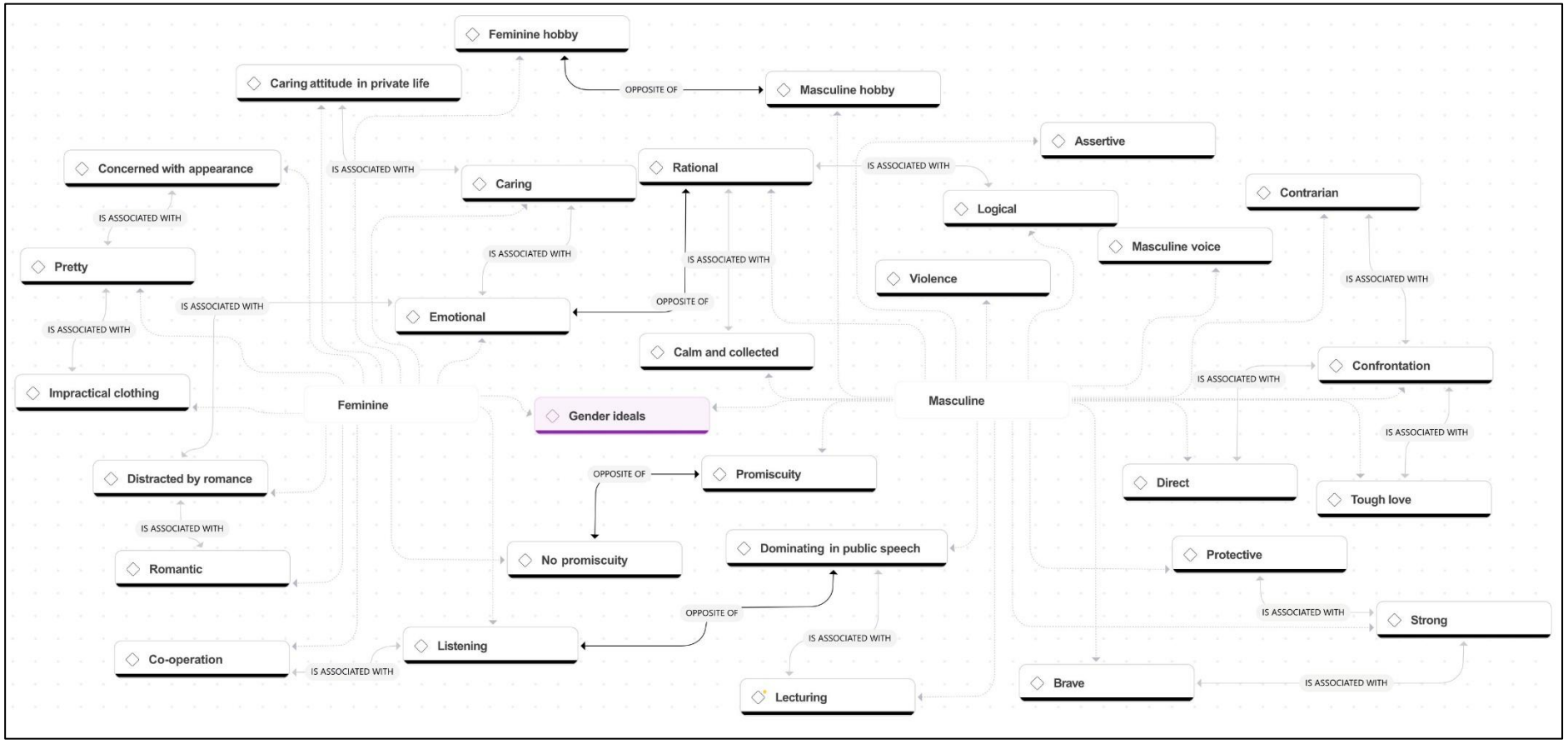


Figure D 1 Code network Gender Ideals

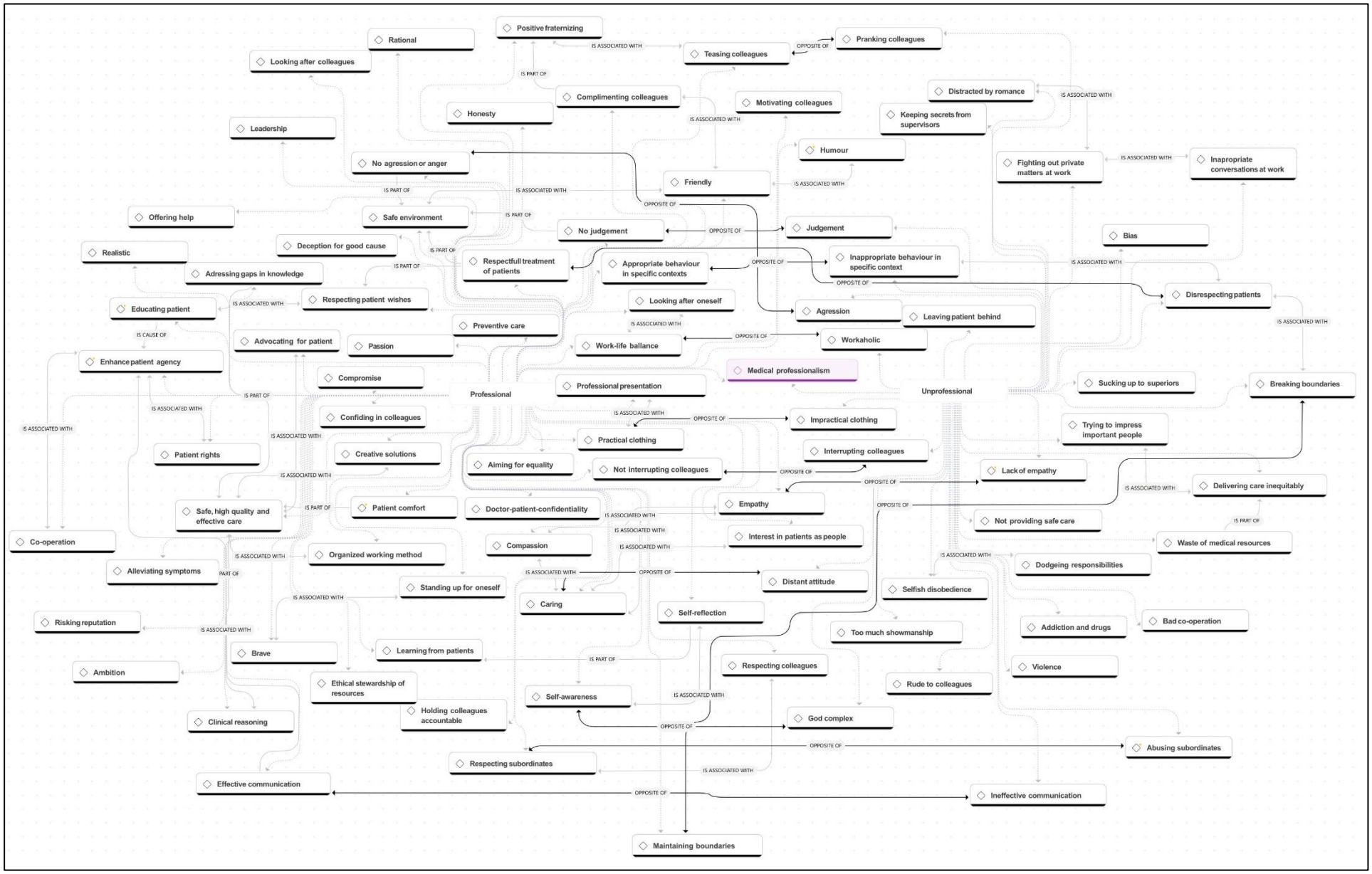


Figure D 2 Code network Medical professionalism

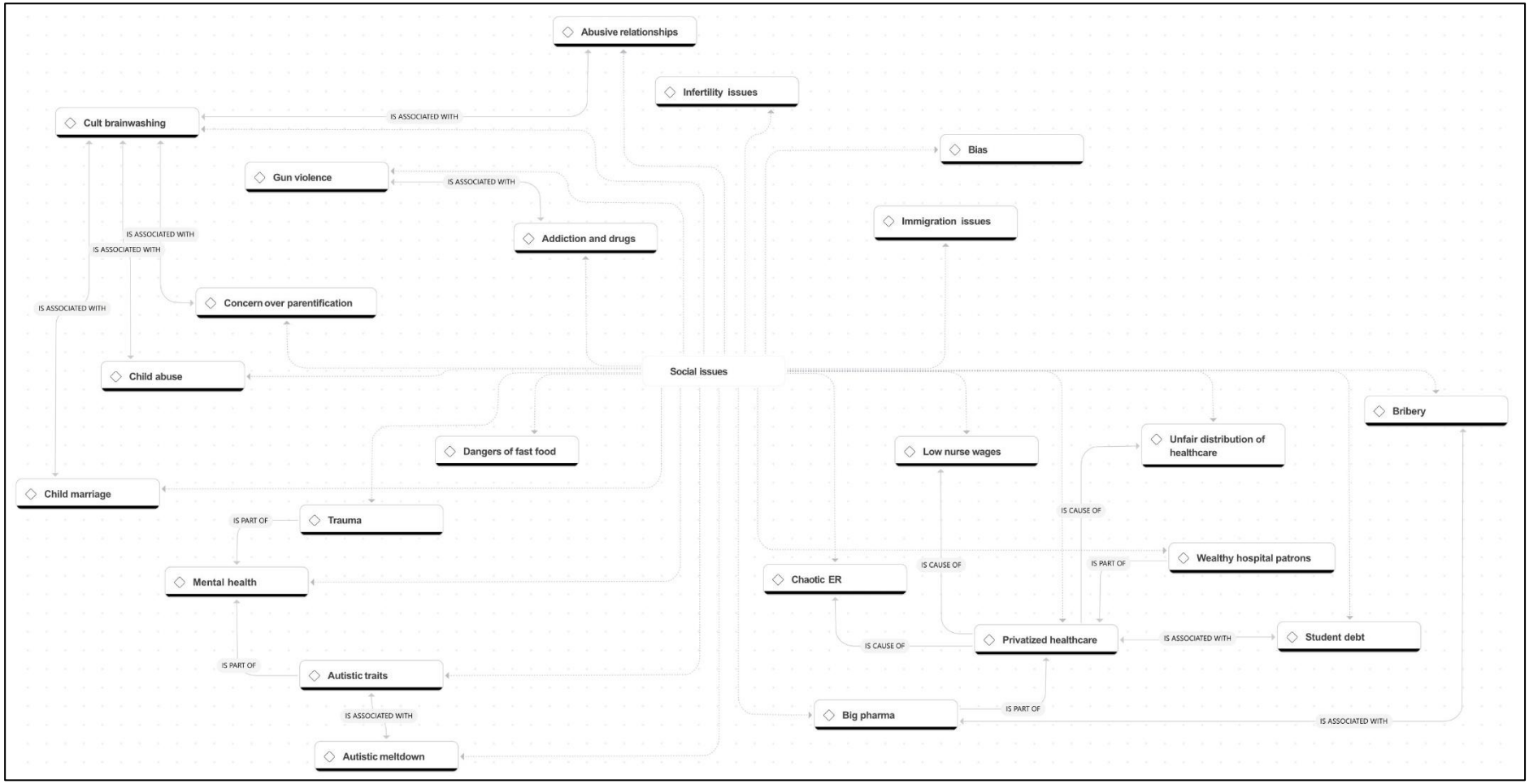


Figure D 3 Code network Social issues

Appendix E: Patient information

Table E 1 Patient information per episode

Patient information per episode								
Show	**S.**	**E.**	**Title**	**Year**	**Patient name**	**Gender**	**Age**	**Ethnicity**	**Diagnosis**
E.R.	1	23	Love Among the Ruins	1995	Unknown	Male	40-50	Unknown	Head wound from violence
					Donald Costanza	Male	40	White	Attempted suicide through car crash
					Howard Davis	Male	40-55	White	Cut in hand from kitchen accident
	4	14	Family Practice	1998	Ruth Greene	Female	60-70	White	Aneurysm
	7	5	Flight of Fancy	2000	Jason	Male	0-12	Mexican	Ear ache
					Tom	Male	20-30	White	Heart attack
					Unknown	Male	20-30	Asian	Pencil stuck in chest
					Unknown	Male	12-18	White	Hand injury, HIV and hit by a car
					Emma	Female	12-18	White	HIV
					Unknown	Male	12-18	White	Cut in arm
	9	18	Finders Keepers	2003	Unknown	Male	20-30	Afro-American	Nail from nail gun in belly
					Unknown	Male	20-30	White	Broken foot
					Unknown	Female	50-60	Afro-American	High blood pressure and diabetes
					Nicky Prumer	Male	20-30	White	Dislocated arm, broken ribs and drug addiction
					Jennifer	Female	24	White	Pregnant and tumour in stomach
					Unknown	Female	40-50	White	Aneurysm
					Mr. Russian	Male	30-40	White	Car crash
					Pilar	Female	9	Mexican	Car crash
					Mindy	Female	15-20	White	Chlamydia
	12	9	I Do	2005	Glenda Bardelarinski	Female	20-30	White	Head wound and drunk
					Unknown	Male	5-12	White	Pneumonia
					Harry Royman	Male	70	White	Drowning in ice
	15	3	The Book of Abby	2008	Paul Traylor	Male	34	Afro-American	Gun shot wound in chest
					Larry Weddington	Male	8-12	White	Throwing up
					Larry Weddington	Male	8-12	White	Throwing up

					Unknown	Male	50-60	Jewish	Black eye
					Roxanne Gaines	Female	60-70	White	Hypertension, oedema, insomnia and diabetes
House	2	2	Autopsy	2005	Andie	Female	9	White	Cancer in the brain and in the heart
					Unknown	Male	20-35	Asian	Circumcision with boxcutters
	4	11	Frozen	2008	Dr. Cate Milton	Female	20-35	White	Broken toe and blood clots
	7	6	Office Politics	2010	Joe Dugan	Male		White	Hepatitis C
					Unknown	Male	20-30	White	Ruptured Achilles heel
Grey's Anatomy	2	16	It's the End of the World	2006	Tucker Jones	Male	35	Afro-American	Brain damage from a car crash
					James Carlson	Male	46	White	Undetonated bomb stuck in abdomen
					Mindy Carlson	Female	40-50	White	Mental shock from witnessing an accident
	5	4	Brave New World	2008	Unknown	Male	60-70	White	Cut and tumour in head
					Duncan	Male	8	White	Unknown
					Unknown	Female	30-40	White	Rash and anaphylaxis
	7	13	Don't Deceive Me (Please Don't Go)	2011	Daniel Cobb	Male	40-50	Afro-American	Alzheimer’s disease
					Martha Elkin	Female	75	White	Multivessel coronary disease
					Dr. Callie Torres	Female	20-30	Mexican	Pregnant
	9	24	Perfect Storm	2013	Dr. Grey	Female	44	White	Giving birth to a baby laying the wrong way
					James Strickland	Male	?	Afro-American	Bleeding in the heart
					Dr. Jackson Avery	Male	32	Afro-American	Burns
	12	8	Things We Lost in the Fire	2015	Casey	Male	60-70	White	Severe burns all over
					Charlotte	Female	30-40	White	Burn on behind
					Unknown	Male	30-40	White	Burn on abdomen
	14	17	One Day Like This	2018	Dr. Marsh	Male	43	White	Side-effects from a kidney transplant
					Eli Rigler	Male	60-70	Jewish	Severe rash from antibiotics
	17	4	You'll Never Walk Alone	2020	Dr. Grey	Female	51	White	Covid-19
					Dave Oyadomari	Male	37	Asian	Head wound from fall and Covid-19
	20	5	Never Felt So Alone	2024	Eddie Oliver	Male	18-25	Afro-American	Dislocated shoulder and suicide ideation
					Sophia Valdez	Female	26	Mexican	Impaled by a beam
Chicago Med	3	10	Down By Law	2018	Margo Dimilio	Female	30-40	White	Heart attack
					Unknown	Male	19	Afro-American	Gun shot wound to the chest
					Barry Vaughn	Male	30-40	Afro-American	Gun shot wound to the leg

					Lindsay	Female	14	White	Uterine cancer
					Ben Samuels	Male	20-30	White	Violent OCD
					Miguel Garcia	Male	55	White	Gun shot wound to the chest
					Dr. Manning	Female	25-35	White	Concussion
	6	5	When Your Heart Rules Your Head	2021	Dr. Coleman	Male	60-70	Jamaican	Drug abuse and mixed meds
					Mrs. Coleman	Female	60-70	Jamaican	Drug overdose
					Mr. Booker	Male	30-40	Afro-American	Heart failure due to Covid-19
					Anna Charles	Female	15-20	White	Unplanned pregnancy
	9	2	This Town Ain't Big Enough for Both of Us	2024	Sheryl Martin	Female	30-40	White	Hit by a car
					Dr. Archer	Male	63	White	Kidney failure
					Louis Obrador	Male	20-30	Venezuelan	Fight wounds and flea infection
					Allision Livine	Female	39	White	Lung infection
The Good Doctor	3	11	Fractured	2020	Kerry	Female	30-45	Afro-American	Broken leg and drug addiction
					Luca	Male	30-40	Mexican	Drug balloons stuck in belly
	6	10	Quiet and Loud	2023	Lea Dillalo	Female	34	White	Pregnancy and damaged uterine lining
					Drew	Male	17	White	Gardener's syndrome
The Resident	2	16	Adverse Events	2019	Henry Barnett	Male	0-12	White	Malfunctioning Vagus Nerve stimulator
					Marylin Spoelstra	Female	50-60	White	Gallbladder attacks and diabetes
					Simon Ortiz	Male	60-70	Mexican	Tumour in the heart and heart infection
	5	16	6 Volts	2022	Eliza Brockton	Female	32	White	Attempted suicide by jumping
					Unknown	Female	50-60	Afro-American	Kidney failure
					Pastor Aaron	Male	30-40	Afro-American	Heart attack due to heart catheter
New Amsterdam	1	7	Domino Effect	2018	Matthew Levy	Male	30-40	White	Liver failure
					Aminah Ali	Female	30-40	Indian/Pakistani	Liver failure
					Gianna Morales	Female	12	Mexican	Cystic fibrosis
					Jemma	Female	12-18	White	Anger management issues
	4	10	Death is the Rule. Life is the Exception	2021	Kaelen	Male	12-18	White	Infection with an antibiotic resistant virus
					Dr. Walsh	Male	30	White	Infection with an antibiotic resistant virus
					Kaelen's mother	Female	35-45	White	Severe mental shock from losing their son

Appendix F: Highest scores per show

Table F 1 Most feminine doctor per show

Most feminine doctor per show							
	Name		**Gender**	**Show**		**Behaviours**	
1	Nurse/Dr. Lockheart	12	Female	E.R.	4,7	Support	5
						Friendliness	3
						Connection	2
2	Dr. Lauren Bloom	6,5	Female	New Amsterdam	3,9	Caring/nurturing	3
						Friendliness	3
						Support	2
3	Dr. Robert Chase	6	Male	House M.D.	2,79	Caring/nurturing	3
						Friendliness	2
4	Dr. April Kepner	6	Female	Grey's Anatomy	2,93	Emotional	2
						Polite	2
4	Dr. George O'Malley	6	Male	Grey's Anatomy	2,93	Emotional	3
5	Dr. Jordan Allen	6	Female	The Good Doctor	3		
6	Dr. Conrad Hawkins	6	Male	The Resident	3,33	Emotional	2
						Support	2
7	Dr. Will Halstead	5	Male	Chicago Med	2,93		

Table F 2 Most masculine doctor per show

Most masculine doctor per show							
	Name		**Gender**	**Show**		**Behaviours**	
1	Dr. Robert Romano	29	Male	E.R.	7,1	Rude	21
						Direct	6
						Dominating in public speech	5
						Confrontation	3
2	Dr. Gregory House	23	Male	House M.D.	6,7	Direct	8
						Rational	6
						Rude	5
						Opposition	4
3	Dr. Shaun Murphy	11	Male	The Good Doctor	3,3	Direct	4
						Rational	2
						Protective	2
4	Dr. Preston Burke	8	Male	Grey's Anatomy	3,33	Protective	3
5	Dr. Natalie Manning	7	Female	Chicago Med	3,4	Direct	2
						Brave	2
6	Dr. Lauren Bloom	4,5	Female	New Amsterdam	2,92	Assertive	2
6	Dr. Vijay Kapoor	4,5	Male	New Amsterdam	2,92		
7	Dr. Conrad Hawkins	4	Male	The Resident	3,11	Opposition	2
7	Dr. Devon Pravesh	4	Male	The Resident	3,11		

Table F 3 Most professional doctor per show

Most professional doctor per show							
	Name		**Gender**	**Show**		**Behaviours**	
1	Dr. Gregory House	50	Male	House M.D.	16	Appropriate humour	24
						Clinical reasoning	7
						Creating a safe environment	5
						Advocating on patients behalf	5
2	Nurse/Dr. Lockheart	50	Female	E.R.	15	Appropriate humour	11
						Effective communication	7
						Empathy	6
						Creating a safe environment	5
3	Dr. Noah Sexton	23	Male	Chicago Med	11	Empathy	5
						Creating a safe environment	2
4	Dr. Conrad Hawkins	20	Male	The Resident	12	Clinical reasoning	3
						Advocating on patients behalf	3
						Effective communication	2
						Appropriate humour	2
5	Dr. April Kepner	17	Female	Grey's Anatomy	5,7	Respecting patient preferences	2
						Empathy	2
						Insuring patient comfort	2
6	Dr. Iggy Frome	16	Male	New Amsterdam	10	Appropriate humour	4
						Empathy	3
7	Dr. Morgan Reznick	15	Female	The Good Doctor	8,8	Appropriate humour	2
						Empathy	2
						Advocating on patients behalf	2
						Respecting patient preferences	2
7	Dr. Shaun Murphy	15	Male	The Good Doctor	8,8	Clinical reasoning	2
						Effective communication	2
						Respecting patient preferences	2
						Respecting colleagues	2

Table F 4 Most unprofessional doctor per show

Most unprofessional doctor per show							
	Name		**Gender**	**Show**		**Behaviours**	
1	Dr. Gregory House	34	Male	House M.D.	8,1	Breaking boundaries	9
						Disrespecting colleagues	6
						Untrustworthiness	3
						Wasting medical resources	3
2	Dr. Robert Romano	29	Male	E.R.	4,9	Disrespecting colleagues	14
						Inappropriate humour	7
						Not looking after colleagues	5
						Breaking boundaries	4
3	Dr. Shaun Murphy	6,5	Male	The Good Doctor	3	Disrespecting colleagues	3
						Inappropriate behaviour in specific context	2
						Not looking after oneself	2
4	Dr. Alex Karev	6	Male	Grey's Anatomy	2	Disrespecting colleagues	3
						Lack of empathy	3
5	Dr. Max Goodwin	5	Male	New Amsterdam	2,13	Ineffective communication	2
6	Dr. Natalie Manning	3,5	Female	Chicago Med	2,29	Not looking after oneself	4
7	Dr. Randolph Bell	2	Male	The Resident	1,33	Not looking after oneself	2